

Tribal Medicaid Outreach and Linkage Plan

Tribal Medicaid Administrative Claiming (TMAC)



I. PREFACE

This document describes the Tribal Medicaid Administrative Claiming (TMAC) Plan for the State of Alaska. It is designed to be used by the federally recognized Tribes and Tribal health organizations in Alaska that participate in TMAC activities. This plan has been developed by the Alaska Department of Health and Social Services (DHSS) in consultation with the Tribes associated with the Alaska Native Tribal Health Consortium (ANTHC) and the Centers for Medicare and Medicaid Services (CMS).

The purpose of the TMAC activities is to:

1. strengthen the partnership between DHSS and participating federally recognized Tribes and Tribal organizations;
2. share in the responsibility for promoting access to DenaliCare (Medicaid)/Denali KidCare(M-CHIP) for Alaska Natives and American Indians; and
3. reimburse the Tribes and Tribal health organizations for performing DenaliCare/Denali KidCare outreach and linkage activities.

This activity is intended to support the effective and efficient administration of the DenaliCare/Denali KidCare Programs, which include provision of outreach and linkage activities to Alaska Natives (AN), American Indians (AI) and non-Tribal members served by Tribes and Tribal health organizations in Alaska. It is hoped that TMAC activities will increase the enrollment and retention of Alaska Natives and American Indians in DenaliCare and Denali KidCare and the adoption of Tribal Technical Advisory Group (TTAG) Option 5, development of an administrative fee, will provide an incentive to the Tribes and Tribal health organizations for improving their enrollment and retention processes and systems.

Since the underlying costs of Alaska TMAC are nominal and the human resource burden on both Tribes and the DHSS is significant to perform a random one-week quarterly time study, it is the goal of DHSS and the Tribal health organizations to revise the TMAC methodology in Alaska consistent with a combination of TTAG options 5 and 6 outlined in the *CMS Claiming Requirements for Tribal Medicaid Administrative Costs*¹ document incorporated by reference in this plan. These two options combine 1) payment of an administrative fee and 2) execution of a memorandum of agreement.

II. TRIBAL HEALTH PROVIDERS

A. Tribal Organizations In Alaska

The Tribal health care delivery system in Alaska is operated under a statewide compact with the Federal government authorized under PL 93-638 dividing the 229 federally recognized tribes in Alaska into 9 health care delivery areas. In each area, the tribes have selected an entity to provide the health care services for the area, although some tribes have chosen to retain provision of local health care services.

There are 6 rural hospitals operated by the tribes, with tertiary care services provided at the Alaska Native Medical Center in Anchorage, which is operated by the Alaska Native Tribal Health Consortium representing all the tribes. There are over 25 health centers with at least a mid-level practitioner providing health care services. Each small village has a local clinic staffed by Community Health Aides and Practitioners. Mid-level clinics exist in many larger communities. In addition to the primary care services, most Tribal health care programs include mental health and substance abuse programs and some level of home and community based services supporting the elderly and disabled within their communities.

The Indian Health Care Improvement Act of 1974 amended the Social Security Act making it possible for CMS, to pay the IHS for the Medicare and Medicaid services they provide to AN/AI beneficiaries. Medicaid is financed by both the Federal and State governments. The Federal Medical Assistance Percentage (FMAP) is the proportion paid by the Federal government and the remainder is the state general fund match for direct care services. In Alaska, the state general fund match for Medicaid direct services is approximately 50% and the corresponding Federal financial participation (FFP) for Medicaid administration is 50%. However, for direct care services provided to AN/AI Medicaid clients by Tribal health providers the state is reimbursed 100%. It is important to note that the reimbursement to Tribal facilities is set by CMS at an all-inclusive/encounter rate and often is substantially higher than rates paid to non-Tribal facilities for the same service. The 100% FMAP exists in recognition of the fact that Indian health care is a recognized Federal trust responsibility. TMAC reimbursement for administrative activities related to DenaliCare and Denali KidCare eligibility, enrollment and outreach is reimbursed at 50% FFP. Only federally recognized Tribes and eligible Tribal health organizations may participate in TMAC.

The financial stability of the Tribal health care delivery system infrastructure helps to ensure access to health care for all residents, both Native and non-Native, in many areas of the state. For Tribal beneficiaries, the 100% Federal pass through Medicaid funding for eligible beneficiaries helps to ensure the stability of the Tribal health infrastructure to enable limited IHS funding to be used for non-eligible beneficiaries and contracted health services. State general fund costs may be avoided if services received by Tribal Medicaid beneficiaries are within the Tribal health care delivery system. With financial stability, Tribal facilities avoid having to cut health care services, dropping or placing on-hold plans for future improvements, or turning away non-Native patients who currently rely on them for their health care services. There are administrative costs to the State to serve AN/AI beneficiaries and 100% FMAP for direct services is not necessarily always captured.

