Tribal Medicaid Administrative Claiming

TMAC

Alaska

Tribal Medicaid
Outreach and Linkage Plan

TMAC TRIBAL MANAGER GUIDE

Guide Contents

Introduction	Pages 3-5
Medicaid Outreach & Enrollment	Pages 6-8
Quarterly Submission & Reporting	Pages 9-13
Quarterly Invoicing	Pages 12-14
Reconciliation & Audit	Pages 14
Summary	Pages 15-18
Appendix A: Flow Chart	Page 19
Appendix B: Acronyms	Page 20
Appendix C: How to Establish DSM	Page 21
Appendix D: How to Submit an ACH	Page 22
Appendix E: How to Receive an EFT	Page 23
Appendix F: TMAC Forms	Page 24
Appendix G: TMAC Contact List	Page 25

Introduction to TMAC

GOAL: Increase enrollment and retention of Alaska Natives and American Indians in DenaliCare and Denali KidCare via outreach, enrollment and renewal activities

Introduction to TMAC

New Methodology:

- The new TMAC plan requires outreach and attestation.
- Payment is based on a cost-based fee multiplied by unduplicated recipients served in the quarter.

Introduction to TMAC

1

Tribe / THO Front Line Staff

Outreach at patient registration & at community events (ex. health fairs)

2

Tribe / THO Manager or Designated Fiscal Staff

Compile patient registration & outreach lists

Compile unduplicated Medicaid services recipient list

3

Tribe / THO

Submit Lists w/ Attestation

Submit the non-Federal portion of the Tribal/state match via IGT thru EFT/ACH/EDI

Submit Administrative Fee Invoice via DSM and email

4

State of Alaska

DHSS/HCS

Payment of administrative fee to Tribes & THO's within several days thru EFT/ACH/EDI

5

State of Alaska DHSS/HCS

Reconciliation of Medicaid services recipient list against Medicaid claims list

TMAC Outreach & Enrollment

Medicaid and Denali KidCare Application

http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Add to your internet favorites bar

TMAC Outreach

Registration	Health Fairs	Other Community Events
• Was registrant screened and enrolled for Denali Care / Denali Kid Care?	• Was Medicaid outreach provided by the Tribe or THO at Health Fairs?	• Was Medicaid outreach provided by the Tribe or THO at other events?

Provide full names of all individuals outreached

Front line staff should look at these sites and be familiar with them – and keep checking as links sometimes change

TMAC Outreach

How to Apply for Medicaid/Denali Kid Care Health Insurance Coverage

Apply Online for public/private insurance on this federally facilitated marketplace

https://www.healthcare.gov

ARIES

Alaska Resource for Integrated Eligibility Services

Self Service Portal

https://aries.alaska.gov/screener/?logIn=N

For Denali Care and Denali KidCare

Need assistance? Contact a DPA office for additional information.

Quarterly Outreach Submission

Form #1

Click Here For TMAC Forms

To be completed by front line staff

TMAC Outreach List

Tribal Health Organization	TMAC Manager Name & Telephone Number	FFY YEAR / QUARTER
Click Here		FFY16, QTR2 (Jan 1, 2016 - Mar 31, 2016)

Due: 45th day after the close of the prior quarter. Submit via DSM to: DHCS.TMAC@direct.dhss.akhie.com

	Alaska Native or American Indian			Non Native Beneficiary		
	Under 21	Adults 21-64	65 or Older	Under 21	Adults 21-64	65 or Older
TOTAL ENTRIES						
	0	0	0	0	0	0
Grand Total Outreach				0		

	Date	Name	Alaska Native or American Indian			Non Native Beneficiary		
			Under 21	Adults 21-64	65 or Older	Under 21	Adults 21-64	65 or Older
	10/1/2015	*Susie Smith*		*1*				
1								
2								
3								

Quarterly Outreach Attestation

Form #2

Tribal Outreach Attestation Submission

(To be submitted through the DSM email address below along with list of patient registration and outreach lists)
Deadline: 45th day after the close of the prior quarter
Send to: DHCS.TMAC@direct.dhss.akhie.com

Tribe or Tribal Health Organization: _____

TMAC Manager: _____ Tel: _____

DSM: _____

Email: _____

Address: _____

City: _____ Zip: _____

Please Specify Quarter and FFY: Click here to select QTR and FFY

Please Specify Outreach Numbers

# of Individuals Outreached at Registration	
# of Individuals Outreached at Other: (please specify below)	
Other:	
Other:	
Other:	
Total # of Individuals Outreached	

I, _____, (TMAC Manager – blue ink) certify and attest that all patient registrants presenting in the undersigned quarter, for the Tribal health medical services, were outreached and provided an explanation, either verbally or visually, of the DenaliCare and/or Denali KidCare public insurance programs, for which they may be eligible, including both local Tribal contact and state contact information.

