

**INDIAN HEALTH SERVICE (IHS)  
ADDENDUM TWO (2)  
SOONERCARE O-EPIC PRIMARY CARE PROVIDER/CASE MANAGEMENT  
for  
AI/AN MEMBERS**

**1.0 PURPOSE**

The purpose of this Addendum (hereafter ADDENDUM 2) is for OHCA and PROVIDER to agree that OHCA will pay for and PROVIDER will provide O-EPIC IP CASE MANAGEMENT (hereafter CM) services.

**2.0 DEFINITIONS**

The terms used in ADDENDUM 2 have the following meanings:

- A. CAPITATION** means a contractual arrangement through which PROVIDER agrees to provide specified health care case management services to members for a specified prospective payment per member per month.
- B. PANEL** means members who have selected PROVIDER as a CM for services.

**3.0 PROVIDER QUALIFICATIONS**

**3.1 Licenses and Permits**

- A. PROVIDER** states it consists of health care providers who:
  - 1. Maintain current licenses, certifications, and permits required for such healthcare in accordance with Federal statutes and regulations;
  - 2. are physicians, physician assistants and/or nurse practitioners who are general practice or are board eligible or certified in family medicine, general internal medicine or general pediatrics, or are specialized in other areas of medicine but practicing in a more general capacity and, in either case, are authorized to serve as CMs.
- B. PROVIDER**, if employing a medical resident(s) serving as a CM, states:
  - 1. He/she is licensed to practice medicine;
  - 2. He/she is at the Post-Graduate (PG-2) level or higher;
  - 3. He/she serves as a CM only within his/her continuity clinic (e.g., family practice residents may only serve as CMs within the family practice residency clinic setting);
  - 4. He/she works under the supervision of a licensed attending physician;

**3.2 PROVIDER Services and Responsibilities**

PROVIDER shall:

- A. Provide case management services and primary care services for O-EPIC IP members assigned to PROVIDER's panel. Case management means:** i) coordinating and monitoring all medical care for panel members; ii) making medically necessary specialty referrals for panel members, including standing referrals (i.e. a PCP referral for a member needing to access multiple appointments with a specialist over a set period of time (such as a year), without seeking multiple referrals that may include a limitation on the frequency or number of visits; iii) coordinating panel members' admissions to the hospital; iv) making appropriate referrals to the Women, Infants and Children (WIC) program; v.) coordinating with mental health professionals involved in panel members' care; vi.) educating panel members to appropriately use medical resources such as emergency room and OHCA's Patient Advice Line;
- B. PROVIDER shall ensure that the services provided are sufficient in amount, duration, and scope to reasonably meet the health care needs of the members assigned to PROVIDER;**
- C. Not require a member to obtain a referral from OHCA for the following services:**
  - 1. outpatient behavioral health services,
  - 2. prenatal and obstetrical supplies and services, meaning prenatal care, delivery, and sixty (60) days of postpartum care,
  - 3. emergency services

4. services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics;
- D. Be accountable for any functions and responsibilities that it delegates to any subcontractor. PROVIDER shall have a written agreement with subcontractor that specifies subcontractor's activities and responsibilities and shall monitor such agreement on an ongoing basis. PROVIDER shall also ensure that subcontractors comply with applicable Federal and State laws and regulations.

### **3.3 Access to Care**

PROVIDER shall:

