

The Oklahoma Health Care Authority



Request for Proposals

Solicitation Number 8070001240

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1 Section 1: Introduction and Solicitation Overview

1.1 RFP Overview

1.1.1 The Oklahoma Central Purchasing Act (74 O.S. §85.1 et seq.) and accompanying OAC provisions

The Oklahoma Central Purchasing Act (the Central Purchasing Act) establishes policies that an Oklahoma state agency must follow to procure products or services from a third-party vendor, including the requirement that, absent an exemption, such contracts must be competitively bid. The Central Purchasing Act provides that all purchasing activities of a state agency shall be under the direction of the Central Purchasing Division of the Office of Management and Enterprise Services (OMES) unless otherwise delegated to the state agency. The Central Purchasing Division has delegated the right to procure needed products and services for the Oklahoma Health Care Authority (OHCA) to OHCA's CEO and other OHCA officers and personnel, subject to certain prior approval requirements from the Oklahoma Health Care Authority Board. In accordance with Oklahoma Administrative Code (OAC) 317:10-1-1, when an acquisition is made by the OHCA, the OHCA's rules, located at OAC 317:10, must be read in conjunction with the OMES Purchasing rules at OAC 260:115. For purposes of the application of the Central Purchasing Act and related OAC provisions to acquisitions by the OHCA, OAC 317:10-1-3 provides that where "State Purchasing Director" is specified, it means the OHCA certified procurement officer and the OHCA CEO and where "Purchasing Division" is specified, it means the OHCA.

1.1.2 The Oklahoma Privatization of State Functions Act (74 O.S. §586 et seq.) and accompanying OAC provisions

The Oklahoma Privatization of State Functions Act (Privatization Act) establishes guidelines for the privatization of state services to ensure that such privatization is cost effective and in the best interest of the state. Due to the size of the Contract(s) to be awarded pursuant this RFP and because of the possibility that the Privatization Act may be found to apply to this RFP and the resulting Contract(s), the OHCA has elected to voluntarily comply with the provisions of Privatization Act. The OHCA has submitted a cost analysis to OMES and OMES has found that the analysis fulfills the content requirements of the Privatization Act. The OHCA has also provided the notices required under Section 589 of the Privatization Act. To the extent that the OHCA receives a response to those notices that requires it to modify or amend this solicitation, those updates or amendments will be posted in accordance with Section 1.8.9: "Changes in Solicitation Specifications or Contract Terms".

Bidders will be required to provide in their Proposal all the information and certifications required by the Privatization Act as more fully discussed in Item 5 "Privatization Act Mandated Representations and Certifications" of Section 2.5.2: "Technical Proposal Contents.": " Failure to provide this information and certifications could result in a Proposal being considered non-responsive and not considered for further evaluation. Failure to abide by the Privatization Act may also result in a Bidder's disqualification.

1.1.3 The RFP

OHCA seeks Proposals for an RFP from qualified Bidders to improve health outcomes, increase access to care, and increase accountability in the State's Medicaid program, referred to as SoonerCare. Successful Bidders will be responsible for coordinating and delivering SoonerCare benefits in a highly coordinated manner, including physical health, behavioral health and pharmacy. OHCA intends to contract on a statewide basis with managed care organizations (MCOs) to deliver risk-based managed care services to SoonerCare Children, Deemed Newborns, Pregnant Women, Parent and Caretaker Relatives, and Expansion Adults (hereinafter referred to as "SoonerSelect Plan"). OHCA also intends to contract with

one MCO to deliver statewide risk-based managed care services for SoonerCare Eligibles who are Former Foster Children, Juvenile Justice Involved, in Foster Care or Children Receiving Adoption Assistance (hereinafter referred to as “SoonerSelect Specialty Children’s Plan”).

The Contracts resulting from the RFP for the SoonerSelect Plan and the SoonerSelect Specialty Children’s Plan will be for an initial one-year term (through June 30, 2021), with five optional one-year extensions at the discretion of OHCA. Enrollment of SoonerCare Eligibles into the SoonerSelect program and the SoonerSelect Specialty Children’s program will be effective October 1, 2021.

1.2 SoonerSelect Goals

The SoonerSelect program has been designed to advance Governor Stitt’s plan to transform Oklahoma into a Top Ten state in health outcomes. OHCA is pursuing a comprehensive Medicaid managed care approach that will allow the State to achieve the following payment and delivery system reform goals:

- Improve health outcomes for Oklahomans;
- Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;
- Improve SoonerCare Eligibles’ access to and satisfaction with necessary services;
- Contain costs through better coordinating services; and
- Increase cost predictability to the State.

1.3 SoonerCare Program Background

SoonerCare is the State of Oklahoma’s Medicaid program. OHCA is the single state agency responsible for administration of SoonerCare. Since 1995, SoonerCare has operated under Section 1115 demonstration authority granted by the Centers for Medicare and Medicaid Services (CMS). SoonerCare services are currently delivered through coordinated care models including patient centered medical homes (PCMH), Health Access Networks (HANs) and the SoonerCare Health Management Program (HMP). All SoonerCare Eligibles currently qualify to receive services through these models, with the exception of the following:

- Dual Eligible Individuals;
- Individuals residing in an institution or nursing home;
- §1915(c) Waiver enrollees;
- Individuals infected with tuberculosis covered under §§ 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of the Act;
- Individuals eligible as a Former Foster Care Child under 42 C.F.R. § 435.150;
- Pregnant women with incomes between 134% and 185% FPL; and
- Individuals with other creditable coverage.

Following is a high level summary of the current care coordination models available to SoonerCare Eligibles.

- Patient Centered Medical Home (PCMH): A statewide enhanced Primary Care Case Management (PCCM) model in which OHCA contracts directly with primary care providers to serve as PCMHs. PCMH Providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet. OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers can also earn “SoonerExcel” quality

incentives for meeting or exceeding various quality-of-care targets within an area of clinical focus selected by OHCA.

- Health Access Network (HAN): Non-profit, administrative entities that work with affiliated Providers to coordinate and improve the quality of care provided to Eligibles. The HANs employ care managers to provide telephonic and in-person care management and care coordination to Eligibles with complex health care needs who are enrolled with affiliated PCMH Providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of aged, blind and disabled (ABD) Eligibles with, or at risk for, complex/chronic health conditions, as well as TANF and related Eligibles with asthma and diabetes, among other conditions.
- Health Management Program (HMP): The SoonerCare HMP is an initiative developed to offer care management to Eligibles most at-risk for chronic disease and other adverse health events. The program is administered by OHCA and is managed by a vendor selected through a competitive procurement. The SoonerCare HMP serves Eligibles ages four through 63 who are not enrolled with a HAN and have one or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease specific, but prominent conditions of Eligibles in the program include asthma, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, heart failure and hypertension.

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is at or below 138% FPL¹ (Expansion Adults). Medicaid expansion will go into effect on July 1, 2021.

OHCA has made great strides in improving care coordination among SoonerCare Eligibles, especially those with chronic conditions through the work of its Chronic Care Unit and Health Management Program. However, Oklahoma continues to rank near the bottom on many indicators of health outcomes. The State was ranked 46th in the nation by America's Health Rankings² and 50th on the Commonwealth Fund's 2019 Scorecard on State Health System Performance.³ Among the measures in which Oklahoma is in the bottom quartile of states include infant mortality, immunization rates, suicide, cancer deaths, smoking, obesity and cardiovascular deaths. In an effort to focus on improving these outcomes, OHCA is seeking Proposals from Bidders with demonstrated success in increasing access to quality care and improving health outcomes through care coordination, prioritization of preventive care and encouraging Eligibles to seek care from the appropriate healthcare provider type.

1.4 Stakeholder Engagement

On July 16, 2020, OHCA issued a Request for Information (RFI) to solicit input and recommendations on the design of this RFP and the SoonerSelect program. Extensive feedback was received from a broad array of stakeholders including provider associations, community organizations, advocacy groups, and MCOs.

¹ Includes the MAGI five percent FPL disregard

² America's Health Rankings analysis of America's Health Rankings composite measure, United Health Foundation, AmericasHealthRankings.org, Accessed August 2020

³ 2019 Scorecard on State Health System Performance, The Commonwealth Fund, <https://www.commonwealthfund.org/publications/fund-reports/2019/jun/2019-scorecard-state-health-system-performance-deaths-suicide>, Accessed August 2020

All told OHCA received and reviewed written responses from 86 individuals or entities. The RFI invited respondents to offer recommendations in the following key areas:

- Managed Care Enrollees: how and when to transition SoonerCare Eligibles by population, Health Plan Enrollee engagement and education activities.
- Benefits Provided through MCOs: strategies for improving access to services, integration of services, and facilitating referrals and tracking for social services. Also, best practices in benefit design related to evidence-based care for Behavioral Health Services and Value-Added Benefits.
- Quality and Accountability: how best to incentivize MCOS to improve outcomes, and recommendations on which outcome measures to track.
- Care Management and Coordination: recommendations on the best utilization management practices and tools, network development strategies to meet Health Plan Enrollee's behavioral health needs, strategies for meeting needs of Health Plan Enrollees with chronic or complex health conditions and populations such as American Indian/Alaska Native (AI/AN) Health Plan Enrollees and justice-involved individuals.
- Member Services: how to measure MCO performance on Health Plan Enrollee services, best practices in serving Health Plan Enrollees who primarily speak a non-English language, technology-driven strategies, and strategies for Health Plan Enrollees living in Rural areas.
- Provider Payments and Services: recommendations on Provider performance measures, minimum levels of reimbursement, and claim payment timeframes.
- Network Adequacy: how best to ensure network adequacy and recommendations on supporting workforce development.
- Grievance and Appeals and Administrative Requirements: strategies for incorporating Grievance and Appeal data into program improvement and streamlining administrative processes.

OHCA has worked to incorporate into this RFP numerous recommendations that came from the RFI responses including, but not limited to:

- Encouraging MCOs to engage with community-based organizations and hire or partner with community-based extenders such as community health workers or other non-traditional health workers to assist with Health Plan Enrollee engagement and address Social Determinants of Health.
- Requiring MCOs to track and report on outcomes of Social Determinants of Health referrals.
- Requiring MCOs to develop and maintain a comprehensive behavioral health crisis response network and promoting integration of behavioral health and primary care services.
- Encouraging MCOs to offer in lieu of services and flexibility in Value Added Benefits to meet Health Plan Enrollee needs.
- Requiring Tribal Government Liaison positions in MCO staffing plans to support and collaborate with Indian Tribes and Indian Health Service, Tribal Health Providers and Urban Indian Health Centers (I/T/Us), as well as assist in informing managed care policy decisions as they relate to the AI/AN population.
- Requiring MCOs to demonstrate sufficient access to I/T/Us by considering I/T/Us essential providers, thereby requiring MCOs to offer contracts to all I/T/Us.
- Conducting annual Provider satisfaction surveys.

- Implementing standardized administrative processes to reduce Provider administrative burden.

1.5 SoonerSelect Enrollment

The enrollment tables presented below are for informational purposes only. The enrollment data used in Capitation Rate setting is presented separately in the SoonerSelect Capitation Rate data book. Data presented below reflects average monthly enrollment between September 2019 through August 2020, with the exception of Expansion Adults which reflects projected monthly enrollment. This data includes enrollment increases that were attributed to COVID-19, including requirements to maintain eligibility for otherwise ineligible individuals in accordance with Section 6008 of the Families First Coronavirus Response Act (FFCRA).

SoonerSelect MCO Populations

Eligibility Group	Enrollment
Children	481,584
Deemed Newborns	1,959
Pregnant Women	21,015
Parent and Caretaker Relatives	62,199
Expansion Adults (projected – enrollment to begin 7/1/21)	175,623
TOTAL	742,380

SoonerSelect Specialty Children’s Plan Populations

Eligibility Group	Enrollment
Former Foster Children	706
Juvenile Justice Involved	558
Foster Care	9,407
Children Receiving Adoption Assistance	20,743
TOTAL	31,414

1.6 Future Reform

OHCA may consider enrollment of additional SoonerCare eligibility groups into the SoonerSelect program in future years. Expansion of enrolled populations would be implemented through the procurement or Contract amendment process.

1.7 Directed Payments to Providers

OHCA intends to transition the current supplemental payments for physicians and hospitals, such as the Supplemental Hospital Offset Payment Program (SHOPP), to directed payments to be made through MCOs to Participating Providers. A CMS proposed rule from 2018⁴ would permit supplemental payments to be converted into transition payments through the MCOs outside of the Capitation Rate. If the proposed rule is finalized before contracts under this RFP are executed, OHCA may take advantage of that flexibility and corresponding payments will be made to MCOs to be paid to affected Providers. If the proposed rule is not finalized before contracts under this RFP are executed, affected supplemental payments will be converted immediately into directed payments and amounts needed will be included in MCO Capitation Rates as an add-on.

Because the 2018 proposed CMS rule does not apply to supplemental payments for all Provider types, whether or not the 2018 proposed CMS rule is finalized, supplemental payments for emergency ground medical transport and community-based mental health centers will be converted into directed payments from the beginning of the SoonerSelect program and amounts needed will be built into the Capitation Rates as an add-on.

1.8 General Solicitation Information

1.8.1 Solicitation Scope

The purpose of this solicitation is to secure Contracts with qualified organizations that have the necessary experience and demonstrated quality to perform all of the duties outlined in Appendix 1: Model Contract (hereinafter referred to as "Model Contract"). Additionally, OHCA intends to obtain CMS approval of a waiver that would authorize it to select one awardee to perform all of the duties in Appendix 2: SoonerSelect Specialty Children's Plan to Eligibles who are Former Foster Children, Juvenile Justice Involved, in Foster Care, Children Receiving Adoption Assistance or Children with an Open Prevention Service Case through Child Welfare Services. Bidders may submit a Proposal for the SoonerSelect Plan, or Proposals for the SoonerSelect Plan and the SoonerSelect Specialty Plan; a Bidder may not submit a Proposal just for the SoonerSelect Specialty Children's Plan. No advantage or disadvantage will result from submitting a Proposal for the SoonerSelect Plan or Proposals for both Plans. OHCA adheres to the concept of best-value contracting, which takes into consideration both past performance and proposed methods when determining a Bidder's capacity to meet Contract standards.

1.8.2 OHCA Sole Point of Contact

OHCA is the issuing agency for this competitive bid RFP. The sole point of contact for the RFP is listed below. All RFP-related inquiries must be directed to this individual. The sole point of contact is the only individual the Bidder should contact, or communicate with, regarding any questions or issues with the RFP or a Bid, and in no instance should a Bidder contact the OHCA Chief Executive Officer, the Oklahoma Health Care Authority Board, or any other official in Oklahoma about the RFP or a Bid. Failure to comply with this requirement may result in the Bid being considered non-responsive or not considered for further evaluation. Failure to abide by this provision may result in a Bidder's disqualification.

Susan Geyer

Email: procurement@okhca.org

⁴ CMS-2408-P available at <https://federalregister.gov/d/2018-24626>

All emails shall include the solicitation name and number in the subject line of the email.

1.8.3 Definitions

Appendices 1A and 1B to the RFP contain definitions of key words and acronyms used in the solicitation and Model Contract.

1.8.4 Effect of the Federal Waiver or State Plan Authority

OHCA shall seek federal authority from CMS to operate SoonerSelect. The Contractor shall comply with any modifications to this RFP and the subsequent Contract resulting from the approval process. In the event CMS denies the request prior to Contract award or signature, OHCA shall be under no obligation to award a Contract as a result of this RFP. In the event CMS denies the request following Contract award and signature, OHCA may terminate the Contract immediately in writing to the Contractor without penalty. OHCA shall not be liable or required to compensate the Contractor for any work performed or expenses incurred prior to termination.

1.8.5 Geographic Scope and Number of Contracts

OHCA intends to award statewide Contracts to multiple Contractors. At its sole discretion, OHCA may issue a future solicitation to procure additional SoonerSelect MCOs in future Contract years.

1.8.6 Cost of Preparation

The Bidder is liable for all costs incurred in preparing its Proposal and participating in any related activities, including oral presentations and Readiness Reviews, if required by OHCA as a condition of award and/or initiation of enrollment.

1.8.7 Certifications

For the purposes of competitive bid, in accordance with 74 O.S. § 85.22, the person whose signature appears on the Proposal affirms that:

- He or she is an authorized Agent for the purpose of certifying facts pertaining to the existence of collusion among and between Bidders and suppliers and State officials or employees, as well as facts pertaining to the giving or offering of things of value to government personnel in return for special consideration in connection with the prospective acquisition.
- Is fully aware of the facts and circumstances surrounding the acquisition or making of the bid to which this statement relates and has been personally and directly involved in events leading to the acquisition or submission of such bid;
- Neither the business entity that is represented in this certification nor anyone subject to the business entity's direction or control has been a party:
 - To any collusion among Bidders or suppliers in restraint of freedom of competition by agreement to bid or contract at a fixed price or to refrain from bidding or contracting;
 - To any collusion with any State official or employee as to quantity, quality or price in the prospective Contract or as to any other terms of such prospective Contract; nor
 - To any discussions between Bidders or suppliers and any State official concerning exchange of money or other thing of value for special consideration in connection with the prospective Contract; and
- If awarded the Contract, neither the business entity represented nor anyone subject to the business entity's direction or control or affiliation has paid, given or donated or agreed to pay,

give or donate to any officer or employee of this State any money or other thing of value, either directly or indirectly, in procuring the Contract to which this statement relates.

By submitting a response to this solicitation, the Bidder and any proposed Subcontractors, Subsidiaries, Affiliates and employees, to the best of their knowledge and belief also certify that:

- In accordance with 74 O.S. § 85.42 and amendments or revisions thereto, no person who has been involved in any manner in the development of this Model Contract while employed by the State of Oklahoma shall be employed by the Contractor to fulfill any of the services provided under the Contract relating from this solicitation;
- No such person or entity is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any federal, State or local department or agency;
- No such person or entity has, within a three-year period preceding this Proposal, been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, State or local) contract; or for violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;
- No such person is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in the previous paragraph;
- No such person or entity has, within a three-year period preceding this application/Proposal, had one or more public (federal, State or local) contracts terminated for cause or default; and
- It will disclose any activity or interest that conflicts or may conflict with the best interest of the State, including, but not limited to, any person or entity currently under contract with or seeking to do business with the State or one of its agencies, its employees or any other third-party individual or entity awarded a contract with the State or one of its agencies. Any conflict of interest shall, in the sole discretion of the OHCA, be grounds for rejection of the bid or partial or whole termination of the Contract.

Pursuant to 74 O.S. § 582(B), Bidder certifies that it is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State. If the Bidder or a Subcontractor is unable to certify any of the statements in this certification, an explanation must be attached to the solicitation response.

1.8.8 Bids Subject to Public Disclosure/Proprietary Information

Unless otherwise specified in the Oklahoma Open Records Act (51 O.S. §24A.1 *et seq.*), the Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a solicitation, including any materials provided at an in-person meeting, are public records and subject disclosure after a contract is awarded or the solicitation is cancelled. No portion of a bid shall be considered confidential after award of the contract or cancellation of the solicitation except, pursuant to 74 O.S. § 85.10, information in a bid determined to be confidential by OHCA. This practice protects the integrity of the competitive bid process and prevents excessive disruption to the procurement process under 51 O.S. § 24A.5(6).

Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the bid with this information redacted, in accordance with instructions provided in Section 2.4.2: "Proprietary Information." OHCA shall make the final determination as to whether the documentation or information is confidential.

1.8.9 Changes in Solicitation Specifications or Contract Terms

Any solicitation amendment shall be set forth at the same online link as the solicitation. If one or more amendments to this solicitation are issued, the Bidder shall acknowledge receipt of any/all such amendment(s) by signing and returning the amendment cover page in accordance with instructions provided in Section 2.5.2: "Technical Proposal Contents." OHCA must receive the amendment acknowledgement(s) by the response due date and time specified for receipt of bids for the bid to be deemed responsive. Failure to acknowledge solicitation amendment(s) may be grounds for rejection.

No oral statement of any person shall modify or otherwise affect the terms, conditions or specifications stated in the solicitation. All amendments to the solicitation shall be made in writing by OHCA.

It is the Bidder's responsibility to check the Bidder's Library frequently for any amendments that may be issued. OHCA is not responsible for a Bidder's failure to acquire any amendment documents required to complete a solicitation.

1.8.10 Waiver of Objections

The Bidder is responsible for reviewing all materials associated with this solicitation and submitting questions and comments in advance of the deadline specified in Section 1.9: "Solicitation Timeline." Protests based on any matter that could have been raised prior to the deadline, but was not, will be considered waived by OHCA.

1.8.11 Accommodations for Bidders with Disabilities

OHCA will make appropriate accommodations for Bidders with disabilities. Bidders seeking accommodations must notify the sole point of contact for the solicitation.

1.8.12 Health Management Associates Disclosure

The State of Oklahoma has engaged Health Management Associates, Inc. (HMA) to assist with the development of the new managed care program for Oklahoma Medicaid. As a result of this work, HMA is precluded from assisting with responses to this RFP solicitation. As part of its normal course of business to protect the State's confidentiality, strategy and proprietary information, HMA has established a firewall where none of the HMA staff working with the State will be available to assist health plans in Oklahoma. This means that there will be no disclosure, discussion or exchange of information between the HMA staff assisting the State and any other HMA teams or individuals assisting health plans with work unrelated to this solicitation. These firewalls and safeguards will remain in operation until the conclusion of the award process for this RFP solicitation. For clarification, there is no prohibition on health plans working with HMA on matters unrelated to this Oklahoma managed care RFP solicitation as long as the firewalls and safeguards are maintained.

1.9 Solicitation Timeline

Key milestone dates for the solicitation and SoonerSelect program implementation are presented in the table below. Dates are subject to change through RFP amendment. All times are Central Time. Unless otherwise specified in the table below, all milestone activity times will occur on, or before, 11:59 pm.

Milestone	Day and Time
Solicitation issue date	October 15, 2020
Deadline for submission of technical questions	October 29, 2020 3 p.m.
Response to questions issued	November 6, 2020
Release of Capitation Rates	December 7, 2020
Actuarial bidder's conference	December 14, 2020
Response due date and time	December 15, 2020 3 p.m.
Oral Presentations	January 18, 2021 – January 22, 2021
Announcement of awards	February 1, 2021
Readiness Review	February 1, 2021– September 30, 2021
Initiation of enrollment	October 1, 2021

OHCA reserves the right to adjust the award announcement date. Initiation of enrollment with a Contractor will be subject to successful completion of Readiness Review activities, in accordance with 42 C.F.R. § 438.66(d).

1.10 Bidder's Library

OHCA has established an on-line Bidder's Library for this solicitation at <http://www.okhca.org/about.aspx?id=74>. New content will be added to the Bidder's Library as appropriate throughout the solicitation. It is the Bidder's responsibility to check the library frequently for updated information. OHCA will not routinely notify Bidders when new material has been posted to the library.

2 Section 2: Solicitation Guidelines

2.1 Overview

This section presents Proposal submission requirements for Solicitation Number 8070001240. The submission requirements have been developed to identify organizations with the necessary experience, demonstrated outcomes, capacity and processes to deliver high quality, cost effective services to SoonerSelect Health Plan Enrollees.

As discussed in more detail below, in conducting this solicitation, OHCA reserves the right to:

- Reject any bids that do not comply with the requirements and specifications of the solicitation. A bid may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation, require indemnification by OHCA, or limit the Bidder's liability to the State;
- Waive minor irregularities in Proposals if determined to be in the best interest of the State. If granted, the waivers will in no way modify the requirements of the solicitation or the obligations of Bidders awarded Contracts;
- Award a Contract based on this solicitation and the Proposals of selected Bidder(s);
- Award the Contract to more than one Bidder, or reject any or all Proposals received, if deemed to be in the best interest of the State of Oklahoma;
- Request clarification or correction of Proposals;
- Amend this solicitation, or any segment hereof
- Cancel this solicitation, if determined to be in the best interest of the State; or
- Discontinue the contracting process at any time.

2.1.1 Submission of Bid

Submitted bids shall be in strict conformity with the instructions to bidders and shall be submitted with a completed Responding Bidder Information, Form 8070001240-C-Proposal Cover Page, and any other forms required by the solicitation.

As discussed in Section 2.4.1: "Electronic Proposals", all Proposals must be submitted electronically.

The required certification statement, "Certification for Competitive Bid and/or Contract (Non-Collusion Certification)", OMEs-Form-CP-004, must be made out in the name of the bidder and must be properly executed by an authorized person, with full knowledge and acceptance of all of its provisions.

The technical requirements of a properly submitted bid are discussed in Section 2.5: "Technical Proposal Requirements". A bid submitted in any other format may not be accepted.

Each bid is required to include relevant information for a designated contact to receive notice, approvals and requests allowed or required by the terms of the Contract.

Proposal shall remain firm for a minimum of one hundred eighty (180) days from the RFP closing date. Bidders guarantee unit prices to be correct. In accordance with 74 O.S 85.40, ALL travel expenses to be incurred by the supplier in performance of the Contract shall be included in the total proposal price/contract amount.

In accordance with 74 O.S. §85.40, all travel expenses to be incurred by a winning Bidder in performance of the Contract shall be included in the total bid price/contract amount. Travel expenses include, but are

not limited to, transportation, lodging and meals. Examples of other miscellaneous travel expenses are referenced in Section 10.14 of the Statewide Accounting Manual.

Pursuant to Oklahoma Attorney General Opinion No. 96-7, OHCA is prohibited from indemnifying a Bidder, any subcontractor or any other party to the Contract. Any Contract between the selected Bidder and OHCA will not contain any terms limiting the liability of the Bidder or providing indemnification by OHCA in favor of the Bidder or any third parties. By submitting a Proposal, the Bidder will be deemed to acknowledge and agree that the State of Oklahoma and its agencies are prohibited from holding an individual or a private entity harmless from liability or providing indemnity to a private entity or individual. Any attempt by the Bidder to add indemnification or limitation of liability provisions in favor of the Bidder (or third parties) to the definitive Contract may render the Bidder's Proposal non-responsive and subject to rejection.

After review of a Bidder's submitted Bid, OHCA may require additional terms related to a solicitation in which consumer data will be accessed, processed or stored by the Contractor.

All bids submitted shall be subject to the Central Purchasing Act, Central Purchasing Rules, and other statutory regulations as applicable.

For the avoidance of doubt, and subject to OHCA protest process discussed in Section 2.9: "Protests", by submitting a Proposal to this RFP, the Bidder stipulates that the courts of the State of Oklahoma sitting in Oklahoma County, Oklahoma shall have personal jurisdiction over its person, and it hereby irrevocably (i) submits to the personal jurisdiction of said courts and (ii) consents to the service of process, pleadings and notices in connection with any and all actions initiated in said courts and waives any objection to venue. The Bidder agrees that a final judgment in any such action or proceeding shall be conclusive and binding and may be enforced in any other jurisdiction. Any disputes will be governed by Oklahoma law, without regard to the principals of conflict of laws of such state.

2.1.2 One Proposal

Except as requested by OHCA, a bid may not be changed after the response due date and time. Bidders may submit only one Proposal in response to this solicitation. If the Bidder needs to change a submitted bid prior to the response due date and time, the Bidder shall withdraw the originally submitted bid and a new bid shall be submitted to OHCA by the response date and time. Bidders may withdraw and resubmit a Proposal at any time prior to the submission deadline. As part of the resubmission process, Bidders must acknowledge in writing that the resubmitted Proposal supersedes all previously submitted Proposals by including the following statement on the superseding bid cover page "THIS BID SUPERSEDES THE BID PREVIOUSLY SUBMITTED". The resubmitted bid should contain the solicitation number and solicitation response due date and time [in the body of the submission email].

2.1.3 Strict Due Date and Time

Bids received by OHCA after the response due date and time shall be deemed non-responsive and shall NOT be considered for any resultant award.

2.1.4 Property of the State

Unless otherwise specified in the Oklahoma Open Records Act, the Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a Bid are public records and subject to disclosure. All material submitted by Bidders becomes the property of the

State of Oklahoma and will be a matter of public record, subject to the procedures for treatment of proprietary information, as described in Section 2.4.2: “Proprietary Information.” OHCA shall have the right to use all concepts described in Proposals, whether or not such Proposals are accepted.

2.1.5 Withdrawal from Solicitation

Bidders may withdraw Proposals and remove themselves from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact at any time prior to the submission deadline. The OHCA sole point of contact is provided in Section 1.8.2: “OHCA Sole Point of Contact.” A bid may not be withdrawn after the response due date and time except as authorized by the OHCA CEO after proof by the Bidder that a significant error by the Bidder exists in the bid.

Unless properly withdrawn, the submitted Proposal is deemed to be a binding offer on the part of the Bidder.

2.1.6 Binding Proposals

All bids shall be firm representations that the responding Bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the Solicitation. Bidders whose Proposals are accepted for evaluation will be bound by the terms of the solicitation and the contents of the Proposals for the duration of the solicitation. Bidders awarded a Contract will be governed by the terms outlined in Appendix 1: Model Contract.

2.1.7 Bid Rejection

The Bidder’s failure to submit required information may cause its bid to be rejected. In addition, a bid received after the bid response date and time shall be deemed non-responsive and shall not be considered unless, in accordance with OAC 260:115-3-11, OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid.

Additionally, failure to comply with these Bidder instructions or solicitation requirements may result in the bid being disqualified from evaluation. Whenever the terms “shall”, “must”, “will” or “is required” are used in the solicitation, the specification being referred to is a mandatory specification of the solicitation. Failure to meet any mandatory specification may cause rejection of a bid. Whenever the terms “can”, “may” or “should” are used in the solicitation, the specification being referred to is a desirable item and failure to provide any item so termed shall not be the cause for rejection of a bid.

A bid may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation, requires OHCA to indemnify the Bidder or a third party or limits the Bidder’s liability. Other possible reasons for rejection are listed in OAC 260:115-7-32(h).

2.1.8 Deficiencies

In accordance with the OAC 260:115-7-32.J, OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do not prejudice the other Bidders. OHCA may also permit Bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the Contract.

2.2 Submission of Questions

Bidders may submit written questions by email only to OHCA sole point of contact. Questions must be submitted using Form 8070001240-A-Questions included in the Bidder’s Library. The form must be submitted in original Excel format.

OHCA will provide written answers to all technical Proposal and price questions received on or before the dates specified in Section 1.9: "Solicitation Timeline." Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid by the State. No Bidder shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee.

2.3 Actuarial Bidders' Conference; Evaluation

2.3.1 Bid Public Opening

OHCA will hold an actuarial Bidder's conference at OHCA offices on the date and time specified in Section 1.9: "Solicitation Timeline." Additional information about the Bidder's conference will be provided in advance of the session.

2.3.2 Evaluation

A responsive bid will proceed to the evaluation process. The evaluation process will be conducted in accordance with Section 2.7: "Proposal Evaluation". Bids will be evaluated on a "best value" criteria. Bid past performance may be considered when evaluating a Bid.

2.4 Proposal Structure & Submission Requirements

2.4.1 Electronic Proposals

All proposals will be submitted electronically. Bidders will e-mail procurement@okhca.org to set up their large file upload for Bidder submissions. Bidder submissions will include the solicitation name and number in the subject line of the email. The body of the email will state:

1. Large file request for [Your Company Name];
2. Name of requestor; and
3. E-mail address of requestor.

OHCA procurement officer for this solicitation will send an email to the Bidder's specified email address that states, "You've been invited to share large files."

1. The Bidder will click on the "Upload Files" button on the e-mail and will be directed to get an access key;
2. The access key will be sent in a separate email and will need to be copied and pasted into the email requesting the access key;
3. The Bidder will receive a secure e-mail to send their large files;
4. The Bidder will add the files and send their proposal; and
5. The Bidder will receive a message that the email was sent.

OHCA encourages Bidders to request a test submission to make sure they understand the process and are comfortable using the large file submission software. Once you have uploaded files from a request you can no longer upload files (i.e. you cannot upload a test file and then use the same access key to upload your solicitation response). If you need to upload more files or make corrections a new large file request will have to be submitted.

All large file submissions for this solicitations should be requested seven days in advance.

2.4.2 Proprietary Information

Documents and information a Bidder submits as part of or in connection with a solicitation are public records and subject to disclosure, unless otherwise specified in applicable law. Bidders claiming any portion of their bid as proprietary or confidential must conspicuously mark on the first page that its bid contains information considered confidential, specifically identify what documents or portions of documents they consider confidential, enumerate the specific grounds, based on applicable laws, which support treatment of the marked information as exempt from disclosure, explain why disclosure is not in the best interest of the public and submit an additional electronic copy of the bid with this information redacted (marked out to be illegible). The additional copies should be clearly labeled "Redacted Copy." OHCA shall make the final decision as to whether the documentation or information is confidential.

A bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid) shall not be considered confidential. Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a Bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is intended to address information often marked confidential that is not exempt from disclosure and is not an exhaustive list.

OHCA has no responsibility to independently review an entire bid for a confidentiality claim. Likewise, confidentiality claims of a Bidder will not be considered if a bid does not comply with the requirements of this Section 2.4.2 and applicable law, including OAC 260:115-3-9, and the information will be subject to disclosure pursuant to State law.

If the Bidder provides a copy of this Proposal with proprietary and confidential information redacted and OHCA appropriately supplies the redacted Proposal to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the Bidder agrees to indemnify OHCA and step in to defend its interest in protecting the referenced redacted material.

For the avoidance of doubt, if a Bidder wishes to seek an exemption from disclosure under the Oklahoma Open Records Act or other statutory or regulatory requirements, it is the responsibility of the Bidder to assert any right of confidentiality that may exist. The OHCA will not make that assertion on behalf of a Bidder.

2.5 Technical Proposal Requirements

2.5.1 Format

Technical Proposals must conform to the following formatting requirements:

- Proposal header must include the solicitation number and the Bidder's legal name.
- Proposal footer must include a page number. Pages must be numbered sequentially, beginning with the transmittal letter and continuing to the end of the technical Proposal. Pages must run 1, 2, 3 etc., without starting over and with no section or question prefixes. It is not necessary to erase page numbers on pre-printed documents, such as solicitation amendments, as long as the sequential page numbering is visible. The original worksheet files included in Proposal Forms folder do not require page numbers that align with the consolidated hard copy and PDF versions.
- Narrative submission responses must be in 12-point or greater Calibri or Times New Roman font, with a minimum of one-inch margins and 1.15 line spacing.

- Wording in any exhibits included or attached to Proposal narrative must be in 8-point or greater font.
- Narrative submission responses should begin by restating the submission requirement number (i.e., Item Number) and bold-faced title. It is not necessary to restate the question.
- Page limits, where applicable, are noted at the end of a submission requirement. Page limits include headers, footers and titles. Page limits also apply to exhibits and attachments, unless otherwise specified. OHCA will not review material outside of page limits.
- The Proposal and each form and document submitted as part of the Proposal must have the Bidder’s legal name and complete address, the solicitation number and the closing date of the RFP.

2.5.2 Technical Proposal Contents

The Technical Proposal must contain the elements listed below, in the order shown. Mandated forms/templates are included in the Bidder’s library.

In preparing technical Proposals, Bidders are encouraged to:

- Be as specific as possible when documenting past performance (i.e., outcomes) and when describing actions or initiatives to be undertaken on behalf of SoonerSelect Health Plan Enrollees;
- Use flow charts and other exhibits to help illustrate processes, where applicable;
- Address diversity within the State when describing challenges to, and strategies for, meeting program requirements, including but not limited to differences between urban and rural areas;
- Discuss innovative programs and best practices implemented in other states or for other Oklahoma populations that also will be offered to the SoonerSelect population;
- Avoid use of tentative language such as “may undertake” or “will explore doing,” as this may result in the proposed activity or initiative being given reduced or no weight in the evaluation; and
- Reference publicly available data and reports, including but not limited to, Dashboards, Fast Facts, and OHCA Annual Reports, online at www.okhca.org/data.