B. Participating Tribal Organizations

The Tribes and Tribal health organizations currently contracted to participate in TMAC are listed in Addendum A and will be updated as Tribes are contracted or are no longer eligible to participate in TMAC.²

Tribal health organizations and Tribes currently not contracted to perform DenaliCare/Denali KidCare outreach and linkage activities may contact the DHCS T-MAC manager 907-465-5829 for more information. A Tribe or Tribal health organization, not currently contracted, may participate in TMAC, once an agreement has been executed and will be paid an administrative fee described in Section III below, based on a methodology which addresses the costs incurred in a urban versus rural population further broken down by recipient size within the rural component of the methodology.

III. ALASKA TMAC CLAIMING METHODOLOGY

Under Title XIX of the Social Security Act (SSA), the Federal government and state share the cost of funding the Medicaid program. Also under the SSA, under Title XXI, the Federal government and state share the cost of funding the Children's Health Insurance Program (CHIP), an expansion of Medicaid services to optionally targeted low-income children in Alaska known here as Denali KidCare. The state, in general, receives an enhanced FMAP for funding these children except when a Tribal child or adolescent receives DenaliCare/Denali KidCare services outside their Tribal health organization. If that occurs, then the FMAP reverts to the lower regular Medicaid FMAP where the state matches the FMAP with GF. These two programs provide Medicaid services to low-income individuals in Alaska. Federal financial participation (FFP) is the Federal government's share for the state's Medicaid program expenditures. States may claim FFP for providing administrative activities that are found to be necessary by the Secretary of the U.S. Department of Health and Human Services for the proper and efficient administration of the Medicaid State Plan.

To establish an administrative fee for Medicaid administrative activities, Department staff first met with CMS Region X and Central Office staff to review the TTAG options formulated by CMS and the TTAG. DHSS staff then asked the Medicaid Rate Setting Office to review TMAC costs for the 2010 and 2011 FFYs and the total number of DenaliCare/Denali KidCare recipients served by the same Tribal health organizations during that time period. Costs per recipient of providing DenaliCare/Denali KidCare outreach and linkage were calculated for each participating THO based on their actual direct and indirect costs incurred in the two referenced years and percentage of time spent on Medicaid administration. DenaliCare/Denali KidCare recipients rather than enrollees were chosen as the base unit because there are fewer recipients than enrollees and Tribal members receive assistance with Medicaid administrative activities such as enrollment, renewal, travel etcetera before a DenaliCare and Denali KidCare direct service is rendered. In addition, our Rate Setting Office can only work with claims data which contains recipient information for those who have received a DenaliCare/Denali KidCare service. The Rate Setting Office does not have access to enrollees who have not received services and our Rate Setting Office will be responsible for the reconciliation of recipients. The Medicaid administrative fee/recipient/quarter is unduplicated by the Tribal health organization providing the administrative service. Therefore, only one administrative fee/recipient/quarter will be paid to each organization where the DenaliCare/Denali KidCare

recipient is seen. The Tribal health care organizations can streamline eligibility, increase efficiency and reduce administrative costs if eligible DenaliCare/Denali KidCare clients are maintained and not allowed to fall off the program. In addition, the Medicaid administrative fee is an incentive to Tribes for keeping eligible DenaliCare/Denali KidCare clients enrolled which leads to the provision of necessary prevention and treatment services and should help minimize higher costs associated with emergent and specialty care. The administrative costs described below are not the same costs associated with or included in the encounter or all inclusive rate and are not a part of the Medicaid direct services provision.

The cost elements utilized in calculating the initial per recipient and quarter costs were quarterly payments/wages of surveyed individuals, provider specific fringe benefit rates and provider specific negotiated indirect cost rates. Quarterly payment/wage rates were reviewed for reasonableness. Non-professional wage rates ranged from \$11 to \$23 per hour. The higher rates were experienced in more rural locations. These wage rates were determined reasonable. Some nurse's time was reported and this wage rate was approximately \$41 per hour. This professional wage rate was reasonable in comparison to the Department of Labor, Division of Labor Statistics. Staffing costs that were directly reimbursed by the Federal government were removed. Provider specific fringe benefit rates ranged from 20 to 38%. These rates are consistent with fringe benefit rates experienced in other healthcare providers in the state and were determined reasonable. The negotiated indirect cost rates for each provider are developed by the provider and the Indian Health Service and are considered reasonable. No other costs were included. An individual time study rate, based on the one-week time-studies, was applied to the direct cost elements described above for Medicaid administrative activities, non-Medicaid activities and other related activities. Medicaid activities in the 2010 and 2011 cost calculations follow:

1. Code A: Eligibility (to qualify/entitle to participate – application/renewal)
2. Code B: Referral (to send or direct for treatment, aid, information or decision)
3. Code C: Transportation (to arrange travel for DenaliCare/Denali KidCare clients)
4. Code D: EPSDT under age 2 (well-child activities and other follow-up)
5. Code E: Community Outreach (activities to increase community awareness – health fairs/information booths)
6. Code F: Medicaid Training (general program information training to providers or providing/receiving training relating to outreach/linkage)

There were also three Non-Medicaid related activities tracked in the 2010 and 2011 time study which follow:

1. Code G: All other work activities for which you are paid by your employer
2. Code H: Paid time off (vacation, sick time, holiday, taking comp time, paid lunch time, paid break time, any time away from work if the time is paid)
3. Code I: Not working (before or after work, unpaid lunch break, or other time not paid by employer)

