



## Chapter 3

# SoonerCare Choice



## INTRODUCTION

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SoonerCare Choice is Oklahoma's Medicaid Managed Care program.

SoonerCare Choice began in 1996 in 61 rural counties in Oklahoma. This program was expanded statewide in April 2004 to include urban counties that had been previously covered under the SoonerCare program. The Choice program provides primary and preventive health care services. Health care is provided and managed by a Primary Care Provider/Case Manager (PCP/CM) that contracts for a prepaid, capitated payment with the Oklahoma Health Care Authority (OHCA). Capitation payments are paid on a per member/per month basis for a specific set of primary and preventive care service. Rates are determined yearly, actuarially certified and approved by the Center for Medicare/Medicaid Services (CMS). Physicians, nurse practitioners and physician assistants in primary care specialties can contract as PCP/CMs.

### Quality Assurance

The OHCA is committed to ensuring that high quality health care is always available to its members. SoonerCare Choice providers agree to cooperate with external review organizations, internal reviews and other quality assurance efforts.

#### Quality Assurance (QA) Tools

Quality assurance measures may include:

##### CAHPS Report Card

Annual telephone and mail surveys of SoonerCare Choice members are conducted by an external review organization, which measures health care satisfaction, including care provided by their PCP/CM.

##### After-Hours Surveys

Telephone surveys are conducted by the OHCA or one of its agents to ensure that PCP/CMs provide information concerning after-hours access to medical information or a medical professional.

##### Member Reports

Member calls to the SoonerCare Helpline for issues regarding quality of care or access to care needs are documented and forwarded to the OHCA for research and/or resolution.

##### On-Site Audits

On-site audits are conducted by OHCA Provider Services as well as OHCA Quality Assurance/Quality Improvement staff.

##### Encounter Data Reviews

Data reflecting medical care use rates, preventive care services and referral patterns are reviewed and analyzed. This information is used in determining use patterns, referral patterns, rate setting and other reporting purposes.

#### Emergency Room Utilization Profiling

OHCA Quality Assurance/Quality Improvement staff perform quarterly analysis of PCP/CM office encounter claims submission versus emergency room claim submission. The results of these reports are forwarded to the PCP/CMs as well as SoonerCare Provider Services. The goal of this project is to reduce inappropriate use of emergency rooms.

## **SECTION A: COVERED MEMBERS**

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The Oklahoma Department of Human Services (OKDHS) determines the eligibility for all SoonerCare members. Members must meet financial, residency, disability status and other requirements before they can become eligible for SoonerCare.

SoonerCare Choice covers members who qualify for medical services through the Temporary Aid to Needy Families (TANF) program or those who qualify due to age or disability. Members may also include women who have been diagnosed with breast or cervical cancer under Oklahoma Cares, or children with disabilities who qualify under the Tax Equity and Fiscal Responsibility Act (TEFRA).

### **NATIVE AMERICANS**

Native Americans who are eligible for SoonerCare Choice must enroll with a Primary Care/Case Manager. They may choose a traditional SoonerCare Choice provider or enroll with an Indian Health Service, Tribal, or Urban Indian (I/T/U) clinic provider that participates in the program. All Native American members have the option to self-refer to any I/T/U facility for services that can be provided at these facilities. However, a referral from the member's assigned PCP/CM will be required if they are assigned to any provider other than an I/T/U provider and require services that cannot be provided at one of these facilities.

### **SOONERCARE CHOICE EXEMPT**

Most members who are eligible for SoonerCare benefits will be enrolled in the SoonerCare Choice program. Individuals who are exempt from this mandate are persons who are

- eligible for Medicare and SoonerCare Traditional;
- enrolled in a waiver program, i.e. Advantage or Home/Community waiver;
- residing in a long-term care center or institution;
- enrolled in a private Health Maintenance Organization (HMO);

- children in state or tribal custody; or
- a subsidized adoption.