ITEM	INSTRUCTIONS
1	<p>Bidder Proposal Submission Checklist</p> <p>Complete and include a copy of Form 8070001240-B Bidder Proposal Submission Checklist. Indicate whether each submission item is included by checking “Yes” or “No.” If “No” is checked for an item, explain the reason, which is to be submitted with Bidder's Proposal.</p> <p>Note that failure to submit a required submission item may result in rejection of the Bidder’s Proposal as non-responsive.</p> <p>(Page Limit: N/A)</p>
2	<p>Transmittal Letter</p> <p>Include a dated Proposal Transmittal Letter signed by an individual authorized to bind the Bidder’s organization to the terms of the solicitation.</p> <p>The contents of the letter must include:</p>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Solicitation number, Bidder’s full legal name, physical and mailing address and FEIN. • Name and contact information for a single point-of-contact for ongoing communication. • A statement attesting to the accuracy and truthfulness of all information contained in the Proposal. • A statement that a true and correct List of Authorized Signatories of the Bidder is attached to the Proposal Transmittal Letter as an exhibit. • A statement that the Bidder is willing to enroll and serve all Health Plan Enrollees eligible for the SoonerSelect program as identified in Model Contract Section 1.4: “Mandatory, Voluntary and Excluded Populations.” • A statement that the entity proposing to contract with OHCA is located inside the United States. • A statement that the Bidder has reviewed and accepts the SoonerSelect Capitation Rates as calculated, the Capitation Rate methodology and methodology for updating the rates. <p>The letter also must include either:</p> <ul style="list-style-type: none"> • A statement that the Bidder has read, understands and is able and willing to comply with all terms of the Model Contract and standards and participation requirements described in the solicitation; or • A statement specifying any objections the Bidder has to one or more solicitation terms or conditions. Each objection to a solicitation term or condition shall identify (i) the document and section reference of the specific affected term or condition and (ii) either that the term is inapplicable and should be intentionally omitted or offer alternative language. OHCA has no responsibility to independently review an entire bid for objections and any objection embodied in a section of the bid but not listed in the Proposal Transmittal Letter will not be considered. • Any additional terms that the Bidder requests be applicable to the Contract shall also be included in the Proposal Transmittal Letter and shall also be provided in a separate Word format document. OHCA has no responsibility to independently review an entire bid for additional terms and any such terms not listed in the Proposal Transmittal Letter shall not be considered. <p>OHCA reserves the right to disqualify a Proposal with objections or additional Bidder terms on the grounds of non-responsiveness. Even if OHCA does not disqualify a Proposal, it makes no commitment to modifying terms and conditions based on the Bidder’s objections.</p> <p>If a bid includes an offer of value-added products and/or services, such offer shall be included in the Proposal Transmittal Letter and include associated pricing and any other information relevant to such value-added offer. However, OHCA is not obligated to purchase value-added products or services.</p>

ITEM	INSTRUCTIONS
	(Page Limit: N/A)
3	<p>Solicitation Amendments</p> <p>RFP amendment(s), if any, will be located at the same online link as the RFP. The Bidder shall acknowledge agreement with each RFP amendment, if any, by including a cover page from each RFP amendment, signed by an authorized signatory of the Bidder, in its bid.</p> <p>(Page Limit: N/A)</p>
4	<p>OMES- and OHCA-Mandated Representations and Certifications</p> <p>Include completed <u>Form 8070001240-C-Cover Page and Form 8070001240-D-Bidder Representations and Certifications</u>. Note that Form 8070001240-D consists of both a Word document and Excel File (“companion templates”). Include a hard copy of the Excel file content immediately behind Form 8070001240-D. If a template within the Excel file does not contain data, enter “N/A” in the first row of the template and include in the proposal.</p> <p>Form 8070001240-C and Form 8070001240-D include signature requirements. The forms should be signed by the same individual signing the Bidder’s Transmittal Letter.</p> <p>(Page Limit: N/A)</p>
5	<p>Privatization Act Mandated Representations and Certifications</p> <p>Include a section in the Bidder’s Proposal which addresses the following items:</p> <ul style="list-style-type: none"> • A description of any past (within the past ten years) or present litigation involving the Bidder. Include the case name, court, case number, and a brief description of the case and any judgments, settlements or decisions. • The financial stability of the Bidder, including its ability to fund its operations during the term of the Contract. • At least three references related to the Bidder’s performance of a contract with a governmental entity or agency. • A detailed description of how the Bidder will perform the Contract, including anticipated staffing and equipment information. <p>Include a certification, in accordance with 74 O.S. § 589, certifying that the Bidder:</p> <ul style="list-style-type: none"> • Will offer available employee positions pursuant to the Contract to qualified employees of OHCA who meet the hiring criteria of the Bidder (or any applicable Subcontractor) and whose State employment is terminated because of the awarding of the Contract to the Bidder. • Agrees that the Contract shall provide that the dollar amount agreed upon in the Contract may be reduced if the agency experiences a budget shortfall. • Is financially stable as of the date of its Proposal and shall maintain a financially stable operation in accordance with all State and federal laws, regulations and guidance during the term of the Contract, including any extensions thereof. <p>(Page Limit: N/A)</p>

ITEM	INSTRUCTIONS
6	<p>Executive Summary</p> <p>Include an Executive Summary of your Proposal to serve SoonerSelect Health Plan Enrollees. The Executive Summary should describe your approach to improve health outcomes, increase access to care and increase accountability in the SoonerCare program. Information included in the Executive Summary may be used by OHCA when preparing public announcements concerning solicitation awards.</p> <p>(Page Limit: Six pages)</p>
7	<p>Oklahoma Experience</p> <p>Describe your organization’s experience in the State of Oklahoma serving publicly- and privately-funded populations. Limit your response to the years 2015 and later.</p> <p>Provide examples of innovative programs and initiatives implemented for Oklahoma populations, results achieved and how these programs and initiatives will be integrated into your strategy for serving SoonerSelect Health Plan Enrollees.</p> <p>Also include Form 8070001240-E-Oklahoma Experience.</p> <p>(Page Limit: Five pages, excluding Form 8070001240-E)</p>
8	<p>Medicaid Experience</p> <p>Describe your organization’s experience serving the Medicaid populations covered under SoonerSelect in other states. Limit your response to the years 2015 and later.</p> <p>As part of your response, provide examples of innovative programs and initiatives implemented in other states, results achieved, and data collected to document and measure those results. Describe their relevance to the SoonerSelect program, potential barriers to implementation in Oklahoma and how you intend to overcome these barriers.</p> <p>Also include Form 8070001240 – F- Other State Medicaid Experience.</p> <p>(Page Limit: Six pages, excluding Form 8070001240 – F)</p>
9	<p>References</p> <p>References shall be submitted using Form 8070001240 – G-References in accordance with the instructions on the front page of the form. It is the responsibility of the Bidder to collect references from their customers. All references should be signed and clearly list the contact information of the responding customer. Bidder will submit three to five references where the proposed solution is currently in use.</p> <p>(Page Limit: N/A)</p>
10	<p>Litigation</p>

ITEM	INSTRUCTIONS
	<p>Describe whether a contracting party found you to be in breach of any of your physical or behavioral health services contracts within the past five years. The response should include parent organization, affiliates, and subsidiaries conducting Medicaid or other State/federal health business.</p> <ul style="list-style-type: none"> • Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond your control. • If a corrective action plan was imposed, describe the steps and timeframes in the corrective action plan and whether the corrective action plan was completed. • If a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage). • If the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. <p>Responses should also include:</p> <ul style="list-style-type: none"> • A statement of whether there is any pending or recent (within the past five years) litigation against the Bidder. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The Bidder does not need to report workers' compensation cases. If there is pending or recent litigation against the Bidder, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Bidder's performance in a contract. The Bidder shall also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The Bidder shall also address the Bidder's parent organization, affiliates, and subsidiaries conducting Medicaid or other State/federal health business. • The Bidder shall specify whether there is any pending or recent (within the past five years) litigation against a health care service Subcontractor. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or behavioral health services. The Bidder does not need to report workers' compensation cases. If there is pending or recent litigation against a health care service Subcontractor, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also, the Bidder shall include any SEC filings discussing any pending or recent health care service Subcontractor litigation. The Bidder shall address the Subcontractors' parent organization, affiliates, and subsidiaries. <p>(Page Limit: N/A)</p>
11	Company Financial Information

ITEM	INSTRUCTIONS
	<p>Provide a copy of the Bidder's audited financial statements for each of the last three years, including at least a balance sheet, profit and loss statement, or other appropriate documentation, and the auditor's report. This information must also be submitted with respect to the Bidder's corporate parent organization and any Major Subcontractors, as applicable.</p> <p>Also, describe how the Bidder can assist the State with cash flow for start-up costs such as Fee-For-Service claims run out, if the need arises.</p> <p>(Page Limit: N/A)</p>
12	<p>General Terms and Conditions: Reinsurance</p> <p>Describe how you intend to meet the reinsurance requirements outlined in the Model Contract Section 1.1.18.7: "Reinsurance."</p> <p>(Page Limit: One page)</p>
13	<p>Payments to Contractor: Capitation Reconciliation and Overpayment</p> <p>Describe your process for completing a monthly reconciliation of enrollment roster data against Capitation Payments in accordance with Model Contract Section 1.2.2: "Capitation Reconciliation."</p> <p>(Page Limit: One page)</p>
14	<p>Administrative Requirements: Licensure</p> <p>The Contractor must be licensed as an HMO or Domestic Insurer in accordance with Model Contract Section 1.3.1: "Licensure." Include a copy of your license, or if not currently licensed in Oklahoma, your plan for obtaining licensure and the date by which this is anticipated to occur.</p> <p>(Page Limit: Two pages, excluding license. If already licensed statewide, do not submit a narrative.)</p>
15	<p>Administrative Requirements: Accreditation</p> <p>Indicate whether you are currently accredited in accordance with Model Contract Section 1.3.2: "Accreditation." If not currently accredited, describe your plan to achieve accreditation within the required timeframe. Identify the entity from which you will be seeking accreditation.</p> <p>(Page Limit: One page)</p>
16	<p>Administrative Requirements: Major Subcontractors</p> <p>Identify the services to be furnished by Major Subcontractors, as defined in Model Contract Section 1.3.3: "Subcontracting." As part of your response, discuss:</p> <ul style="list-style-type: none"> • Roles and locations of each Major Subcontractor, Subsidiary and Affiliate; • Relevant experience of each Major Subcontractor, Subsidiary and Affiliate;

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Metrics used to evaluate prospective Major Subcontractors', Subsidiaries' and Affiliates' abilities to perform delegated activities prior to delegation; • Policies and procedures for monitoring Major Subcontractor activity; • Enforcement policies used for Major Subcontractor non-performance, including examples; • How you will ensure ongoing collaboration with Major Subcontractors for a streamlined and coordinated approach to serving Health Plan Enrollees and Providers; and • Quality goals and performance oversight activities for Major Subcontractors providing health services. <p>Also include Form 8070001240-H-Major Subcontractors for each applicable Subcontractor.</p> <p>(Page Limit: Six pages, excluding Form 8070001240-H)</p>
17	<p>Administrative Requirements: Oklahoma Presence, Business Relationships & Organizational Structure</p> <p>Describe your organizational structure for the SoonerSelect program, in accordance with Model Contract Section 1.3.5: "Oklahoma Presence." Include a description of the relationship to other Oklahoma lines-of-business and entities described in Model Contract Section 1.3.4: "Business Relationship Disclosure," as applicable. For any functions to be performed outside of Oklahoma, describe how you will ensure a streamlined and coordinated approach to serving Health Plan Enrollees and Providers and how you will ensure the remote location does not hinder OHCA's ability to monitor performance.</p> <p>Also provide:</p> <ul style="list-style-type: none"> • Organizational chart of SoonerSelect plan showing functions, staff types including number of full time employees and their reporting relationships. Identify functions located within and outside of Oklahoma and functions performed by Subcontractors. • Chart depicting SoonerSelect plan's relationship to parent and affiliate plans, as applicable. <p>(Page Limit: Four pages, excluding charts)</p>
18	<p>Administrative Requirements: Key Staff</p> <p>Describe your management structure and include a copy of Form 8070001240-I-Key Staff identifying the individuals who will serve in the Key Staff positions described in Model Contract Section 1.3.6.2: "Key Staff," if known. Also:</p> <ul style="list-style-type: none"> • Include a job description for each position denoted on Form 8070001240-I that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable.

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Include a current resume for each of the individuals identified on Form 8070001240-I. Resumes must include at least the following information: Summary of relevant experience; work history up to the present time; educational history; and licenses/credentials, if applicable, and history of exclusion, debarment or other sanction; and history of audit or investigation by any federal, State authority or entity or Subcontractor thereof related to managed care activities in any state. • Provide a summary of recruitment timelines and activities for Key Staff positions for which individuals have not been identified. Describe contingency plans should these positions continue to remain open after Contract award. <p>(Page Limit: Three pages, excluding Form 8070001240-I, job descriptions, resumes, recruitment timelines and contingency plans)</p>
19	<p>Administrative Requirements: Board of Directors</p> <p>Describe your Board of Director’s constituted for purposes of the SoonerSelect program. Include in your response:</p> <ul style="list-style-type: none"> • Description of how Board members are selected. • If the Board will be local. • A biographical description for each Board member. <p>(Page Limit: Three pages)</p>
20	<p>Administrative Requirements: Staffing</p> <p>Describe your staffing plan for the SoonerSelect program that meets the requirements of Model Contract Section 1.3.6: “Staffing.” Include the basis utilized for determining required numbers of staff by position type. Also include a copy of Form 8070001240-J-Plan Staffing denoting the estimated number of staff, by position, along with a job description for each position denoted on Form 8070001240-J that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable.</p> <p>(Page Limit: Three pages, excluding Form 8070001240-J and job descriptions)</p>
21	<p>Location of Staff within Oklahoma</p> <p>Identify your existing and proposed office locations within Oklahoma and any other office locations outside of Oklahoma. Describe your basis for selecting these locations, including a service area-level map denoting the locations.</p> <p>Also describe how staff located outside of Oklahoma will be structured to ensure compliance with Contract requirements and how Oklahoma-based staff will maintain a full understanding of the operations conducted out-of-state.</p> <p>(Page Limit: Three pages, excluding map)</p>

ITEM	INSTRUCTIONS
22	<p>Economic Impact</p> <p>Describe how your organization will contribute to the Oklahoma economy, in terms of jobs created specifically for this Model Contract.</p> <p>Also include a copy of Form 8070001240-K-Economic Impact documenting the estimated economic impact of your proposed Oklahoma-based staff.</p> <p>(Page Limit: Two pages, excluding Form 8070001240-K)</p>
23	<p>Administrative Requirements: Staff Training</p> <p>Describe your approach to staff training that meets the requirements of Model Contract Section 1.3.6.8: “Staff Training.” Also include a description of your approach to monitoring Subcontractor training.</p> <p>(Page Limit: Two pages)</p>
24	<p>Administrative Requirements: Policies and Procedures</p> <p>Describe your process and timeline for development and internal approval of policies and procedures in accordance with SoonerSelect program requirements outlined in Model Contract Section 1.3.9: “Policies and Procedures.”</p> <p>(Page Limit: Three pages)</p>
25	<p>Implementation Plan</p> <p>Address your plan for implementation through all of the following:</p> <ul style="list-style-type: none"> • Identify key implementation activities and describe your approach for ensuring these activities will be completed prior to the onsite Readiness Review scheduled to occur approximately 120 days prior to initial enrollment of SoonerSelect Eligibles; • Required OHCA resources to ensure Bidder readiness; • Discuss potential barriers or risks to timely implementation and your process for addressing; • Discuss your results of Readiness Reviews conducted in other Medicaid managed care programs. Limit examples to 2015 or later. Identify all examples of functions that failed at the time of the review and any corrective action plans issued as a result; and • Include an implementation work plan created in Microsoft Project or equivalent format that presents major implementation milestones and associated tasks by functional area between Proposal submission and 90 days post-go live. (The format specification is for presentation purposes only; the implementation plan should be submitted as part of the larger PDF Proposal.) The work plan should be in sufficient detail to serve as a management tool for tracking implementation progress in the event of Contract award. <p>(Page Limit: Seven pages, excluding work plan)</p>

ITEM	INSTRUCTIONS
26	<p>Mandatory, Voluntary and Excluded Populations</p> <p>Identify any populations mandatorily or voluntarily enrolled in SoonerSelect, as identified in Model Contract Section 1.4: “Mandatory, Voluntary and Excluded Populations,” that you do not have experience covering under a risk-based Medicaid managed care contract. Describe how you will prepare as an organization to deliver services to these population(s) in accordance with Model Contract requirements.</p> <p>(Page Limit: Three pages)</p>
27	<p>Covered Benefits</p> <p>Describe how you will prepare as an organization to deliver the benefits in accordance with Model Contract requirements. Identify any covered benefits specified in Model Contract Section 1.6: “Covered Benefits” that you do not have experience offering on a risk basis.</p> <p>(Page Limit: Three pages)</p>
28	<p>Covered Benefits: Service Integration</p> <p>Provide a detailed description of how your operational structure and practices will support the integrated delivery of physical health, behavioral health, pharmacy benefits and services addressing Social Determinants of Health. Describe your strategies to ensure coordination of care for Health Plan Enrollees receiving, or in need of, dental services through the separate Dental PAHP and services eligible for 100% federal match delivered by IHCPs.</p> <p>(Page Limit: Five pages)</p>
29	<p>Covered Benefits: Behavioral Health Benefits</p> <p>Describe your relevant experience and proposed approach for delivering behavioral health benefits to SoonerSelect Health Plan Enrollees in accordance with the requirements outlined in Model Contract Section 1.6.2: “Behavioral Health Benefits.” Include in your response:</p> <ul style="list-style-type: none"> • Processes for ensuring compliance with the Mental Health Parity and Addictions Equity Act; • Strategies to integrate behavioral and physical health services, including proposed approach for all minimum required components in the Model Contract Section 1.6.2.3: “Behavioral and Physical Health Integration;” • Strategies to improve coordination between ERs, primary care physicians and MAT Providers; • Proposed processes for crisis services in accordance with Model Contract Section 1.6.2.6: “Behavioral Health Crisis Services;” • Processes for complying with 42 C.F.R. Part confidentiality provisions related to substance use disorder diagnosis and treatment in the context of integrated care for Health Plan Enrollees; and • How you will ensure compliance with the pending 1115 IMD Waiver requirements.

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	<p>In addition, provide an example of an innovative approach you took for the following scenarios, the results achieved, and how you will apply this experience to SoonerSelect. Limit your examples to 2015 or later:</p> <ul style="list-style-type: none"> • Providing integrated behavioral and physical health services; • Reimbursement mechanisms or incentives to co-locate services in a primary care setting in compliance with Federal Financial Participation regulations; and • Advancing the use of behavioral health evidence-based practices. <p>If you intend to subcontract to a third party to deliver behavioral health benefits, identify the organization and discuss your existing relationship. Identify the tasks to be performed by the Subcontractor and how you will perform oversight of its functions and ensure delegation does not compromise the integrated delivery of physical and behavioral health benefits.</p> <p>(Page Limit: 15 pages)</p>
30	<p>Behavioral Health Case Studies</p> <p>Describe your approach to addressing the following use cases.</p> <p><u>Use Case 1:</u></p> <p>Sarah is a 16-year-old with a diagnosis of intermittent explosive disorder and at one point in the past was diagnosed with Reactive Attachment Disorder (RAD). She has injured her sister in the past, once with a baseball bat. There is some belief she might be developmentally delayed, yet no application has ever been made for developmental disability services. There was a fire in the family home recently. The parents suspect Sarah of starting the fire but evidence suggests it was electrical. She made a suicide attempt after a family argument and is now hospitalized. The hospital is ready to discharge. The hospital is unsure what to do because the parents are refusing to pick her up, saying they must protect her younger sister. Child protective services is investigating. This young lady was removed from her parents for two years at age two due to neglect.</p> <p><u>Use Case 2:</u></p> <p>Tim is a 32-year-old who has been admitted to Griffin Memorial Hospital for the third time this year. He has a diagnosis of suicidality, with two serious past attempts. In addition, he uses multiple substances. He states he just wants to be left alone to use meth when he wants to do so. He continually refuses to engage into outpatient treatment. Griffin Memorial Hospital is reaching out for assistance with discharge planning.</p> <p><u>Use Case 3:</u></p> <p>James is a 70-year-old with history of multiple addictions. He is confined to a wheelchair and has several medical diagnoses that make it dangerous for him to live alone. He is also diagnosed with major depression with recurring suicidality. In addition, he is a convicted sex offender. He is currently incarcerated and is being discharged in two weeks. The Department</p>

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	<p>of Corrections is reaching out for assistance with appropriate treatment and placement upon discharge from prison.</p> <p><u>Use Case 4</u></p> <p>Miguel has a history of aggression and also has a history of swallowing item such as pen caps, pencils, paper clips, and other miscellaneous items. He is 12 years old and has a history of mental health treatment in inpatient settings. Due to recent incidents in the home and at school where he has attempted to swallow dangerous objects, his parents want to place him in a residential facility. However, they are having difficulty finding a facility that can accommodate his specialized needs.</p> <p>(Page Limit: 20 pages)</p>
31	<p>Covered Benefits: Pharmacy Program</p> <p>Describe your proposed structure for pharmacy benefit management. If you intend to subcontract to a third party Pharmacy Benefit Manager (PBM), identify the organization and discuss your existing relationship. Identify the tasks that will be performed by the PBM and how you will perform oversight of its functions. (Page Limit: Three pages)</p> <p>Also address the following components in your response. Please note the page limit associated with each component.</p> <p>Claims (Page Limit: Three pages)</p> <p>Describe your method for ensuring that drugs are not subject to 340B discounts or paid at 340B rates during claims processing under the pharmacy benefit or medical benefit drug program.</p> <p>Describe the methods and processes used during or after claims processing to reduce or eliminate billing disputes with manufacturers. Describe the processes and procedures used to resolve post-adjudication claims processing errors by pharmacies or Providers for both prescription claims and physician-administered drugs, such as invalid or terminated NDCs, package size errors, etc. Describe how you will support the dispute resolution process. As a part of your response, discuss the types of data and documentation you maintain on record, should a dispute arise. Examples may include, but are not limited to, claims data, contacting the prescribing provider, and requesting copies of doctor’s orders to support invoices.</p> <p>Prospective Drug Utilization Review (proDUR) (Page Limit: Three pages)</p> <p>Describe your prospective DUR program. Provide a description of the program, the edits used, system flexibilities in deploying edits and overrides, and the ability to accommodate specific edits developed by OHCA. Describe any outcomes that have been measured for other programs. Describe if OHCA would have access to the system and the timeline for requested changes to be implemented.</p> <p>Retrospective Drug Utilization Review (retroDUR) (Page Limit: Five pages)</p>

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	<p>Describe the retroDUR program that will be delivered to OHCA. Describe the process for evaluating data, identifying potential interventions, and communicating with Providers, including how often the programs or intervention will be performed. Include a description of the reporting that will be provided to the State, including how outcomes are measured and how often they are reported. Provide examples of successful programs and a description of results for programs that have been provided to other State Medicaid programs.</p> <p>Clinical Program Coordination (Page Limit: Five pages)</p> <p>Describe how proDUR and retroDUR programs are integrated. Also describe how you integrate the findings and results from retroDUR interventions into population health, quality, care coordination or clinical programs. Provide examples of successful program integrations, including outcomes or results, from other State Medicaid programs.</p> <p>SUPPORT Act Implementation (Page Limit: Three pages)</p> <p>Describe how proDUR and retroDUR programs are used to implement SUPPORT Act requirements, including the appropriate use of antipsychotics in children and appropriate use of opiates.</p> <p>Clinical Program (Page Limit: Five pages)</p> <p>Describe any other pharmacy related initiatives or programs you will offer that will benefit Health Plan Enrollee outcomes and improve overall health.</p> <p>Pharmacy Program – Drug Trends and Monitoring (Page Limit: Five pages)</p> <p>Describe how you will monitor new drug utilization and new drugs coming to market to identify trends and potential interventions or management by OHCA. Describe current processes for monitoring the drug pipeline (pharmacy and medical benefit drugs), evaluating the need for utilization management criteria, and recommending clinical programs to ensure proper use. Provide examples of monitoring and program recommendations utilized for other State programs.</p> <p>PBM Monitoring (Page Limit: Eight pages)</p> <p>If you will subcontract with a PBM, describe the process and reporting that will be used to ensure that PBMs do not engage in spread pricing, DIR fees, and that they employ a transparent model. Include a description of the reporting that will be provided to OHCA to ensure compliance with these requirements. If the Contractor does not utilize a PBM, describe the reporting and processes that will be employed to demonstrate compliance.</p> <p>If the Contractor utilizes a PBM, describe the processes, procedures and reporting the Contractor will employ to ensure compliance with the prohibition on patient steering.</p> <p>Also describe the Contractor’s appeals process for under paid claims, including who will be responsible for reporting all appeal outcomes to the State.</p>

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32	<p>Covered Benefits: Non-Emergency Medical Transportation</p> <p>Describe your approach for providing NEMT in accordance with the requirements of Model Contract Section 1.6.7: “Non-Emergency Medical Transportation.” If you propose to Subcontract to deliver NEMT services, describe strategies you will employ to ensure the seamless delivery of services to Health Plan Enrollees.</p> <p>(Page Limit: Five pages)</p>
33	<p>Covered Benefits: Social Determinants of Health</p> <p>Describe your approach for addressing Social Determinants of Health in accordance with the requirements of Model Contract Section 1.6.9: “Social Determinants of Health.”</p> <p>In addition, provide an example of an innovative approach you took to address Social Determinants of Health, the results achieved, and how you will apply this experience to SoonerSelect. Limit your examples to 2015 or later.</p> <p>(Page Limit: Three pages)</p>
34	<p>Covered Benefits: In Lieu of Services</p> <p>Identify any in lieu of services or settings you propose to offer to SoonerSelect Health Plan Enrollees and the basis for their selection. Complete Form 8070001240-L-In Lieu of Services specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or Prior Authorization requirements. Note that Form 8070001240-L must be signed by the actuary attesting to the actuarial value estimate.</p> <p>Include the following description in your narrative response:</p> <ul style="list-style-type: none"> • Evidence the service(s) are medically appropriate and cost-effective alternatives for the substituted State Plan service or setting; and • An assurance Health Plan Enrollees will not be required to use the alternative service or setting. <p>(Page Limit: Two pages, excluding Form 8070001240-L)</p>
35	<p>Covered Benefits: Value-Added Benefits</p> <p>Identify any Value-Added Benefits you propose to offer to SoonerSelect Health Plan Enrollees and the basis for their selection. Complete Form 8070001240-M-Value-Added Benefits specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or Prior Authorization requirements. Note that Form 8070001240-M must be signed by the actuary attesting to the actuarial value estimate.</p> <p>(Page Limit: Two pages, excluding Form 8070001240-M)</p>
36	<p>Covered Benefits: EPSDT</p>

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	<p>Describe your strategies for increasing EPSDT screening visit rates.</p> <p>Provide an example of an innovative approach you took to address EPSDT, the results achieved, and how you will apply this experience to SoonerSelect. Limit your examples to 2015 or later.</p> <p>(Page Limit: Three pages)</p>
37	<p>Covered Benefits: School-Based Services</p> <p>Describe your approach for reimbursing school-based services in accordance with Model Contract Section 1.6.13: “School-Based Services.” Include in your response how you will ensure compliance with the requirements of OAC 317:30-5-1020 through 317:30-5-1027.</p> <p>(Page Limit: Three pages)</p>
38	<p>Covered Benefits: Moral or Religious Objections</p> <p>Provide either:</p> <ul style="list-style-type: none"> • A statement of attestation that the Bidder has no moral or religious objections to providing any covered benefits described in Model Contract Section 1.6: “Covered Benefits;” or • A statement of any moral or religious objections to providing any covered benefits described in Model Contract 1.6: “Covered Benefits.” The statement must describe, in as much detail as possible, all direct and related services that are objectionable. It must include a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. Also describe how Health Plan Enrollees and Providers will be informed when these services are not covered and how to obtain information from OHCA about how to access the services. <p>(Page Limit: Two pages)</p>
39	<p>Medical Management: Evidence-Based Guidelines</p> <p>Describe your relevant experience and approach to developing an evidence-based medical management strategy. As part of your response, describe:</p> <ul style="list-style-type: none"> • How evidence-based guidelines are developed and employed in medical management decision making; • How Providers are educated about guidelines, including updates; • How service utilization and other operational data are used to evaluate the effectiveness of guidelines; and • How guidelines are updated based on outcomes and how they remain current with national trends. <p>In addition, provide two examples of medical management guidelines that were updated in response to evaluation of utilization/operational data or national trends and the impact of the changes. Limit your examples to 2015 or later.</p>

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	(Page Limit: Five pages)
40	<p>Medical Management: Prior Authorization</p> <p>Describe your relevant experience and proposed approach for performing Prior Authorizations (PA) in accordance with the requirements outlined in Model Contract Section 1.7: “Medical Management.” Include a flow chart depicting the proposed workflow for processing PA requests from initial request to final disposition, including the process for expedited authorizations.</p> <p>As part of your response, discuss:</p> <ul style="list-style-type: none"> • External guidelines to be used, if applicable; • How you will identify services that should require PA, beyond those currently required by OHCA; • Methods of PA submission available to Providers; • Processes to ensure timely processing; • Qualifications of PA personnel; • Who will have authority to deny services; • Your peer-to-peer review process; and • How you will ensure consistent application of review criteria. <p>(Page Limit: Five pages)</p>
41	<p>Medical Management: Hospital Utilization</p> <p>Based on available data, provide your assessment of hospital utilization rates within the SoonerSelect population and their potential for being lowered. Describe your strategy for reducing inpatient hospital admission and readmission rates within the SoonerSelect population.</p> <p>In addition, provide an example of an initiative undertaken to reduce hospital utilization. Discuss the identified problem, intervention and results achieved. Limit your examples to 2015 or later.</p> <p>Also include a copy of <u>Form 8070001240-N-Hospital Utilization</u>.</p> <p>(Page Limit: Four pages, excluding Form 8070001240-N)</p>
42	<p>Medical Management: Emergency Room Utilization</p> <p>Based on available data, provide your assessment of emergency room utilization rates within the SoonerSelect population and their potential for being lowered. Describe your strategy for reducing emergency room visit rates within the SoonerSelect population.</p> <p>In addition, provide an example of an initiative undertaken to reduce emergency room utilization. Discuss the identified problem, intervention and results achieved. Limit your examples to 2015 or later.</p>

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	<p>Also include a copy of Form 8070001240-O-Emergency Room Utilization.</p> <p>(Page Limit: Four pages, excluding Form 8070001240-O)</p>
43	<p>Medical Management: High Utilizers</p> <p>Describe your strategy for defining, identifying and improving quality of care and outcomes among high utilizers within the SoonerSelect program.</p> <p>In addition, provide an example of an initiative undertaken to improve quality of care and outcomes for a high utilization population. Discuss the identified problem, intervention and results achieved. Limit your example to 2015 or later.</p> <p>(Page Limit: Four pages)</p>
44	<p>Medical Management: Outpatient Drug Authorizations</p> <p>Describe your pharmacy Prior Authorization (PA) process, from initiation to completion. Include in your description:</p> <ul style="list-style-type: none"> • How incomplete requests are addressed; and • How a 24-hour turnaround time on all pharmacy and medical drug PA requests are ensured. <p>(Page Limit: Three pages)</p>
45	<p>Care Management and Population Health: Risk Stratification Level Framework</p> <p>Describe your proposed Risk Stratification Level Framework that meets the requirements of the Model Contract Section 1.8: “Care Management and Population Health.” Include in your description:</p> <ul style="list-style-type: none"> • Your levels of care management and population health interventions, including: <ul style="list-style-type: none"> ○ The criteria that qualifies a Health Plan Enrollee for each level; ○ The condition(s) targeted at each stratification level and why each condition was selected; ○ Which levels are assigned a Care Manager and associated caseload levels; and ○ The intensity and frequency of interventions received by Health Plan Enrollees in each level. • How you utilize the following minimum strategies to determine the appropriate level of care management and population health intervention for each Health Plan Enrollee: <ul style="list-style-type: none"> ○ Initial Health Risk Screening; ○ Comprehensive Assessment; ○ Predictive modeling; ○ Claims review; ○ Health Plan Enrollee and caregiver requests; ○ Information received from OHCA; and

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	<ul style="list-style-type: none"> ○ Physician referrals. ● How you leverage, coordinate or engage with other entities delivering care coordination or case management to Health Plan Enrollees. ● How community and social support needs of Health Plan Enrollees are addressed in the Risk Stratification Level Framework, including coordination with community-based organizations providing non-Medicaid services to SoonerSelect Health Plan Enrollees, including: <ul style="list-style-type: none"> ○ The types of community-based organizations and resources to be targeted as part of your care management strategy; ○ Your activities to date to identify Oklahoma community-based organizations; and ○ How Care Managers and other staff will integrate community-based services into care management and population health interventions and share data among service providers. ● Methods you utilize to evaluate a Health Plan Enrollee’s need for changes in intensity and frequency of care management and population health interventions, and conditions which trigger a change. ● How the effectiveness of care management and population health interventions will be monitored over time. <p>In addition, provide examples of outcomes achieved in your care management and population health management programs. Limit examples to 2015 or later.</p> <p>(Page Limit: 20 pages)</p>
46	<p>Care Management and Population Health: Health Risk Screening</p> <p>Describe your relevant experience and proposed approach for performing Health Risk Screenings in accordance with requirements outlined in Model Contract Section 1.8.1: “Health Risk Screening.” As part of your response, discuss:</p> <ul style="list-style-type: none"> ● Methods to be used to maximize the reach and screening rates for new Health Plan Enrollees; and ● Conditions which will trigger you to conduct a new Health Risk Screening on a Health Plan Enrollee. <p>In addition, provide a draft Health Risk Screening instrument to be used or a representative tool utilized by the Bidder.</p> <p>Also include a copy of Form 8070001240-P-Health Risk Screening Activity Rates, documenting health risk screening activity.</p> <p>(Page Limit: Five pages, excluding Health Risk Screening instrument and Form 8070001240-P; there is no page limit for the Health Risk Screening instrument and any related instructions.)</p>

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47	<p>Care Management and Population Health: Comprehensive Assessment</p> <p>Describe your relevant experience and proposed approach for performing Comprehensive Assessments in accordance with requirements outlined in Model Contract Section 1.8.2: “Comprehensive Assessment.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • What responses on the Health Risk Screening trigger the determination a Health Plan Enrollee requires a Comprehensive Assessment; • The qualifications of the individuals who will be performing the assessments; • Methods by which Comprehensive Assessments will be completed; • How your methods ensure Comprehensive Assessments are conducted in a culturally competent manner and are accessible to individuals with disabilities and persons with LEP; and • The circumstances that would trigger an early reassessment of a Health Plan Enrollee. <p>In addition, provide a draft of the Comprehensive Assessment tool or a representative tool utilized in another program.</p> <p>Also include a copy of Form 8070001240-Q-Comprehensive Assessment Activity Rates, documenting Comprehensive Assessment activity.</p> <p>(Page Limit: Five pages, excluding the Comprehensive Assessment tool and Form 8070001240-Q; there is no page limit for the Comprehensive Assessment tool and any related instructions.)</p>
48	<p>Care Management and Population Health: Care Planning</p> <p>Describe your relevant experience and proposed approach for developing and implementing Care Plans in accordance with requirements outlined in Model Contract Section 1.8.3: “Care Plans.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • How Providers are engaged in the care planning process; • Procedures and timeframes for development, review and approval of the Care Plan; and • Procedures for review of existing Care Plans. <p>In addition, provide a draft of the proposed Care Plan template or a representative example.</p> <p>(Page Limit: Five pages, excluding Care Plan; there is no page limit for the Care Plan.)</p>
49	<p>Care Management and Population Health: Care Manager Training</p> <p>Describe your relevant experience and proposed approach for the initial and ongoing training programs you will undertake in accordance with the requirements in Model Contract Section 1.8.4.4: “Training.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • Your approach to curriculum development;

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	<ul style="list-style-type: none"> • Your process to ensure all Care Managers receive adequate and ongoing training to meet the requirements in Model Contract Section 1.8: “Care Management and Population Health;” • How attendance will be documented and stored; • How competencies will be evaluated post-training; and • The training modalities to be used for initial and ongoing training. <p>In addition, provide a draft training curriculum to be used or a representative sample utilized in another program.</p> <p>(Page Limit: Three pages, excluding curriculum; there is no page limit for the curriculum.)</p>
50	<p>Care Management and Population Health: Care Manager Changes</p> <p>Describe how continuity of care will be maintained for Health Plan Enrollees when a Care Manager change occurs, whether Health Plan Enrollee- or Contractor-initiated, in accordance with requirements in Model Contract Sections 1.8.4.5: “Care Manager Changes” and 1.8.4.6: “Contractor-Initiated Care Manager Changes.”</p> <p>(Page Limit: Two pages)</p>
51	<p>Care Management and Population Health: Health Plan Enrollee Access to Care Managers</p> <p>Describe the back-up system that will be in place for Health Plan Enrollees when their Care Manager is unavailable, including after hours and holidays, in accordance with requirements in Model Contract Section 1.8.4.7: “Health Plan Enrollee Access to Care Managers.”</p> <p>(Page Limit: Two pages)</p>
52	<p>Care Management and Population Health: Coordination with Other SoonerCare Programs</p> <p>Describe your procedures to coordinate services delivered under the Contract with services Health Plan Enrollees receive from community and social support providers in accordance with Model Contract Section 1.8.5: “Coordination with Other SoonerCare Programs.”</p> <p>Also describe your procedures to coordinate services delivered under the Contract with other state agencies in accordance with Model Contract Section 1.3.8: “Coordination with Other State Agencies.” Provide examples of successful collaborations with other State agencies that have been implemented in other State Medicaid programs.</p> <p>(Page Limit: Three pages)</p>
53	<p>Care Management and Population Health: Lock-In Program</p> <p>Describe your proposed lock-in program that meets the requirements of the Model Contract Section 1.8.6: “Lock-In Program.” Include in your response how findings from the lock-in program are incorporated into your Risk Stratification Level Framework.</p>

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	<p>In addition, provide examples of outcomes achieved in your lock-in program in other states. Limit examples to 2015 or later.</p> <p>(Page Limit: Two pages)</p>
54	<p>Care Management and Population Health: Monitoring Service Delivery</p> <p>Describe your relevant experience and proposed approach for monitoring and evaluating service delivery in accordance with requirements outlined in Model Contract Section 1.8.7: “Monitoring Service Delivery.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • How you will ensure care management tools and procedures are applied in a consistent and objective manner; • How you will track findings at the individual level to identify systemic issues; • How you will track that Health Plan Enrollees are obtaining services when referrals for services have been authorized; and • How you will ensure Service Gaps are identified and addressed in a timely manner. <p>In addition, provide an example of a monitoring activity that resulted in the identification of a service delivery issue. Describe how the issue was identified, the corrective actions taken and the results achieved. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
55	<p>Care Management and Population Health: Case Study (Roger)</p> <p>Roger is a 48-year old male with diagnoses of congestive heart failure, hypertension, hyperlipidemia (high cholesterol), obesity, and a history of Type II diabetes with neuropathy. Roger has had three ER visits and one hospital admission in the last 12 months for congestive heart failure. Just two days ago, Roger was discharged from the hospital for a Stage 3 right foot ulcer with cellulitis. Roger is a new Eligible.</p> <p>Roger has a number of medications prescribed for him by his current cardiologist and PCMH Provider. He has consistently refused insulin for fear of having a hypoglycemic episode. While he takes his other medications, he sometimes “forgets or doesn’t feel he needs to take them every day.”</p> <p>Roger lives with his wife, Olivia, ten-year old son, Michael, and six-year old daughter, Amy. Roger lives a pretty sedentary lifestyle. Roger and his family reside in Tulsa, Oklahoma.</p> <p>Roger is depressed about his health issues. He recognizes his diabetes and eating habits are poorly controlled and are aggravating his foot ulcers and other conditions.</p> <p><u>Instructions</u></p> <p>Describe your strategy for managing the Member’s care. Address the following items in the order presented:</p> <ul style="list-style-type: none"> • <i>Health Risk Screening</i>

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	<ul style="list-style-type: none"> ○ Describe the most pressing risk factors associated with this Health Plan Enrollee that will need to be addressed. ○ List any significant aspects that are unknown to this case that may be relevant in order to assign Roger to a risk level in accordance with your Risk Stratification Level Framework. <ul style="list-style-type: none"> ● <i>Care Management Risk Levels</i> - Identify the assigned risk level in accordance with your Risk Stratification Level Framework and your rationale for the Health Plan Enrollee’s assigned risk level. ● <i>Comprehensive Assessment</i> – Confirm if this Health Plan Enrollee would receive a Comprehensive Assessment in accordance with your Risk Stratification Level Framework. If yes, provide the timeframe to complete the Comprehensive Assessment, sources used to obtain information and the type of Care Manager to be assigned to the Health Plan Enrollee. ● <i>Care Planning</i> – Confirm if this Health Plan Enrollee would receive a Care Plan in accordance with your Risk Stratification Level Framework. If yes, describe your care planning approach. At your option, also provide a Care Plan for the Health Plan Enrollee in a template you propose to use for SoonerSelect or using a relevant template from another program. ● <i>Providers and Services</i> - Discuss any challenges or barriers to ensuring Health Plan Enrollee choice in the selection of Providers and services and how they will be addressed. ● <i>Ongoing Care Management</i> - List pertinent care management interventions, including care transitions (if applicable) for this Health Plan Enrollee. ● <i>Coordination Activities</i> – Discuss coordination with other payers, non-capitated Medicaid service providers and community-based organizations and resources, as applicable. ● <i>Monitoring Service Delivery</i> - Identify the challenges to monitor the Health Plan Enrollee’s service delivery, compliance and health status over time and how they will be addressed. <p>(Page Limit: Seven pages, excluding Care Plan, if provided; there is no page limit for the Care Plan and related service plan. Place the Care Plan at the end of your response, after the narrative.)</p>
56	<p>Care Management and Population Health: Case Study (Wendy)</p> <p>Wendy is a 25 year old Health Plan Enrollee who is four months pregnant. This is her second pregnancy. During her first pregnancy she developed preeclampsia and delivered prematurely. She is not currently under the care of an OB/GYN.</p> <p><u>Instructions</u></p> <p>Describe your strategy for managing the Health Plan Enrollee’s care. Address the following items in the order presented:</p>

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	<ul style="list-style-type: none"> • <i>Health Risk Screening</i> <ul style="list-style-type: none"> ○ Describe the most pressing risk factors associated with this Health Plan Enrollee that will need to be addressed. ○ List any significant aspects that are unknown to this case that may be relevant in order to assign Wendy to a risk level in accordance with your Risk Stratification Level Framework. • <i>Care Management Risk Levels</i> - Identify the assigned risk level in accordance with your Risk Stratification Level Framework and your rationale for the Health Plan Enrollee’s assigned risk level. • <i>Comprehensive Assessment</i> – Confirm if this Health Plan Enrollee would receive a Comprehensive Assessment in accordance with your Risk Stratification Level Framework. If yes, provide the timeframe to complete the Comprehensive Assessment, sources used to obtain information and the type of Care Manager to be assigned to the Health Plan Enrollee. • <i>Care Planning</i> – Confirm if this Health Plan Enrollee would receive a Care Plan in accordance with your Risk Stratification Level Framework. If yes, describe your care planning approach. At your option, also provide a Care Plan for the Health Plan Enrollee in a template you propose to use for SoonerSelect or using a relevant template from another program. • <i>Providers and Services</i> - Discuss any challenges or barriers to ensuring Health Plan Enrollee choice in the selection of Providers and services and how they will be addressed. • <i>Ongoing Care Management</i> - List pertinent care management interventions, including care transitions (if applicable) for this Health Plan Enrollee. • <i>Coordination Activities</i> – Discuss coordination with other payers, non-capitated Medicaid service providers and community-based organizations and resources, as applicable. • <i>Monitoring Service Delivery</i> - Identify the challenges to monitor the Health Plan Enrollee’s service delivery, compliance and health status over time and how they will be addressed. <p>(Page Limit: Seven pages, excluding Care Plan, if provided; there is no page limit for the Care Plan and related service plan. Place the Care Plan at the end of your response, after the narrative.)</p>
57	<p>Care Management and Population Health: Case Study (Bobby)</p> <p>Bobby is a five year old SoonerSelect Health Plan Enrollee who was born premature. He requires a feeding tube and has developmental delays. He is in kindergarten and has an IEP. Bobby’s parents have not yet applied for Supplemental Security Income (SSI). His parents are concerned they do not have the financial resources to adequately meet his nutritional needs.</p> <p><u>Instructions</u></p>

