STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SENIOR & DISABILITIES SERVICES

Intellectual/ Developmental Disabilities

Medicaid Administrative Claiming

Care Coordination

Billing Manual

Revised 09/2020

Table of Contents

Terminology

MAC	Medicaid Administrative Claiming
Provider	Care coordination agency with a current signed agreement with….
CFR	Code of Federal Regulations
HPM	Health Program Manager employed by the State of Alaska
PACAP	Public Assistance Cost Allocation Plan
SDS	Senior and Disability Services Intellectual/ Developmental Disabilities Unit
DSM	direct secure messaging
HID	Harmony Identification number
Provider	Care coordination agency approved to participate in this MAC program

What is Medicaid Administrative Claiming (MAC)?

The following information is taken from the Medicaid Administrative Claiming section of Medicaid.gov. Please follow the link for more information: Medicaid Administrative Claiming

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for a proportion of expenditures for medical assistance under an approved Medicaid state plan, and for expenditures necessary for administration of the state plan. This joint federal-state financing of expenditures is described in section 1903(a) of the Act, which sets forth the rates of federal financing for different types of expenditures.

Under section 1903(a)(7) of the Act, federal payment is available at a rate of 50 percent for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 CFR 433.15(b)(7). The Secretary is the final arbiter of which administrative activities are eligible for funding.

Certain administrative costs may be matched at higher federal financial participation (FFP) rates. (See 42 CFR 433.15(b)(1)-(6) for higher matching rates). Claims for Medicaid administrative FFP must come directly from the single state Medicaid Agency. In addition, the state must ensure that permissible, non-federal funding sources are used to match federal dollars.

On July 8, 2015, the Center for Medicare and Medicaid Services (CMS) provided responses to general questions received on the subject of claiming Federal Financial Participation (FFP) for Medicaid administrative services.

In order for Medicaid administrative expenditures to be claimed for federal matching funds, the following requirements must be met:

- Costs must be "proper and efficient" for the state's administration of its Medicaid state plan (Section 1903(a)(7) of the Act).
- Costs related to multiple programs must be allocated in accordance with the benefits received by each participating program (OMB Circular A-87, as revised and now located at 2 CFR 200). This is accomplished by developing a method to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs.
- Costs must be supported by an allocation methodology that appears in the state's approved Public Assistance Cost Allocation Plan (42 CFR433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a Provider facility.
- Costs must not duplicate payment for activities that are already being offered or should be provided by other entities, or paid through other Medicaid or grant programs including Targeted Case Management (TCM).
- Costs may not supplant funding obligations from other federal sources.
- Costs must be supported by adequate source documentation.

Medicaid Administrative Claiming provides Care Coordination agencies affiliated with the State of Alaska the opportunity to be reimbursed for activities that support the Medicaid program.

Management

The State of Alaska, Department of Health and Social Services (DHSS), Senior & Disability Services (SDS), Intellectual/ Disabilities (IDD) unit manages this MAC program.
An IDD HPMII is responsible for providing quality assurance review and management for this MAC program with oversight from the supervisory team, which includes the IDD HPMIII and SDS HPMIV. The assigned HPMII will be the main contact for Providers entering into Provider Agreements and submitting MAC Invoices for reimbursement under this MAC program.

Provider Agreements

The HPMII will receive requests from Providers who wish to enter into a Provider Agreement for this MAC program. Those requests will include a letter or email stating thus. The HPMII will review the request and approve or deny. If it is approved the request will be moved on to the SDS/DPH Grants Administrator III. The request, along with proof of Federal Tax ID number, a current State of Alaska Business License, a current, in good standing, Medicaid Provider number, and a current State of Alaska Care Coordination certificate, as stated in the Provider Agreement under Provider Eligibility will be reviewed by the Grants Administrator III.

If the Provider Agreement is approved the original signed Provider Agreement will be held at SDS/DPH Grants with copies given to the Provider and the SDS/IDD HPMII.

If the Provider Agreement is denied, the HPMII will send the Provider a formal letter explaining the denial with details on how to remedy the denial or challenge the denial.

Harmony ID (HID)

Each recipient being served under a Provider Agreement in this MAC program will be identified by the Harmony Identification number. This number will be on all MAC Invoices submitted to SDS and on all back-up documentation kept at the Provider's place of business (see QA Audit section).

MAC Invoice Process

The State of Alaska's fiscal year (FY) runs from July 1st to June 30th, therefore the FY quarters are July 1st to September 30th, October 1st to December 31st, January 1st to March 31st and April 1st to June 30th.

The HMPII will send Mac Invoice templates with the correct FY quarter (eg. FY21 Qtr 1) to Providers who have a current, in good standing, Provider Agreement on file in the 1st week of each quarter in which they are to be used. For instance, FY21 Qtr 1 MAC Invoice template will be sent out during the week of July 1st through July 7th. The MAC Invoice template will be accompanied by this MAC Billing Manual. If a Provider enters into a Provider Agreement during the middle of the quarter the MAC Invoice template and MAC Billing Manual will accompany the copy of the signed Provider Agreement sent to the Provider.