The majority of the time spent on TMAC activities falls under Codes A, E and C. The Tribal health organizations have staff members, most commonly known as Family Health Resource

(FHR) workers, who spend the majority of their time working to make sure that Tribal beneficiaries who are eligible are enrolled and renew on time. Most of the organizations have entered into data sharing agreements with the Department and have read-only access to the Medicaid eligibility file. Several of the Tribal health organizations require that all of their beneficiaries apply for DenaliCare/Denali KidCare to determine eligibility to ensure that everyone who is eligible is enrolled which is a way for Tribes to not only increase access to DenaliCare/Denali KidCare services, but also to ensure a stable revenue cycle. Much of the work involved in this process with the Tribes is outreach, enrollment and renewal activities, which include assisting DenaliCare and Denali KidCare clients with completing applications, renewals and collecting necessary documentation. Given that Medicaid is an entitlement, at the end of the continuous eligibility or renewal period, a large percentage of DenaliCare/Denali KidCare clients do not renew and their cases auto close. They tend to come back and apply again for services when they are sick or a service is needed and research shows that this is more costly than trying to maintain eligibility for those who qualify. For example, with children it is not unusual to have 30 to 40% of the cases auto close which is a huge administrative expense and much more costly than keeping children that are eligible enrolled. Assistance with arranging transportation is also a huge administrative activity performed by the Tribal health organizations and involves staff who coordinates with Medicaid clients and the State Travel Office to ensure that travel for DenaliCare and Denali KidCare services occur. Transportation assistance takes place on both ends of the travel as the length of time spent at the regional hub or at the tertiary care facility in Anchorage often changes or other DenaliCare/Denali KidCare transportation or accommodation services are needed and require the administrative staff to assist. The above examples, while not inclusive, provide insight into how the Tribal health organization Medicaid administration is different from administration in a non-Tribal practice site.

The DHSS proposed Medicaid methodology for participating TMAC organizations³ takes the cost per recipient at each participating THO and multiplies that number by the number of unduplicated DenaliCare/Denali KidCare recipients in each Tribe or Tribal health organization on a quarterly basis. This methodology as outlined above accounts for actual direct and indirect costs that were incurred by each participating Tribe or THOs in FFY 2010 and 2011.

Newly added Tribes or THOs will be added based on the following methodology.⁴

- a. Urban Tribes or THOs (Anchorage) will be added and paid the average urban fee/recipient/quarter of \$8.21; and
- b. Rural Tribes or THOs (all other areas of Alaska other than Anchorage) will be paid a rural rate/recipient/quarter based on the following:
 - i. $\leq 2,000$ recipients, a fee of \$28.08/recipient/quarter; and
 - ii. $> 2,000$ recipients, a fee of \$13.46/recipient/quarter.

After the first FFY implementation ends, the 2010 and 2011 FFY cost/recipient/quarter or administrative fees will be adjusted by the Medicaid Rate Setting Office to reflect the percent change from the previous year in the most recent annual *Consumer Price Index for all Urban Consumers (CPI-U)*, all items, for Anchorage, Alaska

published on or before March 1 by the United States Department of Labor, Bureau of Labor Statistics. This CPI-U inflation adjustment will be applied annually thereafter.

If the Department and Tribes determine that rebasing of costs or utilization should occur, a new plan will be submitted to CMS for approval.

Tribal health organizations must have all required documentation (referenced in Section IV below), on file on site and make it available to State or CMS staff within 30 days of receipt of request. This includes all material outlined in this plan and training materials. If a Tribal health organization is non-compliant with documentation requests and/or plan requirements, including unsupported invoices, the State has the ability to terminate the TMAC program immediately without extension or future consideration for reinstatement.

The DHSS will provide all monitoring and oversight of TMAC both at the Department level and the Tribal health organization level through reconciliation and audit (described in Section IV below) of recipient data.

The Tribal liaisons in DHSS will continue to monitor Medicaid outreach and linkage activities under this new plan including linkage to outreach/enrollment collateral materials to all contracted Tribal and Tribal health organization sites to ensure that each patient receiving medical services is outreached with pertinent DenaliCare/Denali KidCare coverage information including local Tribal contact information. The liaisons will provide a report of these activities each time they do a site visit. Knowing that outreach and enrollment are essential components of the CMS approval of TMAC, the Department has designed its training to include links to application materials and assistance. CMS will approve the outreach and distribution plan separately before implementation of this new TMAC plan. The Tribal TMAC Manager at each participating site will attest quarterly that information about DenaliCare/Denali KidCare public health insurance options were provided. In addition, the patient registration lists will be submitted by each participating Tribe or THO via secure transmission (preferably direct secure messaging – DSM) by the 45th day after the close of the prior quarter to DHCS Juneau. The attestation language, certifying that all patient registrants were outreached follows:

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

The DenaliCare/Denali KidCare outreach and enrollment, via patient registration, is completely separate from tracking DenaliCare/Denali KidCare recipients of services for payment of the Medicaid fee. The purpose of this documentation is to show that all patients registered at the Tribe or THO have been outreached about the availability of DenaliCare/Denali KidCare services. The DenaliCare/Denali KidCare outreach materials will either be distributed to individuals when they present at patient registration prior to a medical service or will be reviewed with each individual presenting at patient registration.