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	<p>Describe your strategy for managing the Health Plan Enrollee’s care. Address the following items in the order presented:</p> <ul style="list-style-type: none"> • <i>Health Risk Screening</i> <ul style="list-style-type: none"> ○ Describe the most pressing risk factors associated with this Health Plan Enrollee that will need to be addressed. ○ List any significant aspects that are unknown to this case that may be relevant in order to assign Bobby to a risk level in accordance with your Risk Stratification Level Framework. • <i>Care Management Risk Levels</i> - Identify the assigned risk level in accordance with your Risk Stratification Level Framework and your rationale for the Health Plan Enrollee’s assigned risk level. • <i>Comprehensive Assessment</i> – Confirm if this Health Plan Enrollee would receive a Comprehensive Assessment in accordance with your Risk Stratification Level Framework. If yes, provide the timeframe to complete the Comprehensive Assessment, sources used to obtain information and the type of Care Manager to be assigned to the Health Plan Enrollee. • <i>Care Planning</i> – Confirm if this Health Plan Enrollee would receive a Care Plan in accordance with your Risk Stratification Level Framework. If yes, describe your care planning approach. At your option, also provide a Care Plan for the Health Plan Enrollee in a template you propose to use for SoonerSelect or using a relevant template from another program. • <i>Providers and Services</i> - Discuss any challenges or barriers to ensuring Health Plan Enrollee choice in the selection of Providers and services and how they will be addressed. • <i>Ongoing Care Management</i> - List pertinent care management interventions, including care transitions (if applicable) for this Health Plan Enrollee. • <i>Coordination Activities</i> – Discuss coordination with other payers, non-capitated Medicaid service providers and community-based organizations and resources, as applicable. • <i>Monitoring Service Delivery</i> - Identify the challenges to monitor the Health Plan Enrollee’s service delivery, compliance and health status over time and how they will be addressed. <p>(Page Limit: Seven pages, excluding Care Plan, if provided; there is no page limit for the Care Plan and related service plan. Place the Care Plan at the end of your response, after the narrative.)</p>
58	<p>Transition of Care</p> <p>Describe your relevant experience and proposed approach for completing transition of care activities in accordance with requirements outlined in Model Contract Section 1.9: “Transition of Care.” As part of your response, discuss how you will:</p>

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	<ul style="list-style-type: none"> • Capture existing Prior Authorizations in your medical management system and ensure they are honored during the Continuity of Care period; • Identify Health Plan Enrollees with continuity of care needs beyond the 90 day Continuity of Care Period as described in Model Contract Section 1.9.3: “Transition of Prior Authorizations;” • Ensure Health Plan Enrollee services are not interrupted during the transition period; and • How you will share data and coordinate with other MCOs, OHCA or SoonerCare, and Non-Participating Providers. <p>(Page Limit: Four pages)</p>
59	<p>Transition of Care: Transitions from Inpatient/Residential Settings</p> <p>Describe your relevant experience and proposed approach for coordinating services to Health Plan Enrollees between settings of care in accordance with requirements outlined in Model Contract Section 1.9.9: “Transitions from Inpatient/Residential Settings.” As part of your response, discuss how you will:</p> <ul style="list-style-type: none"> • Identify Health Plan Enrollees in an inpatient/residential setting; • Coordinate with Health Plan Enrollees and relevant Providers to facilitate timely and appropriate discharge planning; • Evaluate risk of hospital readmission; • Identify, refer to, and assist with engagement with appropriate community-based providers; • Identify strategies to support the Health Plan Enrollees in his or her family home and/or community; • Develop a discharge plan; and • Conduct post-discharge outreach to Health Plan Enrollees. <p>(Page Limit: Four pages)</p>
60	<p>Transition of Care: Case Study (Sheila)</p> <p>Sheila is a 42 year-old SoonerSelect Health Plan Enrollee transitioning from the hospital to home after hip replacement surgery. Approximately one month ago, Sheila was diagnosed with Type 2 diabetes, which has been complicated by the stress of her surgery. Sheila also is obese and has hypertension. She is a single mother of two school-age children who reside at home with her. She has a sister who will be staying with her while she recovers.</p> <p>Sheila will require medication adjustments for her diabetes and hypertension when she returns home. She will need physical therapy and follow-up visits to her orthopedic surgeon and PCMH Provider.</p> <p>Describe the transition of care process you will employ for Sheila. Address Health Plan Enrollee outreach, discharge planning and post-discharge activities in your response.</p>

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	(Page Limit: Four pages)
61	<p>Transition of Care: Behavioral Health Case Study (Christine)</p> <p>Christine is a 23-year-old SoonerSelect Enrollee currently receiving treatment in a residential facility for addiction to alcohol. She has successfully completed her treatment after three weeks and is preparing to discharge from the facility. She recently started taking online classes at a community college to further her career. She lives in Guymon with her mother, who helps take care of her two children, ages one and three.</p> <p>Her mother was recently hospitalized and is unable to provide childcare for the next month. Christine is worried about her ability to continue to go to school and find a job. She is worried about relapse and wants to continue outpatient treatment but doesn't know how to find the time, transportation, or childcare.</p> <p>Describe the transition of care process you will employ for Christine.</p> <p>(Page Limit: Five pages)</p>
62	<p>Quality: Quality Assurance and Performance Improvement (QAPI) Program</p> <p>Describe your relevant experience and proposed approach for implementing and administering QAPI programs in accordance with the requirements specified in Model Contract Section 1.10.3: "Quality Assessment and Performance Improvement (QAPI) Program." In your description, address all of the following:</p> <ul style="list-style-type: none"> • The QAPI governance and committee structure, responsibilities and functions; • Provider representation on the QIC and other quality committees, including the total number and types of specialties represented; • How the larger organization, including plan leadership, is committed to quality improvement; • How you will ensure that Providers actively participate in the QAPI program; and • How you will make information about the QAPI program available to Providers and Health Plan Enrollees. <p>In addition, provide two examples of quality improvement initiatives undertaken in collaboration with Participating Providers. Discuss the basis for their selection, the involvement of Participating Providers in their design and implementation and results achieved. Limit your examples to 2015 or later.</p> <p>Also provide a sample QAPI program description, work plan and program evaluation utilized in another program. Include the materials after your narrative.</p> <p>(Page Limit: Eight pages, excluding sample QAPI program description, work plan and program evaluation; there is no page limit for the sample materials.)</p>
63	<p>Quality Improvement: Health Plan Enrollee Satisfaction</p>

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	<p>Provide the two most recent years of CAHPS data available for up to three Medicaid managed care programs. If you do not have CAHPS data but have other Health Plan Enrollee satisfaction data, provide the substitute data along with a description of the methodology employed in its collection and analysis.</p> <p>(Page Limit: N/A)</p>
64	<p>Quality Improvement: Provider Satisfaction</p> <p>Provide results of Provider satisfaction surveys for up to three of Bidder’s Medicaid managed care programs. Limit examples to 2015 or later.</p> <p>If you do not have data for a program that meets the above specifications, indicate such in your response.</p> <p>(Page Limit: N/A)</p>
65	<p>Quality Improvement: Quality Performance Measures</p> <p>Select two measures from Model Contract Section 1.10.5.1: “Physical Health Performance Measures” and two measures from Model Contract Section 1.10.5.2: “Behavioral Health Performance Measures” and describe strategies you employed in one or more Medicaid managed care programs to improve performance on the measure(s). As part of your response, discuss:</p> <ul style="list-style-type: none"> • Why the measure(s) were selected for improvement; • Populations targeted; • Specific interventions undertaken; • Intervention time period; and • Results achieved. <p>(Page Limit: Eight pages)</p>
66	<p>Quality Improvement: HEDIS Measures</p> <p>Provide the two most recent years of audited HEDIS reports available for up to three of Bidder’s Medicaid managed care programs. The reported results must have undergone a HEDIS compliance audit conducted by an NCQA-certified HEDIS compliance auditor. The reports must be the final, auditor-locked version reported to the NCQA’s interactive database. Provide reference to the population(s) for which you are reporting, including geographic location and Health Plan Enrollee demographics. If you do not have data for a program that meets the above specifications, indicate such in your response.</p> <p>(Page Limit: N/A)</p>
67	<p>Quality Improvement: Addressing Health Disparities</p>

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	<p>Describe your relevant experience and proposed approach for reducing health disparities in health care access, services and outcomes in accordance with the requirements of Model Contract Section 1.10.7: “Addressing Health Disparities.”</p> <p>In addition, provide an example of an innovative approach you took to address health disparities, the results achieved, and how you will apply this experience to SoonerSelect.</p> <p>Limit your examples to 2015 or later.</p> <p>(Page Limit: Three pages)</p>
68	<p>Quality Improvement: Performance Improvement Projects (PIPs)</p> <p>Describe your proposed approach to ensure PIPs, as required under Model Contract Section 1.10.6: “Performance Improvement Projects (PIPs),” are effective in addressing identified focus areas and improving outcomes and quality of care for Health Plan Enrollees. Include the following in your response:</p> <ul style="list-style-type: none"> • Lessons learned, challenges and successes you have experienced while conducting PIPs, and how you will consider those experiences in implementing SoonerSelect PIPs; • Proposed PIP focus areas for the first two Rating Periods; • Rationale for proposed PIPs; and • Methods for monitoring and evaluating on an ongoing basis PIP progress and effectiveness. <p>(Page Limit: Four pages)</p>
69	<p>Quality Improvement: Provider Profiling</p> <p>Describe your relevant experience and proposed approach to conducting Provider profiling, in accordance with the requirements outlined in Model Contract Section 1.10.8: “Provider Profiling.” Include the following in your response:</p> <ul style="list-style-type: none"> • Methodology for determining which and how many Providers will be profiled; • Proposed performance measures; • Rationale for selecting proposed measures; • The proposed frequency with which profiles will be distributed. <p>Also include a sample profile report or a representative sample used in another program.</p> <p>(Page Limit: Three pages; there is no page limit for the sample profile.)</p>
70	<p>Quality Improvement: Maternal and Infant Morbidity and Mortality</p> <p>Describe your organization’s relevant experience and proposed approach for decreasing maternal and infant morbidity and mortality including reducing early elective deliveries and cesarean sections. Include information about how perinatal health disparities have been and/or will be addressed and pertinent collaborations with community and other stakeholders.</p>

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	<p>In addition, provide an example of an innovative approach you took to address these issues, the results achieved, and how you will apply this experience to SoonerSelect.</p> <p>(Page Limit: Three Pages)</p>
71	<p>Health Plan Enrollee Services: Accessibility</p> <p>Describe your relevant experience and proposed approach to ensuring that information is accessible to all Health Plan Enrollees, in accordance with requirements outlined in Model Contract Section 1.11: “Health Plan Enrollee Services.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • Your proposed auxiliary aids and alternative formats; • How you will meet in-office interpreter requirements; and • How you will ensure compliance with SoonerSelect cultural competency requirements. <p>In addition, provide an example of an innovative approach you took to make Health Plan Enrollee services accessible to Health Plan Enrollees with disabilities, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
72	<p>Health Plan Enrollee Services: New Health Plan Enrollee Outreach</p> <p>Describe your relevant experience and proposed approaches for conducting outreach to new Health Plan Enrollees and making initial contact in accordance with requirements outlined in Model Contract Section 1.11.5: “New Health Plan Enrollee Materials and Outreach.” As part of your response discuss:</p> <ul style="list-style-type: none"> • How you will undertake and track initial contact efforts; • SoonerSelect population segments most likely to be “hard-to-contact” and steps you will take to reach hard-to-contact Health Plan Enrollees; • How you will ensure distribution of Health Plan Enrollee materials in compliance with timeliness standards; and • Initial Health Plan Enrollee education activities. <p>In addition, provide an example of an innovative approach you took to improve contact rates among hard-to-contact Health Plan Enrollees, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>Also include a copy of Form 8070001240-R-New Health Plan Enrollee Contact Rates.</p> <p>(Page Limit: Five pages, excluding Form 8070001240-R)</p>
73	<p>Health Plan Enrollee Services: New Health Plan Enrollee Outreach Case Study (Rebecca)</p> <p>Rebecca is a 24-year old SoonerSelect Health Plan Enrollee enrolled effective June 1. Rebecca was auto-assigned to your plan. Her enrollment information did not include a phone number and listed an Oklahoma City area homeless shelter as her last place of residence. Rebecca left</p>

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	<p>the shelter on May 25 and the shelter does not know her current whereabouts. Describe how you will attempt to contact Rebecca by June 10.</p> <p>(Page Limit: Three pages)</p>
74	<p>Health Plan Enrollee Services: Website & Social Media</p> <p>Describe your relevant experience and proposed approach to using the Health Plan Enrollee website, social media and mobile applications to enhance communications with Health Plan Enrollees. As part of your response, discuss:</p> <ul style="list-style-type: none"> • The types of social media applications and platforms you will employ; • How social media, the Health Plan Enrollee website and mobile applications will be tailored to the different SoonerSelect populations; • How you will monitor Health Plan Enrollee use and responsiveness to social media, mobile applications and the Health Plan Enrollee website; and • How you will ensure compliance with all State and federal privacy requirements, including but not limited to, HIPAA, 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109. <p>In addition, provide an example of an innovative approach you took to improve Health Plan Enrollee health outcomes through social media, mobile applications or website, the results achieved and how you will apply this experience to the SoonerSelect program. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
75	<p>Health Plan Enrollee Services: Call Center</p> <p>Describe your relevant experience and proposed approach to operating a call center, in accordance with the requirements outlined in Model Contract Section 1.11.7: “Health Plan Enrollee Services Call Center.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • Call center location(s) and hours of operation; • How you will train call center staff; • How you will monitor compliance with performance standards and address staffing needs during unanticipated spikes in volume; • How you will handle calls received from non-English speakers; and • Whether you will operate a combined call center for Health Plan Enrollee and Provider services. If not, describe your proposed Provider Service call center structure in accordance with the requirements of Model Contract Section 1.13.2: “Provider Services Call Center.” <p>Also include a copy of <u>Form 8070001240-S-Call Center Performance</u>.</p> <p>(Page Limit: Five pages, excluding Form 8070001240-S)</p>

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76	<p>Health Plan Enrollee Services: Call Center Scenarios</p> <p>Describe your procedures to address the following calls received at the Health Plan Enrollee Services Call Center:</p> <ul style="list-style-type: none"> • A Health Plan Enrollee has received a bill from a Participating or Non-Participating Provider for a covered benefit. • A Health Plan Enrollee is unable to reach his PCMH Provider during non-business hours. • A Health Plan Enrollee becomes ill while traveling outside of Oklahoma. • A Health Plan Enrollee is unable to find a specialist. • A Health Plan Enrollee poses a clinical question to a Member Services Call Center staff. • A Health Plan Enrollee requests to see a Non-Participating Provider. • A Health Plan Enrollee requests to see a Non-Participating Provider. • A Health Plan Enrollee calls to file a Grievance. • A Health Plan Enrollee calls to file an Appeal. • A Health Plan Enrollee is requesting disenrollment. • A Health Plan Enrollee has run out of medications and calls to ask for assistance in obtaining. • A Health Plan Enrollee calls to report a change in income or mailing address. <p>(Page Limit: 11 pages)</p>
77	<p>Health Plan Enrollee Services: Behavioral Health Services Hotline</p> <p>Describe your relevant experience and proposed approach to operating a Behavioral Health Services Hotline, in accordance with the requirements outlined in Model Contract Section 1.11.8: “Behavioral Health Services Hotline.” As part of your response discuss:</p> <ul style="list-style-type: none"> • The qualifications of Hotline staff; • How you will train Hotline staff; • How you will handle calls received from non-English speakers; • Processes for connecting to crisis response systems and 911; and • How 24 hours a day/seven day a week access will be assured. <p>(Page Limit: Five pages)</p>
78	<p>Health Plan Enrollee Services: Behavioral Health Services Hotline Scenarios</p> <p>Describe your procedures to address the following calls received at the Behavioral Health Services Hotline:</p> <ul style="list-style-type: none"> • A Health Plan Enrollee expresses she is having thoughts of harming herself or others and has a plan to carry out such actions. • A Health Plan Enrollee reports he is shaking and vomiting in response to withdrawal from heroin. • A Health Plan Enrollee’s parent calls and reports her child is out of control. The Health Plan Enrollee’s parent has a high level of emotional distress indicated by anger, agitation, and tearfulness.

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	<ul style="list-style-type: none"> • A Health Plan Enrollee reports that he does not believe the medications he is taking to treat depression are working. • A Health Plan Enrollee reports he does not want to live any longer due to chronic pain he is experiencing. The Health Plan Enrollee does not have a history of substance use. • A Health Plan Enrollee has slurred, bizarre, tangential, or otherwise incoherent speech during the call. <p>(Page Limit: Six pages)</p>
79	<p>Health Plan Enrollee Services: Advisory Boards</p> <p>Describe your relevant experience establishing Health Plan Enrollee and Provider advisory boards and the proposed structure and composition of the SoonerSelect Advisory Board described in Model Contract Section 1.11.10: “Advisory Board” and Section 1.11.10.1: “Behavioral Health Advisory Board.” Discuss the steps you will take to identify, recruit and encourage participation by Health Plan Enrollees.</p> <p>Also, provide two examples of issues brought before your Health Plan Enrollee or Provider advisory board(s) operating in other Medicaid programs, actions taken based on recommendations from the board(s) and results achieved.</p> <p>In addition, as part of the response, you may include a letter of reference from an advisory board member in another program. The letter, if included, should discuss the board member’s experience in terms of having meaningful input into plan decision making and the board member’s opinion of the plan’s level of inclusiveness with respect to soliciting and acting on the recommendations of stakeholders.</p> <p>(Page Limit: Four pages, excluding letter of reference)</p>
80	<p>Health Plan Enrollee Services: PCMH Selection and Assignment</p> <p>Describe your relevant experience and proposed approach for assigning Health Plan Enrollees to PCMH Providers in accordance with requirements outlined in Model Contract Section 1.11.11: “PCMH Selection and Assignment.” As part of your response discuss:</p> <ul style="list-style-type: none"> • Strategies you will implement to achieve high rates of Health Plan Enrollee self-selection of a PCMH Provider; • How you will educate Health Plan Enrollees about their PCMH Provider options, as well as their ability to change their PCMH; • Processes you will implement to ensure Contractor-initiated PCMH Provider assignments meet the criteria outlined in Model Contract Section 1.11.11.2: “Assignment Requirements;” and • How you will monitor trends with regard to PCMH Provider changes and use the data as part of network management activities. <p>(Page Limit: Four pages)</p>

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81	<p>Health Plan Enrollee Services: Marketing</p> <p>Describe your approach for meeting the requirements outlined in Model Contract Section 1.11.15: “Marketing and Outreach.” As part of your response, describe the types of Marketing you intend to undertake. Also discuss how you will ensure compliance with State and federal Marketing standards within your organization, including through training and monitoring activities.</p> <p>(Page Limit: Three pages)</p>
82	<p>Provider Network Development</p> <p>Describe your Provider network development strategy to ensure compliance with access standards outlined in Model Contract Section 1.12.4: “Time and Distance and Appointment Access Standards” at the time of Readiness Review. Also discuss:</p> <ul style="list-style-type: none"> • What you consider to be the most significant challenges to developing a complete statewide Provider network; • Innovative network development strategies you have employed in other programs and how you will implement these strategies for your SoonerSelect network to overcome identified challenges; and • How you will address gaps and barriers-to-care where there are no Providers in a geographic area. <p>(Page Limit: Five pages)</p>
83	<p>Provider Network Development: Monitoring Compliance with Access Standards</p> <p>Describe your relevant experience and proposed approach for monitoring compliance with access standards as described in Model Contract Section 1.12.4: “Time and Distance and Appointment Access Standards” and how you will respond to gaps identified through monitoring activities.</p> <p>In addition, provide an example of an innovative approach you took to close a network gap, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>(Page Limit: Four pages)</p>
84	<p>Provider Network Development: Telehealth</p> <p>Describe your relevant experience and proposed approach for using Telehealth to expand access to services, and specify the clinical areas and service lines with which you have experience. As part of your response, discuss:</p> <ul style="list-style-type: none"> • Any Telehealth initiatives you will undertake in partnership with Participating Provider(s); • Services to be targeted for Telehealth;

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	<ul style="list-style-type: none"> • Geographic areas to be targeted for Telehealth; and • Manner in which you have dealt with technological challenges and confidentiality concerns which have arisen. <p>In addition, provide an example of an innovative approach you took to expanding network capacity/access to care through Telehealth, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>(Page Limit: Four pages)</p>
85	<p>Provider Network Development: Provider Agreements</p> <p>Provide sample Provider agreements in accordance with the requirements of Model Contract Section 1.12.2: “Provider Agreement Requirements.”</p> <p>(Page Limit: N/A)</p>
86	<p>Provider Network Development: Credentialing</p> <p>Describe your relevant experience and proposed approach for meeting the credentialing requirements outlined in Model Contract Section 1.12.3: “Credentialing.” Include in your response:</p> <ul style="list-style-type: none"> • How you will ensure all Participating Providers hold appropriate licensure or certification and are enrolled with SoonerCare; • Description of your credentialing process and timelines, including ways to reduce Participating Providers’ burden and loading Participating Providers into your claims processing system; and • Your experience with utilizing a centralized credentialing agency. <p>(Page Limit: Four pages)</p>
87	<p>Provider Network: Patient Centered Medical Home Model</p> <p>Describe your proposed approach for contracting with PCMH Providers in accordance with requirements outlined in Model Contract Section 1.12.2.4: “Provider Agreement Requirements for Specific Provider Types.”</p> <p>In addition, provide an example of an innovative approach you took to supporting PCMH activities and quality of care through use of health information technology, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
88	<p>Provider Network: Ongoing Monitoring</p> <p>Describe your approach for conducting ongoing monitoring as outlined in Model Contract Section 1.12.3.2: “Ongoing Monitoring.”</p>

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	<p>As a part of your response, discuss:</p> <ul style="list-style-type: none"> • How you collect data for ongoing monitoring; • Your internal review and validation process for the data; and • Your process for reviewing and addressing poor quality performance by Participating Providers. <p>(Page Limit: Four Pages)</p>
89	<p>Provider Services</p> <p>Describe your relevant experience and proposed approach to preparing Participating Providers to serve SoonerSelect Health Plan Enrollees and for ongoing network management in accordance with Model Contract Section 1.13: “Provider Services.”</p> <p>As part of your response, discuss:</p> <ul style="list-style-type: none"> • Network education and training activities prior to go live; • Assessment of Provider readiness prior to go live; • Collaboration with Providers to meet performance-based contracting targets; and • Methods for ongoing monitoring of network compliance with program requirements. <p>In addition, provide an example of an innovative approach you took to educating Providers without managed care experience on managed care principles and procedures, the results achieved and how you will apply this experience to SoonerSelect. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
90	<p>Provider Services: Provider Education, Training and Technical Assistance</p> <p>Describe your relevant experience and proposed approach for providing ongoing Provider training, education and technical assistance. Also include your approach to assisting Providers to comply with requirements concerning Prior Authorization, claims payment, and quality-related data reporting. Include in your response methods for identifying Providers which require targeted outreach.</p> <p>(Page Limit: Three pages)</p>
91	<p>Provider Services: Provider Complaint System</p> <p>Describe your relevant experience and proposed approach for operating a Provider Complaint system in accordance with Model Contract Section 1.13.6: “Provider Complaint System.”</p> <p>(Page Limit: Three pages)</p>
92	<p>Provider Payment: Performance-Based Provider Payments</p>

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	<p>Describe your relevant experience and proposed approach for meeting the performance-based Provider payment thresholds outlined in Model Contract Section 1.14.1.10: “Performance-Based Provider Payments.” As part of your response:</p> <ul style="list-style-type: none"> • Separately discuss PCMH, specialist, hospital and behavioral health Providers; • Outline the specific reimbursement methodology, or methodologies, to be implemented, including payment structure, performance incentives and metrics; and • Describe how data sharing and reporting will be used to promote transparency, collaboration and accountability with Provider partners of all types. <p>Also provide an example of an innovative performance-based purchasing initiative you have undertaken, including objectives for the initiative, month/year of implementation, barriers encountered, how these barriers were overcome and the results achieved. Limit your example to 2015 or later.</p> <p>(Page Limit: Five pages)</p>
93	<p>Provider Payment: Claims Processing</p> <p>Describe your claims system and proposed processes for meeting the requirements outlined in Model Contract Section 1.14.4: “Claims Processing.” As part of your response, describe:</p> <ul style="list-style-type: none"> • Procedures for receipt and adjudication of electronic and paper claims; • Process for identification and resolution of Provider- or system-level issues; and • Processes for ensuring compliance with timely payment requirements. • Process for ensuring claims accuracy. <p>Also include a copy of Form 8070001240-T-Claims Processing.</p> <p>(Page Limit: Ten pages, excluding Form 8070001240-T)</p>
94	<p>AI/AN Population and IHCPs: Tribal Government Liaison</p> <p>Describe your relevant experience and proposed approach for undertaking an outreach strategy for AI/AN Health Plan Enrollees and how you will use the Tribal Government Liaison position to support AI/AN Health Plan Enrollees and IHCPs in accordance with the requirements outlined in Model Contract Section 1.15.1: “Tribal Government Liaison.”</p> <p>(Page Limit: Three pages)</p>
95	<p>AI/AN: Care Management</p> <p>Describe how you will make AI/AN Care Managers available to AI/AN Health Plan Enrollees, in accordance with the requirements outlined in Model Contract Section 1.15.3.5: “Care Management.” Discuss how you will contract with qualified IHCPs to perform care management activities.</p> <p>(Page Limit: Three pages)</p>

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96	<p>AI/AN: Indian Health Care Providers</p> <p>Describe how you will meet the network requirements outlined in Model Contract Section 1.15.4: “Indian Healthcare Providers (IHCPs).”</p> <p>(Page Limit: Three pages)</p>
97	<p>Health Plan Enrollee Grievances and Appeals</p> <p>Describe your proposed structure and process for meeting the requirements outlined in Model Contract Section 1.16: “Health Plan Enrollee Grievances and Appeals.” As part of your response discuss:</p> <ul style="list-style-type: none"> • How you will provide assistance to Health Plan Enrollees in filing Grievances or Appeals; • How you determine if a Grievance or Appeal will undergo an expedited review; • Who in your organization will serve as decision makers when reviewing Grievances and Appeals; • How you will ensure compliance with timeliness requirements; • Processes for continuing or reinstating benefits; • How you will incorporate Grievance and Appeals data into your quality improvement process; and • Your process for remediation as required by certain grievance and appeals outcomes. <p>In addition, provide an example of a trend you identified through analysis of Grievances data, the steps you took to address and the results achieved. Provide a separate example for a trend identified through analysis of Appeals data. Limit your examples to 2015 or later.</p> <p>Also include a copy of <u>Form 8070001240-U-Health Plan Enrollee Grievances and Appeals Resolution.</u></p> <p>(Page Limit: Seven pages, excluding Form 8070001240-U)</p>
98	<p>Cost Sharing</p> <p>Describe your methodology, in accordance with the requirements of Model Contract Section 1.17: “Cost Sharing,” for the following:</p> <ul style="list-style-type: none"> • Systematically identifying Cost Sharing exempt Health Plan Enrollees; • Ensuring Cost Sharing is not imposed on Cost Sharing exempt services; • Reducing claims payment to Providers by the amount of a Health Plan Enrollee’s Cost Sharing obligation; • Notifying Providers when a Health Plan Enrollee is exempt from Cost Sharing; and • Tracking and responding to the five percent Cost Sharing limit. <p>(Page Limit: Four pages)</p>
99	<p>Program Integrity</p>

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	<p>Describe your structure and proposed processes for meeting the requirements outlined in Model Contract Section 1.18: “Program Integrity.” As part of your response, provide an overview of your Compliance Program and discuss:</p> <ul style="list-style-type: none"> • Your procedures for educating and training both employees and Subcontractors in accordance with Model Contract Section 1.18.2.2: “Compliance Education and Training;” • Your internally-focused and externally-focused Fraud and abuse detection methodologies, including but not limited to, analytics, referral processes, audit techniques (or practices), and reporting; • Your procedures for reporting changes in Health Plan Enrollee or Provider circumstances; • Your procedures for suspending payments for credible allegations of Fraud; and • Your procedures for verifying delivery of services to Health Plan Enrollees. <p>(Page Limit: Five pages)</p>
100	<p>Information Technology: General Requirements</p> <p>Describe your capacity and proposed approach for meeting the requirements outlined in Model Contract Section 1.19.1: “General Requirements.” Include in your response the following:</p> <ul style="list-style-type: none"> • A description and system diagram of the proposed Management Information System (MIS) solution that will support the SoonerSelect program. Ensure at a minimum the response covers all systems that support the required functional areas that you will provide as a part of your solution. • Describe how you will interface and use the current EVV vendor tools in support of processing claims for benefits requiring EVV. • Provide a narrative and diagram that demonstrates an understanding of all required interfaces. • Describe and discuss your data analytics and reporting tools capabilities. How do your tools and processes provide you with the capability to prepare timely and accurate reports for submission to OHCA as required? Describe internal reports you can create to monitor internal operations and system performance. Describe your standard (out of the box) reporting as well as your ability to provide ad hoc reporting based on the changing CMS environment. • Describe and discuss your current status of readiness for implementation of the features and functions required in the 21st Century CURES act – specifically the support application programming interface (API), easy access to Eligibles data in real time, Interoperability and application authentication and Anti-blocking provisions. If not currently operational, indicate when the compliance systems will be in place.

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Describe your IT infrastructure regarding the MIS MCO platform; explain your IT Roadmap for continued development and improvements in the care management enterprise. • Discuss your System Development Lifecycle (SDLC) for new development and correcting defects and how you will notify and keep OHCA, Health Plan Enrollees and Providers informed of any updates or releases to your systems. • Confirm your ability to utilize all batch and online HIPAA transactions listed in Model Contract Section 1.19.1. • Describe how you propose to interface with OHCA Care Management System to share data as described in Model Contract Section 1.19.1.2. • Confirm your ability and experience in providing T-MSIS data to State Medicaid agencies for submission to CMS. <p>(Page Limit: Ten pages; page limit does not include IT Roadmap or MIS Diagram)</p>
101	<p>Information Technology: Operations Support and Integration of IT Systems</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.2: “Operations.” Include in your response:</p> <ul style="list-style-type: none"> • How your IT solution integrates and makes available in real time, all data captured by your various functional operational units. • A description of your care management operational unit and system. Describe how the data the care management unit needs and creates is shared among the various modules/subsystems in your MIS. • A description and explanation of your systems capabilities for detecting duplicate Health Plan Enrollee records. What tools are in place to merge duplicate records or unmerge records that were incorrectly merged? • A description of how you will ensure complete and accurate data, including from any Subcontractors prior to submitting any required reports to OHCA and including provisions for responding to requests by Eligibles to a change in or amendment to a medical record. <p>(Page Limit: Four pages)</p>
102	<p>Information Technology: Communications with OHCA</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.3: “Communications with OHCA.” Include in your response an explanation of how you will communicate with OHCA, including how you will meet OHCA security standards for encryption of confidential information.</p> <p>(Page Limit: Three pages)</p>
103	<p>Information Technology: Health Plan Enrollee Encounter Data</p>

ITEM	INSTRUCTIONS
	<p>Describe your approach to meeting the requirements of Model Contract Section 1.19.4: "Health Plan Enrollee Encounter Data." Include in your response:</p> <ul style="list-style-type: none"> • A detailed diagram and narrative that specifically discusses and demonstrates how your system collects data from your claims system and Subcontractors to create the required Encounter Data file in the required format as specified in the Contract. • A description of your ability to meet the format requirements specified in the Contract, including specific discussion of your ability to provide drug rebate information. • A description of your internal quality assurance (QA) and validation process to analyze the Encounter Data file prior to sending to OHCA. If encounters are handled at the national level, describe how you will work with the local Oklahoma office/staff to coordinate submission of the Encounter Data file and/or to resolve any errors detected. • In the event that errors are found, whether during your internal QA or by rejected transactions from the State's MMIS, describe your process for reconciliation, resolving, and resubmitting any errors. • Confirm and describe how you will ensure that all claims data, including not only paid claims but denied claims, voided claims, zero dollar paid and claim adjustments will be included in your Encounter Data submissions to both the State MMIS and State HIE. • Statistics from at least two other states that demonstrate your ability to submit timely, accurate and complete Encounter Data. <p>(Page Limit: Five pages)</p>
104	<p>Information Technology: Health Information Exchange</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.4.4: "Health Information Exchange." In addition to the items outlined in the aforementioned section, specifically address the following items in your response:</p> <ul style="list-style-type: none"> • Your proposed plan to integrate with the State's HIE. What additional data will you share and what data do you expect to pull from the HIE? • As it relates to your implementation of CURES Act, specifically interoperability and anti-information blocking, explain your system capabilities and processes to share the core data (required in the CURES Act) set with other MCOs and OHCA as Health Plan Enrollees move or transition to another MCO. • Discuss your experience submitting Encounter Data to a State HIE as well as a State Medicaid MMIS system. • Discuss how you will train and monitor Participating Provider's compliance with the requirement to connect to the State HIE and submit and receive clinical health information including Admission, Discharge and Transfer (ADT) orders. • Discuss how you will monitor Provider's use of Electronic Health Records (EHRs) connected to the State HIE. What actions will you take upon discovering that a Participating Provider connected to the State HIE is not submitting or receiving clinical health information?

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Discuss how you will train and monitor Provider’s use of the State HIE provider portal to query patient data when the Provider does not have an EHR system. What actions will you take upon discovering that a Participating Provider does not use the State HIE provider portal? • Discuss your approach and processes for converting incoming paper claims to HIPAA standard formats for claims processing and Encounter Data generation. <p>(Page Limit: Five pages)</p>
105	<p>Information Technology: Enrollment Data</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.5: “Enrollment Data.” Include in your response:</p> <ul style="list-style-type: none"> • Description of your experience and process for receiving daily 834 transactions and reconciling them to both your capitation payment file and your internal Health Plan Enrollee system. • Discussion of your current abilities to make use of a statewide e-Master Person Index (e-MPI) as a unique statewide identifier. <p>(Page Limit: Two pages)</p>
106	<p>Information Technology: Preferred Drug List and State MAC List</p> <p>Describe your approach to meeting the requirements of Model Contract Sections 1.19.6: “Preferred Drug List” and 1.19.7: “State MAC List.” Include in your response:</p> <ul style="list-style-type: none"> • Description of your experience and process for loading and using the required Preferred Drug List in pharmacy claim processing. • Description of your experience and process for loading and using the State MAC List in pharmacy claim processing. <p>(Page Limit: Two pages)</p>
107	<p>Information Technology: System Security</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.8: “System Security.” Include responses to the following questions:</p> <ul style="list-style-type: none"> • Description of your overall cybersecurity methodology, with an emphasis on which best practices your organization follows to manage its cybersecurity risks. Clarify whether your methodology adheres to any cybersecurity frameworks, including but not limited to, National Institute of Standards and Technology (NIST), or ISO/IEC 27001. If so, provide documentation on how your practices align. • Description of what auditing capabilities exist in the system. What are your processes around security audits to include frequency, results reporting, and corrective actions?

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • How you will manage security authorizations to the system. At a minimum, include content regarding processes for role-based security, fine-grained controls for authorization, and your processes for identification and authentication. • What encryption level does your system support and what type of encryption do you recommend and upon what bases? • What type of security controls and measures will you implement? Include both system and physical security controls at national offices and any proposed local Oklahoma offices. • What is your process for handling security incidents? “Security Incident” refers to attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with the hosted environment used to perform the services. • Describe your process for corrective action should a system error or penetration test reveal that PHI/PII could have been or was compromised. • Describe how you perform data masking in test environments and/or production. • Describe data management techniques and processes as they relate to security. • Describe your security monitoring and evaluation activities. Include both system monitoring and operational monitoring and evaluation activities. • What type of security and privacy training do you provide? How often and to whom? • Describe the extent of your latest SOC Type II, HiTrust, or equivalent audit and whether you had any findings. If so, what corrective actions were done or will be done to address the findings? • If you are utilizing a cloud hosting service, describe a breakdown of security shared responsibility model, with supportive roles, processes, policies, and procedures defining how those security responsibilities are being maintained. • Describe any third-party security assessments performed on your cloud providers. • Do you classify assets by risk and criticality? If so, describe your methodology and approach to classifying your IT assets. • If you upgrade your system(s), what kind of security testing is done prior to implementing the new solution or fix? <p>Include a copy of Form 8070001240-V-MCO Security Specifications, Form 8070001240-W-OMES Cloud Computing Certification and Form 8070001240-X-OMES Hosting Agreement. Please note that in Form 8070001240-W, the maturity levels for each control are based on NIST 800-53 Rev 5 guidance.</p> <p>(Page Limit: Ten pages; does not include Forms 8070001240-V, -W and -X)</p>
108	<p>Information Technology: Business Continuity and Disaster Recovery</p> <p>Describe your approach to meeting the requirements of Model Contract Sections 1.19.9: “Disaster Preparation and Data Recovery” and 1.19.10: “Back-up Plan.” Include in your response:</p>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • A high level narrative of your BCDR plan. • Description of your testing procedures for the BCDR Plan. Include description of frequency of testing and where your offsite recovery centers are located. • Discussion of the last time you invoked your BCDR plan and how you ensured services to Health Plan Enrollees were not disrupted. <p>Also submit a copy of your current BCDR plan.</p> <p>(Page Limit: Four pages; does not include BCDR plan)</p>
109	<p>Information Technology: Accessibility</p> <p>Describe your approach to meeting the requirements of Model Contract Section 1.19.11: “Accessibility.” Include in your response:</p> <ul style="list-style-type: none"> • Description of functionality for your proposed Web Portals (Health Plan Enrollee and Provider). Discuss compliance with section 508 requirements. • Describe any development efforts required either on the proposed IT system infrastructure to comply with Contract requirements or the required reporting capabilities to meet the Contract requirements in this section. • Discussion of your ability to meet the requirements listed in Model Contract Section 1.19.11.1: “System Performance Requirements.” <p>(Page Limit: Three pages)</p>
110	<p>Third Party Liability</p> <p>Describe your relevant experience and proposed approach for identification and management of TPL in accordance with the requirements outlined in Model Contract Section 1.20.4: “Third Party Liability.”</p> <p>(Page Limit: Three pages)</p>
111	<p>Reporting</p> <p>Describe your relevant experience and proposed approach for meeting the requirements outlined in Model Contract Section 1.21: “Reporting.” As part of your response, discuss:</p> <ul style="list-style-type: none"> • Your monitoring and evaluation procedures for ensuring reports are accurate and submitted timely; • Your ability to generate ad hoc reports if requested by OHCA; • How changes to reporting requirements will be addressed, including testing and quality assurance procedures; • How reports are continually analyzed and incorporated into quality improvement initiatives; • Your process for monitoring, tracking and validating data from Subcontractors; and

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> Your capability to produce system-generated reports versus manual. <p>(Page Limit: Five pages)</p>
112	<p>Contractor Performance Standards</p> <p>Describe your relevant experience and proposed approach for monitoring performance against program standards and identifying and correcting deficiencies proactively. As part of your response, discuss:</p> <ul style="list-style-type: none"> The role individual departments will play in monitoring performance; Whether there will be a centralized function within the plan responsible for monitoring performance; and Process for identifying, reporting and remediating performance issues. <p>Also include a copy of <u>Form 8070001240-Y- Contractor Performance History.</u></p> <p>(Page Limit: Four pages, excluding Form 8070001240-Y)</p>
113	<p>Contract Termination</p> <p>Describe whether your organization has had a contract terminated or not renewed for any reason within the past ten years. The response should include parent organization, affiliates, and subsidiaries conducting Medicaid or other state/federal health business. Include a description of the issues and the parties involved and provide the name, title, email address and direct telephone number of the primary contact for the party with whom the contract was held.</p> <p>(Page Limit: N/A)</p>
114	<p>Customizations</p> <p>Describe the level of customization to your current programming and operations your organization will need to implement to comply with the terms of the SoonerSelect Model Contract.</p> <p>(Page Limit: Ten pages)</p>
115	<p>Contract Compliance</p> <p>Describe the processes you have in place to achieve compliance with the terms of the SoonerSelect Model Contract.</p> <p>(Page Limit: Four pages)</p>
116	<p>Strategic Alignment</p> <p>Provide a detailed description of your success in “moving the needle” on each payment and delivery system reform goal articulated in Section 1.2: “SoonerSelect Goals.”</p>

ITEM	INSTRUCTIONS
	(Page Limit: 15 pages)

SoonerSelect Specialty Children’s Plan

The following questions are only required for bidders of the SoonerSelect Specialty Children’s Plan. The evaluation and scoring of the responses following questions will be evaluated and scored separately from the previous set of questions. Bidder’s should prepare responses with the assumption that some or all of the reviewers will not have read the of the Bidder’s responses to the SoonerSelect questions.