## **SECTION B: ACCESS TO CARE**

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SoonerCare Choice PCP/CMs are required to maintain access to primary and preventive care services in accordance to its contract. The following standards apply:

1. PCP/CMs must maintain 24 hour, seven day per week telephone coverage, which will either page an on-call medical professional or give alternate information to members concerning who they can contact to obtain medical advice. PCP/CMs are allowed to use the SoonerCare Patient Advice Line (PAL) for this purpose during the PAL's operating hours. These hours are 5:00 p.m. to 8:00 a.m., Monday through Friday. The PAL is available 24 hours per day on weekends and state of Oklahoma legal holidays. Please note, the PAL is not intended to replace a PCP/CMs obligation to assess and triage patients during normal business hours.
2. PCP/CMs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCP/CMs must provide medical evaluation and treatment within 24 hours for urgent medical conditions. Generally, urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability.
4. PCP/CMs must provide routine or non-urgent medical care within three weeks. Routine physicals or chronic conditions that require less frequent care may be excluded from this three-week period
5. PCP/CMs must provide all capitated medical services for all of their assigned members. A list of these required services is found in Attachment A of the SoonerCare Choice contract.
  - If a PCP/CM can not provide one of these capitated services, the provider must make arrangements for these services to be provided by an alternate provider at that provider's expense. The OHCA will not reimburse an alternate provider for these services.
  - PCP/CMs that provide services to members 18 years old or younger are required to participate in the Vaccines for Children program through the Oklahoma State Department of Health (OSDH) and document immunization data in the Oklahoma State Immunization Information System (OSIIS) database.
  - PCP/CMs can not exclude members who have been assigned to them because they are new or for health history.

- PCP/CMs can not charge a co-payment for its assigned members' services.

## Emergency Care

PCP/CMs are not required to provide emergency care either in its office or in an emergency room. PCP/CMs that do provide emergency care in the emergency room will be reimbursed based on current OHCA policy.

PCP/CMs should not refer members to an emergency room for non-emergency services. Providers should interact with its assigned members to discourage inappropriate emergency room use. PCP/CMs should manage follow-up care from the emergency room as needed.

## SECTION C: MEMBER ENROLLMENT/DISENROLLMENT

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### SOONERCARE CHOICE ENROLLMENT EXCEPTIONS

Exceptions to enrollment in SoonerCare Choice are individuals who are

- enrolled in an HMO;
- in a subsidized adoption;
- in state or tribal custody;
- in a nursing home or special care center;
- in a home and community-based waiver; or
- eligible for Medicare and SoonerCare Traditional coverage.

SoonerCare member benefits start when DHS determines eligibility for SoonerCare Traditional and certifies the case. The effective date of SoonerCare Choice members' benefits depend on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll free EVS line, through the swipe machine or on Medicaid on the Web Secure Site.

**NOTE:** *Medical care during the time a member is eligible for SoonerCare Traditional, but not yet effective in SoonerCare Choice, will be covered under the SoonerCare Traditional fee-for-service program.*

Continuing eligibility for SoonerCare benefits must be recertified periodically. The recertification intervals vary according to the type of assistance members receive. SoonerCare members are notified in writing by DHS prior to the expiration of benefits.

Breaks in eligibility may mean a disruption in continuity of care. If the PCP/CM's capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCP/CM's panel.

Members may reenroll with a PCP/CM by calling the SoonerCare Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility within 365 days are assigned to their most recent PCP/CM, if the PCP/CM has available capacity and is within the PCP/CM's scope of practice.

### **Choosing a PCP/CM**

The OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, the OHCA will choose a PCP/CM for the member.

Families with more than one eligible member are allowed to choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect at the beginning of each month. The OHCA provides the PCP/CM with his or her new enrollees and continuing members on a new SoonerCare Choice eligibility listing prior to the first day of each month.

### **Capacity (Number of Members requested per PCP/CM)**

The PCP/CM specifies the maximum number of members he or she is willing to accept. The maximum number is 2,500 members for each physician PCP/CM. The maximum capacity for physician assistants and nurse practitioners serving as PCP/CMs is 1,250 members. The OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in its capacity by submitting a written request to the Provider Enrollement division of the OHCA. If approved, the OHCA will implement the change on the first day of the month with sufficient notice.

If a PCP/CM requests a lower capacity - within program standards, and it is approved by the OHCA - the reduction in numbers of members will be accomplished through attrition as members change PCP/CMs or lose eligibility. Members will not be disenrolled to achieve a lower capacity.