It is hoped that this focus on Medicaid enrollment and retention will strengthen the Tribal processes and will reduce churn of Tribal enrollees.

At a minimum, the DHSS in collaboration with the Tribes will ensure that:

1. the financial data that is submitted as the basis for the initial fee/rate calculations is true and correct;
2. the non-Federal share of the required state match is provided through intergovernmental transfer (IGT) with the State assuring that the non-Federal share of Medicaid expenditures is provided by a unit of government, including an Indian Tribe or Tribal health organization providing health care, using appropriate sources of revenue;
3. appropriate documentation is maintained to support the claims submitted for payment;
4. non-duplication of claiming for administrative claims;
5. non-duplicate performance of services or administrative activities;
6. medical services, activities that were considered integral to, or an extension of, a medical service were not claimed as an administrative expense; and
7. administrative activities claimed for reimbursement were directly related to a Medicaid state plan or waiver service.

IV. DOCUMENTATION, INVOICING, PAYMENT, RECONCILIATION, AND AUDITING

The Tribe or Tribal health organization will invoice the DHSS, DHCS, by the 45th day after the end of the prior quarter for their administrative fee based on the number of unduplicated recipients of DenaliCare/Denali KidCare services provided at each Tribal health organization and will transfer with the invoice, the non-Federal portion of the required state match via IGT through EFT/ACH/EDI.

The following attestation shall be made on each Invoice submitted to the State for payment for TMAC:

The undersigned Tribe or Tribal health organization will attest to the following: "I certify (CFO) under penalty of perjury that the information provided on this invoice is true and correct, based on the methodology outlined in Section III and further defined in Section IV above for the period referenced and that the funds transferred via IGT from the Tribes to the SoA, DHSS 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 nor shall not subsequently be 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.”

The DHSS, DHCS will make payment to the Tribal health organizations within several days of the receipt of the IGT and invoice from the Tribes or Tribal health organizations. The IGT or the non-federal share of funding to the State by the Tribes must occur prior to the State’s payment of the total computable cost-based fee (Medicaid FFP plus non-federal share) to the Tribes for Medicaid administrative activities. The State must have complete administrative control of the non-federal share of funding prior to payment of the cost-based fee (Medicaid FFP plus non-federal share) to the Tribes for Medicaid administrative activities. The number of unduplicated recipients served at each Tribe or Tribal health organization during the referenced quarter will serve as the required documentation for the Medicaid fee as referenced in Section III above. Therefore, an administrative fee/recipient, as described in the methodology in Section III above, may be paid to each Tribe or Tribal health organization that provided a DenaliCare/Denali KidCare service to a recipient during the quarter. It is possible that an administrative fee will be paid to more than one Tribe or Tribal health organization in the same quarter for the same recipient and will offset the costs of administration to each Tribe or Tribal health organization that provided Medicaid services to the recipient.

The reconciliation and audit procedure for the Medicaid fee based on unduplicated recipients at each Tribe or THO rolled to a single date of service follow:

1. Tribes will provide an unduplicated DenaliCare/Denali KidCare ID recipient list rolled to a single date of service for all TMAC claims quarterly.
2. The Office of Rate Review will run a Cognos report for Tribes to match against their TMAC claim. Once this is accomplished any Tribal DenaliCare/Denali KidCare IDs that do not have matching Cognos claims should be billed appropriately prior to the next quarter TMAC submission.
3. Each subsequent quarter, the tribes will submit a new unduplicated DenaliCare/Denali KidCare ID recipient list rolled to a single date of service and combine with the outstanding list that had not been billed for from the previous quarter. This will be matched against the Cognos claims list from ORR. Once again the list of unduplicated DenaliCare/Denali KidCare ID recipients rolled to a single date of service that do not match claims processed will be listed and sent to the tribes letting them know that they must bill for these services.
4. This process will be completed on a quarterly basis. Once there is an unduplicated DenaliCare/Denali KidCare ID recipient list rolled to a single, date of service that does not match any claims processed in MMIS Enterprise in the past 12 months, the tribes will reimburse TMAC as their claim will be untimely. This reimbursement will be set up as an offset so it will process against a future quarter’s payment. This reconciliation system will continue each quarter as long as the tribe(s) continues to participate in TMAC.

V. TRAINING

Training for outreach, enrollment and linkage is done by the TMAC staff and Tribal liaisons within the (DHSS) on a routine basis which includes training on read-only access to Medicaid Eligibility Information System (EIS) data. CMS and the Alaska Native Tribal Health Consortium (ANTHC) generally convene an annual training in Anchorage with the Tribes which includes a segment on TMAC. The DHSS TMAC staff provides routine telephone training to Tribal staff members involved in the claiming process and will coordinate with Tribal liaisons to do onsite training if necessary.

V. TRIBAL CONSULTATION POLICY

The *DenaliCare/Denali KidCare Tribal Consultation Policy and Procedure*⁵ is incorporated by reference. While this new TMAC plan does not involve a state plan amendment, waiver request or proposal for a demonstration project which require Tribal consultation, it will have a direct effect on Tribes and Tribal health organizations in Alaska; thus, the reason for the Alaska DHSS to seek informal advice on this new TMAC plan.