ITEM	INSTRUCTIONS
117	<p>Technical Approach Summary</p> <p>Provide a summary of your proposed technical approach to provide the full scope of work for this population. The technical approach must include your approach to coordinating Health Plan Enrollees’ care in alignment with the State’s existing system of care. The summary must:</p> <ul style="list-style-type: none"> • Include your strategy and approach to partnering with Oklahoma’s OHCA, DHS and OJA to coordinate care for this population; • Demonstrate an expert understanding of the needs of Oklahoma’s Medicaid Eligibles who are Former Foster Children, in Foster Care, receiving prevention services, receiving Adoption Assistance or involved in the juvenile justice system; • Identify distinguishing features, innovations, and/or a description of how the approach will result in improved health outcomes for these populations; and • Describe the barriers and/or issues you anticipate and your experience/solutions addressing these barriers/issues for similar populations. <p>(Page Limit: Ten pages)</p>
118	<p>Managed Care Experience with Similar Populations</p> <p>Provide a list of the Bidders’ current and/or recent (within five years of the issue date of this RFP) contracts for managed care (medical care and/or integrated medical and behavioral health services) that include the specialty populations. Bidders without managed care experience may include any relevant contract experience with any of the specialty population. Provide the following information per contract in an attachment using a table format:</p> <ul style="list-style-type: none"> • Contracted Entity (Legal Full Name) and relationship to Bidder, if applicable; • Client Name, authority (e.g., State of Nevada’s Medicaid Agency), and address; • Medicaid Enrollment: total, Children (under 21) and Adults, and by specialty population(s): (Former Foster Children (FFC), select juvenile justice involved (JJ), in Foster Care (FC), receiving prevention services, or receiving Adoption Assistance (AA)); • Contract Name (if applicable), Type (specialty or non-specialty) and time period of the contract; • Reimbursement mechanism (capitated, fee-for-service or other payment method);

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Brief narrative describing the role of the Bidder, scope of the work performed, and covered services (medical care and/or integrated medical and behavioral health services); • Administrative subcontractors and scope of work; • Implementation: timeliness and lessons learned including: <ul style="list-style-type: none"> ○ Scheduled and actual implementation dates; and ○ Barriers encountered and resolutions <p>Additionally, provide a summary of lessons Bidder has learned through experience and related solutions and methods Bidder has utilized to address challenges in serving these populations in states with a similar SOC (public child welfare system) including:</p> <ul style="list-style-type: none"> • Customized policies and procedures for alignment with the current system of care; • Need for maintaining and expanding a provider network with sufficient expertise in evidence-based services; • Coordination of services with State agencies for children in the custody of the State; • Successful implementation of innovative and person-centered program/initiatives and outcomes; and • Fragmented data sets and the need to collect and/or exchange data across State agencies and accessible to Health Plan Enrollees, caregivers, and Providers. <p>(Page Limit: Eight pages, excluding attachment)</p>
119	<p>Administrative Requirements: Key Staff</p> <p>Describe your management structure and include a copy of Form 8070001240-Z-Key Staff identifying the individuals who will serve in the Key Staff positions, if known as described in Section 1.3.6.2: “Key Staff,” of the SoonerSelect Model Contract and Section 2.4.2: “Key Staff” in Appendix 2. Also:</p> <ul style="list-style-type: none"> • Include a job description for each position denoted on Form 8070001240-Z that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable. • Include a current resume for each of the individuals identified on Form 8070001240-Z-Key Staff. Resumes must include at least the following information: Summary of relevant experience; work history up to the present time; educational history; and licenses/credentials, if applicable. • Provide a summary of recruitment timelines and activities for Key Staff positions for which individuals have not been identified or deemed “interim.” Describe contingency plans should these positions continue to remain open after Contract award. • Identify any additional staff (if applicable) that will assist the Strategy Officer during the implementation phase. • Describe any differentiators related to staffing specific to patterns necessary to support this scope of work for this specific population (e.g., supervision hierarchy, care management team structures).

ITEM	INSTRUCTIONS
	(Page Limit: Three pages, excluding Form 8070001240-Z, job descriptions and resumes)
120	<p>Administrative Requirements: Organizational Structure and Staffing</p> <p>Describe your staffing plan that meets the requirements of Model Contract Section 1.3.6: “Staffing” and Sections 2.4.1: “Staffing” thru Section 2.4.4: “Health Plan Enrollee Care Support Staff” in Appendix 2. Identify staff and/or teams (e.g., Health Plan Enrollee Service Staff) that will be dedicated to the SoonerSelect Specialty Children’s Plan and describe how dedicated staff/teams fit into the organization. Include the basis utilized for determining required numbers of staff by position type. Also include a completed copy of Form 8070001240-AA-Plan Staffing along with a job description for select positions denoted on Form 8070001240-AA that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable.</p> <p>Include a revised version of the Chart submitted as part of your response to Item #16 that includes all staff and teams of the organization (that will serve all populations) showing functions, staff types and reporting relationships. Identify functions located within and outside of Oklahoma and functions performed by Subcontractors.</p> <p>(Page Limit: Four pages, excluding Form 8070001240-AA, job descriptions and Chart)</p>
121	<p>Location of Staff within Oklahoma</p> <p>Identify your existing and proposed office locations within the State and the locations of other field-based staff, if applicable (i.e., if staff will be working from virtual offices) and describe your basis for selecting these locations. Include a service area-level map denoting the locations.</p> <p>(Page Limit: Two pages, excluding map)</p>
122	<p>Administrative Requirements: Staff Training</p> <p>Describe your approach to staff training that meets the requirements of Section: 2.4.5: “Staff Training” of Appendix 2. Also include a description of your approach to monitoring Subcontractor training as it relates to serving the specialty populations.</p> <p>(Page Limit: Four pages)</p>
123	<p>Covered Benefits: Service Integration</p> <p>Provide a detailed description of how your operational structure and practices will support the integrated delivery of physical health, behavioral health, pharmacy benefits, and services addressing social determinants of health specifically for this population. Describe your strategies to ensure coordination of care for Health Plan Enrollees receiving services provided by other entities (e.g., Dental PAHP), outside the capitation (e.g., excluded benefits), and services provided as part of a case plan through the DHS and/or OJA.</p> <p>(Page Limit: Four pages)</p>

ITEM	INSTRUCTIONS
124	<p>Covered Benefits: In Lieu of Services</p> <p>Identify any in lieu of services or settings you propose to offer and the basis for the selection. Complete Form 8070001240-BB-In Lieu of Services specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or prior authorization requirements. Note that Form 8070001240-BB must be signed by the actuary attesting to the actuarial value estimate.</p> <p>Examples of in lieu of services include, but are not limited to:</p> <ul style="list-style-type: none"> • Applied Behavior Analysis (e.g., for children with low IQ’s and/or specific behaviors); and • Multi Systemic Therapy (e.g., for children with oppositional behaviors not in the custody of OJA). <p>Include the following description in your narrative response:</p> <ul style="list-style-type: none"> • Gaps in the service continuum the in lieu-of service aims to address; • Evidence the service(s) are medically appropriate and cost-effective alternatives for the substituted State Plan service or setting; • Clinical criteria (if applicable); and • An assurance Health Plan Enrollees will not be required to use the alternative service or setting. <p>(Page Limit: Three pages, excluding Form 8070001240-BB)</p>
125	<p>Covered Benefits: Value-Added Benefits</p> <p>Identify any Value-Added Benefits you propose to offer and the basis for their selection. Complete Form 8070001240-CC-Value-Added Benefits specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or prior authorization requirements. Note that Form 8070001240-CC must be signed by the actuary attesting to the actuarial value estimate.</p> <p>(Page Limit: Two pages, excluding Form 8070001240-CC)</p>

ITEM	INSTRUCTIONS
126	<p>Medical Management: Customized Approach</p> <p>Describe your proposed approach to customizing your clinical criteria, utilization review, and approval practices and procedures. As part of your response include:</p> <ul style="list-style-type: none"> • How your approach addresses barriers and eases access to care specific to this population; • How you will partner with stakeholders (e.g., state agencies and Providers) to modify clinical criteria; • How you educate stakeholders (Providers, state agencies, and caregivers) about these differentiators including, for example, parameters of open access Prior Authorizations (PAs); and • A description of the quality improvement mechanisms you will utilize to: <ul style="list-style-type: none"> ○ Ensure consistent application of the clinical criteria; and ○ Evaluate the utilization of the service relative to the review criteria. <p>Describe how you will approach the open access Prior Authorizations (PA) requirement described in Section 2.9.4: “Authorization Process” in Appendix 2.</p> <p>(Page Limit: Six pages)</p>
127	<p>Medical Management: Customized Approach Examples</p> <p>Therapeutic Foster Care and Intensive Treatment Family Care require Prior Authorization in accordance with criteria specified in rule (OAC 317:30-5-741 & OAC 317:30-5-751), respectively. Describe your approach and recommendations related to customizing the clinical criteria, utilization review, and approval practices and procedures for each service. Specifically include:</p> <ul style="list-style-type: none"> • A description of the service and current clinical criteria; • A description of the staff/roles/positions that would be involved in the process; • A description of the resources you would utilize as part of the process (e.g., evidence-based guidelines, national expertise, etc.); • A description of the stakeholder feedback (who, what, how) that you would utilize in the process; and • A description of the (recommended) updated clinical criteria. <p>(Page Limit: Six pages)</p>
128	<p>Care Management: Coordination with Targeted Case Management Activities</p> <p>The DHS and OJA provide Targeted Case Management (TCM) services to children at risk of or in the custody of the respective state agency. TCM activities include connecting children to needed medical, social, educational and other services. TCM services are (and will continue to be) provided by CW Specialists and OJA TCMs as part of their overall caseworker responsibilities. Based on this information, describe your approach to developing and operating a collaborative and coordinated Care Management and Population Health Program.</p>

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> • Describe your approach to developing a collaborative and coordinated Care Management and Population Health Program including methods by which you will engage and partner with stakeholders; • Describe your approach to designing a Care Management and Population Health Program that clearly delineates the activities to be completed through TCM services and those through the Care Management program; and • Describe your approach to implementing and sustaining an operational collaborative and coordinated Care Management and Population Health Program including methods by which planning will anticipate evolving approaches to improve efficiencies, effectiveness, and quality. <p>(Page Limit: Eight pages)</p>
129	<p>Care Management Program</p> <p>Describe your comprehensive and holistic Care Management and Population Health approach and the related strategies you will employ <u>specific to the specialty populations</u>. Include in your description:</p> <ul style="list-style-type: none"> • Your levels of care management and population health interventions, including: <ul style="list-style-type: none"> ○ The criteria that qualifies a Health Plan Enrollee for each level; ○ The condition(s) targeted at each stratification level and why each condition was selected; ○ Which levels are assigned a Care Manager and associated caseload levels; and ○ The intensity and frequency of interventions received by Health Plan Enrollees in each level. • How you utilize the following minimum strategies to determine the appropriate level of care management and population health intervention for each Health Plan Enrollee: <ul style="list-style-type: none"> ○ Information received from the DHS and OJA (when applicable); ○ Initial Health Risk Screening; ○ Comprehensive Assessment; ○ Predictive modeling; ○ Claims review; ○ Health Plan Enrollee, caregiver, and CW/OJA Specialist requests; ○ Information received from the OHCA; and ○ Physician referrals. • How community and social support needs of Health Plan Enrollees are addressed in the Risk Stratification Level Framework, including coordination with community-based organizations providing non-Medicaid services to Health Plan Enrollees, including:

ITEM	INSTRUCTIONS
	<ul style="list-style-type: none"> ○ The types of community-based organizations and resources to be targeted as part of your care management strategy; ○ Your activities to date to identify Oklahoma community-based organizations; and ○ How Care Managers and other staff will integrate community-based services into care management and population health interventions and share data among service providers. <ul style="list-style-type: none"> ● Methods you utilize to evaluate a Health Plan Enrollee’s need for changes in intensity and frequency of care management and population health interventions, and conditions which trigger a change. ● How you leverage, coordinate or engage with other entities delivering care coordination or case management to Health Plan Enrollees. ● What specific care management programs you will leverage targeted to the unique needs of this population/subpopulations ● How you will address care coordination immediately for children taken into care including when eligibility assignment to the Plan may not yet be in effect. ● How you will track population health outcomes as well as individual outcomes for Health Plan Enrollees in most-in-need/highest tier stratification. ● How the effectiveness of care management and population health interventions will be monitored over time. <p>In addition, provide examples of outcomes achieved in your care management and population health management programs specific to these populations. Limit examples to 2015 or later.</p> <p>(Page Limit: 20 pages)</p>
130	<p>Care Management and Population Health: Care Manager Training</p> <p>Describe your relevant experience and proposed approach for the initial and ongoing training programs you will undertake in accordance with the requirements in Section 1.8.4.4: “Training” in the SoonerSelect Model Contract and in Section 2.11.4.4: “Training” in Appendix 2. As part of your response, discuss:</p> <ul style="list-style-type: none"> ● Your approach to curriculum development; ● Your process to ensure all Care Managers receive adequate training to meet the described requirements; ● Differences between onboarding versus ongoing training; ● Training topics of emphasis and rationale; and ● How competencies will be evaluated post-training and issues addressed. <p>In addition, provide a draft Care Manager training curriculum.</p>

ITEM	INSTRUCTIONS
	(Page Limit: Three pages, excluding curriculum; there is no page limit for the curriculum)
131	<p>Transition of Care: Transitions between Levels of Care</p> <p>Describe your relevant experience and proposed approach to coordinating services for Health Plan Enrollees transitioning between levels of care that include a placement component. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> • Psychiatric Residential Treatment Facility (PRTF) to a group home with RBMS; and • TFC to a foster home. <p>As part of your response:</p> <ul style="list-style-type: none"> • Describe how you will track Health Plan Enrollees’ locations including settings/placements; and • Describe how you will develop a discharge plan that includes: <ul style="list-style-type: none"> ○ Assessment criteria for making sure the Health Plan Enrollee can be served safely at a lower level placement; ○ Coordination with the Health Plan Enrollee, authorized caregivers, DHS and/or OJA staff, existing Providers and referral sources; ○ Medication plan that addresses how the Health Plan Enrollee will access medications received while in an inpatient setting upon discharge (or a pharmaceutical equivalent); ○ Identify, refer, and coordinate services as appropriate to the Health Plan Enrollee’s lower level of care (placement) and required timeframes (e.g., follow up treatment with seven days of an inpatient discharge); ○ Evaluate the risk of readmission to a higher-level of care (placement); ○ Transfer of Health Plan Enrollee’s information to Providers and caregivers, as appropriate, while maintaining the protection of the Health Plan Enrollee’s privacy consistent with confidentiality requirements; and ○ Conduct post-discharge outreach to the Health Plan Enrollee, caregiver and/or DHS and OJA staff as appropriate. <p>(Page Limit: Five pages)</p>
132	<p>Transition of Care: Example</p> <p>Provide an example Discharge Plan for a Health Plan Enrollee transitioning from a TFC home in Oklahoma City to a foster home in Durant. Include a description of the Health Plan Enrollees’ background in the narrative of the response that supports the associated Discharge Plan.</p> <p>(Page Limit: Two pages, excluding Discharge Plan)</p>
133	<p>Health Plan Enrollee Services</p> <p>Caregivers and DHS/OJA staff responsible for FC and JJ Health Plan Enrollees, may change during a Health Plan Enrollees enrollment in the Plan. Describe your experience and approach</p>

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	<p>to assisting caregivers and DHS/OJA staff through the following resources while maintaining appropriate safeguards:</p> <ul style="list-style-type: none"> • Health Plan Enrollee Services Call Center • Health Plan Enrollee portal • Behavioral Health hotline <p>(Page Limit: Three pages)</p>
134	<p>Health Plan Enrollee Services: PCMH Selection and Assignment</p> <p>Describe your approach to assisting FC and JJ Health Plan Enrollees select a PCMH Provider in accordance with Section 2.14.6: “PCMH Selection and Assignment” in Appendix 2. upon:</p> <ul style="list-style-type: none"> • Initial enrollment into the Health Plan; and • Moving (change in placement). <p>(Page Limit: Two pages)</p>
135	<p>Provider Network Development: Telehealth</p> <p>Describe your relevant experience and proposed approach for using Telehealth to promote continuity of care and expand access to services. As part of your response, discuss:</p> <ul style="list-style-type: none"> • Any Telehealth initiatives you will undertake to enable Health Plan Enrollees to maintain access to a Provider (e.g., Health Plan Enrollee moves out of the Providers’ geographical area); and • Any Telehealth initiatives you will undertake in partnership with Participating Provider(s) specific to the populations served through this Contract. <p>(Page Limit: Two pages)</p>
136	<p>Provider Network: Development, Retention, and Support</p> <p>DHS has decreased the use of shelters as placements for FC children by successfully implementing targeted initiatives to increase the number of other placement types (e.g., group homes, TFC, and foster homes).</p> <p>Describe your experience and proposed approach to:</p> <ul style="list-style-type: none"> • Partnering with DHS to support (placement-based) initiatives; • Developing innovative solutions to increase TFC or other types of therapeutic placements; • Coordinating access to services that promote placement stability for Health Plan Enrollees; and • Developing supports designed to prevent attrition of placement-based Providers. <p>(Page Limit: Four pages)</p>
137	<p>Provider Network: Specialty Providers</p> <p>The State of Oklahoma has limited inpatient and residential Providers able or willing to accept children with complex behavioral issues (e.g., low IQ and aggressive behaviors). Historically, many of these children have ended up going out-of-state to obtain treatment. Describe:</p>

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	<ul style="list-style-type: none"> Your approach and experience solving for this issue with similar populations; Recommended short-term and long-term strategies for reducing out-of-state treatment and/or expanding the capabilities of Oklahoma-based Providers. <p>(Page Limit: Six Pages)</p>
138	<p>Provider Services: Provider Education, Training and Technical Assistance SoonerCare Providers, including, TFC and ITFC Providers are unfamiliar with managed care.</p> <p>Describe your experience and proposed approach to helping Providers, unfamiliar with managed care, transition to successfully provide services in a managed care setting. Include education, training and technical assistance as components of your response.</p> <p>(Page Limit: Three pages)</p>
139	<p>Member Services: Case Study (Sarah) Sarah is a 17-year-old female who was adopted two years ago by a couple her family knew through her church. Sarah came into custody at age 14 after her father completed suicide and there were no other family members capable of caring for her. Prior to entry into care, Sarah lived with her older brother (18) and father, who had Bipolar Disorder.</p> <p>Sarah recently gave birth to a daughter, Summer. Summer was delivered by emergency cesarean section, full-term, at six lbs. five ounces. Due to complications from the caesarean section, Sarah needed a lot of help from her parents (Kate and Greg) for the first three weeks of Summer’s life. Summer is now eight weeks old and while Sarah is taking on more responsibility, Kate and Greg were concerned that Sarah needed to be prompted to feed and take care of Summer. Both felt that this was very unlike Sarah, who tended to be very “take charge,” organized, and self-reliant for a young woman her age.</p> <p>Kate contacts the Health Plan Enrollee Call Center for assistance. She explains the situation and adds that Sarah has also been anxious, tearful, and unsure of herself – all of which are atypical for her. Kate describes Summer as a healthy baby that is more difficult to sooth, get to sleep or stay asleep, than any of her three children were, but at Sarah’s six week post-partum checkup Sarah’s OB didn’t seem concerned.</p> <p><u>Instructions:</u> Describe your strategy for managing Sarah and Summer’s care. Begin by describing next steps by the Health Plan Enrollees Services staff. Include the following in your description:</p> <ul style="list-style-type: none"> Internal and/or external referrals; Screenings and/or assessments and by who and how; and Services and follow up activities. <p>(Page Limit: Five pages)</p>
140	<p>Care Management and Population Health: Case Study (Charlie) Charlie is a six-year old male who entered foster care one month ago due to substantiated allegations of abuse and neglect. He resides in a foster home with his two younger siblings</p>

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	<p>(ages four and three). The family came to the attention of CWS after police were called due to a verbal and physical altercation between the parents in the parking lot outside of a Tulsa homeless shelter. The family, originally from Iowa, had been living in their van and had parked at the shelter during the night. Both parents were arrested and charged with battery and possession of methamphetamines. The children were found in the van and taken into custody.</p> <p>While Charlie’s siblings have adjusted well to the placement, Charlie has not responded well to the structure (routine) provided in the home. Charlie exhibits: frequent aggressive outbursts, self-harming behaviors (i.e., head banging when angry and skin picking when anxious), and attempts to bite, kick, and hit others when angry or frustrated. Due to concerns about exposure to Covid-19 (the foster dad has a heart condition), the foster mom is home schooling Charlie. Unlike Charlie’s four-year-old sister, Charlie cannot consistently recite his ABC’s, count past 29, or read simple words.</p> <p>As both parents are still incarcerated and the family only recently moved to Oklahoma, little is known about the children’s medical or educational background.</p> <p><u>Instructions:</u> Describe your strategy for managing Charlie’s care. Address the following items in the order presented:</p> <ul style="list-style-type: none"> • Communication and coordination with Charlie’s CW Specialist. Specifically, describe your planned approach to: <ul style="list-style-type: none"> ○ Obtaining screening and assessment information that has been completed to date; and ○ Integrating the information into your Care Management approach. <p>Additionally, include how you would approach the following:</p> <ul style="list-style-type: none"> • <i>Health Risk Screening</i> <ul style="list-style-type: none"> ○ Describe the most pressing risk factors associated with Charlie that will need to be addressed. ○ List any significant aspects that are unknown to this case that may be relevant in order to assign Charlie to a risk level in accordance with your Risk Stratification Level Framework. • <i>Care Management Risk Levels</i> - Identify the assigned risk level in accordance with your Risk Stratification Level Framework and your rationale for Charlie’s assigned risk level. • <i>Comprehensive Assessment</i> – Identify how you would complete a Comprehensive Assessment that included information from the screening and assessments completed by the CWS. Identify the timeframe to complete the Comprehensive Assessment, additional sources used to obtain information and the type of Care Manager to be assigned to Charlie. • <i>Care Planning</i> –Describe your approach to developing a Care Plan in accordance with your Risk Stratification Level Framework. At your option, also provide a Care Plan for

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	<p>Charlie in a template you propose to use for SoonerSelect Specialty Children’s Plan or using a relevant template from another program.</p> <ul style="list-style-type: none"> • <i>Providers and Services</i> - Discuss your approach to identifying Providers and services that address Charlie’s identified needs and ongoing care. • <i>Ongoing Care Management</i> - List pertinent care management interventions, including care transitions (if applicable) for Charlie. • <i>Coordination Activities</i> – Discuss ongoing coordination with the CW Specialist, other payers, non-capitated Medicaid service providers and community-based organizations and resources, as applicable. • <i>Monitoring Service Delivery</i> - Identify your approach to monitor Charlie’s access to care over time. <p>(Page Limit: Seven pages, excluding Care Plan, if provided; there is no page limits for the Care Plan and related service plan. Place the Care Plan at the end of your response, after the narrative.)</p>
141	<p>Care Coordination: Case Study: (Dakota)</p> <p><i>For the following case study Bidders should assume that the Bidder is the State’s selected SoonerSelect Specialty Children’s Plan, Dakota is initially enrolled in the Bidder’s SoonerSelect Plan, and becomes enrolled in the SoonerSelect Specialty Children’s Plan through a request to change enrollment.</i></p> <p>Dakota is a ten-year-old male who, up until recently, has lived with his mother, Daisy, at his grandparent’s home in Muskogee. Dakota’s behaviors have recently become unmanageable for his grandparents, so they asked he and his mother to leave their home, which has left them homeless. Previous psychological testing determined that Dakota has an IQ of 48, experiences episodic outbursts which often result in Dakota hitting, kicking and biting his mother, and causing destruction to property. The first night that Dakota and his mother were at a homeless shelter, Dakota began exhibiting extremely aggressive behaviors resulting in his mother taking him to the local emergency room (ER). At the ER, a hospital employee made a referral to DHS child welfare. The DHS worker arrived and began working with Daisy on a safety plan for when the ER discharges Dakota. The DHS worker explained the option to change Dakota’s SoonerSelect Health Plan selection (as he is now involved with DHS) to the SoonerSelect Specialty Children’s Plan and offers to assist Daisy. However, Daisy chooses not to change Dakota’s Health Plan at that time. Over the next 48 hours, Dakota was seen at four different emergency rooms between Muskogee, Tulsa and Oklahoma City. All of the ER’s state that Dakota needs residential treatment, but there are no facilities in Oklahoma that will admit children with IQ’s below 70.</p> <p>At the fourth ER, the hospital social worker assists Daisy with calling the Health Plan Enrollee Services Call Center to assist with care coordination. Daisy explains the issues with Dakota and her desire to have Dakota enrolled in the SoonerSelect Children’s Specialty Plan. The Call Center representative confirms that as Dakota is now involved with DHS, he is eligible for the</p>

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	<p>SoonerSelect Children’s Specialty Plan, and follows the OHCA’s procedures to immediately enroll Dakota into the SoonerSelect Children’s Specialty Plan.</p> <p>Dakota is now enrolled in the SoonerSelect Children’s Specialty Plan. Time is limited in the ER. The social worker has indicated that they are going to discharge Dakota and Daisy within four hours to a homeless shelter in Oklahoma City. Given his recent behaviors, it is highly probable that his behaviors will escalate resulting in yet another ER visit.</p> <p>Describe in detail the action steps (who, what, where, when, and how) you will take to address the immediacy of the situation to ensure Dakota is safe. At a minimum include:</p> <ul style="list-style-type: none"> • Next steps the Call Center representative will take to address Dakota’s needs (e.g., referrals to the BH hotline and/or care management); • Next steps the internal referral sources will take to address Dakota’s needs; <p>Assume that in-state residential Providers will not accept Dakota and six different out of state residential Providers have waiting lists of one month or longer.</p> <ul style="list-style-type: none"> • External referrals, services, and supports; • Coordinate with OHCA and/or DHS to exchange information, coordinate Dakota’s care, and/or leverage other state resources; and • Work with DHS to ensure that this remains a prevention case, preventing DHS from having to take custody. <p>(Page Limit: Eight pages)</p>
142	<p>Quality Improvement</p> <p>Describe any differentiators for your approach to quality improvement specific to the service delivery system, Plan infrastructure, and multiple stakeholders for the specialty population.</p> <p>(Page Limit: Three pages)</p>
143	<p>Inter-Agency Coordination, Communication, and Training Strategy</p> <p>The selected Contractor serving FC and JJ Health Plan Enrollees will be required to partner with multiple Oklahoma agencies to develop procedures and practices to facilitate and coordinate services. Describe your experience and approach to:</p> <ul style="list-style-type: none"> • Partnering with state agencies to develop population-specific, procedures and practices; • Developing communication protocols and tools to ensure the Contracting entity (e.g., OHCA) is informed and provided requests for written authorizations throughout the process. (The state anticipates the Contractor will develop procedures with the OJA and DHS through meetings without the OHCA. The OHCA must review and approve of all procedures in writing.) • Ensuring procedures and practices align with Contractual requirements; and

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	<ul style="list-style-type: none"> Partnering with the OHCA and state agencies to develop an initial and ongoing training to agency staff. Include recommended components of the training as part of your response. <p>(Page Limit: Four pages)</p>
144	<p>Data Sharing Approaches and Tools</p> <p>Describe your experience and proposed approach to:</p> <ul style="list-style-type: none"> Partnering with state agencies to develop platforms and/or mechanisms to share data; Developing and/or modifying internal platforms for data sharing purposes and/or enable single sign on capabilities; Collecting and maintain Health Plan Enrollee level data from multiple sources; Enabling Health Plan Enrollees, caregivers, Providers, and DHS/OJA staff to access information specific to their relationship with the Health Plan Enrollee including case plans, services received, and medications; and Protecting Health Plan Enrollee information in accordance with state and federal privacy rules. <p>(Page Limit: Four pages)</p>

SoonerSelect Solicitation Forms – Summary Listing (Forms are located in Bidder’s Library)

Form Number	Form Title
Form 8070001240 - A	SoonerSelect Solicitation Questions
Form 8070001240 - B	Bidder Proposal Submission Checklist
Form 8070001240 - C	Cover Page
Form 8070001240 - D	Bidder Representations and Certifications
Form 8070001240 - E	Oklahoma Experience
Form 8070001240 – F	Other State Medicaid Experience
Form 8070001240 – G	References
Form 8070001240 – H	Identification of Major Subcontractors
Form 8070001240 – I	Key Staff
Form 8070001240 - J	Plan Staffing
Form 8070001240 – K	Economic Impact
Form 8070001240 – L	In Lieu of Services

Form 8070001240 – M	Value-Added Benefit
Form 8070001240 – N	Hospital Utilization
Form 8070001240 – O	Emergency Room Utilization
Form 8070001240 – P	Health Risk Screening Activity Rates
Form 8070001240 – Q	Comprehensive Assessment Activity Rates
Form 8070001240 – R	New Health Plan Enrollee Contact Rate
Form 8070001240 – S	Call Center Performance
Form 8070001240 – T	Claims Processing
Form 8070001240 – U	Health Plan Enrollee Grievances and Appeals Resolution
Form 8070001240 – V	MCO Security Specifications
Form 8070001240 – W	OMES Cloud Computing Certification
Form 8070001240 – X	OMES Hosting Agreement
Form 8070001240 – Y	Contractor Performance History
Form 8070001240 – Z	SoonerSelect Specialty Children’s Plan – Key Staff
Form 8070001240 – AA	SoonerSelect Specialty Children’s Plan – Plan Staffing
Form 8070001240 – BB	SoonerSelect Specialty Children’s Plan – In Lieu of Services
Form 8070001240 – CC	SoonerSelect Specialty Children’s Plan – Value-Added Benefits

2.6 Written Clarification and Oral Presentations

OHCA reserves the right, at its sole discretion, to request clarifications of bid information or to conduct discussions for the purposes of clarification with any or all Bidders. The purpose of any such discussion shall be to ensure full understanding of the bid. If clarifications are made because of such discussion, the Bidder(s) shall put such clarifications in writing. Bidder answers that are outside the scope of the clarification questions shall be disregarded. Oral explanations or instructions provided to a potential Bidder is not binding.

If a bidder fails to notify OHCA of an error, ambiguity, conflict, discrepancy, omission or other error in the Solicitation, known to the Bidder, or that reasonably should have been known by the Bidder, the Bidder shall submit a bid at its own risk; and if awarded the contract, the Bidder shall not be entitled to additional compensation, relief or time, by reason of the error or its later correction. If a Bidder takes exception to any requirement or specification contained in the Solicitation, these exceptions must be clearly and prominently stated in their Proposal

OHCA also may schedule oral presentations as part of Proposal evaluation activities. OHCA may invite some or all Bidders to participate in oral presentations. Further information on oral presentation schedule and content requirements will be provided after the Proposal submission deadline.

2.7 Proposal Evaluation

Following the closing of the RFP, an administrative review and evaluation process will be conducted to determine the responsiveness and quality of each Proposal.

Proposals will be evaluated based upon the ability of the Bidder to satisfy the requirements of the RFP in best serving the interests of the citizens of Oklahoma. Each of the evaluation steps is described below with a brief explanation of the evaluation criteria in that step. The points associated with each evaluation area are indicated following the category name.

2.7.1 Step One – Administrative Review (Pass/Fail)

OHCA will review the Bidder’s Proposal for timely submission, completeness, and compliance with general submission guidelines outlined in this RFP. The Administrative Review will also determine compliance with mandated forms and ability to meet risk-based capital requirements. Inability to meet any Mandatory Requirements will be grounds to disqualify a response from further consideration.

2.7.2 Step Two – Technical Proposal Evaluation (1650 points)

OHCA will review each Proposal passing the Administrative Review and use the Evaluation Areas and points below to determine a Technical Proposal score for each Bidder.

Evaluation Area	Points Possible
Executive Summary	25
Staffing and Organizational Structure	75
References and Past Performance Information	50
Corporate Information and Experience in Improving Outcomes includes: <ul style="list-style-type: none"> • Oklahoma Experience • Medicaid Experience • Proposed Oklahoma Economic Impact 	100
Implementation Plan	50
Provider Network	75
Covered Benefits	100
Rural Health Strategy	75
American Indian/Alaska Native Health Understanding and Strategy	50
Care Management and Population Health	150

Evaluation Area	Points Possible
Medical Management	100
Quality Improvement	100
Health Plan Enrollee Services including: <ul style="list-style-type: none"> • Health Plan Enrollee Grievance and Appeals • Call Center 	75
Provider Services including: <ul style="list-style-type: none"> • Claims Payment Processing • Call Center 	75
Program Integrity	75
Information Technology Including: <ul style="list-style-type: none"> • General Requirements Response • Encounter Processing • Interoperability Rule Readiness • HIE Response • System Security and Privacy • Business Continuity and Disaster Recovery Plan 	100
Financial Standards and Third Party Liability	75
Reporting	50
Behavioral Health Integration	100
Value-Based Payment Strategy	50
Case Studies	75
Contractor Performance/Compliance Strategy	25

The CEO of OHCA or their designee(s) will, in the exercise of their sole discretion, determine which Proposal(s) offer the best means of serving the interests of the State based on overall RFP scores. The exercise of this discretion will be final.

2.7.3 Step Three – SoonerSelect Specialty Children’s Plan Evaluation (400 points)

Child welfare sections will be evaluated if the Bidder chose to submit a Proposal for the SoonerSelect Specialty Children’s Plan. One Bidder will be awarded a Contract. Only Bidders selected for a SoonerSelect MCO Contract will be eligible to be awarded the SoonerSelect Specialty Children’s Plan addendum.

Evaluation Area	Possible Points
Technical Approach and Experience with specialty populations	70
Staffing	30
Covered Benefits	40
Medical Management	30
Care Management and Transition of Care	75
Health Plan Enrollee Services	35
Provider Network	30
Case Studies	30
Quality Improvement	20
Inter-Agency Coordination and Data Sharing	40

The CEO of OHCA or their designee(s) will, in the exercise of their sole discretion, determine which Proposal(s) offer the best means of serving the interests of the State based on overall RFP scores. The exercise of this discretion will be final.

2.7.4 Step Four – Final Negotiations

In accordance with the Oklahoma Central Purchasing Act and Oklahoma Administrative Code (OAC) 260:115, OHCA reserves the right to negotiate with one, selected, all or none of the Bidders responding to this RFP to obtain the best value for OHCA. OHCA reserves the right to limit negotiations to those Proposals that received the highest rankings during the initial evaluation phase. Negotiations will be conducted in accordance with OAC 260:115-7-34, and may be conducted in person, in writing or by electronic means. Negotiations could entail discussions on products, services, pricing, Contract terminology or any other issue that mitigate OHCA's risks. OHCA will consider all issues negotiable and not artificially constrained by internal corporate policies. Negotiation may be with one or more Bidders, for any and all items in the Bidder's Proposal. Bidders that contend a lack of flexibility because of corporate policy on a particular negotiation item shall face a significant disadvantage and may not be considered.

2.7.5 Step Five – Award of Contract

Contract awards shall be made in accordance with OAC 260:115-7-36. OHCA may award the Contract to more than one Bidder by awarding the Contract(s) by item or groups of items or may award the Contract on an all or none basis, whichever is deemed to be in the best interest of OHCA.

Pursuant to Oklahoma Attorney General Opinion No. 06-23, any Bidder that has assisted in preparing the solicitation or developing the procurement terms, either directly or indirectly, is precluded from being awarded the Contract or from securing a sub-contractor that has provided such services.

Prior to award, OHCA may choose to request information from the Bidder to demonstrate its (and/or its parent's or subsidiary's) financial status and performance.

2.7.6 Step Six – Notice of Award

1. The successful Bidder(s) shall be notified they have been selected for award, and before the official award, the following shall be requested to be completed:
 - a. In order to receive an award or payments from the State of Oklahoma, Bidder must be a registered vendor. The Bidder registration process can be completed electronically through the website at the following link: <https://www.ok.gov/dcs/vendors/index.php>.
 - b. The successful Bidder shall register with the Oklahoma Secretary of State or shall attach a signed statement that provides specific details supporting the exemption the supplier is claiming. The Oklahoma Secretary of State Office's contact information is as follows: www.sos.ok.gov or 405-521-3911.
 - c. Bidder is required to provide a certificate of liability insurance showing proof of compliance with Model Contract Section 1.1.18: "Insurance."
2. A notice of award in the form of a purchase order or other Contract documents resulting from this RFP shall be furnished to the successful Bidder(s) and shall result in a binding Contract.
3. Notification of award shall also be posted on OHCA website.

2.8 Debriefings

Bidders may request copies of Proposals and evaluation and award materials after the Contract has been awarded. Due to limited staff time, OHCA is unable to provide formal debriefings for any Bidder.

2.9 Protests

Protest of awards under this solicitation will be addressed by OHCA in accordance with administrative rules found at OAC 317:2-1-14. In summary, a Bidder who wishes to protest the award of a contract under the solicitation must submit a written notice to the OHCA Legal Division within ten Business Days of the contract award. The protest must state the relevant facts and the Bidder's grounds for protest. The OHCA Legal Division will respond to the Bidder's protest within ten Business Days of its receipt of the Bidder's properly submitted written notice of protest. The OHCA will determine, in its sole discretion, if a written notice of protest was properly submitted in accordance with OAC 317:2-1-14. The OHCA Legal Division reserves the right to decline to consider any protests that are not submitted in conformity with OAC 317:2-1-14.

Notwithstanding anything in OAC 317:2-1-14 or OAC 317:2-1-2 to the contrary, by submitting a Proposal, the Bidder agrees that if it wishes to appeal the OHCA Legal Division's decision, the Bidder may request an administrative hearing before an administrative law judge (ALJ) by filing a Form LD-3 with the OHCA's docket clerk within 30 calendar days of its receipt of the written denial from the OHCA Legal Division. The ALJ's decision will constitute the final administrative decision of the OHCA.

Any claims, disputes or litigation relating to the solicitation shall be governed by the laws of the State of Oklahoma. Venue for any action, claim, dispute or litigation relating in any way to the solicitation shall be in Oklahoma County, Oklahoma.

1 Appendix 1: Model Contract

OKLAHOMA HEALTH CARE AUTHORITY

AND

[CONTRACTOR NAME]

The purpose of this Model Contract is for the Oklahoma Health Care Authority (OHCA) and **[CONTRACTOR NAME] (Contractor)** to provide health-care services to certain Eligibles in the Oklahoma Medicaid program known as SoonerCare.

1.1 General Terms and Conditions

1.1.1 Parties

1.1.1.1 Oklahoma Health Care Authority

The OHCA is the single State agency designated by the Oklahoma Legislature through 63 O.S. § 5009(B) to administer Oklahoma's Medicaid program, known as SoonerCare. The OHCA has the authority to enter into this Model Contract pursuant to 63 O.S. § 5006(A)(2) and 74 O.S. § 85.1. The OHCA's Chief Executive Officer has authority to execute this Model Contract on OHCA's behalf pursuant to 63 O.S. § 5008(B)(4) and (5).

1.1.1.2 Contractor

Contractor's Full Legal Name:

Point of Contact:

Address:

Phone Number:

Fax Number:

Email Address:

Web Address:

FEI/SSN:

PeopleSoft Vendor Number:

The Contractor states that it has the experience and expertise to perform the services required under the Contract. The Contractor has the authority to enter into the resulting Contract pursuant to its organizational documents, bylaws or properly enacted resolution of its governing authority. The person executing the Contract for the Contractor has authority to execute the Contract on the Contractor's behalf pursuant to the Contractor's organizational documents, bylaws or properly enacted resolution of the Contractor's governing authority.

1.1.2 Contract Administration

1.1.2.1 OHCA

OHCA has appointed a contracts designee responsible for all matters related to the Contract. The designee shall be the Contractor's primary liaison in working with other OHCA staff.

