

## 100% FMAP STATE HEALTH OFFICIAL LETTER

### CONCEPTS AND IDEAS

On April 15, OHCA held their first 100% FMAP Tribal Workgroup conference call.

Our intent is to keep this process simple, straightforward, and not burdensome for any of the three parties (OHCA, I/T/U's, providers).

The following are a few concepts and ideas we would like to explore:

- Care Coordination Agreements:
  - CMS simply refers to a “written agreement” with four minimum requirements
    - The IHS/Tribal facility practitioner provides the request for specific services and relevant information about the patient to the non-IHS/Tribal provider
    - The non-IHS/Tribal provider sends information about the care provided to the patient to the IHS/Tribal facility practitioner
    - The IHS/Tribal facility practitioner continue to assume responsibility for the patient’s care by assessing the information and taking appropriate action; and
    - The IHS/Tribal facility incorporates the patient’s information in his/her medical record.
  - The first two requirements are likely in everyone’s PRC contracts. We need to check our respective templates to make sure they are covered.
  - The last two are independent of the outside Provider. So, the I/T/U need only state/certify that it is our policy and practice to do those things for referred care.
  - OHCA does not need to maintain copies of PRC contracts.
  - Recommendations are:
    - OHCA “request” each I/T/U to provide a Written Certification (we could develop a format):
      - Identifying the list of contracted providers;
      - Attesting that the first two requirements are covered in the written contract;
      - Attesting that we have a policy that requires the last two requirements be done for follow up to referred care.
    - The OHCA provides some form of “Admin payment” for providing this Certification (annually for an updated list?)
      - CMS guidance implies that Admin payments might be acceptable: “However, states can set rates that address unique needs in particular geographic areas or encourage provider participation in underserved areas.”
  - Referrals:
    - CMS guidance says for claims made by the outside provider:

- “The claim must include field(s) such as a code or check-box that document that the service was “received through” an IHS/Tribal facility to ensure proper FMAP”
  - OHCA could simply include that on the claim form, and also have a drop down to select the Medicaid I/T/U provider that the referral came from.
  - OHCA should provide an admin payment for each claim documented as an I/T/U referral
  - OHCA should maintain compliance with random checks of outside providers for documentation.
- We don’t believe the I/T/U entering a special entry for the referral on the front-end is necessary. It seems unnecessary and creates extra work for the referred care staff.

Other Ideas we would like to explore:

1. Explore new provider types and new authorities for Medicaid that would be beneficial. In one state with tribal constituents they are adding Pharmacists, mental health professionals, Adult EPTSD, Behavioral Health aides, dental health aides and community health aides.
2. Other thoughts include patient housing, evaluation of quality and safety for patient's homes, both as new opportunities for revenue.
3. Provide some type of incentives for the providers (to do something to keep them in Medicaid) - could be through an administrative claim fee.
4. Per Member, per month payment for care coordination on top of managing care of individual.

# OHCA Tribal Workgroup: 100% fmap Re-definition

May 18, 2016

## Objective:

OHCA to collect maximum FMAP for services referred through an ITU. To ensure compliance with CMS documentation requirements, OHCA will capture pertinent information through an electronic referral and standardized coordination agreements.

Based on stakeholder input, OHCA plans to develop an approach to minimize the administration burden on I/T/U's and pursue option #1 presented in SHO #16-002

## Approach:

OHCA's goal is to implement 100% FMAP in three phases

Phase I – Choice members, ITU is the assigned PCP – *we are already doing - PCP + referrals*

- No change on the referral or claim
- No provider training needed
- Include CCA attestation checkbox
- Minor OHCA system changes
- No increase in referrals from ITUs

*match claim to referral  
- NO ↑ or admin. burden on  
ITU or provider.*

Phase II – Choice members, ITU is not the PCP

- No change on the referral or claim
- ~~○ Training for non-ITU providers needed~~
- Increased referrals from ITUs

*Educate ITU on current PCP  
process change*

Phase III – Title 19 members, no PCP assignment required

- LTC, Dual elig, Foster Care, AMO* ○ No change on the referral or claim
- Training for ITU providers needed
- Training for non-ITU providers needed
- Significant increase of referrals from ITUs

*FFS  
ref. not req'd.*

OHCA will also need to identify an approach to verify **care coordination agreements (CCA)** between IHS/Tribal facilities and non-IHS/Tribal providers meet the four elements identified in SHO #16-002. "At a minimum, care coordination will involve:

- (1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;
- (2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;

- (3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
- (4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means."

External tribal workgroup prefers PRC provider agreements be utilized in lieu of creating new care coordination agreements. CMS directed OHCA to visit with Indian Health Service as they are currently revising their PRC agreements to incorporate the 4 minimum requirement language.

Electronic attestation of care coordination agreements on OHCA provider portal.

How to address informal agreements?

**Project High-Level Timeline:**

Task Name	Start	Finish
OHCA workgroup convene	03/16	11/16
Tribal workgroup convene to develop proposal for implementation	04/16	11/16
Approval by OHCA executive staff	05/16	05/16
Develop final proposed process	05/16	07/16
Tribal consultation (expedited); notice to ITU providers	08/16	09/16
Implementation	09/16	11/16

**Updates:**

ITU stakeholders developed a white paper to present to OHCA detailing recommendations on implementation of this policy re-interpretation.

- "special entry" on the referral; claim cannot be modified
- Attestation of CCA – electronic on referral page with a checkbox
- Administrative payment – current ITU PCP care management fee; TMAM; 50% fmap

Per 5/2 OHCA call with CMS, CMS is developing a set of Q&A's that will be coming out soon.

Outstanding questions for CMS:

- Will 'episodes of care' be allowed?
- Attestation of CCAs