The DHSS has worked with tribal health organizations and CMS to define/determine a process for Tribal consultation within the DHSS that meets the requirements of CMS to consult with Tribes regarding state plan amendments, waiver request or proposal for a demonstration project that directly or indirectly affect Tribal health beneficiaries and Tribal health programs statewide.

¹ *CMS Claiming Requirements for Tribal Medicaid Administrative Costs*, Tribal Tag Technical Advisory Group (TTAG), developed to address concerns raised by States and Tribes in late 2009 or early 2010.

² Addendum A – listing of Tribes and Tribal health organizations contracted with DHCS for TMAC outreach and linkage activities.

³ Addendum B – Tribal Medicaid Administrative Claiming Cost per Quarter utilizing cost time study survey and recipient data from FFY 2010 and 2011.

⁴ Addendum C – Tribal Medicaid Administrative Claiming fee methodology for newly added Tribes and Tribal health organizations.

⁵ *Alaska Medicaid and Denali KidCare Tribal Consultation Policy and Procedure* as referenced in the AK Medicaid State Plan, TN No. 12-002, approval date of May 3, 2012 and effective date of January 1, 2012.

Addendum A: Tribal Medicaid Outreach and Linkage Plan – TMAC***List of participating Tribes and Tribal Health Organizations***

1. Alaska Native Medical Center – ANMC
2. Alaska Native Tribal Health Consortium – ANTHC
3. Bristol Bay Area Health Corporation – BBAHC
4. Kenaitze Indian Tribe - KIT
5. Ketchikan Indian Corporation – KIC
6. Maniilaq Association
7. Native Village of Eyak
8. Norton Sound Health Corporation – NSHC
9. Seldovia Village Tribe - SVT
10. Southcentral Foundation – SCF
11. Southeast Alaska Regional Health Consortium – SEARHC
12. Tanana Chief Conference – TCC
13. Kodiak Area Native Association – KANA
14. Yukon-Kuskokwim Health Corporation - YKHC

**Tribal Medicaid Administrative Claiming
New Total TMAC Cossts Based on Medicaid Expansion
2011**

Purpose:

To calculate the estimated number of Medicaid recipients based on Medicaid expansion.

	A	B	C	D	E	F	G	H
	Current Costs Based on Past Payments	Number of THO Recipients Before Medicaid Expansion	Rate	Percent of Total THO Recipients	Medicaid Expansion (15,700 AN/AI)	WoodWork Effect	New Total Medicaid Recipients	TMAC Costs in 2014 with Expansion
Alaska Native Medical Center	\$ 556,437.93	68,791	\$ 8.09	37.05%	5,816	964	75,571	\$ 611,277.20
Bristol Bay Area Health Corporation	\$ 292,701.49	14110	\$ 20.74	7.60%	1,193	198	15,501	\$ 321,549.62
Kenaitze Indian Tribe	\$ 39,094.23	3,461	\$ 11.30	1.86%	293	48	3,802	\$ 42,951.49
Ketchikan Indian Corporation	\$ 39,137.72	1,670	\$ 23.44	0.90%	141	23	1,834	\$ 42,990.41
Maniilaq Association	\$ 62,746.92	5,283	\$ 11.88	2.85%	447	74	5,804	\$ 68,934.97
Native Village of Eyak	\$ 14,808.23	296	\$ 50.03	0.16%	25	4	325	\$ 16,266.36
Seldovia Village Tribe	\$ 54,409.84	1,893	\$ 28.74	1.02%	160	27	2,080	\$ 59,770.85
Southcentral Foundation	\$ 537,237.91	64,490	\$ 8.33	34.73%	5,453	903	70,846	\$ 590,190.21
Southeast Alaska Regional Health Consortium	\$ 258,803.05	25,697	\$ 10.07	13.84%	2,173	360	28,230	\$ 284,313.43
Total Per Recipient Per Qtr	1,855,377.32	185,691.00	\$ 9.99	100.00%	15,701	2,601	203,993	\$ 2,038,244.55

A	The total salary and benefit costs from all employees who participated in the time study associated with Medicaid Administrative Claiming.
B	Total number of recipients per Tribal Health Organization obtained via STARS. This total is the accumulated unduplicated recipients per quarter for FFY 2010 and FFY 2011. The number of recipients per a specific quarter was left off the above total if the Tribal Health Organization did not submit time studies during the corresponding period. This matching ensures no extra quarters of cost or recipients is included if a THO skipped any quarter for time studies.