The contracts designee is Susan Geyer. Once a contract has been awarded, the Contractor shall not refer any matter to the OHCA Chief Executive Officer, the Oklahoma Health Care Authority Board, or any other official in Oklahoma unless initial contact regarding the matter has been presented to the contracts designee both orally and in writing.

1.1.2.2 Contractor

The Contractor shall designate a Contract Officer. Such designation may be changed during the period of the Contract only by written notice. The Contract Officer shall be listed on the Contractor's List of Authorized Signatories provided to the OHCA, as the same may be amended from time to time, and shall

be authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of the Contract.

1.1.3 Legal Contract

Submitted bids are rendered as a legal offer and any bid, upon acceptance by the OHCA, shall constitute a contract. The Contract resulting from this solicitation will consist of the following documents in order of preference:

- Contract award documents, including but not limited to this Model Contract, purchase orders, any addendum to the Contract, Contract modifications or amendments, negotiated statements of work, required certifications, affidavits, and change orders;
- Approved corrective action plans submitted by the Contractor in response to deficiencies documented by OHCA through Readiness Reviews, operational/financial audits, routine reporting and/or other oversight activities as described in Section 1.22: "Contractor Performance Standards" of this Model Contract;
- The RFP in its entirety, including any amendments or attachments such as drawings, attachments, schedules, diagrams, illustrations, OHCA answers to Bidder's questions that lead to a change in the project scope, and the like; and
- The Bidder's accepted Proposal, including Bidder's responses to OHCA questions.

This Contract constitutes and defines the entire agreement between the Contractor and OHCA. No documentation shall be omitted which in any way bears upon the terms of that agreement.

In the event of a conflict between any of the provisions of this Model Contract, precedence shall be given in the following order:

- Betterments: Any portions of the accepted Proposal (including, but not limited to, Bidder's answers to OHCA questions asked in response to a Proposal) which both conform to and exceed the requirements of the RFP;
- Contract award documents, including but not limited to this Model Contract, the Purchase Order, Contract modifications, negotiated Statements of Work, required certifications, affidavits, and change orders;
- The RFP in its entirety, including any amendments or attachments; and,
- All other provisions of the accepted Proposal to the extent that the Proposal does not conflict with the requirements of this Model Contract award documents, this RFP, or applicable law.

In the event that an issue is addressed in the accepted Proposal that is not addressed in this RFP or Contract award documents, no conflict in language shall be deemed to occur. However, OHCA reserves the right to clarify, in writing, any contractual relationship with the concurrence of Contractor(s), and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP. Such clarifications shall be issued solely by the OHCA's Chief Executive Officer or designee for this Model Contract.

The State may award the Contract, in accordance with the State Health Plan and in compliance with federal law, to more than one Bidder by awarding the Contract(s) by item or groups of items, or may award the Contract on an all or none basis, whichever is deemed to be in the best interest of OHCA and the State of Oklahoma.

Either OHCA or the Bidder(s) may discontinue the contracting process at any time.

1.1.4 Approval of the Contract

Award of this Contract is contingent on approval by the OHCA Board and the Centers for Medicare and Medicaid Services (CMS). In accordance with 42 C.F.R. § 438.3, CMS has final authority to approve this Model Contract. If CMS does not approve the Contract entered into under the terms and conditions described herein, it will be considered null and void.

1.1.5 Notices

Whenever a notice is required to be given to the other party, it shall be made in writing and delivered to that party personally, by reputable courier service such as Federal Express (signature required), or by registered or certified mail, return receipt requested, to the addresses below or to such other address as may be designated by a party. Delivery shall be deemed to have occurred if a signed receipt is obtained, either when delivered by hand, by courier or return receipt requested. Notices shall be effective upon receipt if delivered personally, one business day after sent if delivered by courier service (three Business Days if the addressee is outside the United States) and three Business Days after sent if delivered by registered or certified mail (five Business Days if the addressee is outside the United States). All notices must be in English.

1.1.5.1 Notices to OHCA

Susan Geyer
Financial Manager III
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

1.1.5.2 Notices to the Contractor

Name
Address

1.1.6 Notification of Material Changes

The Contractor shall promptly notify OHCA of all changes materially affecting the delivery of care or the administration of its program. Material changes include, but are not limited to, any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent of Health Plan Enrollees or Participating Providers. The Contractor shall also notify OHCA within three Business Days of any change to its Contract Officer, and shall provide an updated List of Authorized Signatories reflecting the same.

1.1.7 Contract Term

In accordance with Article X of the Oklahoma State Constitution, the initial Contract shall begin upon Contract award and terminate on June 30, 2021. There shall be options to renew for five additional one-year periods. The option to renew shall be contingent upon the needs of OHCA and funding availability, as more fully discussed below, and is at the sole discretion of OHCA.

The engagement under this Contract and any purchase order issued under this Contract are contingent upon sufficient appropriations being made by the federal government, the Oklahoma state legislature or

other appropriate government entity. Notwithstanding any language to the contrary in this Contract or in any purchase order or other document, OHCA may terminate its obligation under this Contract if sufficient appropriations are not made by the legislature or other appropriate governing entity to pay amounts due for multiple year agreements. OHCA's decision whether sufficient appropriations are available shall be accepted by the Contractor and shall be final and binding.

OHCA may choose to exercise an extension for up to 180 days beyond the final renewal option period at the Contract pricing rate; the extension shall be executed by mutual agreement. If this option is exercised, OHCA shall notify the other party in writing prior to the Contract end date.

OHCA may choose to exercise subsequent extensions, up to 180 days each, by mutual agreement and at the Contract pricing rate, to facilitate the finalization of related terms and conditions of a new contract or as needed for transition to a new Contractor. Payment terms for any renewal period shall be administered in accordance with Section 1.2: "Payments to Contractor" of this Model Contract.

The Contractor shall have certain obligations that will survive Contract expiration. These obligations are described in the relevant sections of the Contract, including but not limited to Section 1.24: "Termination" of this Model Contract.

The initial Rating Period shall be nine months (October 1, 2021 through June 30, 2022). Each subsequent Rating Period shall be 12 months (July 1-June 30).

1.1.8 Consideration of New Contracts during Contract Period

OHCA, at its discretion, reserves the right to enter into new Contracts with outside organizations during this Contract term. For the purposes of this Section, Contract Term is in accordance with the requirements outlined in Section 1.1.7: "Contract Term" of this Model Contract. Changes to the composition of Contractors shall be effective at the start of a Contract year, unless otherwise necessary to ensure a continued choice of Contractors.

1.1.9 Amendments or Modifications

This Contract contains all of the agreements of the parties and no oral representations from either party that contradict the terms of this Model Contract are binding. Any modifications to this Contract must be in writing and signed by both parties.

Legislative, regulatory and programmatic changes may require changes in the terms and conditions of this Model Contract. Modifications of terms and conditions of this Contract shall be authorized in such cases upon approval by OHCA and the Contractor. At all times, all parties shall adhere to the overall intent of the Contract.

1.1.10 Assignment

The Contractor shall not assign or transfer any rights or obligations under this Contract without prior written consent of OHCA. Such consent, if granted, shall not relieve the Contractor of its responsibilities under the Contract. For purposes of this section, any merger, reorganization or change in ownership of the Contractor shall constitute an assignment of the Contract.

1.1.11 Waivers

No covenant, condition, duty, obligation or undertaking in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant,

condition, duty, obligation or undertaking to be kept, performed or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, duties, obligations and undertakings is achieved.

Waiver of any breach of any term or condition in the Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of the Contract shall be held to be waived, modified or deleted except by an instrument, in writing, signed in advance by the parties hereto.

1.1.12 Policy Determinations

In the event that the Contractor may, from time to time, request OHCA to make policy determinations or to issue operating guidelines required for proper performance of the Contract, OHCA shall do so in a timely manner, and the Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines and shall incur no liability in doing so unless the Contractor acts negligently, maliciously, fraudulently or in bad faith.

Such determinations shall only be made by OHCA's contracts designee.

1.1.13 Disputes

A Contract dispute shall mean a circumstance whereby the Contractor and OHCA are unable to arrive at a mutual interpretation of the requirements, limitations or compensation for performance of the Contract.

Prior to the institution of arbitration or litigation concerning any dispute arising under the Contract, the CEO or their designee (CEO designee) is authorized to settle, compromise, pay or otherwise adjust the dispute by or against or in controversy with, the Contractor. This authority to settle or resolve disputes, as well as the process for such settlement or resolution, is subject to any limitations or conditions imposed by federal and State law. Such disputes or controversy may include a claim or controversy based on the Contract, mistake, misinterpretation or other cause for Contract modification or rescission, but exclude any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official, other than the CEO or CEO designee, are specifically authorized to settle or determine such controversy.

The CEO designee shall be authorized to settle Contract disputes between the Contractor and OHCA, upon submission of a request in writing from either party. Such a request shall provide:

- A description of the problem, including all appropriate citations and references from the Contract;
- A clear statement by the party requesting the decision or interpretation of the Contract; and
- A proposed course of action to resolve the dispute.

The CEO designee shall determine whether the interpretation provided is appropriate, whether the proposed solution is feasible and/or whether another solution is feasible or negotiable. If a dispute or controversy cannot be resolved by mutual agreement, the CEO designee shall promptly issue a decision in writing after receipt of a request for dispute resolution. A copy of the decision shall be mailed or otherwise furnished to the Contractor.

If the CEO designee does not issue a written decision within 45 days after written request for a final decision, or within such longer period as might be established in writing by the parties to the Contract, then the Contractor may proceed as if an adverse decision had been received.

1.1.14 Inspection and Audit Rights

As used in this clause, “records” includes books, documents, accounting procedures and practices, statistical, fiscal and other records and data regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form. In accordance with 42 C.F.R. § 438.3(h), the Contractor shall allow any pertinent State or federal Agency, including, but not limited to, OHCA, the State Auditor and Inspector (SA&I), Office of State Finance—Central Purchasing Division (CPD), Oklahoma Attorney General’s Medicaid Fraud Control Unit (MFCU), CMS, the Office of the Inspector General (OIG), the Comptroller General, and their designees or Subcontractors to:

- Inspect and audit any records or documents of the Contractor or Subcontractors at any time; and
- Inspect the Contractors and Subcontractors premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.

This right to inspect and audit Contractor’s records extends beyond the term of this Agreement pursuant to federal regulation.

In accordance with Section 1903(m)(2)(A)(iv) of the Act, the Secretary, DHHS and the State, or any person or organization designated by either, shall also have the right to audit and inspect any books or records of the Contractor or its Subcontractors, Subsidiaries or Affiliates pertaining to:

- The ability of the Contractor to bear the risk of financial losses; and
- Services performed or payable amounts under the Contract.

In accordance with 42 C.F.R. § 438.3(u), the Contractor and its Subcontractors shall retain, as applicable:

- Health Plan Enrollee Grievance and Appeal records, in accordance with 42 C.F.R. § 438.416;
- Base data, in accordance with 42 C.F.R. § 438.5(c);
- MLR reports, in accordance with 42 C.F.R. § 438.8(k); and
- Data, information, and documentation, specified in 42 C.F.R. §§ 438.604, 438.606, and 438.610.

This list is neither exclusive nor exhaustive and Contractor, Subsidiaries, Affiliates and Employees shall retain records in compliance with both the provisions and spirit of 42 C.F.R. § 438. The Contractor and its Subcontractors, Affiliates and Employee are required to retain records relative to the Contract for the duration of the Contract and for a period of ten years following completion and/or termination of the Contract. If an audit, litigation or other action involving such records is started before the end of the ten-year period, the records are required to be maintained for two years from the date that all issues arising out of the action are resolved, or until the end of the ten-year retention period, whichever is later. The State, CMS, the OIG, the Comptroller General and their designees shall maintain the right to audit records or documents of the Contractor and its Subcontractors for the duration of this record retention requirement. The Contractor shall not destroy or dispose of records that are under audit, review or investigation when the ten-year limit is met. The Contractor shall maintain such records until informed in writing by the auditing reviewing, or investigating agency that the audit, review or investigation is complete.

Pursuant to 74 O.S. § 85.41, OHCA, the SA&I, the State Purchasing Director and OMES shall have the right to examine the Contractor’s books, records, documents, accounting procedures, practices or any other items relevant to this Model Contract.

The Contractor acknowledges that OHCA has advised the Contractor that it is a “governmental body” subject to the Oklahoma Open Records Act, which provides generally that all records relating to a public body’s business are open to public inspection and copying unless exempted under such act, and the Oklahoma Open Meetings Act, which provides generally for open meetings for public bodies, and record retention requirements applicable to agencies of the State of Oklahoma (collectively with the Open Records Act, the “Public Records Laws”), and that the Contractor is familiar with the legal requirements imposed upon OHCA by the Public Records Laws. Accordingly, OHCA is not required to maintain the confidentiality of non-public information that is furnished by the Contractor to OHCA to the extent that OHCA believes, after due inquiry, that it is required to disclose such information pursuant to the Public Records Laws. The Contractor acknowledges and agrees that OHCA in its sole discretion shall determine whether OHCA is legally required to disclose non-public information pursuant to the Public Records Laws.

OHCA shall allow for the inspection of public records in accordance with the provisions of the Oklahoma Open Records Act, 51 O.S. §§ 24A.1--29.

1.1.15 Confidentiality; HIPAA and Business Associate Requirements

1.1.15.1 Definitions

The following terms in this section shall have the same meaning as those terms in the HIPAA Rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information and Use.

Discovery or Discovered shall generally mean the first day a Security Incident or Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor. Contractor shall be deemed to have knowledge of a Security Incident or Breach if known, or if, by exercising reasonable diligence, the Security Incident or Breach would have been known, to any person other than the person committing the Breach, who is an employee or Agent of Contractor (determined in accordance with the federal common law of agency). HIPAA Rules shall mean Health Insurance Portability and Accountability Act of 1996, the Privacy, Security, Breach, Notification and Enforcement Rules at 45 C.F.R. Parts 160 and 164 and related regulations, including the Administrative Simplification rules at 42 U.S.C. § 1320d *et seq.*, and the Health Information Technology for Economic and Clinical Health Act of 2009 (“HITECH”) and its associated rules, including but not limited to those at 45 C.F.R. Parts 160 and 164.

1.1.15.2 Permitted Uses and Disclosures by Contractor

Except as otherwise provided in this Model Contract, Contractor may use or disclose PHI on behalf of, or to provide services to, OHCA solely to provide the services specified in this Contract (including any additional services necessary to carry out the specific services in this Contract) and only if such use or disclosure of PHI would not violate the HIPAA Rules if performed by OHCA. Any use or disclosure of PHI shall be consistent with OHCA’s minimum necessary standards and the regulations and guidance issued by the Secretary regarding minimum necessary standards for Contractor to perform its obligations under this Model Contract. Subject to the foregoing, Contractor may:

- Use the PHI for the purpose of determining and reporting potential improper billing and fraud in the Oklahoma Medicaid Program and, if directed to do so in writing by OHCA, disclose the PHI as needed to cooperate in Oklahoma Medicaid Fraud investigations conducted by authorized State or federal entities.

- Use PHI to de-identify the information in accordance with 45 C.F.R. § 164.514(a)-(c), with OHCA's prior written consent.
- Disclose PHI to report violations of law to appropriate federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1). OHCA shall be furnished with a copy of all correspondence sent by Contractor to a federal or State authority.
- If directed to do so in writing by OHCA, create a limited data set as defined at 45 C.F.R. § 164.514(e)(2), for use in public health, research, or health care operations. Any such limited data sets shall omit all of the identifying information listed in 45 C.F.R. § 164.514(e)(2). Contractor will enter into a valid HIPAA-compliant Data Use Agreement, as described in 45 C.F.R. § 164.514(e)(4), with the limited data set recipient. Contractor will report any material breach or violation of the data use agreement to OHCA immediately after it becomes aware of any such material breach or violation.
- If authorized to do so in writing by OHCA, use or disclose PHI for public health activities in accordance with 45 C.F.R. § 164.512(b)(1)(i)-(iv) and State public health reporting requirements established by the Oklahoma State Department of Health.
- Use or disclose PHI within limitation(s) of OHCA's notice of privacy practices, in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Contractor's use or disclosure of PHI.

Contractor may not use or disclose PHI in a manner that would violate the HIPAA Rules (including but not limited to Subpart E of 45 C.F.R. Part 164) if done by OHCA, except that Contractor may, if necessary:

- Use PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor.
- Disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of Contractor if the disclosure is required by law; or if the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person notifies Contractor of any instances of which it is aware in which the confidentiality of the information has been breached.
- Provide data aggregation services relating to the health care operations of OHCA.

1.1.15.3 Obligations of the Contractor

Contractor is OHCA's Business Associate and agrees to comply with the HIPAA Rules and all other terms as required in this Model Contract.

Contractor agrees not to use or further disclose PHI (including but not limited to electronic PHI) in whole or in part, other than as permitted by this Contract or as Required by Law.

Contractor agrees not to use or disclose information in a manner that would violate the provisions of 42 C.F.R. Part 2 (regarding substance abuse information), 43A O.S. § 1-109 (regarding mental health records), or any other applicable privacy law.

Contractor acknowledges that SoonerSelect Health Plan Enrollee information is confidential and not to be released pursuant to 42 U.S.C. § 1396a(a)(7), 42 C.F.R §§ 431.300 - 431.307 and 63 O.S. § 5018. The Contractor agrees not to release the information governed by these laws and regulations to any other person or entity without the approval of OHCA, or as required by law or court order.

Contractor agrees that SoonerSelect Health Plan Enrollee and Provider information cannot be re-marketed, summarized, distributed, or sold to any other organization without the express written approval of OHCA.

Contractor will not use or further disclose PHI other than as permitted or required by this Contract or as Required by Law, including but not limited to HIPAA.

Contractor will implement, maintain, and document appropriate technical, physical, and administrative safeguards and comply with 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of PHI other than as provided for by this Model Contract, and will protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits for or on behalf of OHCA in accordance with the HIPAA Rules, including but not limited to training all employees, agents, and Subcontractors in HIPAA to protect OHCA's PHI and prevent, detect, contain, and correct security violations in accordance with the HIPAA Rules. The Contractor agrees to report potential known violations of 21 O.S. § 1953 to the OHCA Privacy Officer within one hour of discovery of an unauthorized act. In general, this criminal statute makes it a crime to willfully and without authorization gain access to, alter, modify, disrupt or threaten a computer system.

The Contractor shall report to OHCA any Use or Disclosure of PHI not provided for by this Contract of which it becomes aware, including breaches of Unsecured PHI, as provided herein and in accordance with the HIPAA Rules, including but not limited to 45 C.F.R. § 164.410. Where this Contract requires a shorter notification period than the HIPAA Rules, the Contract provisions control. Contractor shall notify the OHCA Privacy Officer of such breach in writing within one hour from Discovery. Contractor shall be diligent in monitoring systems and taking appropriate measures to become aware of Security Incidents.

The Contractor shall report to OHCA any Security Incident of which it becomes aware within one hour of Discovery of the incident. For purposes of this Model Contract, Security Incident means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system. Examples of Security Incidents include, but are not limited to, unauthorized use of a system for processing, accessing, or storing ePHI; changes to system hardware, firmware, or software without Contractor's consent; or suspicious patterns of DDoS attacks, pings, port scans, and similar exploratory contacts or access attempts. Security Incidents will be reported to the OHCA Privacy Officer and the OHCA Compliance Risk Management Analyst via telephone and email within one hour from Discovery. Notwithstanding anything herein, Contractor may report innocuous Security Incidents consisting of unsuccessful attempts that, in Contractor's reasonable determination, do not present a legitimate risk of unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations (such as random pings, DDoS attempts, port scans, similar exploratory contacts, and unsuccessful log-on attempts) in the form of a brief general summary statement provided via email not more than every 60 days upon OHCA's request.

Contractor will cooperate, if requested, with OHCA's breach analysis and response procedures, including risk assessment. Contractor shall cooperate with OHCA in the determination as to whether a Breach of Unsecured PHI has occurred and whether notice to Individuals and/or other entities is required. Contractor will investigate the potential Breach and report its findings to OHCA, and will continuously provide OHCA with additional information related to a suspected or actual Breach as it becomes available.

In the event that OHCA informs Contractor that (i) OHCA has determined that the affected Individuals must be notified because a Breach of unsecured PHI has occurred; and (ii) Contractor is in the best position to notify the affected Individuals of such Breach, Contractor shall, within ten days from receipt of such notice, provide a draft letter for OHCA to approve for use in notifying the Individuals, and upon OHCA's approval, Contractor shall give the required notice (1) within the time frame defined by 45 C.F.R. § 164.404(b); (2) in a form and containing such information reasonably requested by OHCA; (3) containing the content specified in 45 C.F.R. § 164.404(c); and (4) using the method(s) prescribed by 45 C.F.R. § 164.404(d). In addition, in the event that OHCA indicates to Contractor that OHCA will make the required notification, Contractor shall promptly take all other actions reasonably requested by Covered Entity related to the obligation to provide a notification of a Breach of unsecured PHI under 45 C.F.R. § 164.400 *et seq.*

In addition, the Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of this Model Contract. If OHCA requests, Contractor shall promptly submit a proposed remediation plan to address the Breach and prevent further Breaches for OHCA's approval. Once approved by OHCA, Contractor will remediate the Breach in accordance with the approved plan.

In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, the Contractor will ensure that any Subcontractors, vendors, and agents to whom it provides PHI or that create, receive, maintain, transmit, or access PHI on behalf of the Contractor agree to the same restrictions, conditions and requirements that apply to the Contractor with respect to such information. The Contractor must obtain satisfactory written assurance of this obligation, in the form of a HIPAA-compliant business associate agreement, from the Subcontractor, vendor, or agent. Contractor will provide a copy to OHCA upon request.

Contractor will make available, in a timely manner, PHI maintained by Contractor in a Designated Record Set to OHCA, or if directed by OHCA, to an Individual as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.524, including, if requested, a copy in electronic format.

Contractor will, in a timely manner, make any amendment(s) to PHI in a designated record set as directed or agreed to by OHCA pursuant to 45 C.F.R. § 164.526 at the request of OHCA or an Individual, and take other measures as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.526, including the obligation to make PHI available in a timely manner for amendment.

The Contractor shall maintain and make available the information necessary to provide an accounting of disclosures to OHCA as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528. Contractor will provide all such information requested by OHCA within 15 days from OHCA's request. If directed by OHCA, Contractor agrees to provide all such information to an Individual, as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528. Contractor shall meet documentation and retention requirements as necessary to satisfy OHCA's obligations under 45 C.F.R. § 164.528.

To the extent the Contractor is to carry out one or more of OHCA's obligations under Subpart E of 45 C.F.R. Part 164, the Contractor shall comply with the requirements of Subpart E that apply to OHCA in the performance of such obligations.

The Contractor shall make its internal policies, procedures, practices, books and records related to the use and disclosure of PHI received from, or created or received by Contractor on behalf of OHCA available to the Secretary for purposes of determining compliance with HIPAA Rules.

Contractor will indemnify and hold OHCA harmless from all liability, costs, expenses, claims, or other damages that OHCA or any of its directors, officers, agents, or employees may sustain as a result of Contractor's breach or Contractor's Subcontractor's, Affiliate's, Agent's, employee's or independent contractor's breach, of its obligations under this section.

Contractor will respond to OHCA's request for confirmation and certification of Contractor's ongoing compliance with the HIPAA Rules, including but not limited to conducting regular security audits and assessments as necessary to evaluate its security and privacy practices.

Contractor will timely provide OHCA with all information, documentation, or other artifacts, access, and resources needed for OHCA to conduct or comply with required audits, inspections, assessments, or evaluations.

Contractor will not receive remuneration from a third party in exchange for disclosing PHI received from or on behalf of OHCA.

Except as otherwise provided for in this Model Contract, any disclosure of OHCA data shall be approved in advance and in writing by OHCA and then only to persons expressly authorized to review such information under applicable federal or State laws. If Contractor, employees, or Subcontractors disclose(s) or attempt(s) to disclose OHCA data, an injunction may be sought to prevent that disclosure as well as any other remedies of law that may be available. Contractor shall provide written notice to OHCA of any use or disclosure of OHCA data not provided for by this Contract of which Contractor becomes aware within five Calendar Days of its discovery.

Notwithstanding anything to the contrary herein, Contractor shall promptly provide written notice to OHCA upon receipt of a subpoena or other legal process that seeks disclosure of OHCA data, so that OHCA may have the opportunity to seek a protective order, on its own behalf, with respect to such data. Contractor will, to the extent allowed by law, fully cooperate with any attempt by OHCA to seek such a protective order, including but not limited to withholding from production any data before OHCA has had a reasonable opportunity to seek such an order or to seek review of the denial of such an order or the issuance of an order that OHCA deems insufficiently protective.

1.1.15.4 Obligations of Contractor upon Termination

Upon termination of this Contract for any reason, the Contractor, with respect to PHI received from OHCA, or created, maintained or received by the Contractor on behalf of OHCA, shall:

- Retain only that PHI which is necessary for the Contractor to continue its proper management and administration or to carry out its legal responsibilities;
- Return to OHCA or, if agreed to by OHCA, and if feasible destroy the remaining PHI that the Contractor still maintains in any form. If return or destruction is not feasible, Contractor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
- Extend the protections of this Contract and continue to use appropriate safeguards to protect PHI it maintains in any form and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic

PHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as the Contractor retains the PHI; and

- Return to OHCA or, if agreed to by OHCA, destroy the PHI retained by the Contractor when it is no longer needed by the Contractor for its proper management and administration or to carry out its legal responsibilities.

The Contractor will transmit the PHI to another Business Associate or designee of OHCA at termination and the Contractor is obligated to obtain or ensure the destruction of PHI created, received or maintained by Subcontractors. Contractor shall send OHCA written certification on oath of such destruction within 20 days from the date of destruction.

The obligations of the Contractor under Section 1.1.15: “Confidentiality; HIPAA and Business Associate Requirements” of this Model Contract shall survive the termination of the underlying Contract.

1.1.15.5 Obligations of OHCA

OHCA shall notify the Contractor of any limitation(s) in OHCA’s notice of privacy practices, in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Contractor’s use or disclosure of PHI.

OHCA shall notify the Contractor of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent such changes may affect the Contractor’s use or disclosure of PHI.

OHCA shall notify the Contractor of any restriction to the use or disclosure of PHI that OHCA has agreed to or is required to abide by in accordance with 42 C.F.R. § 164.522, or as mandated pursuant to Section 13405(c) of the HITECH Act, to the extent that such restriction may affect the Contractor’s use or disclosure of PHI.

Except to the extent allowed by 45 C.F.R. § 164.502(b), OHCA agrees to make reasonable efforts to disclose to the Contractor only the minimum amount of PHI necessary to accomplish the services covered under this Model Contract.

1.1.15.6 Miscellaneous

Any reference to the HIPAA Rules within this Contract section refers to the HIPAA Rules in current effect. Any ambiguity in this section shall be interpreted to permit compliance with the HIPAA rules.

1.1.15.7 Confidentiality: Substance Use Disorder Diagnosis and Treatment in Compliance with 42 C.F.R. Part 2

The Contractor shall establish policies and procedures to guide Contractor, Affiliates, Subsidiaries, employees and independent contractors in properly disclosing Substance Use Disorder diagnosis and treatment information about Health Plan Enrollees in compliance with 42 C.F.R. Part 2 and 43A O.S. § 43A-1-109 and shall ensure compliance with those requirements.

1.1.16 **Conflict of Interest**

The Contractor certifies and agrees that it presently has no interest and shall not acquire any interest, either direct or indirect, which would conflict in any manner or degree with the performance of the Contract.

If Contractor acquires such a conflict it shall notify OHCA in writing within five Business Days.

1.1.17 **Hold Harmless**

The Contractor shall indemnify, defend, protect and hold harmless OHCA and the State and any of its officers, Agents and employees from:

- Any claims for damages or losses arising from any breach of this Contract by the Contractor, its officers, Agents, employees, Subcontractors, or Providers and any of their respective Affiliates;
- Any claims for damages or losses arising from services rendered by any Subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the Contract;
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including but not limited to, disregard of federal or State Medicaid regulations or legal statutes, by the Contractor, its officers, Agents, employees, Subcontractors, or Providers and any of their respective Affiliates, in performance of the Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its officers, Agents, employees, Subcontractors, or Providers and any of their respective Affiliates, by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or State regulations or statutes;
- Any damages or losses arising from any failure of the Contractor, its officers, employees, agents, Subcontractors, or Providers and any of their respective Affiliates to comply with any federal or State laws, regulations, rules, policies or guidance, including but not limited to labor laws and minimum wage laws; and
- Any claims for damages, losses or costs associated with legal expenses, including but not limited to those incurred by or on behalf of OHCA in connection with the defense of claims for such injuries, losses, claims or damages specified above.

Before delivering services under the Contract, the Contractor shall provide adequate demonstration to OHCA that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 1.1.18: "Insurance" of this Model Contract.

1.1.18 **Insurance**

The Contractor shall procure, at its own expense, the following insurance coverage with the applicable liability limits set forth below:

- Automobile insurance;
- Comprehensive liability insurance;
- Errors and omissions insurance;
- Commercial general liability insurance;
- Medical malpractice insurance;
- Professional liability insurance;
- Directors and officers liability insurance;
- Security and privacy liability insurance;
- Property damage insurance; and
- Worker's compensation and employer's liability insurance.

Before commencement of any work in connection with the Contract, the Contractor shall provide proof of such insurance showing annual coverage, and providing proof of coverage annually on the anniversary date thereafter. The Contractor's obligation to maintain insurance coverage under the Contract is a continuing obligation until the Contractor has no further obligation under the Contract. In addition, the Contractor shall promptly notify OHCA of any modification, restriction, or limitation on coverage.

The required insurance policies shall be provided by carriers authorized to do business within Oklahoma and rated as "A+" or higher by the A.M. Best Rating Service. The required insurance policies shall contain the following endorsement:

"The State of Oklahoma and the Oklahoma Health Care Authority are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies, boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be cancelled or materially charged without 30 days' written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company."

The Contractor's Certificates of Insurance shall be incorporated as an attachment to the Contract. Each certificate will state the policy number, the insured and the insurance period. Each insurance policy shall contain a clause that requires OHCA to be notified in writing at least 30 days prior to cancellation and shall name the State of Oklahoma and OHCA as additional named insureds. Such Certificates of Insurance must be submitted to OHCA within 30 days of notification of Contract award and prior to commencement of services under this Model Contract. Upon request by OHCA or the State, the Contractor shall promptly provide proof of any renewals, additions, or changes to such insurance coverage.

The Contractor shall require that each of its Subcontractors, independent contractors, or Affiliates of those entities or individuals, maintain insurance coverage as specified in this section or in the alternative, the Contractor may provide coverage for each Subcontractor's, independent contractor's, agent's, or employees and Affiliates thereof, liability and employees. The provisions of this clause shall not be deemed to limit the liability or responsibility of the Contractor or any of its Subcontractors.

The insurance requirements herein are minimum requirements for this Contract and in no way limit the indemnity covenants contained in this Model Contract. The State in no way warrants that the minimum limits contained herein are sufficient to protect the Contractor from liabilities that arise out of the performance of the work under this Contract by the Contractor, its agents, representatives, employees or Subcontractors, and the Contractor is free to purchase additional insurance.

OHCA reserves the right to review or make modifications to the insurance limits, required coverages, or endorsements throughout the term of this Model Contract, as deemed necessary by OHCA in its sole discretion. Such action will not require a formal Contract amendment. The Contractor shall be in compliance with all applicable insurance laws of the State and federal government throughout the duration of the Contract.

1.1.18.1 Professional Liability Insurance

The Contractor shall obtain and maintain, for the duration of the Contract, professional liability insurance in the amount of at least \$5,000,000 for each occurrence.

No later than June 1 of each Contract year, the Contractor shall advise OHCA if any of its Subcontractors are covered by the Oklahoma Governmental Tort Claims Act and thus, in the Contractor's opinion, do not require professional liability insurance. Such proposed coverage of the Subcontractors by the Oklahoma Governmental Tort Claims Act as a substitute for professional liability insurance is subject to OHCA's approval.

Failure to advise OHCA that it is the Contractor's intention for Subcontractors, independent contractors, agents, or employees or affiliates thereof, to utilize such insurance coverage in lieu of professional liability insurance will result in the Contractor being obligated to substitute professional liability insurance for said Subcontractors during the Contract term.

1.1.18.2 Minimum Liability and Property Damage Insurance

The Contractor shall obtain, pay for and keep in force:

- Commercial general liability insurance covering the risks of personal injury, bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of liability of not less than \$5,000,000 per occurrence;
- Automobile liability insurance with limits of liability of not less than \$5,000,000 combined single limit each accident; and
- Insurance against liability for property damages, as well as first party fire insurance, including contents coverage for all records maintained pursuant to the Contract, in the amount of \$5,000,000 for each occurrence.

1.1.18.3 Directors and Officers Liability Insurance

The Contractor shall obtain, pay for and keep in force directors and officers liability insurance which shall include employment practices liability as well as consultant's computer errors and omissions coverage, with limits not less than \$5,000,000 per occurrence.

1.1.18.4 Security and Privacy Liability Insurance

The Contractor shall obtain, pay for and keep in force security and privacy liability insurance, including coverage for failure to protect confidential information and failure of the security of the Contractor's computer systems that results in unauthorized access to OHCA data with limits \$10,000,000 per occurrence.

1.1.18.5 Errors and Omissions Insurance

The Contractor shall obtain, pay for and keep in force for the duration of the Contract errors and omissions insurance in the amount of \$10,000,000.

1.1.18.6 Workers' Compensation and Employer's Liability Insurance

The Contractor shall obtain, pay for and keep in force for the duration of the Contract worker's compensation and employer's liability insurance in accordance with and to the extent required by applicable law.

1.1.18.7 Reinsurance

The Contractor shall have the option of purchasing reinsurance from a commercial reinsurer. The Contractor may elect to self-insure based upon the Contractor's ability to survive a series of adverse financial events. The Contractor shall provide to OHCA the risk analysis, assumptions, cost estimates and rationale supporting its proposed reinsurance arrangements. OHCA reserves the right to require the

Contractor to modify its coverage arrangements and level of coverage, including reinsurance attachment point and coinsurance percentage, if the Contractor's proposed coverage is deemed insufficient, or its cost excessive.

1.1.19 Ownership of Data and Reports

Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under the Contract shall be deemed to be owned by the State of Oklahoma. This provision is made in consideration of the Contractor's use of public funds in collecting or preparing such data, information and reports.

1.1.20 Intellectual Property Infringement, Hold Harmless and Specific Performance

Contractor represents that it owns and/or has secured all intellectual property rights and all other rights, approvals, and releases necessary to provide the services pursuant to this Model Contract. The Contractor represents that, to the best of its knowledge, none of the software or any other products, information, or materials to be used, developed or provided pursuant to the Contract violates or infringes upon any patent, copyright, trademark, trade secret, or any other right of a third party.

If any claim or suit is brought against OHCA for the alleged infringement of such patents, copyrights, trademarks, trade secrets, or any other proprietary property arising from the Contractor's products, materials or services provided by Contractor under this Model Contract, or from OHCA's use thereof, then the Contractor shall, at its expense, hold harmless and defend, at its own expense, all suits, claims or proceedings against OHCA. The Contractor shall satisfy any final award for such infringement (including attorney's fees), whether it is resolved by settlement or judgment involving such a claim or suit.

If use of the products or services in question is held to infringe and the use thereof enjoined, or if in light of the circumstances OHCA determines that it is advisable to do so, Contractor shall, at its own expense, either (i) procure the right for OHCA to continue to use such products or services; (ii) replace the same with products or services which do not give rise to allegations of infringement; or (iii) modify such products or services to remove the basis for allegations of infringement without interruption of services under this Model Contract. Because a breach of these provisions may give rise to damages suffered by OHCA which may be difficult or impossible to ascertain, OHCA may at its option obtain specific enforcement of Contractor's obligations hereunder.

1.1.21 Publicity

Any publicity given to the program or services provided therein, including but not limited to notices, information pamphlets, press releases, research, reports, signs and similar public notices prepared by or for the Contractor or its Subcontractors, shall identify the State of Oklahoma as the sponsor and shall not be released without prior written approval from OHCA. In circumstances where time is of the essence, OHCA will make a good faith effort to review and respond within one business day.

1.1.22 Employment Relationship

This Contract does not create an employment relationship with Contractors, its Agents, Subcontractors, independent contractors, or affiliates thereof. Individuals performing services required by this Contract are not employees of the State of Oklahoma or OHCA. The Contractor's employees shall not be considered employees of the State of Oklahoma, nor of OHCA for any purpose, and accordingly shall not be eligible for rights or benefits accruing to State employees.

1.1.23 Force Majeure

Neither the Contractor nor OHCA shall be liable for any damages or excess costs for failure to perform their Contract responsibilities if such failure arises from causes beyond the reasonable control and without fault or negligence by the Contractor (including its Subcontractors) or OHCA. Such causes may include, but are not limited to, catastrophic events, pandemics or acts of God. In all cases, the failure to perform must be beyond the reasonable control of, and without fault or negligence of, either party or its Subcontractors.

The Contractor shall have in place a disaster recovery plan that has been reviewed and approved by OHCA and that meets the specifications of Section 1.19.9: "Disaster Preparation and Data Recovery" of this Model Contract.

1.1.24 Compliance with Law

The parties hereto acknowledge that this bid process and Medicaid managed care are highly regulated by federal statutes and regulations. The parties further acknowledge that any and all references to Code of Federal Regulation (C.F.R.) citations in this Model Contract, and other statutes and regulations applicable to Medicaid managed care, are to those in effect on October 15, 2020. The parties to this Contract acknowledge and expect that changes may occur over the term of this Contract regarding federal or State Medicaid statutes and regulation and State statutes and rules governing health insurers and the practice of health care professions. In the event any indicated C.F.R. citation, federal or State Medicaid statute or regulation or State statute or rule governing health insurers and the practice of health care professions or related requirements are amended during the term of this Contract, all parties to this Model Contract shall be mutually bound by the amended requirements in effect at any given time following Contract execution.

In accordance with 42 C.F.R. § 438.3(f)(1), the Contractor shall comply, and shall ensure that its officers, employees, Providers, Subcontractors and their respective Affiliates comply, with all applicable federal and State laws, regulations, rules, policies and guidance including but not limited to:

- Title VI of the Civil Rights Act of 1964;
- The Age Discrimination Act of 1975;
- The Rehabilitation Act of 1973;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- The Americans with Disabilities Act of 1990 as amended;
- Section 1557 of the Patient Protection and Affordable Care Act (ACA);
- Healthcare Insurance Portability and Accountability Act, 42 U.S.C. 290dd-2;
- Mental Health Parity and Addiction Equity Act, 42 C.F.R. Part 2;
- Oklahoma Electronic Information Technology Accessibility (EITA) Act (Oklahoma 2004 HB 2197) regarding information technology accessibility standards for persons with disabilities;
- Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;
- Oklahoma Worker's Compensation Act, 85A O.S. §1 *et seq.*;
- 74 O.S. § 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225 or 230 as applicable to the Contractor's entity) purchased with monies received from OHCA pursuant to this Contract;
- Title 317 of the Oklahoma Administrative Code ("OAC");

- Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and
- Deceptive Trade Practices; Unfair Business Practices
 - Contractor represents and warrants that neither Contractor nor any of its Subcontractors:
 - Have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §751 *et seq.*;
 - Have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding;
 - Have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violation; and,
 - Have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation or other proceeding.

In accordance with 42 C.F.R. § 438.100(a)(2), the Contractor shall also comply with any applicable federal and State laws that pertain to Health Plan Enrollee rights and ensure that its employees and Participating Providers observe and protect those rights.

The explicit inclusion of some statutory and regulatory duties in this Contract shall not exclude other statutory or regulatory duties.

All questions pertaining to the validity, interpretation and administration of this Contract shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed.

The venue for civil actions arising from this Contract shall be Oklahoma County, Oklahoma. For the purpose of federal jurisdiction, in any action in which the State of Oklahoma is a party, venue shall be United States District Court for the Western District of Oklahoma.

If any portion of this Contract is found to be in violation of State or federal statutes, that portion shall be stricken from this Contract and the remainder of the Contract shall remain in full force and effect.

