10A

DRAFT

MEMORANDUM OF UNDERSTANDING TO COORDINATE CARE BETWEEN (NAME) AND [NAME OF PROVIDER]

I. Purpose and Summary

This Care Coordination Memorandum of Understanding (hereinafter “Agreement”) is made between [name of PROVIDER] (hereinafter “Provider”) and [Name of Tribal Facility] (hereinafter “Covered Facility”) . The purpose of this Agreement is to implement written care coordination, identify the parties to this Agreement and describe their roles and responsibilities. The parties desire for this Agreement to help ensure that practitioners at the Covered Facility will be able to coordinate and manage the care furnished to their eligible American Indian and Alaska Native patients who are also Medicaid beneficiaries (hereinafter “Patient” or “Patients”) by Provider, on request by the Covered Facility practitioners, so that such individuals will receive appropriate care.

II. Definitions

a. “Care coordination” means, for purposes of this agreement, determining the Patient’s needs; overseeing and managing the Patient’s care, including diagnosis, treatment, including prescriptions, and follow-up, and ensuring the care is fully recorded in the Patient’s medical records.

b. "Indian Health Service (IHS) program” means a health care clinic or office operated in Oregon by an Indian Tribe or Tribal organization under the auspices of the Indican Health Service (IHS) within the U.S. Department of Health and Human Services established by IHCIA Section 601, 25 USC § 1661.

c. “Patient” means, for purposes of this agreement, a Medicaid-eligible and OHP-enrolled American Indian or Alaska Native eligible to receive covered services from the IHS, per 42 CFR Part 136; for purposes of this Agreement, the same as an “OHP-Enrolled IHS Beneficiary”.

d. “Telehealth and Related Technologies” means the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration.

e. “Tribal health program” has the meaning given in IHCIA Section 4(25), 25 U.S.C. § 1603(25).

III. Care Coordination Arrangement

a. In General. Care coordination means that the practitioners at the Covered Facility will be responsible for determining the Patient’s needs and coordinating and managing the Patient’s care; that all such care, including diagnosis, treatment, and prescriptions, will be recorded in the Covered Facility’s medical records for the Patient; and that such records will be available to inform the Covered Facility’s practitioners’ ongoing management of the course of care for the Patient.

b. Existing Patient Relationship. A Covered Facility practitioner must have established a patient-practitioner relationship with the Patient before requesting services from Provider under this Agreement, and maintain that relationship during the provision of care by the Provider. The Covered Facility practitioner may establish a patient-practitioner relationship through telehealth and related technologies.

c. Scope of Practice. The Covered Facility practitioner, consistent with the scope of practice under applicable law, may request that Provider furnish a service to an eligible American Indian or Alaska Native beneficiary in accordance with this Agreement. The Covered Facility practitioner is not required to request the services of Provider exclusively, and nothing in this Agreement shall affect the right of Patients to their freedom of choice of provider.

d. Scope of Services. The service requested by the Covered Facility practitioner must be within the scope of services that are authorized under the Indian Health Care Improvement Act and that are also covered under the approved [STATE] Medicaid Plan, including long-term services and supports, and transportation if covered as a service under the state Medicaid Plan.

e. Form of Request. The request for services from the Covered Facility practitioner to Provider may be transmitted electronically or by paper copy, and must include a clear description of the identity of the Patient and the specific requested service or services to diagnose or treat the Patient for an identified episode of care. The request should also include the date of the request and any additional medical information necessary for provision of the requested service in accordance with the practitioner's determination of the Patient needs and the course of care. The Covered Facility must maintain documentation of the request; documentation may be electronic or in writing.

f. Provision of Services. On accepting a request for a service from a Covered Facility practitioner, Provider will furnish the requested service to the Patient as soon as feasible.

g. Follow-Up and Medical Records. Within no more than [ ] days of furnishing the requested service, Provider will transmit, electronically or in writing, the medical information, test results, and any diagnostic findings and treatment procedures and recommendations resulting from the provision of the service to the requesting practitioner directly Such information must be transmitted more promptly when medically warranted, such as in emergency circumstances. In any such transmission, Provider] will specifically identify needs for additional care and treatment, including follow-up care. Upon receiving this transmission, the Covered Facility practitioner will ensure that the information is incorporated into the Patient's medical record being maintained by the Covered Facility, either through the "Health Information Exchange," as applicable, or other agreed-upon means. The Covered Facility practitioner will review the medical information, test results, and any diagnostic findings and treatment recommendations received from Provider and take medically appropriate follow-up action as indicated, including, when necessary, furnishing or requesting additional services to the Patient. The Covered Facility practitioner shall remain responsible for overseeing his or her Patient's care and the Covered Facility shall retain control of the Patient's medical record being maintained by the Covered Facility.

DRAFT

h. Billing For Services. Provider shall be the party responsible for billing Medicaid for services under this agreement.

IV. Obligations of Provider

a. Provider agrees to carry out and comply with the requirements of this Agreement.

b. Provider shall enroll in the [STATE] Medicaid program, if not already enrolled, and remain in good standing as a participating provider in such program.

c. Provider shall maintain malpractice insurance in the form and minimum amount required by the State in which the services are performed, and shall keep and maintain all required records of care, referrals, invoices, and billing documents. Services provided by Provider pursuant to this Agreement are not covered by the Covered Facility's Federal Tort Claims Act coverage.

V. Obligations of Covered Facility

a. Covered Facility agrees to carry out and comply with the requirements of this Agreement.

b. Covered Facility shall enroll in the [STATE] Medicaid program, if not already enrolled, and remain in good standing as a participating provider in such program.

c. Covered Facility shall keep and maintain all required records of care, referrals, invoices, and billing documents for a minimum of seven (7) years after the date of service and make them available upon request, for authorized purposes under state or federal law or regulation, to authorized entities, including the Oregon Health Authority (OHA), the Oregon Secretary of State's Office or Department of Justice and the federal Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS), in accordance with all applicable state and federal laws and regulations regarding transfer of records.

VI. General Provisions

a. On February 26, 2016, CMS issued guidance in SHO letter 16-002, on when services are considered to be "received through" an IHS/Tribal facility by a Patient who is a Medicaid beneficiary. Medicaid covered services ordered by a Covered Facility and provided by Provider to a Patient pursuant to and in accordance with this Agreement are considered to be services "received through" a tribal facility for the purposes of SHO letter 16-002.

b. OHP-Enrolled IHS Beneficiares may not be required to receive services through Covered Facility or that facility's referred Provider for the purpose of qualifying the service for 100% FMAP. Nothing in this Agreement shall affect the entitlement of OHP-Enrolled IHS Beneficiares to freedom of choice of provider under section 1902(a)(23) of the Social Security Act or to exemption from managed care enrollment.

c. Persons who are documented American Indian and Alaskan Native (AI/AN) may not be required to enroll in a managed care entity such as a coordinated care organizarion (CCO) for the purpose of qualifying a service for 100% FMAP. These beneficiaries are exempt from auto assignment or mandatory enrollment in managed care plans, as specified in 42 USC 1932, 2 (C), and OAR 410-141-0060 (4), but may elect voluntary enrollment

DRAFT

d. Both Parties will independently comply with the laws and regulations applicable to them regarding the confidentiality and security of health information.

e. This Agreement will remain in effect until terminated. The Agreement may be terminated by either Party by giving 30-days written notice.

______________________________	______________________________
TRIBE	CEO, [Name of Provider]
______________	______________
Date	Date

DRAFT