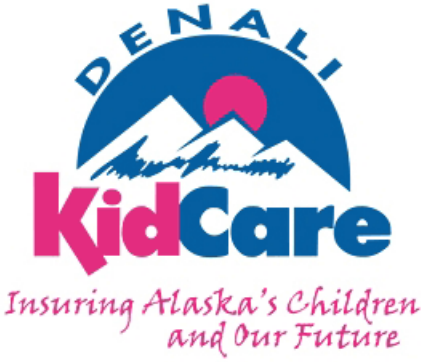
Tribal Medicaid Outreach and Linkage Plan
Tribal Medicaid Administrative Claiming
(TMAC)



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 H&SS and participating federally recognized Tribes and Tribal organizations (see Addendum A).
2. Share in the responsibility for promoting access to Denali KidCare (M-CHIP) for Alaska Natives and American Indians.
3. Reimburse the Tribes and Tribal Health Organizations for performing Denali KidCare outreach and linkage activities

This activity is intended to support the effective and efficient administration of the Medicaid and Denali KidCare programs, which include provision of outreach and linkage activities to Alaska Natives (AN), American Indians (AI) and non-Tribal members served by the 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 Medicaid 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 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 Requirement's for Tribal Medicaid Administrative Costs* document incorporated by reference in this plan (see Addendum F). These two options combine 1) payment of an administrative fee and 2) execution of a memorandum of agreement.

II. TRIBAL HEALTH PROVIDERS

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% including non-Tribal providers with signed care coordination agreements with the Tribal Health provider. 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 Medicaid 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 and for the care coordination agreements mentioned above. 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.

Tribal health organizations and Tribes currently not contracted to perform Medicaid/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 including when they see non-Tribal providers with care coordination agreements

described previously except when a Tribal child or adolescent otherwise receives Medicaid/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 US Department of Health and Human Services for the proper and efficient administration of the Medicaid State Plan.

When a recipient is seen, the Tribal Health Care Organizations can streamline eligibility, increase efficiency and reduce administrative costs if eligible Medicaid and 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 Medicaid and 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.

To establish a rebased administrative fee for Medicaid administrative activities, after consultation with CMS Region X staff in spring 2017, the Department undertook a random moment time study (RMTS) with which to calculate newly rebased rates (see Addendum B).

Cost per unduplicated recipient per quarter of providing Medicaid/Denali KidCare outreach and linkage was calculated for the Tribal health organizations utilizing a RMTS for the time period July 1 through September 30, 2017 and associated direct and indirect costs for the same time period.

Absent a software solution with which to conduct a RMTS, after consultation with CMS, the Department gathered time studies for Tribes for all 15 minute moments during the quarter. The RMTS component occurred during the calculation phase, in which the Department utilized excel to randomly select moments to test to inform the percentage of time that the Tribal health organization employees spent on Tribal Medicaid Administrative Claiming (TMAC) activities. In the time study documents, tribal employees detailed which activity, out of those listed below, that the employee spent a majority of the 15 minutes on. Only the moments selected to test informed the percent of TMAC time for the tribe.

A Eligibility – Medicaid (Application / Renewal)
B Eligibility – Non-Medicaid (Application / Renewal)
C Referral – Medicaid (to send or direct for treatment, aide, information, or decision
D Referral – Non-Medicaid (to send or direct for treatment, aide, information, or decision
E Community Outreach – Medicaid (Health Fairs/Information Booths)
F Community Outreach – Non-Medicaid (Health Fairs/Information Booths)
G Training – Medicaid (general program training to providers or providing/receiving training
H Training – Non-Medicaid (general program training to providers or providing/receiving training

I Transportation – Medicaid (to arrange travel for Medicaid/Denali KidCare)
J Transportation – Non Medicaid (to arrange travel for Non-Medicaid recipients)
K All other work activities for which you are paid by your employer
L Paid time off (vacation, sick leave, holiday, paid lunch, paid break)
M Unpaid time (unpaid lunch, or other time not paid by employer)

Work performed under codes A, C, E, and G were classified as TMAC time for all tribes. For tribes which do not separately book and bill for transportation for Medicaid recipients, code I was also classified as TMAC time.

The TMAC rate will be a single unduplicated quarterly recipient rate that will be utilized by each of the approved TMAC providers.

The numerator of the rate calculation utilizes the cost of TMAC activities for the participating Tribal health organizations. First the individual Tribal health organization TMAC costs is calculated using the salaries of the tribe's employees who conducted a TMAC time study multiplied by the tribe's fringe benefit percentage multiplied by the tribe's federal indirect rate and multiplied by the percent of TMAC time as determined by the RMTS. For the numerator, the TMAC costs for the participating Tribal health organizations is added together. The denominator of the calculation is the number of unduplicated quarterly Medicaid recipients for the participating Tribal health organizations during dates of service July 1 through September 30, 2017. Claims data from the Medicaid Management Information System (MMIS) was pulled at the beginning of December 2017 for all provider types under the Federal Employer Identification Numbers (FEIN). The unduplicated quarterly recipient count was calculated for each participating Tribal health organization and then added together for all participating Tribal health organizations. The final calculation is the costs of TMAC activities for all participating Tribal health organizations divided by the unduplicated quarterly recipient counts by Tribal health organization for all Tribal health organizations.