C	The rate is calculated as Cost divided by Number of Recipients for each Tribal Health Organization. These are the proposed rates. Each tribal health organization would receive its own rate based on the time period used (FFY10 & FFY11)
D	The percent of total applicants is each THO's number of recipients divided by the total number of recipients. These percentages are used to allocate new Medicaid recipients to the tribes.
E	Healthier Alaskans Create a Healthier State Economy, published by ANTHC ,used analysis from The Urban Institute and Alaskan-based Northern Economics, Inc to determine the estimated number of individuals who would be eligible for Medicaid. On page 5/38 the paper estimates that 15,700 new Alaska Native and American Indians will be eligible for Medicaid under the expansion in 2014.
F	Healthier Alaskans Create a Healthier State Economic, published by ANTHC, used analysis from The Urban Institute and Alaskan-based Northern Economics, Inc. to determine the estimated number of "Wood Work" individuals who would be enrolled in Medicaid. The Wood Work Effect is the increase in enrollment of previously eligible, but not enrolled persons. Page 19/38 of the report estimates in 2014 that 6,503 Woodwork individuals would become enrolled. Of these, it is estimated that 40% of them would be AN/AI (page 31/38).
G	The new total of Medicaid recipients is the cumulative of the current Medicaid recipients (Col. B), the AN/AI Medicaid expansion (Col. E) and the Woodwork effect recipients (Col. F)
H	TMAC Costs in 2014 from the Medicaid Expansion is the proposed rate for each tribal health facility (Col. C) multiplied by the New Total Medicaid Recipients (Col. G) for each THO. The amounts for each THO in Column H are added together for the total financial impact to the program. This amount in total (\$2,038,244.55) is the same amount as paying each recipient , regardless of THO, \$9.99 (\$9.99*203,933 total recipients = \$2,037,290.6). The variance of \$953.90 is from having to round total recipients to the nearest person.

**Tribal Medicaid Administrative Claiming
Proposal for New TMAC THOs
2011**

Purpose:

To calculate a rate for new Tribal Health Organizations for Tribal Medicaid Administration claiming. These rates are based on cost survey and recipient data from FFY2010 and FFY2011. New THP's would be given the urban or rural rate calculated below depending on their program location.

1. Urban rate per recipient per quarter.

	A	B	C
	Costs	Number of Recipients	Rate
Alaska Native Medical Center	\$ 556,437.93	68,791	\$ 8.09
Southcentral Foundation	\$ 537,237.91	64,490	\$ 8.33
URBAN RATE PER RECIPIENT PER QTR	\$ 1,093,675.84	133,281	\$ 8.21

2. Rural rate per recipient per quarter with >2,000 recipients

	A	B	C
	Costs	Number of Recipients	Rate
Bristol Bay Area Health Corporation	\$ 292,701.49	14,110	\$ 20.74
Kenaitze Indian Tribe	\$ 39,094.23	3,461	\$ 11.30
Maniilaq Association	\$ 62,746.92	5,283	\$ 11.88
Southeast Alaska Regional Health Consortium	\$ 258,803.05	25,697	\$ 10.07
RURAL >2,000 RECIPIENT RATE PER RECIPIENT PER QTR	\$ 653,345.69	48,551	\$ 13.46

2. Rural rate per recipient per quarter with <2,000 recipients

	A	B	C
	Costs	Number of Recipients	Rate
Ketchikan Indian Corporation	\$ 39,137.72	1,670	\$ 23.44
Native Village of Eyak	\$ 14,808.23	296	\$ 50.03
Seldovia Village Tribe	\$ 54,409.84	1,893	\$ 28.74
RURAL <2,000 RECIPIENT RATE PER RECIPIENT PER QTR	\$ 108,355.79	\$ 3,859.00	\$ 28.08

A	The total salary and benefit costs from all employees who participated in the time study associated with Medicaid Administrative Claiming.
B	Total number of recipients per Tribal Health Organization obtained via STARS. This total is the accumulated unduplicated recipients per quarter for FFY 2010 and FFY 2011. The number of recipients per a specific quarter was left off the above total if the Tribal Health Organization did not submit time studies during the corresponding period. This matching ensures no extra quarters of cost or recipients is included if a THO skipped any quarter for time studies.
C	The rate is calculated as Cost divided by Number of Recipients for each Tribal Health Organization.

The purpose of this addendum is to address the additional steps that will be taken by the Tribes or Tribal health organizations to ensure that no duplicate payments for Medicaid administrative costs will be made by the Medicaid program for the outreach and enrollment assistance to recipients of Medicaid services.

The Alaska Department of Health and Social Services proposes to CMS that the Tribes or Tribal health organizations shall be responsible for the following tasks and attestations, which include the original attestations outlined in the approved claiming plan, under Sections III and IV, and the updates to them found herein:

1. **Review and compare** their CMS Connecting Kids to Coverage grant list provided to the Tribal Liaison at the Division of Health Care Services on a monthly basis and at the end of each quarter to determine from **the cumulative lists of children any duplicate children, and remove those children found on the Covering Kids and Families application/renewal assistance list from the quarterly Tribal Medicaid Administrative Claiming (TMAC) listing that will be submitted via DSM to the Division of Health Care Services.** Duplicate children are to be removed from the TMAC claim so as not to duplicate FFP provided to the Tribes/Tribal health organizations for Medicaid administrative outreach and enrollment services already provided to these children under the CMS Connecting Kids to Coverage outreach and enrollment funding.
2. **Provide an attestation on the outreach and enrollment form**, found under Section III of the Tribal Outreach and Linkage Plan, that the children provided Medicaid/CHIP administrative outreach and enrollment assistance under the CMS Connecting Kids to Coverage grant have been removed from the TMAC recipient of services list to ensure that there is no duplication of children included in the claim that the Tribes/Tribal health organizations will send quarterly via DSM to the Division of Health Care Services. The attestation to be signed by the Tribes/THOs for outreach can be modified to say something like this:

I, _____, certify and attest that all

(TMAC Manager – blue ink)

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

Addendum D – Approved by CMS - 08/13/2015 – Update to Tribal Medicaid Outreach and Linkage Plan – Tribal Medicaid Administrative Claiming (TMAC) – Updates to both Tribal invoice and outreach attestation related to CMS Connecting Kids to Coverage funding or other federal funding for Medicaid administration related to outreach and enrollment assistance.