In addition, If this Tribe or Tribal health organization is the recipient of a CMS Connecting Kids to Coverage Grant or any other CMS grant award for Medicaid administrative activities, I certify and attest that the children who have been outreached and provided application and renewal assistance under the Connecting Kids to Coverage grant or any other federal grant funding for Medicaid outreach and enrollment assistance may also appear in this list since the aggregate total of children outreached and provided application and renewal assistance will likely be a part of this list; however, those children will be eliminated from the unduplicated list of recipients that the Tribe and Tribal health organization submit along with the invoice for payment under TMAC, to carve out these children to prevent duplication of payment for these Medicaid administrative activities (please refer to corresponding invoice attestation).

TMAC Manager: _____

TMAC Manager Signature: _____

Date: _____

See Appendix C for DSM setup

1st Attestation

Click Here For TMAC Forms

Quarterly Unduplicated DenaliCare / Denali KidCare Recipient List

Deadline: 45th day after the close of the prior quarter

Submit via Direct Secure Messaging (DSM)*
DHCS.TMAC@direct.dhss.akhie.com
* See Appendix C

To be completed by the TMAC Manager or designated fiscal staff

Form #3

Denali Care / Denali KidCare Unduplicated Medicaid Recipients

Tribe or THO	QTR / FFY	This section will auto tabulate						
Select Tribe or THO from drop down list (click here)	Select from drop down list (click here)	Under 21	Adults 21-64	65 or Older	Under 21	Adults 21-64	65 or Older	Total
		0	0	0	0	0	0	0

Due: 45th day after the close of the prior quarter. Submit via DSM to: DHCS.TMAC@direct.dhss.akhie.com

	DenaliCare / Denali KidCare Identifiers			Alaska Native or American Indian			Non Native Beneficiary			Total
	Recipient Medicaid ID Number	Recipient Name	Date of Birth	Under 21	Adults 21-64	65 or Older	Under 21	Adults 21-64	65 or Older	
1	1234567890	Joe Example	1/1/1985		1					1
2										
3										
4										
5										
6										
7										
8										
9										

Click Here For TMAC Forms

FFY means **Federal Fiscal Year** and runs October thru the following September. Therefore, the **FFY quarters** are **Q1** = October, November & December, **Q2** = January, February & March, **Q3** = April, May & June, and **Q4** = July, August & September.

Quarterly Invoice of Administrative Fees

Form #4

Tribal Medicaid Administrative Claiming

Invoice and Attestation Submission

Due: 45th day after the close of the prior quarter. Submit via DSM to: DHCS.TMAC@direct.dhss.akhie.com

State of Alaska
Department of Health & Social Services
Health Care Services
PO Box 110660
Juneau, AK 99811-0660

Claiming Tribe or THO	Select Tribe or THO from drop down list (click here)
Street or PO Box	
City, State	
FFY / Quarter	Select from drop down list (click here)
TMAC Manager	
TMAC Manager Telephone #	
TMAC Manager Email	

INVOICE

Description	Quantity	Rate	Amount
Total unduplicated number of DenaliCare / Denali KidCare enrolled individuals provided with services	12	#N/A	#N/A
Non-Federal portion / Required FFP to be sent via IGT electronic transfer			#N/A

☑ Check here if funds were transferred electronically

Prepared by	Telephone #	Date

I, _____, certify (CFO in blue ink) under penalty of perjury that the information provided on this invoice is true and correct, based on the approved methodology outlined in Section III and further defined in Section IV of the Tribal Medicaid Outreach and Linkage Plan for the period referenced and that the funds transferred via IGT from the Tribes to the State of Alaska Department of Health & Social Services represent the non-Federal share of the Federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these public funds are not Federal funds and have not been and will not be subsequently used for Federal match in this or any other program. I have notice that the information is to be used for filing of a claim with the Federal Government for Federal Funds and knowing misrepresentation constitutes violation of the Federal False Claims Act. If this Tribe or Tribal health organization is the recipient of a CMS Connecting Kids to Coverage Grant or any other CMS grant award for Medicaid administrative activities, I further certify that the children outreached and provided application and renewal assistance under this Tribe's or Tribal health organization's CMS Connecting Kids to Coverage grant funding or any other federal grant funding for Medicaid outreach and enrollment assistance have been carved out from the list of unduplicated recipients of services provided to DHCS through DSM which has prevented any duplication of payment related to Medicaid administrative activities provided otherwise.