After the first FFY implementation ends, the TMAC fees will be adjusted by the Department 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. The CPI-U inflation adjustment will be applied annual 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 outlines in the plan and training materials. If a THO is no-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 Medicaid/Denali KidCare coverage information including local Tribal contact information. 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 Medicaid/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 Medicaid/Denali KidCare public insurance programs for which they were eligible, including both local Tribal contact and state contact information.

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. Financial data that is submitted as the basis for the initial fee/rate calculations are true and correct.
2. The non-Federal share of the required State match is provided through the intergovernmental transfer (IGT) with the State assuring that the non-Federal share of Medicaid expenditures is provided by a unit of government, including and Indian Tribe or a 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 Medicaid/Denali KidCare recipients of Medicaid services. Unduplicated recipient counts are

drawn from the universe of Medicaid enrolled providers at each Tribe or Tribal health organization under each organization's FEIN. The Tribe or Tribal health organization will transfer with the invoice, the non-Federal portion of the required state match via IGT through EFT/ACH/EDI to the State Treasury

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 outline in Section III and further defined in Section IV above for the period reference 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 the 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 Medicaid/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. Quarterly, Tribes or Tribal health organizations will submit to DHCS an unduplicated Medicaid/Denali KidCare ID recipient of Medicaid services list rolled to a single date of service for that quarter. As mentioned previously, unduplicated recipient counts are drawn from the universe of Medicaid enrolled providers at each Tribal entity under each organization's FEIN.
2. The Office of Rate Review will run a Cognos report to match the unduplicated Medicaid/Denali KidCare recipient list submitted by each THO against Medicaid/Denali KidCare claims.

3. At the end of each 12-month timely filing period for Medicaid/Denali KidCare claims and after each successive 5th consecutive quarter, the original unduplicated recipient lists are again matched to claims. The unduplicated recipient list is reconciled with the claims database and the remaining unmatched recipients of Medicaid services are determined and the recoupment fees are offset against the TMAC payment for the current quarter.

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 *Medicaid/Denali KidCare Tribal Consultation Policy and Procedure* is incorporated by reference (see Addendum E). 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.

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. Eastern Aleutian Tribes - EAT
5. Kenaitze Indian Tribe – KIT
6. Ketchikan Indian Corporation – KIC
7. Kodiak Area Native Association - KANA
8. Maniilaq Association
9. Native Village of Eyak
10. Norton Sound Heath Corporation – NSHC
11. Seldovia Village Tribe – SVT
12. Southcentral Foundation – SCF
13. Southeast Alaska Regional Health Consortium – SEARHC
14. Tanana Chief Conference – TCC
15. Yukon-Kuskokwim Health Corporation – YKHC

Addendum B - Tribal Medicaid Administrative Claiming Proposal for New TMAC Rates – 2018

Purpose:

To calculate proposed rates for Tribal Health Organizations (THOs) for Tribal Medicaid Administrative claiming. The proposed rates below are based on Medicaid Management Information System (MMIS) recipient data from July 1 – September 30, 2017 (Q4 FFY 2017) and a random moment time study performed by the Department. The proposed rate is a single rate for all Tribal health organizations.

	A	B	
	TMAC Costs Q4 FFY17	**Number of Unduplicated Quarterly Recipients DOS Q4 FFY17**	
Alaska Native Tribal Health Consortium	$ 329,581.80	13,321	
Southcentral Foundation	$ 220,982.21	13,461	
Norton Sound Health Corporation	$ 24,034.29	2,880	
Southeast Alaska Rural Health Corporation	$ 16,121.59	4,737	
Tanana Chiefs Conference	$ 47,845.48	3,502	
Yukon Kuskokwim Health Corporation	$ 33,641.81	8,711	
Bristol Bay Area Health Corporation	$ 25,133.76	1,887	
Eastern Aleutian Tribes	$ 2,303.07	185	
Kenaitze Indian Tribe	$ 1,831.69	598	
Seldovia	$ 15,572.10	589	
UNDUP. RECIP PER QTR RATE	**$ 717,047.80**	**49,871**	**$ 14.38**

A	The TMAC Costs Q4 FFY17 is calculated for each Tribal health organization using the salaries of the participating employees multiplied by the fringe benefit percentage for the Tribal health organization multiplied by the Tribal health organization's federal indirect rate multiplied by the percent of the Tribal health organization's participating employees time spent on TMAC activities as determined by the random moment time study conducted during dates July 1 through September 30, 2017.
B	The number of unduplicated quarterly recipients for dates of services Q4 FFY17 is calculated for each Tribal health organization using claims data from the Medicaid Management Information System (MMIS) for dates of services July 1 through September 30, 2017 pulled in December 2017 for all services provided under the Tribal health organization’s Federal Employer Identification Number (FEIN).