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

1.1.25 Titles Not Controlling

Titles of paragraphs used herein are for the purpose of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

1.1.26 Counterparts

The Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

1.1.27 Administrative Procedures Not Covered

Administrative procedures not covered in the Contract will be set forth where necessary in separate memoranda from time to time.

1.1.28 Days Terminology

Unless otherwise specified, “days” as used in this Contract shall mean Calendar Days.

1.1.29 Performance Bond or Substitutes

The Contractor shall furnish a performance bond, cash deposit, US Treasury Bill or an irrevocable letter of credit. The performance bond shall be in a form acceptable to OHCA. For Contractors who are self-insured, the value of the performance bond or substitute shall not be less than \$25,000,000.00.

If a cash deposit is used, it must be placed in different financial institutions to a maximum of \$250,000 per deposit. If a letter of credit is used, it must be issued by a bank or savings and loan institution doing business in the State of Oklahoma and insured by the Federal Deposit Insurance Corporation or a credit union doing business in the State of Oklahoma and insured by the National Credit Union Administration.

The amount of the performance bond, cash deposit or letter of credit shall be one dollar for each capitation dollar expected to be paid to Contractor in month one of the Rating Period.

This requirement must be satisfied within ten Business Days following notification by OHCA of the required amount. Thereafter, OHCA shall evaluate enrollment and Capitation Payment data on a monthly basis. If there is an increase in Contractor’s monthly Capitation Payment that equals or exceeds ten percent above the payment amount used to calculate the performance bond, cash deposit, US Treasury bill or letter of credit requirement, OHCA shall require a commensurate increase in the amount of the performance bond, cash deposit, US Treasury bill or letter of credit. The Contractor shall have ten Business Days to comply with any such increase.

OHCA may, at its discretion, permit the Contractor to offer substitute security in lieu of a performance bond, cash deposit, US Treasury bill or letter of credit. In that event, the Contractor shall be solely responsible for establishing the credit worthiness of all forms of substitute security. The Contractor also shall agree that OHCA may, after supplying written notice, withdraw its permission for substitute security, in which case the Contractor shall provide OHCA with a form of security as described above.

In the event of termination for default, as described in Section 1.24: “Termination” of this Model Contract, the performance bond, cash deposit, US Treasury bill, letter of credit or substitute security shall become payable to OHCA for any outstanding damage assessments against the Contractor. Up to the full amount also may be applied to the Contractor’s liability for any administrative costs and/or excess medical or other costs incurred by OHCA in obtaining similar services to replace those terminated as a result of the default. OHCA may seek other remedies under law or equity in addition to this stated liability.

1.2 Payments to Contractor

OHCA shall pay the Contractor a monthly Capitation Payment for each Health Plan Enrollee through the MMIS, in accordance with the rate schedule provided in the bidder's library. The Contractor and OHCA agree that Capitation Payments must be in accordance with 42 C.F.R. § 438.3(c) and approved as actuarially sound by CMS in accordance with 42 C.F.R. § 438.4. Capitation rates shall be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles.

The Contractor agrees the Capitation Payment shall represent OHCA's payment in full (subject to any risk mitigation and risk adjustment provisions) for all services furnished under this Model Contract. In accordance with 42 C.F.R. § 438.3(c)(2), Capitation Payments may only be made by OHCA and retained by the Contractor for Medicaid-eligible Health Plan Enrollees.

The Contractor shall accept payment from OHCA by direct deposit to Contractor's financial institution. OHCA shall make payment in accordance with information supplied by Contractor via an electronic funds transfer (EFT) form to be provided by OHCA. The Contractor shall update direct deposit information as needed by sending a signed EFT form to OHCA.

1.2.1 Payment Schedule

The Contractor shall be notified of Enrollment and Disenrollment updates through receipt of outbound ANSI ASC X 12 834 electronic transactions. The Contractor shall receive notification of Capitation Payment through receipt of an ASC X12N 820 electronic transaction. Capitation Payment will be made through electronic funds transfer in accordance with a schedule to be published by OHCA.

1.2.2 Capitation Reconciliation

The Contractor shall be responsible for performing a monthly reconciliation of enrollment roster data against Capitation Payments and notifying OHCA of discrepancies in a manner and on a schedule to be defined by OHCA.

1.2.3 Report of Capitation Overpayment

In accordance with 42 C.F.R. § 438.608(c)(3), the Contractor shall report to OHCA within 30 days when it has identified Capitation Payments or other payments in excess of amounts specified in the Contract.

1.2.4 Capitation Payment Recoupment

OHCA shall be the sole determiner of a Health Plan Enrollee's Enrollment and Disenrollment effective dates, as described in Section 1.5: "Enrollment and Disenrollment" of this Model Contract. For Health Plan Enrollees whose enrollment lapses for any portion of a month in which a Capitation Payment was made, as described in Section 1.5.7.4: "Disenrollment Effective Date" of this Model Contract, OHCA shall adjust the Capitation Payment through a reconciliation process to be defined by the OHCA.

1.2.5 Capitation Rate Changes

Material programmatic changes made during the Rating Period that affect Capitation Payment rates shall result in an adjustment to the rates, to be calculated by OHCA's consulting actuary. The rate change(s) shall be included in the Contract amendment issued to the Contractor in accordance with the provisions outlined in Section 1.1.9: "Amendments or Modifications" of this Model Contract.

1.2.6 **Capitation Withhold**

OHCA shall withhold one percent of the Contractor's Capitation Payments beginning January 1, 2022. The Contractor shall be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in Appendix 1D: "Pay for Outcomes." OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment.

1.3 **Administrative Requirements**

1.3.1 **Licensure**

The Contractor shall be licensed as a Health Maintenance Organization (HMO) pursuant to 36 O.S. § 6901, *et seq.* or a Domestic Insurer pursuant to OAC 365:25-7-11 and related provisions of the Oklahoma Insurance Code. A Certificate of Authority must be furnished to OHCA upon Contract award and must include all Oklahoma counties. If at any time during the term of the Contract, the Contractor incurs any change in status, including impairment, censure, or loss of clinical licensure(s), State approval and/or qualifications as an HMO or Domestic Insurer in any geographic area covered under the Contract, such loss shall immediately be reported to OHCA. Such loss may be grounds for termination of the Contract under the provisions of Section 1.24.1: "Early Termination" of this Model Contract.

1.3.2 **Accreditation**

The Contractor shall be accredited by an Accrediting Entity within 18 months of Contract award. If the Contractor is undergoing accreditation, the Contractor shall submit reports documenting the status of the accreditation process as required by OHCA. In accordance with 42 C.F.R. § 438.332(a), the Contractor shall inform OHCA when it has been accredited.

In accordance with 42 C.F.R. § 438.332(b), the Contractor shall authorize the Accrediting Entity to provide OHCA a copy of the Contractor's most recent accreditation review, including:

- Accreditation status, survey type, and level (as applicable);
- Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and
- Expiration date of the accreditation.

OHCA and the Contractor shall post information about the Contractor's accreditation status on OHCA and the Contractor's website. The posted accreditation information shall include the name of the Accrediting Entity, accreditation program, and accreditation level. The website information shall be updated at least annually.

The Contractor shall undergo reaccreditation in accordance with the timeframes required by the Accrediting Entity and federal regulations. Failure to achieve or maintain accreditation in accordance with the provisions of this Model Contract shall be considered a breach of this Model Contract and may result in penalties or termination.

1.3.3 **Subcontracting**

The Contractor may enter into written subcontract(s) for performance of certain responsibilities listed in the Contract. All subcontracts must be in writing and fulfill the requirements of 42 C.F.R. §§ 438.230 and 438.3(k) that are appropriate to the service or activity being delegated. The Contractor shall make available all subcontracts in electronic format for inspection by OHCA and all Subcontractors, including Major Subcontractors, will be approved in advance by OHCA.

If the Contractor uses a Major Subcontractor, as defined below, the Contractor shall obtain OHCA's consent prior to the effective date of any subcontract. A Major Subcontractor is defined as:

- Administrative – Entity anticipated being paid \$2,000,000 or more for Health Plan Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing and Health Plan Enrollee/Provider education;
- Health Service – Entity, not including Participating Providers, that has an executed agreement to deliver or arrange for the delivery of any physical health, behavioral health or pharmacy benefit covered under the Contract in accordance with Section 1.6: "Covered Benefits" of this Model Contract.

If the Contractor proposed a Major Subcontractor in its response to the RFP, and this was accepted by OHCA, no separate OHCA consent is required. Subcontractors include Subsidiaries and Affiliates of the Contractor.

The Contractor shall be responsible for the performance of all Subcontractors and shall be wholly responsible for meeting all the terms of the Contract. The Contractor shall actively monitor Subcontractors to ensure their compliance with the Contract and verify the quality of their services.

No subcontract or delegation shall relieve or discharge the Contractor from any obligation or liability under the Contract. Any Major Subcontractor shall be subject to the same conditions as the Contractor, including Contract modifications subsequent to award, confidentiality, audit, certifications, and other relevant Contract terms.

In accordance with 42 C.F.R. § 438.230(c), if any of the Contractor's activities or obligations under the Contract with OHCA are delegated to a Subcontractor, the activities and obligations, and related reporting responsibilities, must be specified in the Contract or written agreement between the Contractor and the Subcontractor. The Contract or written agreement must also:

- Provide for revocation of the delegation of activities or obligations, or must specify other remedies in instances where OHCA or the Contractor determines that the Subcontractor has not performed satisfactorily;
- Require Subcontractor compliance with all applicable Medicaid laws, regulations, and applicable subregulatory guidance and Contract provisions;
- Specify that the Subcontractor agrees that the State, CMS, the DHHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract for ten years from the later of final date of the Contract period or from the date of completion of any audit; and specify that the Subcontractor will make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Medicaid enrollees; and
- Specify that if the State, CMS, or the DHHS Inspector General determine that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

The Contractor shall provide OHCA written notice at least 30 days in advance of any contractual changes in subcontracted services. Notice of these changes shall include a written transition plan describing how

the Contractor will notify Health Plan Enrollees of the change and how the Contractor will maintain continuity of care for those affected Health Plan Enrollees. At its discretion, OHCA may elect to conduct a Readiness Review of the Contractor and/or Subcontractor(s) pursuant to a change in subcontracted services, to ensure continued compliance with Contract terms.

The Contractor shall provide immediate notice to OHCA of any action or suit filed, including a bankruptcy filing, and of any claim made against the Contractor or its Subcontractor(s) that, in the opinion of the Contractor, may result in litigation related in any way to the Contract with OHCA.

OHCA shall consider the Contractor to be the sole point of contact with regard to contractual matters, including all charges and payments resulting from the Contract.

1.3.4 Business Relationship Disclosure

The Contractor shall provide to OHCA information on its business relationships. This includes any applicable parent organizations, joint ventures, affiliates, subsidiaries and other related parties of the Contractor. The Contractor and its Subcontractors shall agree to disclose business transaction information upon request of OHCA and as otherwise specified in federal and state regulations.

1.3.5 Oklahoma Presence

The Contractor shall have an office, no more than 25 miles from OHCA office, from which, at a minimum, Key Staff members in accordance with Section 1.3.6.2: “Key Staff” of this Model Contract, physically perform the majority of their daily duties and responsibilities, and a major portion of the Contractor’s operations take place. The Contractor shall maintain the following roles and positions at the Oklahoma Office:

- Health Plan Enrollee services staff;
- Health Plan Enrollee care support staff;
- Provider services staff;
- Care managers;
- Tribal Government liaison staff;
- Program Integrity staff;
- Grievances and Appeals staff; and
- Quality management staff.

The Contractor may maintain certain Key Staff such as Care Managers and Health Plan Enrollee Services staff throughout Oklahoma in order to best serve the needs of the Health Plan Enrollees. Any staff working outside of the 25 mile radius of OHCA office must be approved by OHCA.

Additionally, the following staff must be located and operate within 25 miles of OHCA office:

- Health Plan Enrollee services call center as required under Section 1.11.7: “Health Plan Enrollee Services Call Center” of this Model Contract; and
- Provider services call center as required under Section 1.13.2: “Provider Services Call Center” of this Model Contract.

The Contractor shall ensure the location of any staff or operational functions outside of Oklahoma does not compromise the delivery of integrated services to Health Plan Enrollees and Providers. The Contractor shall be responsible for ensuring all staff functions conducted outside of Oklahoma are readily reportable

to OHCA to ensure such location does not hinder OHCA's ability to monitor the Contractor's performance and compliance with Contract requirements.

The Contractor shall enforce Tobacco-Free policies covering 100% of the Contractor's offices statewide. This is an evidence-based intervention for smoking cessation as tobacco free policies create environments that make it much easier to quit and stay quit.

1.3.5.1 Prohibition on Off-Shoring

In accordance with 42 C.F.R. § 438.602(i), the Contractor shall not enter into any subcontract which uses any public funds within its control to purchase services which will be provided outside the United States. This reflects prohibition on the purchase of offshore services. As requested by OHCA, the Contractor shall:

- Disclose the location(s) where all services will be performed by the Contractor and Subcontractor(s);
- Disclose the location(s) where any State data associated with any of the services are provided, or seek to be provided, will be accessed, tested, maintained, backed-up or stored;
- Disclose any shift in the location of services being provided by the Contractor or Subcontractor(s); and
- Disclose the principal location of business for the Contractor and all Subcontractor(s) who are supplying services to the State of Oklahoma under the proposed Contract(s).

If contracted or subcontracted services shall be performed at multiple locations, the known or anticipated value of the services performed shall be identified and reported to OHCA. This information and economic impact on Oklahoma and its residents may be considered in the evaluation.

The Contractor may perform some development functions outside of Oklahoma but within the continental United States. Oklahoma health data must never leave the continental United States. If any Contractor's or Subcontractor(s) work identified for performance in the United States is moved to another country, outside the continental United States, such action may be deemed a breach of the Contract.

1.3.6 **Staffing**

The Contractor shall have sufficient staff to meet all Contract standards. Pursuant to the Oklahoma Privatization Act, 74 OS § 588 *et seq*, the Contractor shall be required to offer available employee positions pursuant to the Model Contract to qualified regular employees of the agency whose state employment is terminated because of the privatization contract and who satisfy the hiring criteria of the Contractor. This includes, at a minimum, the following:

- Key Staff in accordance with Section 1.3.6.2: "Key Staff" of this Model Contract;
- Utilization and medical management staff dedicated to performing utilization management and review activities in accordance with Section 1.7: "Medical Management" of this Model Contract;
- Care managers to staff the Contractor's care management and population health programming required under Section 1.8: "Care Management and Population Health" of this Model Contract;
- Health Plan Enrollee care support staff as described under Section 1.3.6.4: "Health Plan Enrollee Care Support Staff" of this Model Contract;
- Quality management staff dedicated to quality management and improvement activities in accordance with Section 1.10: "Quality" of this Model Contract;

- Grievances and Appeals staff to ensure the timely and accurate processing of all Grievances and Appeals in accordance with Section 1.16: “Health Plan Enrollee Grievances and Appeals” of this Model Contract;
- Provider reconsiderations and appeals staff to ensure timely and accurate processing of all reconsiderations and appeals in accordance with Section 1.13.6: “Provider Complaint System” of this Model Contract;
- Technical support staff to ensure the timely and efficient maintenance of all health information management system functionality, including Encounter Data reporting, required under Section 1.19: “Information Technology” of this Model Contract;
- Health Plan Enrollee services, Marketing and outreach staff to conduct all Health Plan Enrollee activities required under Section 1.11: “Health Plan Enrollee Services” of this Model Contract;
- Compliance and reporting staff to complete all reporting required under Section 1.21: “Reporting” of this Model Contract;
- Program integrity staff to comply with the requirements of Section 1.18: “Program Integrity” of this Model Contract;
- Provider services staff to develop the Contractor’s network and coordinate communications with Participating and Non-Participating Providers as required under Section 1.13: “Provider Services” of this Model Contract;
- Claims processing staff sufficient to meet the timely claims processing standards in Section 1.14.4.2: “Timely Claims Filing and Processing” of this Model Contract;
- Accounting and finance staff; and
- Website staff to maintain and update the Contractor’s Health Plan Enrollee and Provider websites.

The Contractor may combine functions as long as it is able to demonstrate that all tasks are being performed. The Contractor may also use administrative service organizations to perform some or all of the above functions, subject to the conditions specified in Section 1.3.3: “Subcontracting” of this Model Contract.

In addition to meeting the requirements delineated elsewhere in the Contract, the Contractor’s staffing shall comply with the requirements listed below.

1.3.6.1 Board of Directors

The Contractor shall have a Board of Directors specifically constituted for purposes of this Model Contract and any subsequent contracts with OHCA.

1.3.6.2 Key Staff

The Key Staff positions required under the Contract include:

- *Chief Executive Officer (CEO)* who shall have ultimate responsibility for the administration and implementation of all Contract provisions.
- *Chief Financial Officer (CFO)* who shall oversee the budget and accounting systems under the Contract and ensure compliance with Contract requirements for financial performance and reporting.
- *Compliance Officer* who shall, in accordance with 42 C.F.R. § 438.608, be responsible for developing and implementing policies, procedures and practices designed to ensure Contract compliance and shall report directly to the CEO and Board of Directors. The Compliance Officer

shall be responsible for oversight and evaluation of any Contractor corrective actions required to correct non-compliance in accordance with the requirements of Section 1.23: “Non-Compliance Remedies” of this Model Contract.

- *Care Management Director* who shall oversee the Contractor’s care management and population health model in accordance with Section 1.8: “Care Management and Population Health” of this Model Contract.
- *Information Systems Director* who shall oversee, manage and maintain the Contractor’s management information systems in accordance with the requirements of Section 1.19: “Information Technology” of this Model Contract. The Information Systems (IS) Director will serve as a liaison between the Contractor and the State regarding encounter claims submissions, capitation payment, Health Plan Enrollee eligibility, enrollment and other data transmission interface and management issues. The IS Director, in close coordination with other Key Staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The IS Director is responsible for attending all technical meetings called by the State. If the IS Director is unable to attend a technical meeting, the IS Director shall designate a representative to take his or her place.
- *Chief Medical Officer* who shall be board-certified and currently licensed in Oklahoma as a medical doctor or doctor of osteopathy.
- *Health Plan Enrollee Services Director* who shall oversee all Health Plan Enrollee services functionality in accordance with Section 1.11: “Health Plan Enrollee Services” of this Model Contract.
- *Provider Services Director* who shall oversee all Provider services and network development functionality in accordance with Section 1.13: “Provider Services” of this Model Contract. The Provider Services Director is responsible for managing a staff of provider representatives who assist SoonerSelect Providers. The Provider Services Manager is also responsible for the growth and retention of SoonerSelect Providers, creating a qualified and comprehensive Provider network.
- *Utilization Management Director* who shall be responsible for the operation of the Contractor’s utilization management functionality in accordance with the requirements of Section 1.7: “Medical Management” of this Model Contract. The Utilization Management (UM) Director will serve as a liaison between the Contractor and the State regarding Prior Authorization reviews, prepayment retrospective reviews, and any additional utilization management functions. The UM Director, in close coordination with other Key Staff, is responsible for ensuring all utilization reviews are in compliance with the terms of the Contract.
- *Quality Management Director* who shall be responsible for operation of the Contractor’s QAPI program in accordance with the requirements of Section 1.10: “Quality” of this Model Contract. The Quality Management Director will be responsible for developing and managing the Contractor’s portfolio of improvement projects and will work collaboratively with all Contractor’s and OHCA to improve population health outcomes, including addressing health equity and Social Determinants of Health.
- *Behavioral Health Director* who shall be licensed in Oklahoma as a behavioral health professional and responsible for oversight of all behavioral health initiatives and services delivered under the Contract. If the Contractor subcontracts for the provision of Behavioral Health Services, the

Behavioral Health Director shall be responsible for oversight and Contract compliance of the Subcontractor.

- *Data Compliance Manager* who shall provide oversight to ensure all Contract data conforms to OHCA data standards and policies. The Data Compliance Manager shall have extensive experience in managing data quality and exchange processes, including data integration and verification.
- *Pharmacy Director* who shall be an Oklahoma licensed pharmacist. The Pharmacy Director shall represent the Contractor at all meetings of the State’s DUR Board. If the Contractor subcontracts with a PBM, the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM. The Pharmacy Director may not be an employee of the PBM/PBA.
- *Health Plan Enrollee Advocate* who shall be responsible for representation of Health Plan Enrollee’s interest, including input in policy development, planning and decision-making. The Health Plan Enrollee Advocate should have lived experience as a Health Plan Enrollee. The Health Plan Enrollee Advocate shall be responsible for development and oversight of the Health Plan Enrollee Advisory Board.
- *Grievances & Appeal Manager* who shall manage the Contractor’s Grievance and Appeal System in accordance with the requirements of Section 1.16: “Health Plan Enrollee Grievances and Appeals” of this Model Contract.
- *Claims Manager* who shall be responsible for ensuring prompt and accurate claims processing in accordance with the requirements of Section 1.14.4: “Claims Processing” of this Model Contract. The Claims Manager shall also be responsible for managing a staff of claims representatives who monitor billing activities, provide technical assistance, and ensure encounter claims submitted are for actual rendered services performed and meet medical necessity.
- *Transition Coordinator* who shall oversee all Health Plan Enrollee transitions and Contractor compliance with all policies in accordance with the requirements of Section 1.9: “Transition of Care” of this Model Contract.
- *Tribal Government Liaison* who shall be responsible for outreach to Health Plan Enrollees, IHCPs, I/T/Us and Indian Tribe representatives. The Tribal Government Liaison shall serve as a resource to and advocate for AI/AN Health Plan Enrollees and IHCPs in their interactions with the Contractor.
- *Program Integrity Lead Investigator* who shall be responsible for oversight of all Provider or Health Plan Enrollee investigations related to possible Fraud, Waste, or Abuse and coordinating all referrals, investigations, and audits with OHCA in accordance with the requirements of Section 1.18: “Program Integrity” of this Model Contract.
- *Internal Audit Director* who shall serve as an independent party, responsible for oversight of the Contractor’s risk management process. The Internal Audit Director shall analyze operations and critically assess compliance with all requirements as outlined in this Model Contract.

All Key Staff shall be dedicated full-time to the SoonerSelect Contract and based in Oklahoma as required under Section 1.3.5: “Oklahoma Presence” of this Model Contract. OHCA reserves the right to interview any Key Staff, approve or deny the individuals filling Key Staff positions, and request reassignment of Key Staff.

1.3.6.3 Care Management

The Contractor’s care management function shall include sufficient management, supervisory level, direct care, and support staff to support timely Health Risk Screenings, Comprehensive Assessments, Care Plan

development and Health Plan Enrollee interventions in accordance with the Contractor's Risk Stratification Level Framework and the standards described in Section 1.8: "Care Management and Population Health" of this Model Contract.

1.3.6.4 Health Plan Enrollee Care Support Staff

The Contractor shall include within care management, Health Plan Enrollee services, or both, dedicated Health Plan Enrollee care support staff with responsibility for assisting Health Plan Enrollees by:

- Advocating on behalf of a Health Plan Enrollee and his or her preferences with respect to receiving Health Plan Enrollee- and family-centered care;
- Assisting the Health Plan Enrollee to access community-based resources to address non-medical needs and to support the Health Plan Enrollee's Care Plan objectives and independence;
- Obtaining information about available SoonerCare services;
- Helping them with the filing of Grievances and Appeals; and
- Outreach and engagement including, but not limited to re-enrollment and PCMH Provider assignment.

1.3.6.5 Pharmacy Benefit Manager Liaison

The Contractor, or to the extent the Contractor subcontracts with a Pharmacy Benefit Manager, shall employ a State liaison with whom OHCA may communicate directly. The state liaison also must be available for direct communication with pharmacy Providers to resolve issues and to work directly with OHCA to resolve drug rebate disputes or other issues that arise from Contractor's pharmacy and medical claims files. If employed by the Contractor, this role shall not be filled by the Pharmacy Director.

1.3.6.6 Staffing Plan and Implementation Plan

The Contractor shall provide the following for OHCA review and approval no later than 30 days after Contract execution:

- Identification of the Contractor's implementation team;
- Names of the Board of Directors and their current resumes;
- Implementation plan; and
- Hiring and staffing plan which includes a description of the Contractor's diversity and inclusion plans.

The Contractor shall provide regular status updates to OHCA on implementation plan and hiring and staffing plan activities during the Readiness Review, in the timeframe and manner required by OHCA.

1.3.6.7 Changes in Board of Directors and Key Staff

The Contractor shall notify OHCA of all changes in composition of the Board of Directors and Key Staff. The Contractor shall notify OHCA at least five days in advance of the change, whenever practical. The Contractor shall submit a current resume and job description for the new Board of Directors or Key Staff position for OHCA's review.

1.3.6.8 Staff Training

The Contractor shall ensure all staff and Subcontractor staff receive adequate training on the requirements, policies and procedures of the SoonerSelect program. All Contractor staff shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under this Model Contract.

The Contractor shall ensure distinct staff training for the following positions:

- Health Plan Enrollee Services Call Center that meets the minimum requirements of Section 1.11.7.3: “Call Center Training” of this Model Contract;
- Provider Services Call Center that meets the minimum requirements of Section 1.13.2: “Provider Services Call Center” of this Model Contract;
- Care managers that meets the minimum requirements of Section 1.8.4.4: “Training” of this Model Contract;
- Language and cultural competency training, as described in Section 1.11.2: “Cultural Competency” of this Model Contract, to Subcontractors, Care Managers and all Health Plan Enrollee facing staff; and
- Marketing staff in accordance with Section 1.11.15.2: “Training Curriculum” of this Model Contract.

All Contractor staff and Subcontractors shall receive training on security and compliance in accordance with Section 1.18.2.2: “Compliance Education and Training” of this Model Contract. The Contractor shall track and document completion of all staff training and provide evidence of training completion to OHCA upon request.

1.3.7 Coordination with OHCA

OHCA shall conduct meetings and collaborative workgroups for the SoonerSelect program. The Contractor must comply with all meeting requirements established by OHCA and is expected to cooperate with OHCA and its designees in preparing for and participating in these meetings. This includes presenting best practices for topics identified by OHCA as requested. The Contractor shall send qualified representatives to attend those meetings, as instructed by OHCA. OHCA may also require the participation of Subcontractors, as determined necessary.

OHCA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format, or add meetings to the schedule as it deems necessary. At OHCA’s discretion, the Contractor may be permitted to have representatives attend remotely, rather than in person.

The Contractor shall also participate in meetings and proceedings with external entities as directed by OHCA, including but not limited to, the DUR Board, Medicaid Advisory Committee, and legislative hearings.

1.3.8 Coordination with Other State Agencies

The Contractor shall coordinate with other state agencies, in the manner to be determined by OHCA, to ensure that coordinated care is provided to Health Plan Enrollees. This includes, but is not limited to coordination with:

- The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS);
- The Oklahoma State Department of Health (OSDH);
- The Oklahoma Office of Juvenile Affairs (OJA);
- The Oklahoma Department of Corrections (ODOC);
- The Oklahoma State Department of Education (OSDE);
- The Oklahoma Department of Human Services (DHS); and
- Tobacco Settlement Endowment Trust (TSET).

1.3.9 Policies and Procedures

The Contractor and any Subcontractor(s) shall develop and maintain written policies and procedures for administration of the Contract. The policies and procedures shall describe in detail how the Contractor and any Subcontractor(s) will fulfill the responsibilities outlined in the Contract.

The Contractor and any Subcontractor(s) must submit policies and procedures for OHCA's review and approval prior to their adoption and implementation. The Contractor and any Subcontractor(s) shall furnish policies and procedures to OHCA upon request. OHCA will examine policies and procedures as part of Readiness Review activities described in Section 1.3.10: "Readiness Review" of this Model Contract and may require modifications or additions as part of Readiness Review findings.

OHCA reserves the right to review and approve the Contractor and any Subcontractor(s) policies and procedures and related matters associated with meeting the requirements of this Model Contract. Such review and approval may occur as part of the Contractor's Readiness Review but may also occur as part of ongoing oversight activities. This provision applies to all sections of the Contract regardless of whether a section contains separate language concerning review of policies and policies pertaining to that section.

If OHCA identifies necessary revisions to the Contractor's and any Subcontractor(s) policies and procedures to conform to Contract standards, OHCA shall notify the Contractor of the required changes and the date by which proposed revised policies and procedures must be furnished. The Contractor and any Subcontractor(s) shall not be required to adopt the revised policies and procedures until after OHCA has given approval to the revisions.

OHCA shall require an annual certification from the Contractor attesting to updated policies and procedures and the operational execution of such.

1.3.10 Readiness Review

The Contractor shall be required to participate in a Readiness Review process prior to the start of Eligible enrollment. The Contractor must complete all Readiness Review activities to the satisfaction of OHCA and CMS before being eligible to receive enrollment of Eligibles.

In accordance with 42 C.F.R. § 438.66, the Readiness Review shall include a desk review of Contractor documentation and an on-site review at the Contractor's offices. The Contractor's ability and capacity to perform satisfactorily on the following minimum components shall be assessed during the Readiness Review:

- Administrative staffing and resources;
- Subcontracted functionality;
- Health Plan Enrollee and Provider communications;
- Grievances and Appeals;
- Health Plan Enrollee services and outreach;
- Participating Provider management;
- Program integrity and compliance;
- Care coordination and care planning;
- Quality improvement;
- Utilization management;
- Financial reporting and monitoring;

- Financial solvency; and
- Information technology including claims management, Encounter Data and enrollment information management.

Failure of the Contractor to meet Readiness Review requirements shall subject the Contractor to the remedies in Section 1.23: “Non-Compliance Remedies” of this Model Contract.

1.4 Mandatory, Voluntary and Excluded Populations

1.4.1 Eligibility Determinations

OHCA has sole authority for determining eligibility for SoonerCare and for determining whether an Eligible is able to be enrolled in the SoonerSelect program. The eligibility and enrollment process is described in Section 1.5: “Enrollment and Disenrollment” of this Model Contract.

1.4.2 Mandatory Enrollment Populations

The following Eligibles will be mandatorily enrolled with an MCO under the SoonerSelect program:

- Expansion Adults;
- Parents and Caretaker Relatives;
- Pregnant Women;
- Deemed Newborns;
- Children; and
- All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Subpart B (§§435.100 – 435.172) unless otherwise covered by SoonerCare.

The following Eligibles will be mandatorily enrolled in the SoonerSelect Specialty Children’s Plan upon entering custody of the state:

- Foster Care Children (FC); and
- Certain children in the custody of OJA (JJ).

The following Eligibles will be mandatorily enrolled in the SoonerSelect Specialty Children’s Plan if they do not make another selection during the initial selection process described in Section 1.5.2.3: “Initial Health Plan Selection Process” of this Model Contract or fail to make an election on the SoonerCare application after initial SoonerSelect program implementation:

- Former Foster Care (FFC);
- Children with an open prevention service case (PSC) through CWS; and
- Children Receiving Adoption Assistance (AA).

1.4.3 Voluntary Enrollment Populations

Notwithstanding the requirements outlined in Section 1.4.2: “Mandatory Enrollment Populations” of this Model Contract, AI/AN Eligibles who are determined eligible for a SoonerCare population will have the option to voluntarily enroll in the SoonerSelect program through an opt-in process.

1.4.4 Eligibles Opting out of SoonerSelect Specialty Children’s Plan

Former Foster Children and Children Receiving Adoption Assistance shall be enrolled in the SoonerSelect Specialty Children’s Plan. These Eligibles may opt-out of enrollment in the SoonerSelect Specialty Children’s Plan and enroll with a SoonerSelect MCO.

1.4.5 Excluded Populations

The following Eligibles will be excluded from enrollment in SoonerSelect:

- Dual Eligible Individuals;
- Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
- Persons with a nursing facility or ICF-IID level of care, with the exception of Health Plan Enrollees with a pending level of care determination as described in Section 1.6.6: “Nursing Facility and ICF-IID Stays” of this Model Contract;
- Individuals during a period of Presumptive Eligibility;
- Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
- Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
- Individuals enrolled in a §1915(c) Waiver;
- Undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139;
- Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
- Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children (‘Soon-to-be-Sooners’), as allowed by 42 C.F.R. § 457.10; and
- Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

1.4.6 Enrollment Phase-In

OHCA does not anticipate phasing in enrollment of the populations in Section 1.4.2: “Mandatory Enrollment Populations” of this Model Contract. However, OHCA reserves the right to phase-in enrollment by eligibility category, geographic area or other means if deemed necessary for the successful implementation of the SoonerSelect program. The Contractor shall cooperate in the implementation of a phase-in schedule, if one is implemented.

1.4.7 Changes in Covered Populations

OHCA reserves the right, and intends, to enroll Eligibles in a SoonerCare eligibility group outlined in Section 1.4.5: “Excluded Populations” of this Model Contract into the SoonerSelect program in future years. Expansion of enrolled populations would be implemented through the procurement or Contract amendment process and the Contractor would be required to go through the Readiness Review process.

1.5 Enrollment and Disenrollment

1.5.1 Non-Discrimination

Consistent with 42 C.F.R. § 438.3, the Contractor may not refuse an assignment or seek to disenroll a Health Plan Enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against a Health Plan Enrollee on the basis of expectations that the Health Plan Enrollee will require frequent or high cost care,

or on the basis of health status or need for health care services or due to an adverse change in the Health Plan Enrollee's health in Enrollment, Disenrollment, or re-enrollment.

The Contractor shall accept individuals eligible for enrollment in the order in which they are enrolled (unless otherwise authorized by CMS) up to the limits set under the Contract.

The Contractor shall not request Disenrollment because of a change in the Health Plan Enrollee's health status, or because of the Health Plan Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Health Plan Enrollee or other Health Plan Enrollees. The Contractor may only request Disenrollment of the Health Plan Enrollee in accordance with the provisions outlined in Section 1.5.7.1: "Contractor Request" of this Model Contract.

1.5.2 Enrollment Process

1.5.2.1 Enrollment Choice Counseling

OHCA, or its designee, will be responsible for educating Eligibles about the SoonerSelect program and providing unbiased Choice Counseling concerning enrollment options. Choice Counseling will be available at the time of initial enrollment, during the annual Open Enrollment Period described in Section 1.5.5: "Annual and Special Enrollment Periods" of this Model Contract and under the provisions described in Section 1.5.7: "Disenrollment Request Process" of this Model Contract.

OHCA will provide notice to prospective Eligibles regarding the MCO selection process and the importance of making a selection in accordance with informational and timing requirements as specified in 42 C.F.R. § 438.54.

1.5.2.2 Materials for Enrollment Choice Counseling

The Contractor shall furnish materials regarding its MCO and up-to-date Participating Provider rosters in a manner and on a schedule to be defined by OHCA. Materials must comply with OHCA review and approval process described in Section 1.11.15.4: "OHCA Review and Approval Process" of this Model Contract, including adherence to allowable and prohibited Marketing Material requirements. The rosters shall include up-to-date information on whether each Participating Provider has an open or closed panel with respect to accepting new patients. Inaccurate Participating Provider information shall be grounds for Non-compliance Remedies, as described in Section 1.23: "Non-Compliance Remedies" of this Model Contract.

The Contractor shall also supply Participating Provider rosters to the State of Oklahoma HIE vendor in a manner and on a schedule to be defined by OHCA.

The Contractor shall also conduct Marketing and outreach efforts to raise awareness of the SoonerSelect program and their product, subject to the requirements of Section 1.11.15: "Marketing and Outreach" of this Model Contract.

1.5.2.3 Initial Health Plan Selection Process

OHCA, at its discretion, may allow up to 60 days for Eligibles to select an MCO prior to the start of the SoonerSelect program. Subsequent to program start, SoonerCare Applicants eligible for the SoonerSelect

program will have an opportunity to select an MCO on their application. Eligibles who do not make an election within the allowed timeframe will be assigned to an MCO in accordance with the rules outlined in Section 1.5.2.4: “Auto Assignment” of this Model Contract.

1.5.2.4 Auto Assignment

Applicants who are eligible to choose an MCO and fail to make an election on the SoonerCare application, will be assigned to the MCO that is due next to receive an auto assignment taking into account quality weighted assignment factors. Once assigned to an initial MCO, the Health Plan Enrollee shall have 90 Calendar Days to request a transfer to another MCO.

OHCA reserves the right to modify the auto-assignment algorithm at any time.

Notwithstanding the above language, OHCA will not make auto-assignments to the Contractor if any of the following conditions exist:

- The Contractor’s maximum enrollment has been capped under the terms outlined in Section 1.5.6: “Enrollment Caps” of this Model Contract, and actual enrollment has reached 95% of the cap;
- The Contractor has been excluded from receiving new enrollment due to the imposition of Non-Compliance Remedies, as outlined in Section 1.23: “Non-Compliance Remedies” of this Model Contract; or
- The Contractor has failed to meet Readiness Review requirements.

It is OHCA’s intent to modify the assignment algorithm in future Contract years of the SoonerSelect program to take into consideration the Contractor’s performance on improving health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.1.9: “Amendments or Modifications” of this Model Contract.

1.5.3 **Enrollment Effective Date**

It is OHCA’s intent that Eligibles, with the exception of Deemed Newborns, who select or are assigned to an MCO before the fifteenth day of the month shall be enrolled effective on the first day of the following month. Eligibles who select or are assigned to an MCO on the fifteenth day of the month or later will be enrolled effective on the first day of the second following month. Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA. Deemed Newborns eligible for the SoonerSelect program shall be enrolled effective as of the date of birth, if the newborn’s mother also is enrolled in the SoonerSelect program.

Notwithstanding the foregoing, the effective date of enrollment with the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

1.5.4 **Enrollment Lock-In Period**

Health Plan Enrollees will be permitted to change MCOs, without showing cause, during their first 90 days of enrollment with the Contractor, or during the 90 days following the date OHCA sends the Health Plan Enrollee notice of that enrollment, whichever is later. After the Health Plan Enrollee’s period for Disenrollment from the Contractor has lapsed, Health Plan Enrollees will remain enrolled with the Contractor until the next annual Open Enrollment Period, unless:

- The Health Plan Enrollee is disenrolled due to loss of SoonerCare eligibility;
- The Health Plan Enrollee becomes a foster child under custody of the State;
- The Health Plan Enrollee becomes juvenile justice involved under the custody of the State;
- The Health Plan Enrollee is a Former Foster Child or Child Receiving Adoption Assistance and opts to enroll in the SoonerSelect Specialty Children’s Plan;
- The Health Plan Enrollee demonstrates cause in accordance with Section 1.5.7.2: “Health Plan Enrollee Request” of this Model Contract;
- A temporary loss of eligibility or enrollment has caused the Health Plan Enrollee to miss the annual Disenrollment period, then the Health Plan Enrollee may disenroll without cause upon reenrollment; or
- OHCA imposes Intermediate Sanctions on the Contractor and allows Health Plan Enrollees to disenroll without cause.

1.5.5 Annual and Special Enrollment Periods

OHCA will conduct an annual Open Enrollment Period. Written notice of the Open Enrollment Period and Health Plan Enrollee Disenrollment rights will be provided to Health Plan Enrollees at least 60 days prior to the start of the Open Enrollment Period, in accordance with 42 C.F.R. § 438.56. OHCA, or its designee, will provide Health Plan Enrollees information on their MCO options for the coming year. The Contractor shall cooperate with OHCA in furnishing requested materials to current and prospective Health Plan Enrollees.

Health Plan Enrollees will be informed that if they do not request a new MCO, they will remain in their current MCO. All Health Plan Enrollees, including those who do not make a change, will be permitted to change MCOs during the first 90 days of the new enrollment period in accordance with the process outlined in Section 1.5.4: “Enrollment Lock-In Period” of this Model Contract.

OHCA, at its sole discretion, may schedule a special Open Enrollment Period, under the following circumstances:

- In the event of the early termination of an MCO under the process described in Section 1.24.1: “Early Termination” of this Model Contract; or
- The loss of a major Participating Provider places the Contractor at risk of failing to meet service accessibility standards and the Contractor does not have an acceptable plan for mitigating the loss or finding of non-compliance.

The Contractor shall cooperate as directed by OHCA in facilitating the special Open Enrollment Period.

1.5.6 Enrollment Caps

OHCA, at its sole discretion, may impose a cap on the Contractor’s enrollment, in response to a request by the Contractor or as part of a corrective action occurring under Section 1.23: “Non-Compliance Remedies” of this Model Contract.