Date: _____ Signature: _____

Claiming Tribe or THO: drop down selection list; enter address (address, city, state, zip)

Invoice Quarter/Year: drop down selection list

TMAC Manager/Tel/Email: enter name, tel, email

Invoice: Enter number from quarterly total summary; rate and total will auto-populate

Click Here For TMAC Forms

The non-Federal portion of the required state match to be sent via Intergovernmental Transfer (IGT) by the deadline (45th day after the closing of the quarter).*

Tribal Health Organization	FFY - Qtr	Alaska Native or American Indian			
Enter Tribe Name Here	2015	Under 21	Adults 21-64	65 or Older	Total
	Q1	0	1	0	1

* See appendix C

Quarterly Invoice of Administrative Fees

Invoice (non-Federal Share) Attestation

Form #4 (continued)

2nd Attestation

I, _____, certify (CFO in blue ink) under penalty of perjury that the information provided on this invoice is true and correct, based on the approved methodology outlined in Section III and further defined in Section IV of the Tribal Medicaid Outreach and Linkage Plan for the period referenced and that the funds transferred via IGT from the Tribes to the State of Alaska Department of Health & Social Services represent the non-Federal share of the Federal matching funds pursuant to the requirements of 42 CFR 433.51, for allowable administrative activities and that these public funds are not Federal funds and have not been and will not be subsequently used for Federal match in this or any other program. I have notice that the information is to be used for filing of a claim with the Federal Government for Federal Funds and knowing misrepresentation constitutes violation of the Federal False Claims Act. ***If this Tribe or Tribal health organization is the recipient of a CMS Connecting Kids to Coverage Grant or any other CMS grant award for Medicaid administrative activities****, **I further certify that the children outreached and provided application and renewal assistance under this Tribe's or Tribal health organization's CMS Connecting Kids to Coverage grant funding or any other federal grant funding for Medicaid outreach and enrollment assistance have been carved out from the list of unduplicated recipients of services provided to DHCS through DSM which has prevented any duplication of payment related to Medicaid administrative activities provided otherwise.***

Click here for TMAC forms

DHSS - HCS
TMAC Funds Flow Chart

DHSS OFFICE OF RATE REVIEW
Quarterly match of Enterprise claims against each quarter's unduplicated Medicaid recipients list submitted by Tribe/THO

DHSS Health Care Services Juneau
Identify recipients that do not match Enterprise claims. Tribe's must submit Medicaid claim for each recipient by 4th consecutive quarter or the administrative fee will be offset from future payments from DHCS to Tribe/THO (recoupment)

Tribe / THO submits to DHCS:

Submit Invoice and Attestation form via DSM

Submit IGT, Non-Federal portion of the required state match via ACH transaction

DHSS

Issue EFT payment to Tribe / THO w/in several days of the cost-based fee (Medicaid FFP plus non-Federal share)

DHSS

After 4th consecutive quarter: Submit recoupment form and reconciliation to the Tribe /THO