### **Changing PCP/CMs**

The OHCA or the SoonerCare Helpline may change a member from one PCP/CM to another PCP/CM for the following reasons:

- Without cause up to four times per year upon the member's request.
- When a PCP/CM terminates his or her participation in the SoonerCare Choice program.

### **Disenrollment At The Request of the PCP/CM**

The OHCA may also change a member from the assigned PCP/CM to another PCP/CM for good cause and upon written request of the assigned PCP/CM. If the request is a good cause change, the

OHCA will act upon the request within thirty days of receipt from the OHCA SoonerCare Choice division.

Good cause is defined as:

- Non-compliance with PCP/CM's direction.
- Abuse of PCP/CM and/or staff (includes disruptive behavior).
- Deterioration of PCP/CM- member relationship.
- Three no-show appointments.

The dismissal request and supporting documentation should be forwarded for processing to the appropriate SoonerCare Choice provider representative. Members may not be notified by the PCP/CM until approval for disenrollment is granted by the OHCA.

Either party has the right to appeal the decision to the administrative law judge, pursuant to OAC 317:2-1-2 (the Authority's Grievance Procedure)

## **SECTION D: REFERRALS**

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SoonerCare Choice referrals

- are made on the basis of medical necessity as determined by the PCP;
- are required for all inpatient hospital services except OB delivery;
- are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP/CM; and
- must have the correct provider referral number to ensure payment to the "referred to" provider (provider/referral numbers are site specific).

Referrals must be signed by the PCP/CM or a designee within the PCP/CM's office who is authorized to sign for the provider.

Some services may also require prior authorization. It is up to the "referred to" provider, or provider ordering services, to obtain prior authorization as needed. Prior authorizations for services are obtained through the Medical Authorization Unit at OHCA.

SoonerCare Choice referrals must be made if the member requests a second opinion when surgery is recommended. Following the second opinion, any treatment received by the member is to be rendered by the PCP or through a referral made by the PCP/CM.

SoonerCare Choice referrals may be made to another PCP/CM for services equal to those of a specialist. Examples of this are, a family practitioner could refer to another family practitioner who performs a surgical procedure, or a general practitioner could refer to an internist who manages complicated diabetic patients.

SoonerCare Choice referrals may be made to a provider for ongoing treatment for time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the referred-to provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

SoonerCare Choice referrals are not required for

- child physical/sexual abuse exams;
- services provided by a PCP /CM for members enrolled or assigned to the PCP/CM;
- emergency room care;
- obstetrical care;
- vision screenings for members younger than 21 years;
- basic dental for members younger than 21 years (benefit is limited to emergency extractions for members older than 21 years);
- behavioral/mental health;
- family planning;
- inpatient professional services;
- routine laboratory and x-ray; or
- services provided to Native Americans in a tribal, IHS or Urban Indian Clinic facility.

### **Inappropriate Referrals**

Referrals should not be written for capitated services that are within the provider's field of expertise or scope of practice. Federal regulations prohibit the OHCA from paying twice for the same service.

### **Payment of Referred Services**

Payment for referred services is subject to coverage limitations under the current Medicaid reimbursement policies. Payment for referred services are limited to four specialty visits per month for adults older than 21 years. Visits to their PCP are excluded from this limitation. To ensure payment, PCP/CMs must refer only to Medicaid providers that have an active SoonerCare Traditional contract.

### **Documenting the Medical File**

Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the referred-to provider when this information is known, e.g. ancillary services.

Documentation in the medical record should include a medical report from the referred-to provider. The referred to provider should report its findings to the referring PCP/CM within two weeks of the member's appointment. In the event a medical report is not received within a reasonable time, the PCP/CM should



contact the referred-to health care provider to obtain this information.

### **Unauthorized Use of Provider's Number**

Unauthorized use of a SoonerCare Choice provider's number may result in official action to recover unauthorized reimbursements from the billing provider.

### **Referral Form and Instructions**

In the SoonerCare Choice program, the PCP/CM is responsible for providing primary care and making specialty referrals. The PCP/CM completes the referral form, including the referral number. The PCP/CM's SoonerCare Choice provider number serves as their referral number. The provider/referral number is site specific and must be for the site where the member is enrolled or assigned. The referral includes ancillary services rendered, or required, by the "referred to" specialist.