- A. Ensure the availability of twenty-four (24) hour per day, seven (7) days per week telephone coverage with immediate availability of an on-call medical professional. PROVIDER shall provide all panel members with the information necessary to access the 24-hour coverage. PROVIDER may use OHCA's Patient Advice Line after regular office hours as a resource to fulfill the after hours telephone coverage requirement;
- B. Make a medical evaluation or cause such an evaluation to be made:
  1. For new or existing members with urgent medical conditions: within twenty-four (24) hours with appropriate treatment and follow up as deemed medically necessary. Urgent medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent lay person could expect that the absence of medical attention within twenty-four (24) hours could result in: (i.) placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy; or (ii) serious impairment to bodily function; or (iii) a serious dysfunction of any body organ or part;
  2. For new or existing members with non-urgent medical problems: within three (3) weeks. This standard does not apply to appointments for routine physical exams, nor for regularly scheduled visits to monitor a chronic medical condition, if that condition calls for visits to occur less frequently than once every three weeks;
- C. Offer hours of operation that are no less than the hours of operation offered to commercial members or hours comparable to those offered to SoonerCare Traditional members if PROVIDER serves only SoonerCare members;
- D. Offer its panel members access to medical coverage through other SoonerCare contracted providers if PROVIDER is unable to maintain regular office hours for a period of three or more consecutive days. This coverage must be arranged by PROVIDER;
- E. Evaluate members' needs for hospital admissions and services and coordinate necessary referrals. If PROVIDERS in GROUP do not have hospital admitting privileges, PROVIDER shall make arrangements with the practitioners specified on PROVIDER's application form to coordinate the member's admission to the hospital. PROVIDER shall coordinate the member's hospital plan of care with the receiving practitioner if appropriate, until the member is discharged from the hospital.

### **3.4 Emergency Services**

PROVIDERS shall not refer patients to the emergency room for non-emergency conditions. Medical care for non-emergency medical conditions shall be provided in the office setting. PROVIDER shall advise members of the proper use of the emergency room. Nothing in this paragraph shall limit PROVIDERS ability to provide emergency room services to a panel member consistent with his/her legal scope of practice in an emergency room setting.

### **3.5 Record Keeping and Reporting**

PROVIDER shall:

- A. Document in the member's medical record each referral to other health care providers. PROVIDER shall also keep a copy of each medical report(s) submitted to PROVIDER by any referring provider. If a medical report is not returned in a timely manner, PROVIDER will contact the health care provider to whom the referral was made to obtain such report(s);

- B. Report to the O-EPIC Helpline at 1-888-365-3742 any member status changes such as births, deaths, marriages, and changes of residence in a timely manner when known;
- C. Provide data as requested by OHCA to support research and quality improvement initiatives;
- D. Obtain proper consent and transfer a copy of member medical records free of charge, if requested, in the event that the member moves or changes CMs.

#### **4.0 PROVIDER PANEL REQUIREMENTS**

##### **4.1 Panel Capacity**

- A. PROVIDER shall specify a capacity of O-Epic members the facility is willing to accept under SOONERCARE PROGRAMS. The maximum capacity for all programs combined (i.e. O-Epic and Choice) is two thousand five hundred (2,500) for a full-time O-Epic physician in the PROVIDER GROUP. For each full-time physician assistant or advanced registered nurse practitioner in the PROVIDER GROUP, the maximum is one thousand two hundred fifty (1,250). For each medical resident in the PROVIDER GROUP, enrollment shall not exceed eight hundred seventy-five (875) members. If PROVIDER GROUP is also a Choice PCP, PROVIDER GROUP shall not exceed these capacities for both panels combined.
- B. OHCA does not guarantee PROVIDER an enrollment level nor will OHCA pay for members who are not eligible or excluded from enrollment.
- C. PROVIDER may request a change in the panel capacity by submitting a written request signed by PROVIDER. This request is subject to review according to program standards. In the event PROVIDER requests a lower capacity, OHCA may lower the capacity by disenrolling members to achieve that number or allowing the capacity to adjust as members change their CM or lose eligibility.

##### **4.2 Non-discrimination**

Unless approved by OHCA, PROVIDER must accept members in the order in which they apply without restriction up to the capacity established by the ADDENDUM 2. PROVIDER may not refuse an assignment or will not discriminate against members on the basis of health status or need for health care services. PROVIDER will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, unless superseded by another Federal statute.

##### **4.3 Continuity of Care**

PROVIDER shall provide medically necessary health care case management services for any member who has selected or been assigned to PROVIDER's panel until OHCA officially reassigns the member. PROVIDER shall not notify the member of a change of CM until PROVIDER has received notification from OHCA.