1.5.7 **Disenrollment Request Process**

1.5.7.1 Contractor Request

The Contractor must comply with Section 1.5.1: “Non-Discrimination” of this Model Contract, and seek to disenroll a Health Plan Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

- Health Plan Enrollee requires specialized care for a Chronic Condition and the Health Plan Enrollee or Health Plan Enrollee’s representative, the Contractor, OHCA and receiving MCO agree that assignment to the receiving MCO is in the Health Plan Enrollee’s best interest;
- Health Plan Enrollee has been enrolled in error, as determined by OHCA;
- Health Plan Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the Contractor has made all reasonable efforts to accommodate the Health Plan Enrollee; or
- Health Plan Enrollee has committed Fraud, including but not limited to, loaning an ID card for use by another person.

The Contractor must make a written request to OHCA for Health Plan Enrollee Disenrollment, in a format to be specified by OHCA. The Contractor’s request for disenrollment must document that reasonable steps were taken to educate the Health Plan Enrollee regarding proper behavior and that the Health Plan Enrollee refused to comply, if applicable. The Contractor also must communicate its request to the Health Plan Enrollee in writing, in a format to be specified by OHCA.

OHCA shall have sole authority to grant or deny the Disenrollment request.

1.5.7.2 Health Plan Enrollee Request

Health Plan Enrollees shall be permitted to disenroll from the Contractor without cause, in accordance with the provisions of Section 1.5.4: “Enrollment Lock-In Period” of this Model Contract.

During the lock-in period, Health Plan Enrollees may be disenrolled for cause, at any time, in accordance with 42 C.F.R. § 438.56(d) and under the following conditions:

- The Health Plan Enrollee moves out of the Contractor’s service area;
- The Health Plan Enrollee requires specialized care for a Chronic Condition and the Health Plan Enrollee or Health Plan Enrollee’s representative, the Contractor, OHCA and receiving MCO agree that assignment to the receiving MCO is in the Health Plan Enrollee’s best interest;
- Health Plan Enrollee seeks covered benefits that the Contractor does not cover for moral or religious reasons;
- Health Plan Enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the Contractor’s network; and the Health Plan Enrollee’s PCMH Provider or another Provider determines that receiving the services separately would subject the Health Plan Enrollee to unnecessary risk;
- Health Plan Enrollee has filed and prevailed in a Grievance regarding poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the Health Plan Enrollee's health care needs or other matters deemed sufficient to warrant Disenrollment; or
- Health Plan Enrollee has been enrolled in error, as determined by OHCA.

Health Plan Enrollees shall seek redress through the Contractor's Grievance process before OHCA will make a determination on a Health Plan Enrollee's request for Disenrollment. The Contractor shall accept Health Plan Enrollee requests for Disenrollment orally or in writing. The Contractor shall complete a review of the request within ten days of the Health Plan Enrollee filing the Grievance. If the Health Plan Enrollee remains dissatisfied with the result of the Grievance process, the Contractor shall refer the Disenrollment request to OHCA. The Contractor shall send records gathered during the Grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA consistent with Section 1.5.7.4: "Disenrollment Effective Date" of this Model Contract.

1.5.7.3 At OHCA's Initiation

OHCA will initiate Disenrollment of Health Plan Enrollees under the following circumstances:

- Loss of eligibility for Medicaid;
- Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
- Health Plan Enrollee becomes enrolled in Medicare;
- Death;
- Health Plan Enrollee becomes a foster child under the custody of the State;
- Health Plan Enrollee becomes juvenile justice involved under the custody of the State;
- Health Plan Enrollee becomes an inmate of a public institution;
- Health Plan Enrollee commits Fraud or provides fraudulent information; or
- Disenrollment is ordered by a hearing officer or court of law.

1.5.7.4 Disenrollment Effective Date

Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on a Health Plan Enrollee's health, it is OHCA's intent that a Disenrollment shall be effective on the first day of the second following month. Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the Health Plan Enrollee's health care needs or other matters deemed sufficient to warrant Disenrollment under Section 1.5.7.2: "Health Plan Enrollee Request" of this Model Contract must be completed within this timeframe. If the Contractor fails to complete the Grievance process in time to permit Disenrollment by OHCA, the Disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe.

Disenrollments for any of the following reasons shall be effective as of the date that the Health Plan Enrollee's SoonerSelect program eligibility status changes:

- Loss of eligibility for Medicaid;
- Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
- Health Plan Enrollee becomes a foster child under the custody of the State;
- Health Plan Enrollee becomes juvenile justice involved under the custody of the State;
- Health Plan Enrollee becomes eligible for Medicare;
- Death;
- Health Plan Enrollee becomes an inmate of a public institution;
- Health Plan Enrollee commits Fraud or provides fraudulent information; or

- Disenrollment is ordered by a hearing officer or court of law.

Health Plan Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination is finalized as further described in Section 1.6.6: “Nursing Facility and ICF-IID Stays” of this Model Contract.

Notwithstanding the foregoing, the effective date of Disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

1.5.8 Health Plan Enrollee Status Changes

The Contractor shall notify OHCA, in the manner required by OHCA, within five Business Days of learning of any change in a Health Plan Enrollee’s status or circumstances that could affect the Health Plan Enrollee’s eligibility for the SoonerSelect program.

1.5.9 Retroactive Dual Eligibility

Dual Eligible Individuals are excluded from SoonerSelect program enrollment. Health Plan Enrollees who become a Dual Eligible Individual will be disenrolled as of their Medicare eligibility effective date. In the event a Health Plan Enrollee becomes retroactively Medicare eligible, the Contractor shall recover claims payments made to Providers during the months of retroactive Medicare eligibility. The Contractor shall also notify the Provider of the requirement to submit the claim to Medicare for reimbursement. OHCA will recoup the Capitation Payments paid for months of retroactive Medicare eligibility.

1.5.10 Reenrollment Following Loss of Eligibility

Health Plan Enrollees who lose and regain eligibility for SoonerSelect program for a period of two months or less will be re-enrolled automatically with the Contractor. Re-enrolled Health Plan Enrollees will have the right to change MCOs in accordance with Section 1.5.4: “Enrollment Lock-In Period” of this Model Contract.

1.6 Covered Benefits

The Contractor shall be responsible for furnishing the physical health, behavioral health and pharmacy benefits described in this section. The Contractor shall also coordinate with Providers of benefits outside of the SoonerSelect capitation to promote service integration and the delivery of holistic, person- and family-centered care. This includes:

- SoonerSelect-covered non-capitated benefits, as outlined in Section 1.6.4: “Excluded Benefits” of this Model Contract; and
- Other benefits a Health Plan Enrollee receives, regardless of payer, including volunteered services.

In accordance with 42 C.F.R. § 438.210(a), in furnishing covered benefits, the Contractor shall ensure:

- Each service is provided to Health Plan Enrollees in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided under the SoonerCare fee-for-service program;
- Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished; and
- It does not arbitrarily deny or reduce the amount, duration, or scope of a required service on the basis of the diagnosis, type of illness, or condition of the Health Plan Enrollee. Notwithstanding the foregoing, in accordance with Section 1.7: “Medical Management” of this Model Contract, the

Contractor may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, such as medical necessity, or for utilization control, provided the services furnished can reasonably achieve their purpose and services supporting Health Plan Enrollees with ongoing or Chronic Conditions are authorized in a manner that reflects the Health Plan Enrollee’s ongoing need for such services and supports.

The Contractor shall furnish all Medically Necessary capitated benefits in accordance with applicable OHCA policies and rules in effect at the time of Contract execution, or as updated in accordance with the amendment process outlined in Section 1.1.9: “Amendments or Modifications” of this Model Contract.

The Contractor may require Prior Authorization of benefits to the extent these are required under OHCA’s policies and rules. The Contractor may propose to impose additional Prior Authorization requirements, subject to OHCA’s review and approval, except for those benefits identified as exempt from Prior Authorization, as delineated in this section.

Health Plan Enrollees who are Children, Deemed Newborns, Pregnant Women or Parent and Caretaker Relatives shall receive covered benefits in accordance with the State Plan. Expansion Adults shall receive covered benefits in accordance with the Alternative Benefit Plan (ABP).

1.6.1 Medical and Related Benefits

The Contractor shall furnish the medical and related benefits outlined in the table below. Annual benefit limits are tracked on a Contract year basis.

Service	Children (under 21)	Adults
Advanced Practice Registered Nurse (APRN) (317:30-5-375 – 317:30-5-376)	Covered	Covered; four outpatient visits per month ABP: Four outpatient visits per month limit can be exceeded based on medical necessity
Allergy testing (317:30-5-14.1.(a)(4))	Covered	Covered, limited to 60 tests over three years ABP: Limit can be exceeded based on medical necessity
Ambulance or emergency transportation (317:30-5-335 – 317:30-5-337; 317:30-5-339; 317:30-5-344)	Covered	Covered

Service	Children (under 21)	Adults
Ambulatory surgical center (317:30-5-565 – 317:30-5-568)	Covered	Covered; Reimbursement outlined in Oklahoma Medicaid State Plan
Bariatric surgery (317:30-5-137-317:30-5-137.2; 317:30-5-140-317:30-5-141)	Covered, upon meeting pre-surgical evaluation and weight loss requirements Prior authorization required	Covered, upon meeting pre-surgical evaluation and weight loss requirements Not covered for the treatment of obesity alone Prior authorization required
Certified Registered Nurse Anesthetist and Anesthesiologist Assistants (317:30-5-605 – 317:30-5-607; 317:30-5-611; 317:30-5-612 – 317:30-5-615)	Covered	Covered
Chemotherapy (317:30-5-15 and 317:30-5-42.3)	Covered	Covered
Clinic services (317:30-5-575 – 317:30-5-579)	Covered Some services may require Prior Authorization	Covered Some services may require Prior Authorization
Diabetes Education (317:30-5-1082 and 317:30-5-1083)	Covered, ten hours per first year; two hours per subsequent year Limits can be exceeded based on medical necessity and under EPSDT	Covered, ten hours per first year; two hours per subsequent year ABP: Limit can be exceeded based on medical necessity

Service	Children (under 21)	Adults
Diagnostic testing entities (317:30-5-907 – 317:30-5-907.3)	Covered Some services may require Prior Authorization	Covered Some services may require Prior Authorization
Durable medical equipment supplies and appliances (317:30-5-210 – 317:30-5-211.7; 317:30-5-211.10 – 317:30-5-211.28; 317:30-5-214 – 317:30-5-215; 317:30-5-217 – 317:30-5-218)	Covered Requires prescription by a medical Provider May require Prior Authorization	Covered Requires prescription by a medical Provider May require Prior Authorization
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Early intervention services, including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests; necessary follow-up care; and Applied Behavioral Analysis (ABA) services (317:30-3-65 – 317:30-3-65.12)	Covered Some services may require Prior Authorization	Covered for Health Plan Enrollees under age 21 Some services may require Prior Authorization
Emergency department (317:30-5-42.7)	Covered	Covered
Family planning services (317:30-5-12)	Covered	Covered
Federally Qualified Health Center and Rural Health Clinic services	Covered	Covered

Service	Children (under 21)	Adults
(317:30-5-660 – 317:30-5-664.15; 317:30-5-355 – 317:30-5-363)		
Genetic Counseling and Testing (317:30-5-219 – 317:30-5-223; 317:30-30-5-20; 317:30-5-100 – 317:30-5-106)	Covered for pregnant Health Plan Enrollees and Health Plan Enrollees meeting medical necessity criteria May require Prior Authorization	Covered for pregnant Health Plan Enrollees and Health Plan Enrollees meeting medical necessity criteria May require Prior Authorization
Hearing services (317:30-5-675 – 317:30-5-678; 317:30-5-680)	Covered May require Prior Authorization	Not Covered
Home health care services (317:30-5-545 – 317:30-5-548)	Covered	Covered
Hospice (non-hospital based) (317:30-5-530 – 317:30-5-532)	Covered for Health Plan Enrollees with a life expectancy of six months or less	Not covered
Immunizations, as recommended by the Advisory Committee of Immunization Practices (317:30-5-14(a)(1)-(2))	Covered	Covered
Inpatient hospital services (317:30-5-40 – 317:30-5-41.2; 317:30-5-42.1 – 317:30-5-42.20; 317:30-5-44; 317:30-5-47 – 317:30-5-47.6; 317:30-5-49 – 317:30-5-53; 317:30-5-56 – 317:30-5-58; 317:30-5-110 – 317:30-5-114)	Covered	Covered <ul style="list-style-type: none"> • Inpatient hospital service (inpatient stay): No limit • Inpatient physician services: Covered • Inpatient surgical services: No limit

Service	Children (under 21)	Adults
		<ul style="list-style-type: none"> • Inpatient rehab hospital services: 90 days per individual per SFY <p>ABP limits:</p> <ul style="list-style-type: none"> • Inpatient hospital service (inpatient stay): No limit • Inpatient physician services Covered • Inpatient surgical services: No limit • Skilled nursing facility/ Inpatient rehab hospital services: 90 days per individual per SFY <p>Amount limits can be exceeded based on medical necessity</p>
Laboratory, X-ray, diagnostic imaging, imaging (CT/PET Scans. MRIs) (317:30-5-100 – 317:30-5-106; 317:30-5-24; 317:30-3-31 ; 317:30-5-42.13)	Covered May require Prior Authorization	Covered May require Prior Authorization
Lactation consultant (317:30-5-230 – 317:30-5-235)	Covered for pregnant and postpartum Health Plan Enrollees	Covered for pregnant and postpartum Health Plan Enrollees
Lodging and meals for the Health Plan Enrollee and/or one approved medical escort (317:30-3-92)	Covered if prior approved	Covered if prior approved
Long-term care hospital for children	Covered	Not covered

Service	Children (under 21)	Adults
(317:30-5-60 – 317:30-5-67)		
Mammograms (317:30-5-900 – 317:30-5-901; 317:30-5-903; 317:30-5-905)	Covered	Covered
Maternal and Infant LCSW services (317:30-5-204 – 317:30-5-209)	Covered for pregnant and postpartum Health Plan Enrollees	Covered for pregnant and postpartum Health Plan Enrollees
Non-emergency Medical Transportation (NEMT) (317:30-5-327.1)	Covered	Covered
Nurse midwives (317:30-5-225 – 317:30-5-226; 317:30-5-229)	Covered under EPSDT	Covered
Nursing Facility and ICF-IID services (317:30-3-42)	Covered by Contractor for up to 60 days pending the level of care determination	Covered by Contractor for up to 60 days pending the level of care determination
Nutrition services (dietician) (317:30-5-1075 – 317:30-5-1076)	Covered	Covered up to six hours per year Nutritional services for treatment of obesity is not covered. Services must be expressly for diagnosing, treating or preventing, or minimizing effects of illness. ABP: Limits can be exceeded based on medical necessity
Orthotics	Covered	Not Covered

Service	Children (under 21)	Adults
		ABP: Covered without limitations when Medically Necessary
Outpatient hospital and surgery services (317:30-5-42.1 and 317:30-5-42.14)	Covered	Covered
Parenteral/enteral nutrition (317:30-5-211.14)	Covered May require Prior Authorization	Covered May require Prior Authorization
Personal care (317:30-5-950 – 317:30-5-953)	Covered	Covered
Physician and physician assistant services (317:30-5-1 – 317:30-5-4; 317:30-5-6 – 317:30-5-15; 317:30-5-17 – 317:30-5-25; and 317:30-5-30 – 317:30-5-33)	Covered	Covered; four outpatient visits per month ABP: Four outpatient visits per month limit can be exceeded based on medical necessity
Podiatry (317:30-5-260 – 317:30-5-261)	Covered	Covered
Post-stabilization care services (in accordance with 42 C.F.R. §§ 438.114 and 422.113(c))	Covered	Covered
Pregnancy and maternity services, including prenatal, delivery and postpartum - (317:25-7-2, 317:25-7-10, 317:30-5-1, 317:30-5-2, 317:30-5-22, 317:30-5-22.1, 317:30-5-24, 317:30-5-41,	Covered	Covered

Service	Children (under 21)	Adults
317:30-5-42.13, 317:30-5-226, 317:30-5-229, 317:30-5-356, 317:30-5-361, 317:30-5-664.8, 317:30-5-892, 317:30-5-1076, 317:45-11-10)		
Prescription drugs (317:30-5 Part 5; see also Section 1.6.3: “Pharmacy Program” of this Model Contract)	Covered	Covered, up to six prescriptions per month, including up to two brand name drugs without Prior Authorization and up to three brand name drugs with Prior Authorization (within the six prescription limit)
Preventive Care and Screening	Refer to EPSDT coverage	Covered as outlined in the State Plan pages for Outpatient Hospital Services, Other laboratory and x-ray services, Diagnosis and Treatment of Conditions Found, Clinic Services, Screening Services, and Rehabilitative Services. There is not a standalone preventive services benefit package for adults providing coverage for services identified with an A or B rating by the USPSTF.
Private duty nursing (317:30-5-555 – 317:30-5-560.2)	Covered up to 16 hours per day, with exceptions made to the 16-hour limit made for up to 30 days immediately following hospitalization or the temporary incapacitation of the primary caregiver	Not covered ABP limit: This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered when prior authorized	Limited coverage with required Prior Authorization; only breast

Service	Children (under 21)	Adults
(317:30-5-211.13)		prosthesis and support accessories and prosthetic devices inserted during surgery are covered ABP: Covered without limitations when Medically Necessary
Public Health Clinic services (317:30-5-1150 – 317:30-5-1161)	Covered	Covered; four visits per month ABP: Four visits per month limit can be exceeded based on medical necessity
Radiation (317:30-5-42.3)	Covered	Covered
Reconstructive Surgery (317:30-5-211.3. (c)(1)(E) 317:30-5-8.(c))	Covered May require Prior Authorization	Covered: Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is Medically Necessary May require Prior Authorization
Renal dialysis facility services (317:30-5 Part 29)	Covered	Covered
School-based health related services (317:30-5-1020 - 317:30-5-1027)	Covered	Not covered
Telehealth (317:30-3-27)	Covered	Covered
Therapy services – physical therapy (PT), occupational therapy (OT) and speech therapy (ST)	OT and PT – initial evaluation covered without Prior Authorization; treatment requires Prior Authorization	<i>Rehabilitative Services:</i> 15 visits per year for each OT, PT, & ST

Service	Children (under 21)	Adults
(317:30-5-290.1 - 317:30-5-290.2, 317:30-5-293, 317:30-5-295 - 317:30-5-299, 317:30-5-675 - 317:30-5-678, 317:30-5-680)	ST – evaluation and treatment require Prior Authorization	<p>(cumulative total: 45 visits)</p> <p>ABP Limit:</p> <p><i>Habilitative Services:</i></p> <p>15 visits per year for each OT, PT, & ST</p> <p>(cumulative total: 45 visits)</p> <p><i>Rehabilitative Services:</i></p> <p>15 visits per year for each OT, PT, & ST</p> <p>(cumulative total: 45 visits)</p>
Tobacco cessation products (317:30-5-72.1. Drug benefit)	Nicotine replacement products and Zyban® are covered without Prior Authorization. Chantix® is covered up to 180 days per year	Nicotine replacement products and Zyban® are covered without Prior Authorization. Chantix® is covered up to 180 days per year. Tobacco cessation products do not require a Copayment and do not count against the monthly prescription limit
Transplant services (317:30-3-57) Hospitals/organ transplants (317:30-5-41.2)	Covered when prior authorized (cornea and kidney transplants do not require Prior Authorization)	Covered when prior authorized (cornea and kidney transplants do not require Prior Authorization)
Urgent Care Centers or Facilities	Covered	<p>Covered, up to four outpatient visits per month</p> <p>ABP: Four outpatient visits per month limit can be exceeded based on medical necessity</p>
Vision services	Covered, with a limit of two eyeglass frames per year	Coverage to treat a medical or surgical condition only; no

Service	Children (under 21)	Adults
EPSDT Vision services (317:30-3-65.7) Coverage by category (317:30-5-641)		coverage for routine eye exams; up to four outpatient visits per month ABP: Four outpatient visits per month limit can be exceeded based on medical necessity

1.6.2 Behavioral Health Benefits

The Contractor shall furnish all SoonerCare covered behavioral health benefits as outlined in the table below and in accordance with the State Plan, ABP, and pending 1115 demonstration waiver as described in Section 1.6.2.7: “1115 IMD Waiver” of this Model Contract.

Service	Children	Adults
Day Treatment Services (317:30-5-241.2 (f))	Covered when prior authorized for a minimum of three hours per day for four days per week	Not Covered
Inpatient hospital – freestanding psychiatric (317:30-5-95, 317:30-5-95.1, and 317:30-5 Part 6 Inpatient Psychiatric Hospitals)	Covered when prior authorized	Ages 21-64: Covered when prior authorized in accordance with 1115 IMD waiver pending CMS approval Ages 65 and older: Covered when prior authorized
Inpatient hospital – general acute 317:30-5-95, 317:30-5-95.1 317:30-5-41.1. Acute inpatient psychiatric services 317:30-5 Part 6 Inpatient Psychiatric Hospitals (317:30-5-95 – 317:30-5-97)	Covered when prior authorized	Covered when prior authorized

Service	Children	Adults
Independently Contracted Licensed Behavioral Health Provider (317:30-5-280 – 317:30-5-283)	Covered when prior authorized	Not Covered
Outpatient behavioral health agency services (317:30-5-240 – 317:30-5-241.6, 317:30-5-244 – 317:30-5-245; 317:30-5-248 – 317:30-5-249)	Covered when prior authorized	Covered when prior authorized
Partial Hospitalization (317:30-5-241.2 (e))	Covered when prior authorized for children for a minimum of three hours per day for five days per week with a maximum of four billable hours per day	No coverage
Program of Assertive Community Treatment (PACT) services (317:30-5-241.5 (a))	Covered for ages 18 and older in accordance with OAC 450:55	Covered in accordance with OAC 450:55
Therapeutic behavioral services, family support and training (317:30-5-241.5 (b-c))	Covered for children with SED in a systems of care wraparound team	No coverage
Peer recovery support services (317:30-5-241.5 (d))	Covered for ages 16 and older when prior authorized	Covered when prior authorized
Psychiatric residential treatment facility (317:30-5-95.29 - 317:30-5-95.42, 317:30-5-96.2 - 317:30-5-97)	Covered when prior authorized	Covered under age 21
Qualified Residential Treatment Program (QRTP)	Covered when prior authorized in accordance with 1115 IMD waiver pending CMS approval	Covered under age 21 when prior authorized in accordance with 1115 IMD waiver pending CMS approval
CCBHC Services	Covered	Covered

Service	Children	Adults
(317:30-5 Part 24)		
Psychiatrist (Chapter 30-5-1) Part 1 Physicians: 317:30-5-11 Psychiatric services	Covered	Covered
Independently Contracted Psychologist (317:30-5-275 – 317:30-5- 276, 317:30-5-278 – 317:30-5- 278.1)	Covered when prior authorized	Not Covered
Substance abuse treatment (317:30-5-95.27 – 317:30-5- 95.28)	Covered when prior authorized for outpatient. Covered for inpatient detox only. Residential substance abuse covered in accordance with 1115 IMD waiver pending CMS approval	Covered in accordance with 1115 IMD waiver pending CMS approval
Medication Assisted Treatment (Suboxone® (buprenorphine/ naloxone SL films), Vivitrol, Methadone)	Covered	Covered
Opioid Treatment Programs	Covered when prior authorized	Covered when prior authorized
Targeted Case Management (317:30-5-241.6)	Covered for targeted populations when prior authorized	Covered for targeted populations when prior authorized
Therapeutic Foster Care (317:30-5 Part 83)	Covered when prior authorized	Not covered

1.6.2.1 Mental Health Parity

In accordance with 42 C.F.R. § 438, Subpart K, the Contractor shall ensure all behavioral health benefits are delivered in compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). This includes, but is not limited to:

- Ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits.
- Ensuring compliance with MHPAEA for any benefits offered by the Contractor to Health Plan Enrollees beyond those otherwise specified in the Contract.
- Making the criteria for medical necessity determinations for mental health or substance use disorder benefits available to any Eligible, Health Plan Enrollee or Participating Provider upon request.
- Providing notice of Adverse Benefit Determinations including the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to Health Plan Enrollees.
- Providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.
- OHCA does not impose an annual dollar limit on any medical/surgical benefits or include an aggregate lifetime or annual dollar limit that applies to medical/surgical benefits provided to Eligibles. Therefore, the Contractor shall not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits, in accordance with 42 C.F.R. § 438.905.
- Ensuring that any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification in accordance with 42 C.F.R. § 438.910(b)(1).
- Ensuring any cumulative financial requirements for mental health or substance use disorder benefits in a classification are not accumulating separately from any established medical/surgical benefits in the same classification, in accordance with 42 C.F.R. § 438.910(c)(3).
- Ensuring that mental health or substance use disorder benefits are provided to the Contractor in every classification of benefits in which medical/surgical benefits are provided, in accordance with 42 C.F.R. § 438.910(b)(2).
- Ensuring no non-quantitative treatment limits (NQTLs) are imposed for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification, in accordance with 42 C.F.R. § 438.910(d).

The Contractor shall provide the necessary documentation and reporting, in the timeframe and format required by OHCA, to establish and demonstrate compliance with 42 C.F.R. § 438, Subpart K. In response to this analysis required to establish mental health parity compliance, the Contractor may cover, in addition to services covered under the State Plan, any services necessary for compliance with the parity requirements.

1.6.2.2 Substance Use Disorder Treatment

The Contractor shall work with Providers, facilities, and Health Plan Enrollees to coordinate care for Health Plan Enrollees with a substance use disorder and to ensure Health Plan Enrollees have access to the full

continuum of covered services, including assessment, detoxification, residential treatment, outpatient services, and medication assisted treatment, as Medically Necessary and appropriate.

1.6.2.3 Behavioral and Physical Health Integration

The Contractor shall develop strategies to integrate behavioral and physical health services with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders. The Contractor shall develop policies and procedures to:

- Implement validated behavioral health screening tools for PCMHs to utilize to determine if further Health Plan Enrollee assessment for Behavioral Health Services is necessary, including but not limited to, Screening Brief Intervention and Referral to Treatment (SBIRT).
- Implement a streamlined mechanism for PCMHs to refer Health Plan Enrollees who are screened at risk for a behavioral health need to the appropriate behavioral health provider for further assessment.
- Work with PCMHs and behavioral health providers to facilitate a high degree of coordination and communication across disciplines for the benefit of Health Plan Enrollees.
- Implement best practices to engage Health Plan Enrollees and their physical and behavioral health Providers and address barriers to integration.
- Offer clinical support, such as practice guidelines, consultation with a psychiatrist, or training to Providers treating behavioral health conditions in the primary care setting.
- Support primary care-based behavioral health for Pediatric populations.
- Coordinate with OHCA's efforts to integrate behavioral and physical health services, including policies and processes around co-locating services in a primary care setting.
- Coordinate management of utilization of Behavioral Health Services with services for physical health, including coordination and notification with inpatient and outpatient service Providers following an emergency department and/or inpatient behavioral health care stay.
- Promote care that addresses the needs of Health Plan Enrollees in an integrated manner, with attention to the physical health and chronic disease contributions to behavioral health.
- Promote and support efforts of behavioral health Providers to integrate primary care services within specialty behavioral health settings.

1.6.2.4 Medication Assisted Treatment (MAT)

The Contractor shall develop strategies to improve or expand the infrastructure of MAT Providers for opioid use, alcohol dependence and other substance use disorders to improve Health Plan Enrollee access to MAT, particularly in the Rural Areas of the State.

1.6.2.5 Tobacco Cessation Services

The Contractor shall either: (i) directly contract with the Oklahoma Tobacco Helpline (OTH) vendor; or (ii) enter into a cost share agreement with the OTH, to provide a minimum benefit level as defined by OHCA.

The Contractor shall at a minimum:

- Offer tobacco cessation helpline services which shall include, at a minimum:
 - Providing Health Plan Enrollees with five calls with a quit coach;
 - Ten call sessions with women who are pregnant women, currently breastfeeding and women who gave birth in the past year; and
 - Specialized Behavioral Health Protocol that the vendor offers.

- Partner with the OTH and the OTH's helpline vendor on outreach;
- Submit Marketing and educational materials for review and approval consistent with the requirements of Section 1.11.3.2: "Prior Approval Process" of this Model Contract;
- Promote Helpline services to Health Plan Enrollees and Providers with partnership in development, review and approval from OTH Administration and the Tobacco Settlement Endowment Trust, Health Communications Team;
- Enter into a Data Use Agreement with University of Oklahoma Hudson College of Public Health and Oklahoma Tobacco Helpline Administration for Helpline Experience Extract and reports for evaluation purposes; and
- Promote the Contractor's s tobacco cessation benefit to Health Plan Enrollees.

OHCA standard of care services the Contractor shall provide include, at minimum:

- Eight sessions covering at least 90 minutes of individual, or telephone counseling two or more times per year;
- 180 days of Varenicline per 12 months. No copayment. Does not count against monthly limits.
- Bupropion and Nicotine replacement therapy (patches, gum, lozenges, inhalers, and nasal spray) to include combination therapy of these productions with no duration limit and no copayment. Does not count against monthly limits.
- No Prior Authorization for these products: Varenicline, Wellbutrin, NRT patches, gum, lozenge, inhaler, or nasal spray.

The Contractor shall require tobacco-free policies covering 100% of medical and behavioral health campuses. This is an evidence-based intervention for smoking cessation as tobacco free policies create environments that make it much easier to quit and stay quit. It also eliminates exposure to harmful secondhand smoke/aerosol.

1.6.2.6 Behavioral Health Crisis Services

The Contractor shall develop and maintain a comprehensive behavioral health crisis response network that shall include:

- Crisis responsiveness which includes 24 hours a day, seven days a week, 365 days a year emergency treatment and first response, including, when appropriate, mobile and community based response.
- Provision of or referral to psychiatric and other community services, when appropriate.
- Assessment of any Health Plan Enrollee experiencing a behavioral health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services.
- Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services.
- Follow up with any Health Plan Enrollee seen for or provided with any Emergency Service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within 72 hours of crisis resolution.
- Access to the Behavioral Health Services Hotline 24 hours a day, seven days a week, 365 days a year in accordance with the requirements of Section 1.11.8: "Behavioral Health Services Hotline" of this Model Contract.

1.6.2.7 1115 IMD Waiver

OHCA has submitted for CMS review and approval an 1115 demonstration waiver application to obtain authority to reimburse Medically Necessary residential substance use disorder treatment, facility-based crisis stabilization, and inpatient treatment services within settings that qualify as institutions for mental disease (IMDs). Upon CMS approval, the Contractor shall comply with all waiver special terms and conditions. This includes, but is not limited to:

- Complying with the requirements of the SMI and SUD Implementation Plan Protocols;
- Coordinating with OHCA in implementing all required components of the waiver health information technology (HIT) plans;
- Submitting to OHCA all reports necessary to fulfill OHCA's waiver reporting obligations to CMS;
- Complying with OHCA directives regarding implementation of a value-based payment structure for Medicaid-enrolled residential SUD providers;
- Developing methods, in accordance with the requirements to be issued by OHCA, to track if Participating Providers are accepting new patients for purposes of OHCA completion of the CMS-required mental health availability assessment;
- Authorizing and reimbursing for acute inpatient psychiatric stays in an IMD for no more than 60 consecutive days;
- Authorizing and reimbursing for residential substance use disorder stays and ensuring that the statewide aggregate average length of stay remains at or below 30 consecutive days; and
- Reimbursing qualified residential treatment programs (QRTPs).

1.6.3 **Pharmacy Program**

1.6.3.1 Pharmacy Services

The Contractor must provide coverage of covered outpatient drugs, in compliance with 42 C.F.R. § 438.3(s)(1) as defined in Section 1927(k)(2) of the Act that meets the standards for such coverage imposed by Section 1927 of the Act as if such standards applied directly to the Contractor. The Contractor shall provide notice for all covered outpatient drug authorization decisions in accordance with Section 1927(d)(5)(A) of the Act.

All SoonerSelect MCOs, including the Contractor, shall be required to use a uniform Preferred Drug List (PDL), which shall be developed by OHCA. This common list of covered drugs includes preferred brands as indicated by their placement in lower tiers of tiered therapeutic categories. The MCOs, including the Contractor, shall not put in place or implement any product coverage criteria outside of what OHCA has developed, including products that are covered without criteria.

The Contractor must post the list of covered drugs on its website and post coverage information with a formulary listing service or electronic prescribing service.

New drugs are added to the common list of covered drugs following the protocol of 63 O.S. § 5030.5 which applies Prior Authorization requirements to new drugs. If the new drug is in a category which is already subject to Prior Authorization, the new drug will be subject to Prior Authorization until such time as the OHCA Drug Utilization Review (DUR) Board reviews the category. If the new drug is not part of a category that is already subject to Prior Authorization, it may be prior authorized within 100 days of FDA approval before the DUR Board must review it and recommend Prior Authorization.

The Contractor may substitute “A “-rated generic equivalent drugs, as defined in the Food and Drug Administration Approved Drug Products with Therapeutic Equivalence Evaluations (the Orange Book), whenever such a substitution is considered both bio-equivalent and clinically efficacious and not in conflict with the uniform PDL. The Contractor must provide a brand name exception process whereby a Health Plan Enrollee may seek brand name coverage. In some cases, OHCA will prefer the branded product over the generic due to significant net cost savings. In these cases, the Contractor shall use OHCA’s preferred branded product.

If the Contractor uses financial incentives to influence Provider prescribing and dispensing behaviors, the Contractor must disclose the incentive program to OHCA for approval by OHCA prior to its initial use and prior to any subsequent revisions as well as to the Secretary of Health and Human Services for the purposes of determining compliance. Further, if Contractor operates a Provider incentive plan, it may not make specific payments to Providers directly or indirectly under the plan as an inducement to reduce or limit medically necessary services to an Enrollee and must comply with additional HHS requirements related to protecting Provider from financial risk according to 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R. § 417.479.

If a drug product either can reasonably be dispensed by a pharmacy or administered by a health care practitioner, the Contractor shall follow the SoonerCare pharmacy program policy by making the drug product available through both settings.

Although most diabetic-related products are a DME benefit, the following supplies must be covered under the pharmacy point of sale system: blood glucose test strips, ketone test strips, lancets, lancet devices, meters, syringes, pen needles and control solution. Preferred Diabetic supplies and Continuous Glucose Monitors (CGMs) will be contracted and managed through the uniform PDL process.

1.6.3.2 Physician Administered Drugs

OHCA may develop a preferred drug list for physician administered drugs (PAD). The Contractor will adhere to the PAD list.

1.6.3.3 Participation in DUR Board and Clinical Meetings

The Contractor’s Pharmacy Director will attend all DUR Board meetings and will be required to report on DUR activities, including prospective or retrospective DUR activities and data. Additionally, OHCA will establish a regular and separate meeting to include the Contractor’s Pharmacy Director, and as directed by OHCA, their Chief Medical Officer. OHCA will use this meeting to discuss upcoming Board decisions, proposed PDL changes, and new or updated utilization management requirements. Additionally, OHCA will use these meetings to review Contractor data, proposed DUR programs, and outcomes of ongoing programs. The Contractor will be expected to participate in these meetings, including, but not limited to, providing analysis of drug spend and utilization, recommendations for utilization management programs or changes to existing programs, and clinical program recommendations.

1.6.3.4 Pharmacy Benefit Management Services

1.6.3.4.1 General

If the Contractor utilizes a Pharmacy Benefit Manager (PBM) or pharmacy benefit administrator (PBA), the Contractor shall develop policies and procedures to independently audit payments, eliminate conflicts

of interest with any affiliated pharmacy providers, monitor PBM or PBA performance and ensure the confidentiality of Health Plan Enrollee information and State information that is not public. These policies shall be submitted to OHCA for review and approval during the Readiness Review.

1.6.3.4.2 Data Sharing

The Contractor shall not transfer or share records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a PBM and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review.

1.6.3.4.3 Pharmacy Benefit Financial Disclosures

If the PBM is owned wholly or in part by a health plan, retail pharmacy Participating Provider, chain drug store or pharmaceutical manufacturer, the Contractor shall submit a written description of the assurances and procedures that must be put in place under the proposed PBM subcontract, such as an independent audit, to prevent patient steering, to ensure no conflicts of interest exist and ensure the confidentiality of Health Plan Enrollee and OHCA proprietary information. The proposed PBM subcontract shall meet the requirements specified in 42 C.F.R. § 438.230.

The Contractor shall disclose to OHCA all financial terms and arrangements for payment of any kind that apply between the Contractor or their Subcontractor and pharmaceutical drug manufacturers or distributors. This disclosure shall include financial terms and payment arrangements for formulary management, drug-switch programs, educational support, claims processing, pharmacy network fees, data sales fees, and all other fees. OHCA acknowledges that such information may be considered confidential and proprietary and thus shall be held confidential by OHCA. Upon request, the Contractor will provide a copy of the unedited and unredacted finalized contract with the PBM/PBA/claims processor.

1.6.3.4.4 Rebates and Financial Reports

All rebates for pharmaceutical products and diabetic testing supplies shall accrue to OHCA and shall not be kept or shared by or with the Contractor or its PBM. OHCA shall be responsible for administration of the Medicaid prescribed drug program, including negotiating rebates on all drugs. During the time that the Contractor is required to utilize the Agency's PDL, the Contractor shall not negotiate any drug rebates with pharmaceutical manufacturers for prescribed drugs reimbursed under this Model Contract. OHCA will be the sole negotiator of pharmaceutical rebates for all prescribed drugs, and all rebate payments for prescribed drugs will be made to OHCA. OHCA shall also be the sole negotiator of rebates for all diabetic supplies and continuous glucose monitors, and all rebate payments for these products will be made to the agency.

The Contractor or their PBM shall establish Medicaid-specific Bank Identification Number (BIN) and Processor Control Number (PCN) numbers for point-of-sale pharmacy claims processing, to ensure that the Contractor's BIN and PCN numbers for Medicaid are not the same as for the Contractor's commercial or Medicare part D business lines.

As required in 42 C.F.R. § 438.3(s)(3) and as defined in Section 1927 of the Act, the Contractor or their Subcontractor shall establish procedures, to be approved by OHCA, to ensure that covered outpatient drugs dispensed to Health Plan Enrollees will not be subject to discounts under the 340B drug pricing

program, which would exclude rebate submission from federal and State supplemental rebate programs. OHCA is excluding the Contractor or their Subcontractor from dispensing covered outpatient drugs that are subject to discounts under the 340B drug pricing program to their Health Plan Enrollees. OHCA retains all rights to rebates and discounts for covered outpatient drugs, including but not limited to, federal and supplemental rebates.

1.6.3.4.5 Drug Utilization Review

The Contractor shall have policies and procedures that subject the utilization of prescription drugs to prospective and retrospective review. The Contractor shall operate a drug utilization program that complies with the requirements described in Section 1927(g) of the Act, Subpart K of 42 C.F.R. Part 456, OBRA 1990 and OBRA 1993, and the SUPPORT Act (Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act) as if such requirement applied to the Contractor. The program policies and all program materials shall be submitted to OHCA for review and approval prior to implementation by the Contractor or its PBM.

Prospective review should happen at the point of sale and shall analyze, at a minimum:

- Drug-disease contraindications;
- Drug-drug interactions;
- Dosage appropriateness;
- Inappropriate duration of treatment;
- Drug-to-drug interactions;
- Clinical abuse indicators;
- Drug-pregnancy precautions;
- Over or underutilization;
- Drug-age precautions;
- Duplicative prescriptions or therapies;
- Excessive or low dosages;
- Maximum daily morphine milligram equivalents (MME) on opioids, currently set at 90 MMEs, or as otherwise defined by OHCA; and
- Safety edits for opioid prescriptions as defined by OHCA.

While the prospective review program will be developed and maintained by the Contractor or their Subcontractor, the Contractor should be prepared to implement State-specific criteria as requested.

Retrospective review shall review for, at a minimum Fraud, Abuse, gross overuse, including potential fraud or abuse of opiates and controlled substances, inappropriate utilization, inappropriate or medically unnecessary care, duplicative therapies, or prescribing or billing practices that indicate Abuse or excessive utilization. As required by the SUPPORT Act, retrospective DUR program shall also include review of concurrent use of opiates and benzodiazepines, opiates and antipsychotics, and a review of the appropriateness of antipsychotic agents for all children under 18, including foster children. Pharmacies and prescribing Providers shall be contacted about aberrant drug use patterns, and the Contractor or their Subcontractor will report on program outcomes on a quarterly basis. The Contractor or their

Subcontractor will be responsible for coordinating with the State to identify retroDUR initiatives, perform data-mining and analysis, producing and mailing letters or otherwise delivering correspondence, and measuring and reporting on results.