To be completed by the TMAC Manager or designated fiscal staff

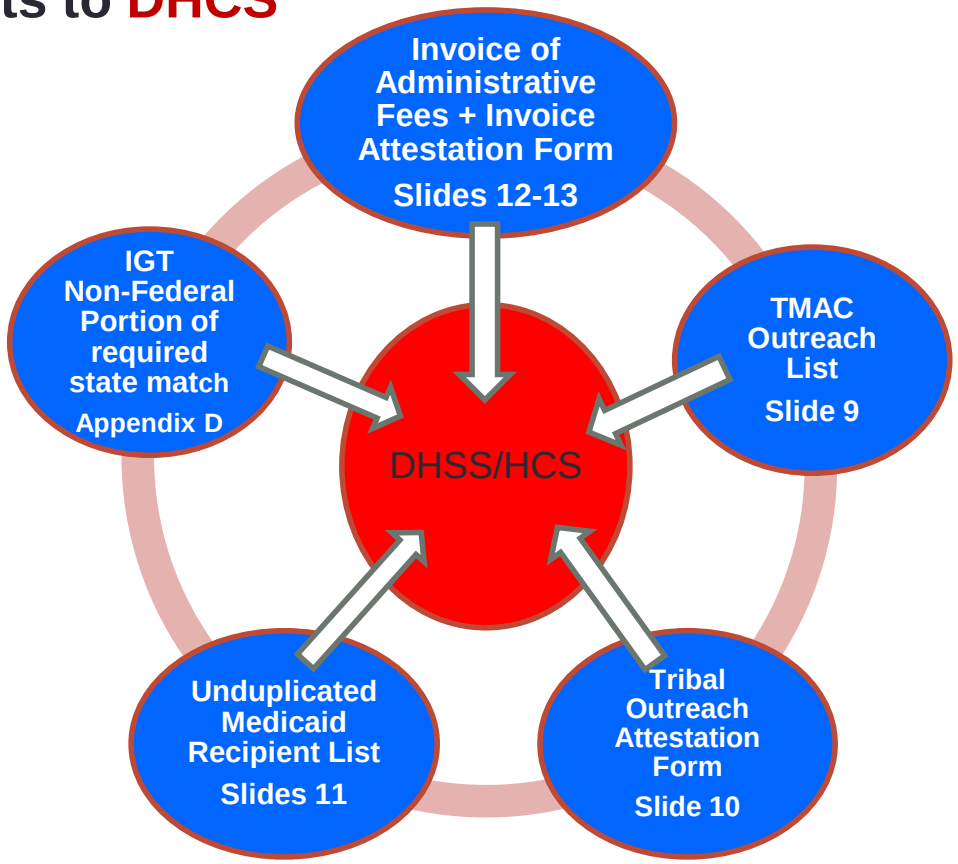
Reference:
Appendix C: DSM
Appendix D: ACH
Appendix E: EFT

State of Alaska
Department of Health & Social Services

Tribe/THO submits to DHCS

A summary of all items to be submitted to the Department of Health & Social Services by the deadline of 45 days after each quarter.

Questions? Contact the Division of Health Care Services Director's office at (907) 465-5829; or tmac.hss@alaska.gov



State of Alaska
Department of Health & Social Services

What to expect from DHCS

A summary of all items to be submitted to Tribe or THO by the Department of Health & Social Services.

Questions? Contact the Division of Health Care Services Director's office at (907) 465-5829 or tmac.hss@alaska.gov

CONTRACT
Maintain Tribal Medicaid Administrative Claiming Agreement

TRAINING
Recorded training sessions and materials available on-demand online

PROMPT PAYMENT OF ADMINISTRATIVE FEE VIA EFT
Upon receipt of the invoice and the non-federal portion of the required state match

QUARTERLY REPORT OF MMIS UNMATCHED LIST
To unduplicated recipient list

OFFSET/RECOUPMENT NOTIFICATION
Reimbursement of administrative fees w/ no matchup after 4 quarters and no matchup of recipients of services to actual claims

FORMS/ENROLLMENT
Online access to forms for reporting and enrollment

State of Alaska
Department of Health & Social Services
2016 Submission Dates

January

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29					

March

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

April

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

July

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

September

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

October

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

November

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

December

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Quarter 1

Quarter 2

Quarter 3

Quarter 4

Last Day of Quarter

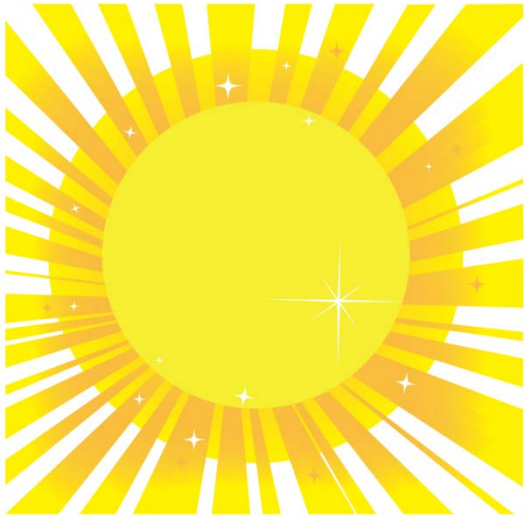
DEADLINE:
Tribes/THO's Submit 45 days after end of quarter
- TMAC Outreach List
- Tribal Outreach Attestation Form
- Unduplicated Medicaid Recipient List
- Invoice of Administrative Fees
- Non-Federal portion of required state match

Additional Information:

If by the 4th consecutive quarter a claim is not submitted; DHSS/HCS will invoice for the return of the administrative fee for that Medicaid recipient.