##### **4.4 Disenrollment at Request of CM with Cause**

PROVIDER may request OHCA to disenroll a member for cause. OHCA will give written notice of the disenrollment request to the member.

#### **5.0 OBLIGATIONS OF OHCA**

OHCA shall:

- A. Mail PROVIDER a monthly list of O-EPIC IP panel members. This capitation roster will be mailed to the "mailing address" listed on the application;
- B. Provide support services to the PROVIDER in the areas of referral arrangements, overall utilization management, claims submission, administrative case management, and member education and discrimination policies;
- C. Provide a Patient Advice Line (PAL) available to panel members via a toll free telephone number between 5:00 PM and 8:00 AM on business days and twenty-four hours per day on weekends and state holidays. PROVIDER may include the PAL telephone number on his/her after-hours telephone message. PROVIDER will receive written information when PAL triages a panel member to the Emergency Room.
- D. Disenroll members from PROVIDER's panel if ADDENDUM 2 is terminated.

## **6.0 FEE PAYMENTS AND REIMBURSEMENTS**

### **6.1 Payment of Base Capitation**

- A. OHCA shall pay PROVIDER a capitated rate for each member enrolled with PROVIDER, which is payment in full, for all case management services.
- B. Capitation rates are shown in Attachment A.1. Actuarially certified rates will be developed for each calendar year in accordance with generally accepted actuarial principles and practices. Attachment A.1 may be amended by OHCA at any time by written notification to PROVIDER.
- C. OHCA shall make capitation payments by the tenth business day of each month. A single capitation amount will represent payment for all eligible members enrolled with PROVIDER as of the first day of that month. This payment will be made for all PROVIDER's panel members, regardless of what, if any, covered services PROVIDERS render during the month.
- D. OHCA will adjust capitation payments based on the member's enrollment or disenrollment effective dates.

### **6.2 Penalties**

If PROVIDER fails to provide required case management services, or access to care as defined in Section 3.3, OHCA may notify PROVIDER and impose penalties including:

- A. "Freezing" PROVIDER's panel, i.e. not allowing new member enrollments; and/or
- B. Permanently reducing PROVIDER's maximum panel size; and/or
- C. Recouping and/or withholding an appropriate portion of the PROVIDER's capitation rate based on the number of panel members affected, the time period of the infraction(s), and the capitation amount attributed to the service; and/or
- D. Contract action up to and including terminating Addendum 2 or PROVIDER's entire SoonerCare Agreement.

## **7.0 OTHER TERMS AND CONDITIONS**

### **7.1 Recoupement of Payments**

In the event ADDENDUM 2 is terminated for any reason, OHCA may recoup any monies owed from PROVIDER to OHCA under this ADDENDUM from PROVIDER's other SoonerCare reimbursements.

### **7.2 Incorporation of Attachments by Reference**

Attachments A.1 to ADDENDUM 2, are incorporated by reference and made part of the ADDENDUM 2. OHCA may amend any attachment to this ADDENDUM 2 at any time by written notification to PROVIDER.

# Attachment A.1 Monthly Rate Schedule

Effective January 1, 2007  
through December 31, 2007

## TANF Members

Rate Category	Age	Case Management
Male/Female	<1	\$3.00
Male/Female	1	\$3.00
Male/Female	2-5	\$2.00
Male/Female	6-14	\$2.00
Female	15-20	\$2.00
Male	15-20	\$2.00
Female	21-44	\$2.00
Male	21-44	\$2.00
Male/Female	45+	\$2.00

## ABD Members

Rate Category	Age	Case Management
Male/Female	<1	\$3.00
Male/Female	1	\$3.00
Male/Female	2-5	\$3.00
Male/Female	6-14	\$3.00
Female	15-20	\$3.00
Male	15-20	\$3.00
Female	21-44	\$3.00
Male	21-44	\$3.00
Male/Female	45+	\$3.00

Individuals who are dually eligible for Medicare/Medicaid are not part of the program at this time.