With the PCP/CM's approval, a specialist may relay a copy of the original referral to other specialists with instructions considered necessary for proper treatment of the member. Payment is subject to the current Medicaid reimbursement policies.

The provider mails the original of the completed form to the specialist, or "referred to" provider. A copy of the form is retained in the patient's medical record.

When a claim is submitted by a "referred to" provider, the referral number must be entered in box 17a of the 1500 claim form, or box 83b of the UB-92 hospital claim form. A copy of the referral is **NOT** attached to the claim. If the referral number is not on the claim form, payment will be denied unless for self-referred services.

Providers with multiple sites must use the referral number for the site where the member is assigned. Referral forms can be accessed and printed from the Forms page on the OHCA Web site at [www.okhca.org](http://www.okhca.org).

## **SECTION E: EPSDT**

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Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program and one of the highest priorities of the SoonerCare Choice program. EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing, and immunization services to SoonerCare Choice members age 20 or younger.

### **Schedule of EPSDT Services**

As a minimum, the following schedule for EPSDT screening is required:

- Six visits during the first year of life.
- Two visits in the second year of life.
- One visit yearly for ages two through five.
- One visit every other year for ages six through 20.
- Metabolic lead screen at ages one and two; or six years old if not done by age 2. *This is mandatory.*

### **Additional Requirement**

The OHCA requires contractors to:

- Conduct and document follow-up appointments with all members younger than 21 years old who miss appointments.
- Administer outreach, including telephone calls or printed notification mailed to a member when a health care screen is indicated or missed. This ensures that all members who are age 20 or younger are current.
- Educate families of members age 20 or younger about the importance of early periodic screening, diagnosis and treatment.

### **EPSDT Bonus Payment**

The OHCA offers bonuses paid to PCP/CMs that demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in the SoonerCare Choice contract (Section 6.2 for year 2007) and for any following contract addendums.

The OHCA may conduct onsite chart audits.

See the Reimbursement section below for further bonus payment details.

## **SECTION F: REPORTING REQUIREMENTS**

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Data, information and reports collected or prepared by the PCP/CMs in the course of performing its duties and obligations as a PCP/CM are owned by the state of Oklahoma. The OHCA and other appropriate entities reserve the right to examine this information upon request. This information includes medical and financial records, accounting practices, and other items relevant to the provider's contract.

The PCP/CM is required to report in writing and within a timely manner to the OHCA any changes to its SoonerCare Choice contract. Report must include demographic, financial and group composition information as reported in their contract.

Claims submitted by the PCP/CM should be submitted in the same manner and on the same claim forms used to submit claims for SoonerCare Traditional members. Encounter Claims must be

submitted within 60 days from the date of services. Denied claims must be corrected and resubmitted within 60 days of adjudication.

## **SECTION G: REIMBURSEMENT**

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### **CAPITATION**

SoonerCare Choice PCP/CMs are prepaid for each member assigned or enrolled with them on a monthly basis (capitation payments).

Capitation payments vary with the member's age, gender and benefit type (TANF or ABD). Case management fees are paid in addition to the benefit payment, and some are enhancements.

Capitation payments are made by the 10<sup>th</sup> working day of each month for all eligible members enrolled with or assigned to the PCP/CM on the first of each month. A single monthly payment is generated and accompanies the Capitation Payment Listing or is deposited directly.

### **ENCOUNTER CLAIMS**

Although SoonerCare Choice PCP/CMs are paid in advance for primary care services, PCP/CMs are required to file a claim with the OHCA each time a service is provided to a member. Claims filed for a prepaid service are called Encounter Claims. Services that are not capitated should be filed on the same claim and will be paid subject to the current SoonerCare Traditional fee schedule and reimbursement policies.

Encounter Claims are to be submitted on a 1500 claim form within 60 days of the date the service was provided. Encounter Claims are verifications of the services provided to SoonerCare Choice members.

### **TANF STOP LOSS**

To limit risk to PCP/CMs, a threshold of \$1,800 per year in capitated services (\$450 per quarter) is established by the stop-loss for members eligible through TANF. This is based on the SoonerCare Traditional fee schedule allowables; not gross charges.

### **IMMUNIZATION INCENTIVE PAYMENT**

Immunization Incentive Payments are available when the PCP/CM provides written notice that it has administered the 4<sup>th</sup> dose of DPT/DTAP to a member before the member's second birthday.