State of Alaska
Department of Health & Social Services

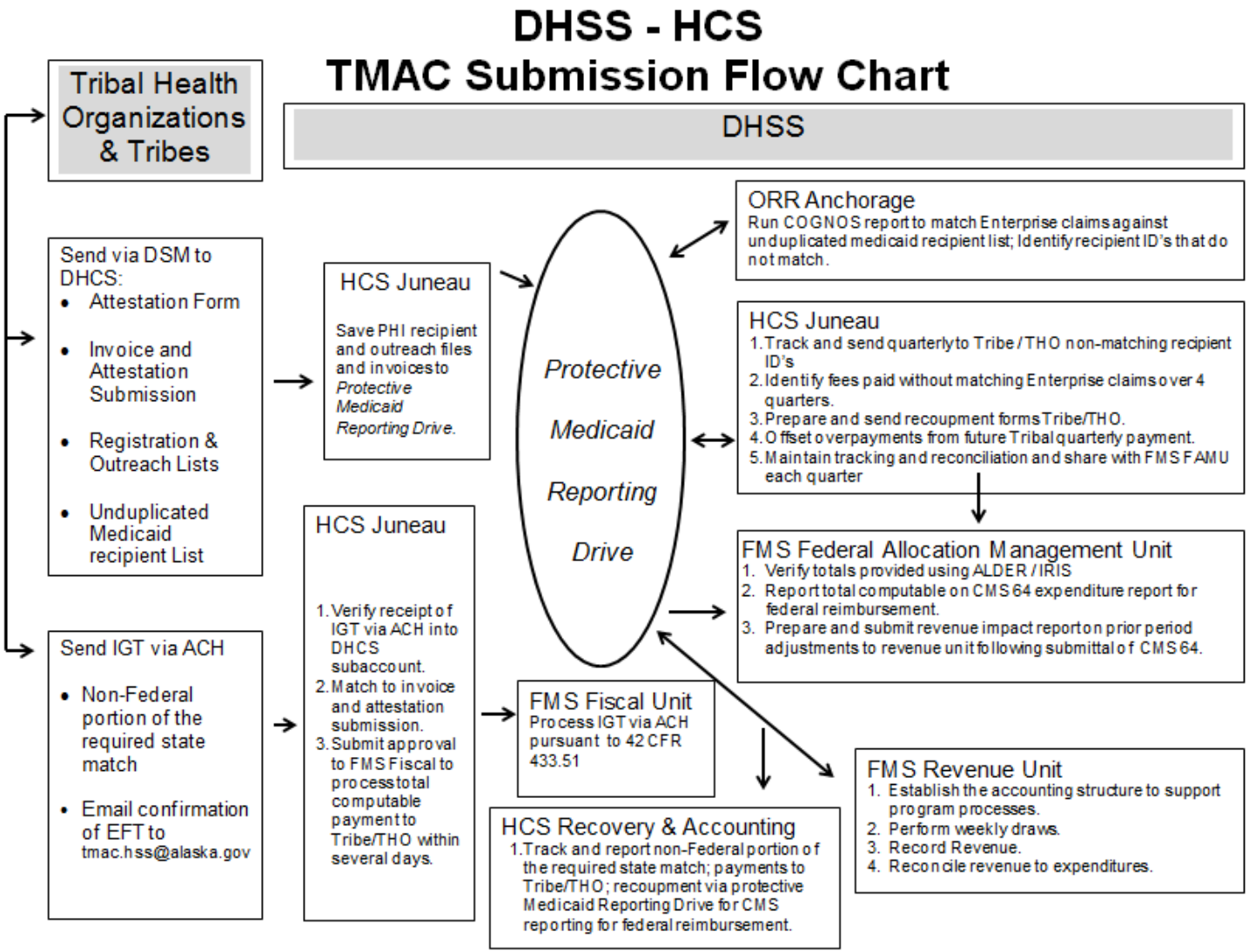
S
U
M
M
A
R
Y



Questions?