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).

3. **Attest on the invoice**, found under Section IV of the Tribal Outreach and Linkage Plan that the unduplicated number of recipients of services does not include the children who were outreached and received application and renewal assistance under the Connecting Kids to Coverage grant funding.

Tribe or Tribal Health Organization attestation:

I, _____, certify (CFO) 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.

Addendum D – Approved by CMS - 08/13/2015 – Update to Tribal Medicaid Outreach and Linkage Plan – Tribal Medicaid Administrative Claiming (TMAC) – Updates to both Tribal invoice and outreach attestation related to CMS Connecting Kids to Coverage funding or other federal funding for Medicaid administration related to outreach and enrollment assistance.



Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

MAY 03 2012

William J. Streur, Commissioner
Department of Health and Social Services
Post Office Box 110601
Anchorage, Alaska 99811-0601

RE: Alaska State Plan Amendment (SPA) Transmittal Number 12-002

Dear Mr. Streur:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Alaska State Plan Amendment (SPA) Transmittal Number 12-002. This amendment implements the consultation of tribal health programs prior to the submission of any plan amendment in compliance with Section 1902(a) (73) of the Social Security Act as required at 5006(e)(2) of the American Recovery and Reinvestment Act.

This SPA is approved effective January 1, 2012. CMS will utilize the process as articulated in reviewing Alaska SPAs, waivers, and demonstration projects going forward.

If you have any additional questions or require any further assistance regarding this amendment, please contact me, or have your staff contact Maria Garza at (206) 615-2542 or via email at maria.garza@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health
Operations

cc: Kimberli Poppe-Smart, Deputy Commissioner

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
12-002

2. STATE
Alaska

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2012

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(73) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 12 \$0
b. FFY 13 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 9
Page 9(i)
Page 9(ii)
Page 9(iii)
Page 9(iv) (added) (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Page 9

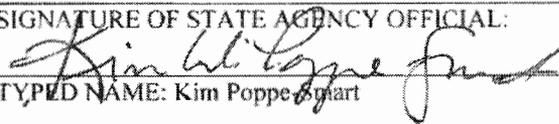
10. SUBJECT OF AMENDMENT:
Tribal Consultation

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED: Governor does not
wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Kim Poppe

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED: February 2, 2012

16. RETURN TO:

Alaska Department of Health and Social Services
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
February 3, 2012

18. DATE APPROVED:
May 3, 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:
Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

Operations

P&I changes authorized by the State on 03/13/2012.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alaska42 CFR 431.12(b) 1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

1. Tribal Consultation Policy

In order to comply with Section 1902(a)(73) and Section 2107(e)(1) of the Social Security Act, the State of Alaska Department of Health & Social Services (Department) establishes this formal policy on tribal consultation for Medicaid and the Children's Health Insurance Program (CHIP). This relationship enhances and improves existing communication between parties and facilitates the exchange of ideas regarding state plan amendments, waivers, and demonstrations related to Medicaid and Denali Kid Care (the Federal Children's Health Insurance Program).

It is the intent and commitment of the Department to solicit advice, review, seek clarification, and utilize the aforementioned as appropriate from the federally recognized tribal health programs and the Indian Health Service (IHS) to ensure that they are included in the decision making prior to changes in programs that are likely to have a direct effect on American Indians or Alaska Natives (AI/ANs), tribal health programs or IHS, while preserving the right of the Department to make appropriate decisions. *Amendments to the State Plan, waivers, or demonstrations are considered to have direct effects on American Indians or Alaska Natives (AI/ANs), tribal health programs or IHS if the changes impact eligibility determinations, reduce payment rates, change payment methodologies, reduce covered services, or change provider qualifications/requirement. Proposals for new demonstrations or waivers will also be included in consultation.*

TN No. 12-02

Approval Date

MAY 03 2012Effective Date January 1, 2012Supersedes TN No. 74-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alaska

The following Tribal Consultation policy statement includes an overview of the notification process the Department utilizes to inform identified/required parties with the timeline that allows for reasonable response time for tribal health programs and IHS to review and comment and for the Department to review and integrate input as deemed appropriate. It will detail the identification of the proposed changes, anticipated impacts on AI/ANs and/or tribal health programs and IHS describe how to provide comment and offer an opportunity to request more direct interaction with the Department regarding proposed changes. The Department will summarize comments received and which, if any, influenced the Department's submission and or changes

2. Communication Methods

The Department will use the following methods to provide notice and request input from tribal health programs and IHS on all issues likely to have an effect on AI/AN beneficiaries.

