Purpose

• Approved tribal health organizations (THO) and Tribes will increase Medicaid and Denali KidCare enrollment and retention of eligible and potentially eligible tribal and non-tribal utilizers using outreach, enrollment, and renewal activities.

• Partner THOs and Tribes will receive reimbursement for some administrative costs associated with performing allowable Medicaid and Denali KidCare outreach and linkage activities.
Tribal Health Organization/Tribe Roles

- Must be an Alaskan Tribal Health Organization or Tribe with a signed TMAC agreement with DHSS
- Conduct approved outreach and enrollment activities for Alaska Natives, American Indians, and non-Tribal members served by the entity
- Utilization of provided forms
- Provide payment of non-Federal portion of the required state match
- Timely submission of requested forms and payment
- Understand TMAC processes using provided training and resources
- Inform DHSS TMAC staff of any contact information changes
DHSS Roles

• Maintain TMAC Memorandum of Agreement
• Provide training sessions upon request
• Make available online access of current forms and processes
• Prompt payment of Administrative Fee to partners
• Provide monitoring and oversight through reconciliation and audit processes
General Process

1. Entity does enrollment outreach
   - Data is collected and entered in forms

2. Entity submits forms and EFT transfer
   - Submission must be timely for payment

3. DHSS pays administrative fees to entity
   - DHSS reconciles Medicaid services recipient list with Medicaid claims list
Approved Outreach and Enrollment Activities

- Medicaid and Denali KidCare application and renewal assistance using Division of Public Assistance (DPA) paper and online applications and through the Federally Facilitated Marketplace
- Arrangement of travel for clients
- Community outreach at events such as health fairs
- Screening and enrolling during patient registration

- **DPA website** includes information and applications
- **Federally Facilitated Marketplace** reviews and may be able to determine Medicaid eligibility
Quarterly Submission Documents

All forms and non-federal portion of the required state match must be submitted to DHCS 45 days after the end of each quarter. Failure to submit timely will result in nonpayment.

1. TMAC Outreach List
2. Tribal Outreach Attestation Submission
3. Medicaid/Denali KidCare Unduplicated Medicaid Recipients
4. Tribal Medicaid Administrative Claiming Invoice and Attestation Submission

*All documents are on the TMAC website or by request at: tmac.hss@alaska.gov
Form 1: TMAC Outreach List

<table>
<thead>
<tr>
<th>Tribal Health Organization</th>
<th>TMAC Manager Name &amp; Telephone Number</th>
<th>FFY YEAR / QUARTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENTER TRIBE NAME HERE</td>
<td>ENTER MGR. NAME/PHONE#</td>
<td>ENTER FFY/QUARTER</td>
</tr>
</tbody>
</table>

**Due: 45th day after the close of the prior quarter. Submit via DSM to: dhcs.tmac@hss.soa.directak.net**

<table>
<thead>
<tr>
<th>Alaska Native or American Indian</th>
<th>Non Native Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 21</td>
<td>Adults 21-64</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adults 21-64</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>65 or Older</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL ENTRIES</td>
<td></td>
</tr>
<tr>
<td>Grand Total Outreach</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Name</th>
<th>Under 21</th>
<th>Adults 21-64</th>
<th>65 or Older</th>
<th>Under 21</th>
<th>Adults 21-64</th>
<th>65 or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2017</td>
<td>Susie Smith</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Provide full names
- Outreach and enrollment employees complete this form
Form 2: Tribal Outreach Attestation Submission

- Outreach and enrollment employees complete this form
- Signed by the entity’s TMAC manager

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@dhss.sld.directak.net

Tribal or Tribal Health Organization: ____________________________
TMAC Manager: ____________________________ Tel: ____________________________
DSM: ____________________________ Email: ____________________________
Address: ____________________________ Zip: ____________________________

Please Specify Quarter and FYY: ____________________________

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) certify and attest that all patient registrants present in the undersigned quarter, for the Tribal health medical services, were outreached and provided an explanation, either verbally or visually, of the DentalCare and/or DentalKidCare 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, these 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 carry out these children to prevent duplication of payment for these Medicaid administrative activities (please refer to corresponding invoice annotation).

TMAC Manager: ____________________________
TMAC Manager Signature: ____________________________
Date: ____________________________
Department of Health & Social Services

Form 3: Medicaid/Denali KidCare Unduplicated Medicaid Recipients

- Provide full names
- TMAC manager or designated fiscal staff completes this form

<table>
<thead>
<tr>
<th>Tribe or THO</th>
<th>QTR / FFY</th>
<th>This section will auto tabulate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast Alaska Regional Health Consortium</td>
<td>FFY18, QTR2 (Jan 1, 2018 - Mar 31, 2018)</td>
<td>Under 21</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

Due: 45th day after the close of the prior quarter. Submit via DSM to: dhcs.tmac@hss.soa.directak.net