Providers are then required to submit MAC Invoices via DSM to sds.iddanchorage@hss.soa.directak.net, via fax at 907-269-3639 or hand delivery to our offices at 550 W. 8th Avenue in Anchorage, Alaska within 30 days after the end of each quarter in which billable activity occurred. The following dates are true for all fiscal years (FY) under this MAC program:

FY Qtr	Qtr dates	MAC Invoice template sent to Provider	MAC Invoice due to HPMII for payment
Qtr 1	07/01 to 09/30	07/01 to 07/07	no later than 10/30
Qtr 2	10/01 to 12/31	10/01 to 10/07	no later than 01/30
Qtr 3	01/01 to 03/31	01/01 to 01/07	no later than 04/30
Qtr 4	04/01 to 06/30	04/01 to 04/07	no later than 07/30

Note: Providers are to report the expenditures for that quarter following the guidance found here (45CFRss95.13), which is summarized:

1) We consider a State agency's expenditure for assistance payments…to have been made in the quarter in which a payment was made.
2) We consider a State agency's expenditure for services to have been made in the quarter in which any State made a payment to the service Provider.
3) The date of expenditure is governed by 45 CFR 1396.52(d).

Payment Rates and Codes

In accordance with the PACAP (X.2.D), revised 9/30/19, "In order to facilitate the smooth transition of Alaskans served in out of state facilities back to the State of Alaska or for Alaskans served within the state facilities back to a home and community based setting, home and community base services Providers or administrative case management Providers must meet with the individual in their current setting to observe behaviors and needs, and also engage the individual's current service Providers in planning for the individual's successful return to a home and community based setting in Alaska."

Given that, there are 3 types of reimbursable activities under this MAC program.

CODES

Code T2022: Case Management- required contact and coordination

- Comply with all requirements under 7 AAC 130.238, 7 AAC 130.240 and Care Coordination Services Conditions of participation.
- Complete and submit the annual ICAP application to SDS/IDD for issuance of annual Level of Care.
- Contact the recipient at least twice a month. Participate in monthly discharge planning meetings with the supporting team and guardian(s). This monthly contact will replace the required 1x per month face to face contact.
- Assist the guardian with discharge planning, including working with in or out-of-state facility on a safe and effective discharge plan back to the recipient's home and community. This includes phone calls, gaining signatures, Releases of Information, sending referrals for potential placements, etc.

Reimbursement is based on a flat monthly encounter rate for case management, per eligible recipient for a maximum of 12 in a calendar year. The current encounter rate for case management has been set at $246.79. A Provider of MAC services may only bill the unduplicated encounter rate once per month, per eligible recipient, and must keep documentation to verify the intensity and duration of the encounter activity.

Code T2024: Plan of Care Development- 1 time per year

- Complete and submit a support plan that meets the requirements of 7 AAC 130.217 and SDS1915(c), minus Medicaid codes, signed by the supporting team and guardian.

Reimbursement is based on a flat annual rate of $394.43 for the development of this support plan for each recipient.

Code 2: Travel

Expenditures for Lodging, Ground Transportation, and Ticket Class are reimbursed in accordance with Alaska Administrative Manual (AAM) 60. Supporting documentation must accompany all claims. Receipts are required. All expenses claimed are subject to review and reimbursement of unsupported expenses may be disallowed. A Face-to Face Invoice will be used for the travel reimbursement and verification. Submission for Face-to-Face Invoice will follow the same timeline described above.

Allowable Provider travel expenditures include:

- Lodging: A Commercial Lodging Facility is a licensed entity that is in the business of selling lodging to the general public and includes hotels, inns, motels, apartments, and campgrounds. Actual costs for short-term lodging are authorized for moderately priced commercial lodging. Each agency must ensure that lodging costs are reasonable and necessary.
- Ground Transportation: Transportation expenses consist of commercial carrier fares, vehicle mileage allowances, taxi fares, bus fares.
- Ticket Class: Lowest ticket class on a regularly scheduled airplane, ship, or train that is the most direct route to accomplish the business purpose of the travel.

The following shall be attached to the Face-to-Face Invoice when submitted for final payment:

- Airplane, ship, or train receipts
- Ground Transport receipts
- Itemized Lodging receipts

The following travel-related expenses are not reimbursable:

- Lost or stolen articles
- Alcoholic beverages
- Food and non-alcoholic beverages
- Damage to personal cars, clothing, or other items
- Services to gain entry to a locked car
- Movies charged to hotel bills.
- All expenses related to the personal negligence of the Traveler, such as fines, parking tickets and traffic citations.
- Entertainment expenses

- Tips and gratuities
- Towing charges
- Expenses for children, spouses, and companions while in Travel Status.
- Personal phone calls or faxes.

The above list is not all-inclusive. Funding for Medicaid Administrative Claiming (MAC) activities must be approved by the HPMII.

QA Audit: Providers can expect to be audited by the Center for Medicaid/Medicare Services or the State of Alaska to ensure all claimable activities have the required supporting documentation. To assist with these audits, SDS will also maintain billing records under this program. However the Care Coordinator providing this service is responsible for maintaining thorough documentation of all services provided under the agreement.