DHCS Internal

Appendix A:



Appendix B: Acronyms

AI	American Indians
AN	Alaska Natives
ANTHC	Alaska Native Tribal Health Consortium
CFFPI-U	Consumer Price Index for Urban Consumers
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DHCS	State of Alaska Division of Health Care Services
DHSS	State of Alaska Department of Health & Social Services
DSM	Direct Secure Messaging
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FMS	DHSS Financial Management Services
FMAP	Federal Medical Assistance Percentage
GF	General Fund
IGT	Intergovernmental Transfer
SSA	Social Security Act
THO	Tribal Health Organization
TMAC	Tribal Medicaid Administrative Claiming
TTAG	Tribal Technical Advisory Group

DenaliCare	Medicaid
Denali KidCare	CHIP

Appendix C: How to Establish Direct Secure Messaging (DSM)

Direct Secure Messaging (DSM): Allows a provider to send a single, encrypted message from point to point (i.e., Tribe or THO to DHSS/DHCS)

To sign up for DSM:

Alaska eHealth Network (AeHN)
Web: http://ak-ehealth.org/for-providers/direct-secure-messaging/
Email: support@ak-ehealth.org
Phone: 1-866-966-9030

Complete the Participation Agreement:
http://ak-ehealth.org/for-providers/join-our-providers/

For fee information:
http://ak-ehealth.org/for-providers/join-our-providers/

TMAC Direct Secure Messaging
DHCS.TMAC@direct.dhss.akhie.com

Appendix D:
How to send ACH Transfers to DHSS/HCS

ACH Transfer Instructions

1. Prepare the amount due.

2. Notify the State of Alaska, Treasury Division by 2:00 p.m. (Alaska Prevailing Time) the business day PRIOR to the ACH settlement date, by email to dor.trs.cashmgmt@alaska.gov. The notice must include the **payor name, payment amount, settlement date, AND that the payment is for ACH 06034.**

3. Instruct your bank to initiate an ACH transfer of funds to be received and credited to the State of Alaska:

   State Street Bank & Trust Company
   Lafayette Corporate Center
   2 Avenue De Lafayette
   Boston, MA 02111

   ABA # 011000028
   State of Alaska – AY01
   General Investment Fund
   Account # 0065718906034

4. Confirmation is available by calling the Alaska Department of Revenue, Treasury Division at (907) 465-2360 or by emailing dor.trs.cashmgmt@alaska.gov.

5. Do not send any other State of Alaska payment types to this account.

Email confirmation of ACH transfer to tmac.hss.alaska.gov

Appendix E:

How to receive electronic payments (EFT) from the State of Alaska

1) Click here to be directed to the State of Alaska Division of Finance Electronic Payments (EFT) web page
2) Review the Frequently asked questions
3) Click and complete the Electronic Payment Agreement form for vendors
4) Fax the form to (907) 465-2169
5) Need assistance? Call (907) 465-5622

Appendix F: TMAC Forms

Outreach Attestation Form

Invoice Form w/ Invoice Attestation

Registration & Outreach Lists

Unduplicated Medicaid Recipient List

Tribal Medicaid Administrative Claiming Checklist

Click here for TMAC forms

Appendix G: Department of Health & Social Services TMAC Contact List

Pagan Hill, TMAC Receipt & Reconciliation, Health Care Services	(907) 465-5829
Pam Halloran, TMAC Receipt & Reconciliation Oversight, Health Care Services	(907) 465-5827
Barbara Hale, Lead TMAC Program Oversight, Health Care Services	(907) 465-5833
Sarah Harlamert, Tribal Health Program Coordinator - TMAC Liaison	(907) 269-7398
Renee Gayhart, Tribal Health Project Coordinator – TMAC Liaison	(907) 465-1619
Margaret Brodie, Division Director, Health Care Services	(907) 334-2400

DHSS HCS General TMAC Email Box: tmac.hss@alaska.gov (For general questions only)

TMAC Mailing Address:
State of Alaska
Division of Health Care Services
TMAC
PO Box 110660
Juneau, AK 99811-0660

TMAC Physical Address:
State of Alaska
Division of Health Care Services
TMAC
240 Main St, Ste 501
Juneau, AK 99801

Direct Secure Messaging
DHCS.TMAC@direct.dhss.akhie.com