## **SECTION H: PROVIDER RESOURCES**

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### **SoonerCare Choice PROVIDER REPRESENTATIVES**

PCP/CMs have SoonerCare Choice provider representatives to answer questions on policy issues and provide on-site training and support. The provider representatives are assigned by region.

Providers can locate their representative by visiting the OHCA Web site at [www.okhca.org](http://www.okhca.org). Once there

1. click on the Provider link in the center of the page;
2. click on the Training link under the Providers header on the left side of the next page; and
3. click on the SoonerCare Choice Training link on the right of the next page where you will find your representative.

### **EDS Field Consultants**

EDS field consultants make onsite visits to assist providers with billing questions, research complex claim issues and train providers to submit online claims through the OHCA Web site. The field consultants conduct bi-monthly training sessions along with the spring and fall workshops. Providers can locate their EDS field consultant by visiting the OHCA Web site at [www.okhca.org](http://www.okhca.org). Once there

1. click on the Provider link in the center of the page;
2. click on the Training link under the Providers header on the left side of the next page; and
3. click on the EDS Field Consultants link on the right of the next page where you will find your field consultant.

### **Patient Advice Line**

The Patient Advice Line is a service available only to SoonerCare Choice members.

#### **Audio Tape Library**

The Member Handbook lists a few of the more than 1,100 recorded topics accessible on the Patient Advice Line. “Parenting and Family Life” is one of the many health-related topics available for SoonerCare Choice members.

#### **SoonerCare Choice Patient Advice Line**

- is accessible Monday through Friday, 5 p.m. to 8 a.m., 24 hours on weekends and State of Oklahoma legal holidays;
- offers triage services to members based on nationally recognized triage protocols; and
- is staffed by registered nurses.

#### **After Hours**

Your after hours recording may instruct your SoonerCare Choice members to call the Patient Advice Line; however, the Advice Line serves as a supportive program and is not a replacement for after-hours provider coverage.

The Patient Advice Line offers assistance in determining if the caller has an emergency or urgent care need and educates the caller on home care.

**ER Visit Notification**

If the Patient Advice Line directs the member to seek emergency room care, your office and the SoonerCare Division of the OHCA will receive fax notifications the next business day.

SoonerCare Choice Patient Advice Line

Toll-free at 800-530-3002

Hearing impaired, dial SBC Relay Oklahoma at  
800-722-0353 (TDD/TTY)

**Translation Services**

The SoonerCare Helpline offers translation services 24 hours a day, 7 days a week. If you cannot communicate with the member because of language, call the SoonerCare Helpline at 1-866-872-0807 and enter state code 53510.

The Patient Advice Line (PAL) is available for translation services from 5 p.m. to 8 a.m. weekdays and 24 hours per day on weekends and state holidays. Please call PAL at 800-530-3002 for assistance during these times. The PAL contract with AT&T's translator service, which can accommodate more than 140 languages and dialects. Physicians with a SoonerCare Choice member in the office who does not speak English can use these services during the member's office visit. They can also connect with this service any time a non-English speaking member calls.

**CARE MANAGEMENT**

The Care Management Department is comprised of registered nurses and licensed practical nurses. These medical professionals assist in facilitating medical services for SoonerCare Choice members with complex medical conditions.

**Care Management Services**

- help members access care and services;
- assist providers with coordination of discharge planning;
- resolve issues and concerns with providers as related to medical care;
- help get approvals for medicines and medical services;
- provide patient education to identified groups;
- assist with coordinating community support and social service systems; and
- offer out-of-state-referrals if no comparable in-state services are offered or in cases of urgent care needs.

**Complex medical conditions include**

- high risk OB cases;
- transplant cases;
- catastrophic illness or injury;

- women enrolled in the Breast and Cervical Cancer (BCC) program; and
- children receiving in-home Private Duty Nursing services (includes periodic home visits to evaluate & certify medically-necessary services).

**Quality Assurance oversees issues with**

- Care Management Referral forms;
- high service utilization;
- medical regimen noncompliance;
- inappropriate ER visits;
- multiple providers/pharmacies;
- scheduled medication requests;
- refusing alternate treatments/prescriptions;
- refusing pain management referrals; and
- drug seeking behaviors