2.1 Written Correspondence (Dear Tribal Leader Letter)

The Department will deliver written notices of state plan amendments, waivers, and demonstrations related to Medicaid and Denali Kid Care (the Federal Children's Health Insurance Program) to designated entities. Designated entities include but are not limited to:

- a. Tribal health programs
 - i. Health Director
 - ii. Board Chair
- b. Alaska Native Health Board
- c. Director, Alaska Area Native Health Service
- d. State/Tribal Medicaid Task Force

The written notice (Dear Tribal Leader Letter) will include, but is not limited to:

- a. Purpose of the proposal/change and proposed implementation plan; and
- b. Anticipated impact on AI/ANs and tribal health programs and IHS as determined by the Department;
- c. Method for providing comments/questions; and
- d. Timeframe for responses

The Department may consolidate notice of multiple changes into a single letter. At the option of the tribal health program, the Department may substitute notification by email or other electronic means for delivery by mail.

2.2 Meetings

Quarterly joint meetings with tribal health programs and IHS and/ or their designees, the Department, and the Alaska Native Health Board or other

TN No. 12-02Approval Date MAY 03 2012Effective Date January 1, 2012Supersedes TN No NA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alaska

designated groups. The Department must be notified in writing if the designees change. This will suffice as documentation that the Department informed the appropriately designated entities.

2.3 Committees/Work Groups

Round tables and work groups should be used for discussions, problem resolution and preparation for communication and consultation. These will provide the opportunity for technical assistance teams from the Department and tribal health programs and IHS to address challenges or barriers and work collaboratively on development of solutions

The Department and/or tribal health programs and IHS will designate technical representation on special workgroups as needed or recommended.

3. Consultation Timeframes

The Department will request consultation at the earliest opportunity, no later than 60 days in advance of submission to the Centers for Medicare and Medicaid (CMS) to give appropriate tribal contact(s) adequate time to consider and respond to the impact of the communication. The tribal health programs and IHS should submit written comment within 30 days so the Department has time to review and incorporate changes as deemed appropriate. If there is a request for a face to face meeting, the Department needs to receive written request within 15 days of the initial notice in order to facilitate a meeting and make changes as deemed appropriate.

4. Implementation Process and Responsibilities

As a component of continued systems accountability, this process will be reviewed and evaluated for effectiveness every four years, or as necessary. A report will be issued 90 days after the Alaska Medicaid and Denali KidCare Tribal Consultation Policy and Procedure review that summarizes the evaluation and details any new strategies and/or specific agreements.

4.1 Department of Health and Social Services

- Solicit advice with tribal health programs and IHS as outlined in the State Plan by Tribal Consultation amendment.
- Maintain electronic information for posting of the Department's Medicaid information for tribal health programs and IHS.
- Provide electronic and or written information through all the methods above.
- Consider input and document action taken with the tribal health programs and IHS prior to final submission of all SPAs, waiver requests, and proposals for demonstration projects to CMS.

TN No. 12-02

Approval Date _____

Effective Date January 1, 2012Supersedes TN No. NA**MAY 03 2012**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alaska

- Provide written documentation of responses to Tribal health programs and IHS comments.

4.2 Tribal Health Programs and IHS

- In order to ensure the success of the Department's commitment to solicit and utilize input from tribal health programs and IHS, the following are strongly encouraged.
- Provide effective representatives to the appropriately designated Quarterly Meetings.
- Representatives share information from committee meetings to others, as appropriate (representatives are responsible to disseminate information from the committee meeting to the appropriate tribal health organizations).
- Identify and facilitate effective participation on issue specific subject matter from representatives on special work groups as requested.
- Keep electronic site updated with current contact information.
- Provide comments/input/advice to help inform the process and ensure that Alaska Medicaid and Denali KidCare meet the needs of AI/ANs and tribal health programs and IHS.
- When specially requested to provide input on a proposed change, please document a response even if there are no comments.

5. Procedures

The Department will notify tribal health programs and IHS, at the earliest opportunity, no later than 60 days in advance of submission to the Centers for Medicare and Medicaid (CMS) of state plan amendments, waiver requests, and proposals for demonstration projects and on a quarterly basis when state plan amendments are submitted and require consultation under this Policy with tribal health programs and IHS.

Tribal health programs and IHS may identify a critical event or issue of concern and make a formal request for consultation with the Department, through the Commissioner's office.

The Department and tribal health programs and IHS will determine the level of consultation needed (written, face to face meeting, or both) to address items #1 and #2, and request consultation as needed.

The parties will determine if work groups should be tasked to work on technical questions in preparation for consultation and the timeline for process completion.

TN No. 12-02

Approval Date _____

Effective Date January 1, 2012Supersedes TN No NA**MAY 03 2012**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Alaska

The Department shall review the results of the consultation policy with tribal health programs and IHS and consider recommended changes.

The Department shall post within 60 days from the close of the consultation period, or as soon as feasible, a summary of the outcome of consultation with tribal health programs and IHS, which may be in the form of a submitted State Plan amendment.

TN No. 12-02 Approval Date _____ Effective Date January 1, 2012

Supersedes TN No NA

MAY 03 2012