<table>
<thead>
<tr>
<th>Recipient Medicaid ID Number</th>
<th>Recipient Name</th>
<th>Date of Birth</th>
<th>Under 21</th>
<th>Adults 21-64</th>
<th>65 or Older</th>
<th>Under 21</th>
<th>Adults 21-64</th>
<th>65 or Older</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567890</td>
<td>Joe Example</td>
<td>1/1/1985</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Form 4: Tribal Medicaid Administrative Claiming Invoice and Attestation Submission

- Quarterly invoice of administrative fees
- Attestation of transferred funds to DHSS represent the non-Federal share of the Federal matching funds for allowable activities
- THO/Tribal CFO signs this form
Direct Secure Messaging (DSM)

- Send forms through a DSM e-mail for HIPAA compliance

To sign up:

- [healthconnect Alaska webpage](#)
- [DSM webpage](#)

E-mail: [healtheConnect@helpdesk.inpriva.net](mailto:healtheConnect@helpdesk.inpriva.net)

Phone: 866-936-1423

TMAC Direct Secure Messaging:

Email: [dhcs.tmac@hss.soa.directak.net](mailto:dhcs.tmac@hss.soa.directak.net)
Each submission encompasses one quarter. All submission documents and EFT of non-federal funds are due 45 days after the last day of each quarter.

Submission Due Dates

- Nov. 14, 2019: FFY19, Q4 (July 1 – Sept. 30)
- Feb. 14, 2020: FFY20, Q1 (Oct. 1 – Dec. 31)
- May 15, 2020: FFY20, Q2 (Jan. 1 – March 31)
- Aug. 14, 2020: FFY20, Q3 (April 1 – June 30)
- Nov. 16, 2020: FFY20, Q4 (July 1 – Sept. 30)
After the 4th consecutive quarter, if there is a recoupment required, it will be subtracted at the time the next EFT is issued to the entity, or an invoice will be issued.

There must be recipient claims submitted by the 4th consecutive quarter or the administrative fee will be offset from future payments from DHCS to the entity.

DHSS does a quarterly match of the Enterprise claims against each quarter’s unduplicated list submitted by the entity. There must be recipient claims submitted by the 4th consecutive quarter or the administrative fee will be offset from future payments from DHCS to the entity.

DHCS issues and EFT payment to the entity.

Entity submits the invoice and attestation forms to DHCS via DSM & and non-Federal portion of the required state match via ACH transaction.
ACH and Wire Transfers to DHSS

**Wire Transfer Instructions**

Notify the State of Alaska, Treasury Division, by 2:00 PM AST the business day prior to the wire transfer settlement date by e-mail to: dot.trs.cashmgmt@Alaska.gov. The notice must include the payer name, payment amount, settlement date, the state agency the funds are for, and the purpose of the payment.

1. Instruct your bank to initiate a wire transfer of funds through the Federal Reserve wire transfer system to be received and credited to the State of Alaska:

   State Street Bank & Trust Company  
   State Street Financial Center  
   1776 Heritage DR  
   North Quincy, MA 02171  
   ABA # 011000028  
   State of Alaska – AY01  
   General Investment Fun  
   Account # 00657189

2. Confirmation is available by calling the Alaska Department of Revenue, Treasury Division at 907-465.2360

3. Do not sent ACH credit Transactions to this account.

**ACH Transfer Instructions**

Notify the State of Alaska, Treasury Division, by 2:00 PM AST the business day prior to the wire transfer settlement date by e-mail to: dot.trs.cashmgmt@Alaska.gov. The notice must include the payer name, payment amount, settlement date, and that the payment is for ACH 06034.

1. Prepare the amount due.

2. 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  
   State Street Financial Center  
   1776 Heritage DR  
   North Quincy, MA 02171  
   ABA # 011000028  
   State of Alaska – AY01  
   General Investment Fun  
   Account # 00657189

3. Confirmation is available by calling the Alaska Department of Revenue, Treasury Division at 907-465.2360

4. Do not sent any other State of Alaska payment types to this account.
DHSS Contacts

Staff

• Kyle Skeek, TMAC Receipt & Reconciliation, Health Care Services: 907.465.5829
• Sarah Harlamert, TMAC Receipt & Reconciliation Oversight, Health Care Services: 907.269.7398
• Sarah Harlamert, TMAC Manager, Health Care Services: 907.269.7398
• Renee Gayhart, Division Director, Health Care Services: 907.334.2400

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

E-mail
General e-mail: tmac.hss@alaksa.gov
DSM e-mail: dhcs.tmac@hss.soa.directak.net
Acronyms

• ACH: automated clearing house
• CFO: Chief Financial Officer
• DHCS: Division of Health Care Services
• DHSS: Department of Health and Social Services
• DPA: Division of Public Assistance
• DSM: Direct Secure Messaging
• EFT: electronic funds transfer
• FFP: federal financial participation
• FFY: Federal Fiscal Year, which has four quarters, Q1 (Oct, Nov, Dec); Q2 (Jan, Feb, March); Q3 (April, May, June); Q4 (July, Aug, Sept).
• IGT: intergovernmental transfer
• THO: tribal health organization
• TMAC: Tribal Medicaid Administrative Claiming
QUESTIONS?

Thank You