CMS Addendum D – Tribal Medicaid and Linkage Plan – Tribal Medicaid Administrative Claiming (TMAC)

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 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 outline 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 a 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 CMS Connecting Kids to Coverage grant have been removed from the TMAC recipient of services list to ensure 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/THO's 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 Medicaid 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)

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 Outline in Section III and further defined in Section IV of the Tribal Medicaid Outreach and Linkage Plan for the period reference and that the funds transferred via IGT from the Tribes the State of Alaska Department of Health and 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 noticed that the information is to be used for filing of a claim with the Federal Government for Federal Funds and knowing misrepresentation constitutes violation for 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 Tribes' 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.

ADDENDUM E

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

MAY 0 3 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-002

2. STATE: Alaska

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:
Kim Wilpoppe Stuart

13. TYPED NAME: Kim Poppe Stuart

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED: Feburary 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:
Carol J.C. Peverly

21. TYPED NAME:
Carol J.C. Peverly

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

23. REMARKS:

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

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Alaska

42 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)(I) 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 affects 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.*

The following Tribal Consultation policy statement includes an overview of the notification process the Department utilizes to inform indentified/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

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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

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.

- 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.

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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.

CMS Claiming Requirements for Tribal Medicaid Administrative Costs

Issue: What are acceptable options for States to claim FFP for allowable Medicaid administrative expenditures on behalf of Tribal governmental entities and Tribal organizations?

Introduction

When States submit claims for FFP on behalf of Tribal governments and organizations for Medicaid administrative expenditures, there are a number of cost allocation requirements that are required. Specifically, only those costs directly related to Medicaid are allowable, and costs must be allocated according to accepted cost principles.

Tribal entities with which they contract to conduct Medicaid administrative activities frequently find these requirements to be overly burdensome, and have requested ease of these requirements. Concern has also been expressed over the difficulty in meeting statistical validity criteria when sampling techniques are utilized. To address these ongoing concerns, CMS is proposing an expanded array of cost allocation options for States on behalf of Tribes, as outlined below, so that Tribes may have some less burdensome requirements to seek reimbursement for administrative costs.

Options

The following are options and a corresponding discussion of the pros and cons of each option that would allow States and Tribes to claim administrative costs incurred by Tribal entities with which they contract. These options are ordered from what CMS thinks is the most burdensome to least burdensome, from a Tribal perspective. These options are intended to initiate a more detailed discussion with Tribes and Washington State in order to put in place an acceptable form of administrative claiming.

1. When the number of participating claiming entities is sufficient, develop a statewide, statistically valid CMS-approved random moment time study, per OMB Circular A-87 cost allocation principles.
2. When the number of participating claiming entities is small, develop a non-statewide CMS-approved random moment time study that is statistically valid when the results from individual claiming entities are aggregated, with FFP distributed in a way that each claiming entity's costs are fully recognized.
3. Select five random days per Tribal staff person with each day considered as the observation unit, and total observations will vary depending on number of Tribal staff. The resulting estimates of reimbursable time would likely reach the desired level of statistical precision for all Tribes, except those with smaller staff sizes. A somewhat larger number of randomly selected days would be required for the smaller tribes to meet statistical validity requirements.
4. Select one random week for all Tribal staff with each week considered as the observation unit. The total number of observations will equal the total number of staff persons

participating in the time study in a given tribe. The random week sampling method will likely fail to produce statistically reliable estimates of reimbursable activity for most Tribes. In order to meet statistical validity requirements, the data from a number of Tribes may have to be combined.

5. In lieu of ongoing time studies, develop a CMS-approved rate, fee schedule or cost-based fee based on a one-time sample. Tribal staff will document and bill for each encounter with a Medicaid eligible individual, who receives Medicaid allowable administrative services.
6. In lieu of conducting a time study, and when underlying costs are nominal and do not exceed a CMS-determined threshold of significance, execute a legal contract directly with the claiming entities that does not involve application of a proportion Medicaid eligibility ratio.

Option 1: *Develop a statewide, statistically valid CMS-approved random moment time study, per OMB Circular A-87 cost allocation principles.*

Pros

- The State's methodology would fully comply with requirements of OMB Circular A-87.
- Medicaid would only be reimbursing for costs directly and solely related to Medicaid.
- There would be sufficient documentation to track costs to assure fiscal integrity of the program.
- Conducted statewide, there would be sufficient staff to meet the statistical validity criteria.

Cons

- Would maintain OMB A-87 requirements on Tribes for tracking administrative services costs.
- Providers may be unwilling to continue to provide administrative activities due to the administrative burden of tracking their costs.
- Most Tribes do not have sufficient staff to generate enough observations to meet statistical validity criteria.

Option 2: *When the number of participating claiming entities is small, develop a non-statewide CMS-approved time study that is statistically valid when the results from individual claiming entities are aggregated, with FFP distributed in a way that each claiming entity's costs are fully recognized.*

Pros

- The State's methodology would fully comply with requirements of OMB Circular A-87.
- Medicaid would only be reimbursing for costs directly and solely related to Medicaid.
- There would be sufficient documentation to track costs to assure fiscal integrity of the program.

Cons

- Would maintain a burdensome requirement on Tribes for tracking administrative services costs.
- Providers may be unwilling to continue to provide administrative activties due to the administrative burden of tracking costs.
- Tribes have expressed concerns related to Tribal sovereignty when data has to be aggregated.

Option 3: *Select five random days per Tribal staff person with each day considered as the observation unit, and total observations will vary depending on number of Tribal staff. The resulting estimates of reimbursable time would likely reach the desired level of statistical precision for all Tribes, except those with smaller staff sizes. A somewhat larger number of randomly selected days would be required for the smaller Tribes.*

Pros

- The State's methodology may produce results that are fully compliant with requirements of OMB Circular A-87.
- Medicaid would most likely only be reimbursing for costs directly and solely related to Medicaid.
- There would be sufficient documentation to track costs to assure fiscal integrity of the program.

Cons

- Would maintain a somewhat burdensome requirement on Tribes for tracking administrative activities and associated costs.
- Smaller Tribes and providers may experience an extremely burdensome requirement for tracking administrative activities and associated costs since they would need more than five random days to meet statistical validity criteria.

Option 4: *Select one random week for all Tribal staff with each week considered as the observation unit. The total number of observations will equal the total number of staff persons participating in the time study in a given tribe. The random week sampling method will likely fail to produce statistically reliable estimates of reimbursable activity for most Tribes. This method, however, may provide statistically reliable estimates if the data from a number of Tribes is combined.*

Pros

- For larger Tribes with sufficient staff, or if data is aggregated from a number of Tribes, the State's methodology may produce results that are fully compliant with requirements of OMB Circular A-87.
- Medicaid would most likely only be reimbursing for costs directly and solely related to Medicaid.

- There would be sufficient documentation to track costs to assure fiscal integrity of the program.
- Method is currently used by a number of Tribes so staffs are trained and familiar with this methodology.

Cons

- Would maintain a somewhat burdensome requirement on Tribes for tracking administrative services costs.
- Smaller Tribes may experience a burdensome requirement for tracking administrative service costs.
- Providers may be unwilling to continue to provide such services due to the administrative burden of tracking costs.
- For most Tribes, the one week per quarter time study will not provide statistically valid results.
- Tribes have expressed concerns related to Tribal sovereignty when data has to be aggregated.

Option 5: *Develop an administrative fee for Tribes providing Medicaid administrative services to Medicaid beneficiaries in lieu of an ongoing time study.*

Pros

- The use of an administrative fee to bill Medicaid for services may be easier than the current one week per quarter, or 100 percent time keeping requirement.
- Once an administrative fee is determined, the Tribe would not need to perform regular time studies.
- Some Tribes already have time study data that can be used to develop an administrative fee.
- An administrative fee would adhere to OMB Circular A-87 cost principles and not require CMS to waiver or relax federal claiming requirements.
- Less ongoing documentation would be required to be maintained by Tribes.

Cons

- Tribes that do not have existing time study data will be required to participate in a time study for some finite period in order to develop the administrative fee.
- CMS would be unable to verify the accuracy of the amounts claimed by the State, without the ongoing time study to capture allowable costs.
- Less documentation would be required to support amounts claimed.

Option 6: *In lieu of time studies altogether, and when underlying costs are nominal and do not exceed a CMS-determined threshold of significance, execute a legal contract directly with the claiming entities that does not involve application of a proportion Medicaid eligibility ratio.*

Pros

- The use of a contract would be less burdensome and disruptive than the current one week per quarter, or 100 percent time keeping requirement.
- Federal and State contract requirements (such as competition and sole source provisions) would apply.
- A legal contract would meet OMB Circular A-87 cost principles and not require CMS to waiver or relax federal claiming requirements.
- Less ongoing documentation would be required to be maintained by Tribes.

Cons

- CMS would not be party to the contract and would therefore be unable to ensure that only allowable costs are claimed.
- CMS lacks statutory authority to require prior approval of contracts if it is not party to that agreement.
- There would be less documentation to support amounts claimed available for CMS review.