The program shall include an educational component to pharmacies, prescribing Providers and/or Health Plan Enrollees, as approved by OHCA.

As required by 42 C.F.R. Part 456, subpart K and 42 C.F.R. § 438.3(s)(4), the Contractor must submit a detailed annual report on the operation of its SoonerCare Drug Utilization Review (DUR) program in a format designated by OHCA. The format of the report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program. The Contractor will also prepare or participate in annual DUR reports as required by CMS and as directed by OHCA.

1.6.4 Excluded Benefits

Dental services will be reimbursed by OHCA outside of the Contractor's capitation and delivered through a Dental PAHP. Notwithstanding the foregoing, the Contractor shall be responsible for trauma-related oral surgeries in the inpatient, outpatient, and ambulatory surgery center settings.

Additionally, in accordance with Section 1.15.4.3: "Payments to IHCPs" of this Model Contract, the Contractor shall not be financially responsible for services rendered by IHCPs that are eligible for 100% federal funding.

1.6.5 State Plan Personal Care Services

Health Plan Enrollees may qualify for Personal Care Services based on the findings of a Comprehensive Assessment. When the Contractor identifies a Health Plan Enrollee has a potential need for Personal Care Services, the Contractor shall conduct an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT) to identify whether the Health Plan Enrollee meets the medical eligibility standards for Personal Care Services in accordance with OAC 317:35-15-4.

Eligibility for Personal Care Services, and corresponding nurse supervision, is contingent upon an individual requiring one or more of the services offered at least monthly that include personal care, meal preparation, housekeeping, laundry, shopping or errands or specified special tasks to meet ADLs or IADLs assessed needs.

The Contractor shall determine medical eligibility for Personal Care Services based on the UCAT and the determination that the Health Plan Enrollee has unmet care needs that require Personal Care Services. To be eligible for Personal Care Services, the Health Plan Enrollee must meet the following conditions:

- Have adequate informal supports that contribute to care or decision-making ability, as documented on the UCAT, to remain in the home without risk to health, safety and well-being:
 - The individual must have the decision-making ability to respond appropriately to situations that jeopardize health and safety or available supports that compensate for lack of ability as documented on the UCAT, or
 - The individual who has decision-making ability but lacks the physical capacity to respond appropriately to situations that jeopardize health and safety and has been informed by the Care Manager of potential risks and consequences may be eligible;

- Require a Care Plan involving the planning and administration of services delivered under the supervision of professional personnel;
- Have a physical impairment or combination of physical and mental impairments as documented on the UCAT. An individual who poses a threat to self or others as supported by professional documentation may not be approved for Personal Care Services;
- Not have members of the household or persons who routinely visit the household who, as supported by professional documentation, pose a threat of harm or injury to the individual or other household visitors;
- Lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others; and
- Require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration.

If it is determined that the Health Plan Enrollee meets criteria for Personal Care Services, based on the UCAT, the Contractor shall authorize these services.

1.6.6 Nursing Facility and ICF-IID Stays

Health Plan Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor. Prior to Disenrollment, these facilities must complete the pre-admission screening and resident review (PASRR) process to receive reimbursement from SoonerCare. The State must then approve the PASRR and designate the nursing facility or ICF-IID level of care. The Contractor shall coordinate care for its Health Plan Enrollees who are transitioning into long-term care and shall be responsible for payment for up to 60 days for Health Plan Enrollees placed in a long-term care facility while the level of care determination is pending.

1.6.7 Non-Emergency Medical Transportation

1.6.7.1 Handling Health Plan Enrollee Requests for NEMT

The Contractor shall operate a reservation system for Health Plan Enrollees to schedule non-emergency transportation (NEMT) services via the following modes, at minimum:

- Toll-free telephone line;
- Email; and
- Website.

The Contractor shall ensure the availability of NEMT, at minimum, from 8:00 am to 6:00 pm Central Time, Monday through Saturday.

1.6.7.2 NEMT Covered Services

The Contractor shall provide NEMT to Health Plan Enrollees to access all SoonerCare covered services in accordance with 42 C.F.R. § 440.170. This includes all benefits for which the Contractor is responsible, as well as benefits which are covered by SoonerCare but not the responsibility of the Contractor as outlined in Section 1.6.4: “Excluded Benefits” of this Model Contract. The Contractor, at its sole discretion, may offer additional NEMT services as a Value-Added Benefit.

1.6.7.3 NEMT Scheduling Timeframes

The Contractor shall require a Health Plan Enrollee to request NEMT for routine non-urgent appointments no more than 72 hours prior to the appointment, excluding weekends and State Holidays. The Contractor

shall develop policies and procedures to make exceptions to the 72-hour advance notice requirement under the minimum following circumstances:

- Urgent Care – An unplanned appointment for a covered medical service and the Health Plan Enrollee must be seen that day or the following day.
- Recently-scheduled Appointments - The appointment was scheduled within 72 hours of the visit.
- Follow-up Appointments – The Health Plan Enrollee must be seen that day or the following day.
- Hospital and Inpatient Mental Health Discharges.
- Standing Appointment Orders – The Contractor shall establish procedures to handle trip requests so that Health Plan Enrollees are not required to continually make arrangements for standing appointments.
- Residential Substance Use Disorder Treatment – Within 24 hours of identifying a receiving facility.

1.6.7.4 NEMT Modes of Transportation

The Contractor shall provide the most appropriate mode of NEMT required or Medically Necessary to safely transport Health Plan Enrollees to their Medicaid covered service. Minimum available modes of transportation shall include:

- *Stretcher Van* - A van or similar vehicle that has been modified, converted, and equipped to safely transport Health Plan Enrollees on one of two types of certified stretchers. Health Plan Enrollees who must travel in a prone position and who do not need any type of medical care or monitoring are transported on a stretcher to Medicaid covered services. Ambulances may be used to provide this level of service.
- *Wheelchair Van* - A motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs, or other mobility devices. Wheelchair van services are used for Health Plan Enrollees who can sit upright and have no acute medical problems that require the Health Plan Enrollee to remain in a lying position, and by Health Plan Enrollees who use a mobility device. The vehicle is configured with side or rear entry and has a ramp or certified motorized lift to load Health Plan Enrollees.
- *Ambulatory* - A vehicle used for transportation of Health Plan Enrollees whose medical condition does not require use of a wheelchair, hydraulic lift or stretcher.
- *Volunteer Driver* - Community organizations that provide transportation services for which mileage reimbursement is available.
- *Personal Vehicle and Mileage Reimbursement* - Mileage reimbursement is available for Health Plan Enrollees to travel roundtrip from their residence to their medical appointments(s) using a personal vehicle.
- *Mass Transit* - Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule and does not deviate from the route or the schedule. Passengers are picked up at designated stops. The Contractor shall only schedule mass transit (bus passes) for Health Plan Enrollees who meet the following criteria:
 - Reside within one quarter of a mile distance from a bus stop;
 - Plan to use a bus line that is operational on the day and/or time of appointment;
 - Are going to a facility within a certain distance;
 - Are not requesting transport for surgical/sedation procedures;
 - Are not going to dialysis; or

- Mass transit is also not suitable for any Health Plan Enrollee under care for a high-risk pregnancy, is in the third trimester of pregnancy, is within six weeks post-partum, or has mobility issues precluding use of mass transit.

1.6.7.5 NEMT Pick-Up and Drop-Off Times

The Contractor shall ensure that transportation Providers arrive on time for scheduled pick-ups. Arrival before the scheduled pick-up time is permitted, however, the Contractor and transportation Provider shall not require a Health Plan Enrollee to board the vehicle before the scheduled pick-up. The transportation Provider is not required to wait more than 15 minutes after the scheduled pick-up time.

If a delay of over 15 minutes occurs in the course of picking up scheduled riders, the Contractor or transportation Provider must contact riders at their pick-up points to inform them of the delay in arrival of vehicle and related schedule. The Contractor or transportation Provider must advise scheduled riders of alternate pickup arrangements when appropriate.

If a return pick-up was not scheduled, the Contractor must ensure that the driver arrives within one-hour from notification. If a delay prevents the driver from picking up the Health Plan Enrollee within the one hour time frame, the Contractor or transportation Provider must contact riders at their pick-up points to inform them of the delay in arrival of vehicle and related schedule. The Contractor or transportation Provider must advise scheduled riders of alternate pickup arrangements when appropriate.

If instances where multiple Health Plan Enrollees simultaneously receive NEMT services from the same transportation Provider in the same vehicle (i.e., shared rides), the Contractor must ensure that no Health Plan Enrollee is forced to remain in the vehicle more than 45 minutes longer than the average travel time for direct transport from point of pick-up to destination.

The Contractor shall ensure that Health Plan Enrollees are reimbursed per mile roundtrip from their residence to their medical appointment(s) using their own personal method of transportation. The Contractor must establish adequate monitoring procedures to prevent fraudulent/unauthorized mileage reimbursement, including use of a Health Plan Enrollee mileage reimbursement request form approved by OHCA. OHCA shall work with the Contractor to implement an acceptable timeframe for providing Health Plan Enrollees with mileage reimbursement payments.

When utilizing mass transit, the Contractor must establish procedures for timely distribution of bus passes to Health Plan Enrollees so that the Health Plan Enrollees are present at the authorized medical appointments on time. The Contractor also must establish adequate monitoring procedures to prevent fraudulent/unauthorized use of bus passes.

1.6.8 **Referrals**

The Contractor shall develop referral policies and procedures to ensure that Health Plan Enrollees have access to participating specialty Providers for Medically Necessary care for their covered conditions. All Health Plan Enrollees and Providers shall be educated on the referral policy and procedures, including which services require referrals.

Health Plan Enrollees shall be educated on the possible consequences of self-referrals, including, but not limited to, experiencing a delay in accessing services. If the Health Plan Enrollee attempts to receive a non-covered service, the Health Plan Enrollee shall be made aware at the point of service that he or she may be billed for the service and how much he or she will be billed.

If the Contractor has exhausted all in-state options, and demonstrated that a Medically Necessary service is unavailable within the State, the Contractor shall provide for these services through out-of-state Providers in accordance with OAC 317:30-3-89 – OAC 317:30-3-92. The Contractor shall facilitate such referrals as appropriate.

The Contractor shall make good faith efforts to ensure that PCMH Providers and Care Managers track and follow up on Health Plan Enrollee referrals as a part of the care management process. The Contractor shall ensure that the PCMH Providers maintain medical records documenting referrals. The Contractor shall maintain referral records which may be audited by OHCA as part of routine oversight activities.

The Contractor must have a process, such as Standing Referrals or approved number of visits, to allow Health Plan Enrollees to directly access a specialist as appropriate for a Health Plan Enrollee's condition and identified needs, when Health Plan Enrollees are determined through an assessment by an appropriate health care professional to need a course of treatment or regular care monitoring. Additionally, Health Plan Enrollee's shall be permitted to self-refer, at minimum, to the following services:

- Behavioral health services, including substance use disorder treatment;
- Vision services;
- Emergency Services;
- Family Planning Services and Supplies;
- Prenatal care;
- Department of Health providers, including mobile clinics; and
- Services provided by IHCPs to AI/AN Health Plan Enrollees.

1.6.9 Social Determinants of Health

The Contractor shall develop strategies to address the Social Determinants of Health impacting SoonerSelect Health Plan Enrollees, including, but not limited to:

- Incorporating relevant questions in the Health Risk Screening Tool and Comprehensive Assessment as described in Section 1.8: "Care Management and Population Health" of this Model Contract;
- Providing Health Plan Enrollees with referrals to social services based on assessed need;
- Tracking and reporting the outcomes of referrals to social services;
- Partnering with community-based organizations or social service providers; and
- Employing or partnering with community health workers or other non-traditional health workers to further address Health Plan Enrollee Social Determinants of Health.

1.6.10 In Lieu of Services

In accordance with 42 C.F.R. § 438.3(e), the Contractor may provide, at its option, services or settings that are in lieu of services or settings covered under the State Plan if:

- The Contractor has proposed any in lieu of services or settings in its response to the Solicitation and OHCA determines that the proposal is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan; and
- The Health Plan Enrollee is not required by the Contractor to use the alternative service or setting.

The approved in lieu of services shall be identified and incorporated into the Contract.

1.6.11 Value-Added Benefits

The Contractor may offer Value-Added Benefits and services in addition to the capitated benefit package to support the health, wellness and independence of Health Plan Enrollees and to advance the State's objectives for the SoonerSelect program. This may include, but is not limited to vision, DME, transportation, pharmacy and physician services for Health Plan Enrollees in excess of fee-for-service program limits.

Value-Added Benefits and Services, if offered, shall not be included in determining the Contractor's Capitation Rates.

If the Contractor has proposed any Value-Added Benefits or services in its response to the Solicitation, and OHCA has approved the proposed benefits and services, the Contractor must furnish these benefits for the duration of the Contract. However, the Contractor may submit a request for revision of the benefits and services for OHCA's review and approval prior to the start of a Contract year, to take effect in the upcoming Contract year.

1.6.12 Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)

The Contractor shall provide EPSDT benefits to all Health Plan Enrollees under age 21, including necessary health care, diagnostic services, treatment and other measures described in Section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the State Plan.

The Contractor shall implement protocols to increase EPSDT screening visit rates, such as:

- Educating Health Plan Enrollees and their caregivers on the value of preventive health care, benefits provided as part of EPSDT, and how to access EPSDT services;
- Providing notification to Health Plan Enrollees under age 21 when appropriate periodic assessments or needed services are due and coordinating appointments for care;
- Tracking Health Plan Enrollee compliance with the EPSDT periodicity and screening schedule and providing outreach when missed appointments are identified; and
- Providing PCMH Providers, on a quarterly basis, a list of Health Plan Enrollees who have not complied with the EPSDT periodicity requirements.

1.6.13 School-Based Services

The Contractor shall reimburse OHCA-enrolled qualified school providers for school-based services, which are medically necessary health-related and rehabilitative services that are provided to a student under the age of 21 pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act (IDEA). School-based services provided pursuant to an Individualized Education Plan (IEP) must meet the requirements of OAC 317:30-5-1020 through 317:30-5-1027 in order to be reimbursed. Contractor must work with Oklahoma State Department of Education's (OSDE) vendor to ensure accurate and timely payment of claims for school-based services, including, but not limited to, development of the IEP, if applicable.

The Contractor shall adhere to the following requirements in support of school-based services:

- The credentialing requirements for school-based Providers will not change under SoonerSelect. The Contractor shall honor the current contracting and credentialing process established by

OSDE but may require a copy of appropriate credentials and OSDE contracts during applicable audits.

- The Contractor shall accept the licensure requirements currently outlined by OSDE.
- The Contractor shall not require any additional paperwork be submitted in order for claims to be submitted by school-based Providers.
- The Contractor shall establish a separate network structure for Providers operating within the school setting. The Contractor cannot opt to close the network for a particular Provider type that could result in denied claims by that Provider type when operating in a school setting/location, when that Provider type is otherwise contracted with OHCA.
- In accordance with OAC 317:30-5-1020:
 - Except for personal care services, which must be prior authorized, a plan of care that meets the requirements of OAC 317:30-5-1020(b) shall serve as a prior medical authorization;
 - For the purposes of occupational therapy services, and services for members with speech, hearing, and language disorders, a plan of care that meets the requirements of OAC 317:30-5-1020(b) shall also, in accordance with 59 O.S. §§ 725.2(H) and 888.4(C), serve as a valid prescription or referral for an initial evaluation and any subsequent services, as is required by 42 C.F.R. § 440.110; and
 - Physical therapy services, by contrast, shall require a signed and dated prescription from the student's physician prior to that student's initial evaluation, in accordance with OAC 317:30-5-291(1). Prescriptions for school-based physical therapy must be reauthorized at least annually, and documented within OSDE's online IEP system.
- The Contractor shall follow the format already established by OHCA for OSDE school-based claiming requirements. OSDE will be consulted on any future changes to this format, which will be implemented consistently across all SoonerSelect MCOs.
- All school-based program components will be managed consistently across all SoonerSelect MCOs as reflected in the OSDE school-based claiming program guide.

Per the evolving nature of the school-based Medicaid Program, the requirements outlined above may be modified in future years to allow for reimbursement of medically necessary health-related and rehabilitative services that are provided pursuant to a 504 Plan or Individualized Family Service Plan in a school setting.

1.6.14 **SoonerStart**

SoonerStart is Oklahoma's early intervention program for families and toddlers, birth to 36 months who have development delays and/or disabilities. The program builds upon and provides supports and resources to assist family members to enhance infant's or toddler's learning and development through everyday opportunities. SoonerStart is dually operated and administered by OSDE and OSDH in accordance with the Individuals with Disability Act (IDEA) Part C and the Oklahoma Early Intervention Act.

The Contractor shall reimburse the Oklahoma State Department of Health (OSDH) in accordance with Section 1.12.4.8: "Department of Health" for all SoonerCare covered benefits received through the SoonerStart program.

1.6.15 Advance Directives

The Contractor shall develop and maintain written policies and procedures for Advance Directives. These policies and procedures shall comply with all State and federal requirements, including but not limited to 42 C.F.R. §§ 422.128, 438.3(j)(1) - (j)(4), Subpart I of 42 C.F.R. Part 489, and 63 O.S. §§3101. 1 through 3101.16, 3102. 1 through 3102. 5 and 3102A. Any and all changes in State law as they pertain to Advance Directives must be incorporated into the written policies and procedures within 30 days of the change and must then subsequently be submitted to OHCA for approval.

Pursuant to 42 C.F.R. §§ 438.3(j)(3)-(4) and O.S. 63 § 3101 *et seq.*, the Contractor shall provide adult Health Plan Enrollees with written information on Advance Directives policies at the time of initial enrollment, as required under OAC 317:30-3-13(a)(2)), and including a description of applicable State law. The format of the Advance Directive will follow State requirements in 63 O.S. § 3101.4.

A Health Plan Enrollee shall be notified of his or her right under State law to accept or refuse medical treatment and the right of formulation of Advance Directives. The Contractor shall be responsible for educating the Health Plan Enrollee on all aspects of care that they are entitled to under Advance Directives, as well as a clear and precise statement of limitation if the Contractor cannot implement an Advance Directive as a matter of conscience, including:

- Clarifying any differences between institution-wide conscience objections and those that may be raised by individual physicians;
- Identifying the State legal authority permitting such objection; and
- Describing the range of medical conditions or procedures affected by the conscience objection.

In accordance with OAC 317:30-3-13(a)(3)), Advance Directives shall be incorporated into the Health Plan Enrollee's Case File within the care management system as well as the Health Plan Enrollee's medical records, as applicable. The Advance Directive becomes operative when it is communicated to the attending physician and the Health Plan Enrollee is no longer able to make decisions for their health, in accordance with 63 O.S. § 3101.5. Revocation of Advance Directive may happen at any time by the Health Plan Enrollee, without regard to their medical or mental health, in accordance with 63 O.S. § 3101.6, and the following:

- If the Health Plan Enrollee is pregnant and the physician is aware, the pregnant patient is to be provided with life-sustaining treatment unless the patient has specifically authorized to withhold treatment during the course of pregnancy, pursuant to 63 O.S. § 3101.8.
- If a physician is unable or unwilling to provide care as per the Advance Directive (63 O.S. § 3101.9), the Contractor will process the information. The physician will transfer care of patient to another physician to comply with medical decisions of the patient. The original physician must comply with the Health Plan Enrollee's Advance Directives during the transfer process, if the Health Plan Enrollee may die, unless the Provider is physically or legally unable to provide without thereby denying the same treatment to another patient.
- An Advance Directive from another state is valid to the extent that it does not exceed authorizations allowed under Oklahoma laws. It must have been executed by the individual the directive applies to and it must specifically authorize withholding/withdrawal of artificial nutrition/hydration and be signed, pursuant to 63 O.S. § 3101.14.

The Contractor shall not administer care conditionally, or otherwise discriminate against the Health Plan Enrollee, based on whether the Health Plan Enrollee has executed an Advance Directive or not, in accordance with OAC 317:30-3-13(a)(4)).

Consistent with OAC 317:30-3-13(a)(5), the Contractor shall ensure that relevant Subcontractors and Contractor staff are educated about its Advance Directive policies and procedures, situations in which Advance Directives would be in the Health Plan Enrollee's best interest and the Contractor's legal obligation to ensure Health Plan Enrollees are informed of their rights as they relate to Advance Directives. These staff and Subcontractors shall be informed about how to assist Health Plan Enrollees to best utilize the Advance Directive mechanism. The Contractor shall specifically designate staff members or Subcontractors to provide this education.

The Contractor shall also provide for community education regarding Advance Directives either directly or in concert with other Providers or entities, as required under OAC 317:30-3-13(a)(5).

The Contractor shall not be required to provide care that conflicts with an Advance Directive.

1.6.16 Organ Transplants

The Contractor shall have written standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to Health Plan Enrollees in accordance with Section 1903(i) of the Act.

1.6.17 Prohibited Payments

The Contractor shall not pay for an item or service for which payment is prohibited by Section 1903(i) of the Act, including but not limited to, services:

- Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act.
- Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).
- Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments.
- With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.
- With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

1.6.18 Emergency and Post-Stabilization Services

In accordance with Section 1852(d)(2) of the Act and 42 C.F.R. §§ 438.114(b), 422.113(c), and 438.114(d), the Contractor must cover and pay for Emergency and Post-Stabilization Care Services. This includes ensuring the determination of the attending emergency physician, or the Provider actually treating the Health Plan Enrollee, of when the Health Plan Enrollee is sufficiently stabilized for transfer or discharge is

binding on the Contractor and State for coverage and payment of Emergency and Post-Stabilization Care Services.

1.6.18.1 Emergency Services

In accordance with Section 1932(b)(2) of the Act and 42 C.F.R. §§ 438.114(c)(1)-(2) and 438.114(c)(1)(ii)(A) - (B) the Contractor shall:

- Pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid if the service had been provided under the State's fee-for-service Medicaid program.
- Cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor.
- Not deny payment for treatment obtained when a Health Plan Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- Not deny payment for treatment obtained when a representative of the Contractor instructs the Health Plan Enrollee to seek Emergency Services.
- Provide coverage and payment for services until the attending emergency physician, or the Provider actually treating the Health Plan Enrollee, determines that the Health Plan Enrollee is sufficiently stabilized for transfer or discharge.

In accordance with 42 C.F.R. §§ 438.114(d)(1)-(2), the Contractor shall not:

- Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- Refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Health Plan Enrollee's PCMH or the Contractor, or applicable State entity of the Health Plan Enrollee's screening and treatment within ten Calendar Days of presentation for Emergency Services.
- Hold a Health Plan Enrollee who has had an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition.

1.6.18.2 Post-stabilization Services

In accordance with 42 C.F.R. §§ 438.114(e), 422.113(c)(2)(i) - (ii), and 422.113(c)(2)(iii)(A) - (C), the Contractor shall cover Post-Stabilization Care Services that are:

- Obtained within or outside the Contractor network that are:
 - Pre-approved by a Contractor Provider or representative.
 - Not pre-approved by a Contractor Provider or representative, but administered to maintain the Health Plan Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.
- Administered to maintain, improve, or resolve the Health Plan Enrollee's stabilized condition without preauthorization, and regardless of whether the Health Plan Enrollee obtains the services within the Contractor network when the Contractor:
 - Did not respond to a request for pre-approval within one hour.

- Could not be contacted.
- Representative and the treating physician could not reach agreement concerning the Health Plan Enrollee's care and a Contractor physician was not available for consultation.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), the Contractor shall limit charges to Health Plan Enrollees for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Health Plan Enrollee if he or she obtained the services through the Contractor.

In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(3)(i) - (iv), the Contractor's financial responsibility for Post-Stabilization Care Services if not pre-approved ends when:

- A Contractor physician with privileges at the treating hospital assumes responsibility for the Health Plan Enrollee's care.
- A Contractor physician assumes responsibility for the Health Plan Enrollee's care through transfer.
- A Contractor representative and the treating physician reach an agreement concerning the Health Plan Enrollee's care.
- The Health Plan Enrollee is discharged.

1.6.19 **Family Planning**

In accordance with Section 1902(a)(23) of the Act and 42 C.F.R. § 431.51(b)(2), the Contractor shall not restrict the Health Plan Enrollee's free choice of Family Planning Services and Supplies Providers.

1.6.20 **Abortions**

In accordance with 42 C.F.R. § 441.202 and the Consolidated Appropriations Act of 2008, the Contractor shall only cover Health Plan Enrollee abortion services in the following situations:

- If the pregnancy is the result of an act of rape or incest.
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

1.6.21 **Delivery Network**

In addition to the benefits described in the sections above, the Contractor shall also cover services in the following situations:

- If a female Health Plan Enrollee's designated PCMH Provider is not a women's health specialist, the Contractor shall provide the Health Plan Enrollee with direct access to a women's health specialist within the provider network for covered routine and preventive women's health care services, in accordance with 42 C.F.R. § 438.206(b)(2).
- The Contractor shall provide for a second opinion from a Participating Provider, or arrange for the Health Plan Enrollee to obtain a second opinion outside the network, at no cost to the Health Plan Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).
- If the Contractor's provider network is unable to provide necessary medical services covered under the Contract to a particular Health Plan Enrollee, the Contractor must adequately and timely cover the services out of network, for as long as the Contractor's provider network is unable to provide them, in accordance with 42 C.F.R. § 438.206(b)(4).

The Contractor shall coordinate payment with Non-Participating Providers and ensure the cost to the Health Plan Enrollee is no greater than it would be if the services were furnished within the network. The Contractor shall also use processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Non-Participating Providers for medical/surgical benefits in the same classification.

1.6.22 Moral Objections

The Contractor shall provide, reimburse for, or provide coverage of all counseling and referral services covered under the Contract unless the Contractor objects to the service on moral or religious grounds. The Contractor shall furnish information about the services it does not cover because of an objection on moral or religious grounds to the State in its response to the Solicitation and whenever the Contractor adopts such a policy during the term of the Contract. Pursuant to 42 C.F.R. § 438.10(e)(2)(v)(C), the State will provide information about counseling or referral services the Contractor will not cover on the basis of moral or religious objections at least 30 days before the effective date of the policy for any particular service.

1.7 Medical Management

The Contractor and OHCA acknowledge that the purpose of medical (utilization) management is to ensure Health Plan Enrollees have appropriate access to Medically Necessary covered services. For the purpose of this Model Contract, Medically Necessary covered services must be furnished in a manner that:

- Is no more restrictive than that used in the Oklahoma Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan and other State policies and procedures;
- Addresses the prevention, diagnosis and treatment of a Health Plan Enrollee's disease, condition and/or disorder that results in health impairments and/or disability;
- Allows Health Plan Enrollees to achieve age-appropriate growth and development; and
- Allows Health Plan Enrollees the ability to attain, maintain or regain functional capacity.

1.7.1 Medically Necessary Services

The Contractor is responsible for providing the full range of EPSDT services to Health Plan Enrollees under age 21, including necessary health care, diagnostic services, treatment and other measures described in section 1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered during screening, whether or not such services are covered under the State Plan.

The Contractor is also responsible for covering and providing other Medically Necessary Services. Services are considered Medically Necessary if they meet the requirements in Appendix 1B: "Definitions," OAC 317:30-3-1(f) and federal requirements described in 42 C.F.R. § 438.210(a)(5).

1.7.2 Medical Management Program Components

The Contractor shall develop a medical management structure for the SoonerSelect program that is integrated with and complementary to the Contractor's QAPI program. This program should have a Medical Management Program description, work plan, an implementation mechanism, policies and procedures and program evaluation with evaluative criteria, all of which shall be reviewed and updated annually.

The Medical Management Program must include:

- Prior authorization;
- Concurrent review;
- Pre-admission criteria for non-emergency admissions;
- Admission review for urgent/emergent admissions on a retroactive basis where necessary;
- Restrictions against requiring pre-admission certification for admissions for the normal delivery of children;
- Prospective review of same day surgery procedures; and
- Identification and management of emergency department utilization data.

OHCA reserves the right to review and approve the Contractor's Medical Management Program description, work plan, policies and procedures and program evaluation with evaluative criteria during Readiness Review, annually and at times specified by OHCA.

1.7.3 **Qualified Staff**

The medical management function shall be overseen by a full-time Utilization Management Director, or equivalent, and a Medical Management (Utilization Management) Committee, which shall be comprised of appropriately credentialed health care Providers. This committee shall report to the Contractor's Quality Improvement Committee.

The Medical Management Program shall be staffed by an appropriate number of credentialed medical professionals. The Contractor shall submit a staffing plan for the Medical Management Program for review by OHCA during Readiness Review. This staffing plan should cover the training that staff receive specific to the area of medical management.

The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to Providers' requests for health care or Service Authorizations for the Contractor's Health Plan Enrollees. Utilization management staff shall receive ongoing training regarding interpretation and application of the utilization management guidelines. The Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon OHCA request.

In accordance with 42 C.F.R § 438.210(e), the Contractor shall ensure compensation to staff and Subcontractors conducting utilization management activities is not structured to provide incentives for denying, limiting, or discontinuing Medically Necessary services to any Health Plan Enrollee.

1.7.4 **Clinical Practice Guidelines**

Pursuant to 42 C.F.R. § 438.236, the Contractor shall adopt physical and behavioral health Clinical Practice Guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of Health Plan Enrollees in each of the eligibility groups enrolled with the Contractor;
- Are adopted in consultation with Participating Providers; and
- Are reviewed and updated as needed, or at least every two years.

The Contractor shall ensure decisions regarding utilization management, Health Plan Enrollee education, coverage of services, and other areas to which practice guidelines apply, are consistent with the practice guidelines. The Contractor may coordinate the development of Clinical Practice Guidelines with other MCOs to avoid the possibility that Providers would receive conflicting Clinical Practice Guidelines from different MCOs. The Contractor shall disseminate Clinical Practice Guidelines to all affected Participating Providers and, upon request, to Health Plan Enrollees or Eligibles. The Contractor shall take steps to encourage adoption of the Clinical Practice Guidelines by Providers and to measure Provider compliance with the Clinical Practice Guidelines.

1.7.5 Medical Necessity Criteria

The Contractor may accept nationally recognized medical necessity criteria, including but not limited to, Milliman Care Guidelines or InterQual. If the Contractor chooses to utilize separate criteria for physical and Behavioral Health Services, the Contractor shall demonstrate that the use of separate criteria would have no negative impact on Health Plan Enrollees, and would not otherwise violate the Contractor's requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA.) Notwithstanding the foregoing, the Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria for authorizing substance use disorder services.

1.7.6 Authorization Process

The Contractor shall develop a Prior Authorization (PA) process as part of the Medical Management Program that comports with all State and federal requirements, including requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. § 438.910(d). In accordance with 42 C.F.R. § 438.210(b), the Contractor and any applicable Subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor's Prior Authorization process shall also put in place mechanisms to ensure consistent application of review criteria for authorization decisions, and consult with the Provider that requested the services when appropriate.

The Contractor shall provide information sufficient for OHCA to comply with its statutory responsibilities under 63 O.S. § 2560 – 2565, as requested.

OHCA reserves the right to standardize certain parts of the PA reporting process across MCOs, such as requiring Contractors to adopt and apply the same definitions regarding approved, pending, denied, suspended requests, and other policies and processes, as determined by OHCA.

The Contractor shall develop plans and processes to monitor Prior Authorization requests and denials. The Contractor shall use this information to identify strategies to address over- and under-utilization of services, sharing monitoring and strategies with OHCA upon request.

1.7.6.1 Services Requiring PA

The Contractor may require PA to the extent required under OHCA's policies and rules and may propose additional PA requirements, subject to OHCA review and approval.

The Contractor shall not be permitted to impose Prior Authorization on any of the following Behavioral Health Services:

- Crisis services;
- Medication-assisted treatment (MAT);
- Programs for assertive community treatment (PACT); or
- Urgent services.

1.7.6.2 Methods of PA Submission

To ease Provider administrative burden, the Contractor shall utilize the standardized OHCA-developed PA Request Form. Providers shall be able to request online. The Contractor shall implement strategies to streamline and simplify online submission processes as that is the primary mode of PA submission currently utilized by SoonerCare Providers. Online requests shall be submitted through the secure Provider portal on the Contractor's website. The Contractor may also allow Providers to submit PA requests by fax or toll-free phone call at their discretion.

If phone requests are allowed, those requests shall be handled by the Contractor's toll-free provider services call center, as described in Section 1.13.2: "Provider Services Call Center" of this Model Contract, or a dedicated toll-free authorization line. The line shall be equipped to respond to Urgent Care Prior Authorization requests on a 24-hour, seven-day per week basis. If an Urgent Care PA request must be recorded by a voice mail system due to capacity issues, that phone call must be returned within 30 minutes and a decision rendered within one hour.

The authorization line or provider services call center shall be equipped after regular business hours to field calls from Providers treating Health Plan Enrollees with Urgent Care needs. Should a Provider determine that a Health Plan Enrollee needs a prompt referral to a specialist, call center policies and procedures shall be able to allow that prompt referral if necessary. All calls regarding Urgent Care situations shall be returned within 30 minutes.

1.7.6.3 Timeliness Standards

The Contractor shall decide standard Prior Authorization requests within 72 hours of receipt of the request or as expeditiously as the Health Plan Enrollee's health requires. If the Provider indicates, or the Contractor is aware, that adhering to the standard 72-hour timeframe could jeopardize the Health Plan Enrollee's life, health or ability to attain, maintain, or regain maximum function, the Contractor shall make an authorization decision as expeditiously as necessary and, in no event, later than 24 hours after receipt of the request for service. Notwithstanding the foregoing, all inpatient behavioral health Prior Authorization requests must be handled within 24 hours.

If the Health Plan Enrollee, or Provider on behalf of the Health Plan Enrollee in the case of standard authorizations, requests the extension or if the Contractor can justify to OHCA the need for additional information and show that the extension is in the Health Plan Enrollee's best interest, the Contractor may have an extension of up to 14 days to complete the PA request, in accordance with a process to be defined by OHCA. If an extension is granted that is not requested by the Health Plan Enrollee, the Contractor shall provide the Health Plan Enrollee with a written explanation and information on how an Appeal may be filed in response to the extension.

1.7.6.4 Service Authorization Approval Notices

When the Contractor denies a Service Authorization request or authorizes services in an amount, duration and scope less than requested, the Contractor shall send a notice in accordance with Section 1.16.2:

“Adverse Benefit Determinations” of this Model Contract. The Contractor shall also provide written notification to Health Plan Enrollees and Providers when a service request is authorized.

1.7.6.5 Concurrent Review

The Contractor shall develop concurrent review policies and procedures as part of its Medical Management Program in order to monitor and review continued inpatient hospitalization, length of stay, and diagnostic ancillary services with respect to their appropriateness and medical necessity.

1.7.6.6 Retrospective Review

The Contractor shall develop retrospective review policies and procedures as part of its Medical Management Program. The retrospective review component of the Medical Management Program shall evaluate the appropriateness of care previously received by a Health Plan Enrollee.

The Contractor shall ensure the retrospective review process evaluates suspended claims within 14 days or sooner, if feasible, and shall deliver the decision on coverage to the Provider no later than the next business day after a decision is reached.

1.7.6.7 Authorization Denials and Peer-to-Peer Review

In accordance with 42 C.F.R. § 438.210(b)(3), any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by an individual who has appropriate expertise in addressing the Health Plan Enrollee’s medical or behavioral health needs.

The Contractor shall permit Providers to request a peer-to-peer review process for all Service Authorization denials or authorizations in an amount, duration, or scope less than requested.

1.7.6.8 Emergency Room (ER) Utilization

The Contractor shall continuously review ER utilization data of all Health Plan Enrollees with the goal of identifying unnecessary or extraneous usage. The Contractor shall report to OHCA, every six months, or as otherwise required in the Reporting Manual, on its ER utilization management activities and evaluation in a format to be specified by OHCA. For Health Plan Enrollees whose utilization exceeds the threshold of ER visits defined by OHCA, the Contractor shall have procedures in place to conduct the appropriate follow-up.

The Contractor shall work with a Health Plan Enrollee in concert with his or her Care Manager and Provider to reduce ER utilization. The Contractor shall ensure that appropriate and timely updates are made to the Health Plan Enrollee’s Care Plan, as applicable, as part of the ER utilization process.

Additionally, the Contractor shall work with hospitals to obtain data on ER utilization for behavioral health reasons and length of time in the ER. The Contractor shall develop remediation plans with hospitals with significant numbers of behavioral health ER stays longer than 23 hours.

1.7.6.9 Outpatient Drug Authorization Decisions

The Contractor shall develop medical management policies for the pharmacy benefit. These policies shall adhere to the requirements and regulations outlined below and in Section 1.6.3: “Pharmacy Program” of this Model Contract. Any Prior Authorization program will adhere to the requirements of Section 1927(d)(5) of the Act and in accordance with 42 C.F.R § 438.210(d)(3) and 42 C.F.R. § 438.3(s)(6), including requirements related to provision of notices.

The Contractor shall only require Prior Authorization for prescription drugs that are required to be prior authorized by OHCA, including new drugs added to OHCA list of covered drugs in accordance with the provisions in Section 1.6.3: "Pharmacy Program." The Contractor or their Subcontractor shall utilize the criteria established by the OHCA Drug Utilization Review Board for medication Prior Authorization determinations. Any step therapy limitations or requirements shall adhere to the requirements of 63 O.S. § 7310. Quantity limits shall not exceed those established by OHCA.

The Contractor may require as a condition of coverage or payment for a covered outpatient drug for which Federal Financial Participation (FFP) is available the approval of the drug before its dispensing for any medically accepted indication only if the system for approval generates a response by telephone or other telecommunications device within 24 hours of a request for Prior Authorization. All Prior Authorizations are required to have a response within 24 hours. Prior authorization requests shall not be denied by non-licensed medical personnel.

If a pharmacist is unable to refill the Health Plan Enrollee's prescription due to a Prior Authorization requirement and the prescribing Provider is unreachable, the Contractor must require the pharmacist to dispense a 72-hour supply of the prescribed medicine. This requirement does not apply if the dispensing pharmacist establishes that dispensing this dosage would jeopardize the health or safety of the Health Plan Enrollee, in which case the pharmacist should contact the prescribing Provider. The Contractor shall compensate the pharmacy for this dosage including the required dispensing fee. The 72-hour supply shall not count against the monthly prescription limitation.

The Contractor will adhere to medical management policies developed by OHCA for physician administered drugs. The Contractor must demonstrate coverage for prescription and outpatient drugs is consistent with the amount, duration, and scope as described by the Medicaid Fee-For-Service program, including the prohibition on experimental treatment and off-label use. Prior Authorization criteria for these drugs and outpatient drugs covered under the medical benefit will be no more restrictive than that utilized by OHCA.

1.8 Care Management and Population Health

The Contractor shall design and operate a care management and population health model subject to OHCA review and approval and in compliance with the requirements of 42 C.F.R. § 438.208. The Contractor's approach shall be person-centered and holistically identify and address the physical health, behavioral health and community and social support needs of its Health Plan Enrollees. The approach shall include interventions which address OHCA clinical and quality improvement focus areas, including, but not limited to:

- Opioid and other substance use disorders;
- Tobacco cessation;
- Childhood obesity;
- Behavioral health;
- Diabetes;
- Cardiovascular disease;
- Prenatal care and post-partum outcomes;
- Children receiving private duty nursing services;

- Access to preventive health services;
- Health Plan Enrollee health literacy; and
- Other emerging health trends among the SoonerCare population at the direction of OHCA or identification by the Contractor.

The Contractor shall propose for OHCA review and approval a Risk Stratification Level Framework that determines the intensity and frequency of care management and population health interventions received by Health Plan Enrollees. The Contractor's Risk Stratification Level Framework shall determine the appropriate level of care management and population health intervention for each Health Plan Enrollee based on assessed needs, as determined through the following minimum strategies:

- Initial Health Risk Screening as described in Section 1.8.1: "Health Risk Screening" of this Model Contract;
- Comprehensive Assessment as described in Section 1.8.2: "Comprehensive Assessment" of this Model Contract;
- Predictive modeling;
- Claims review;
- Health Plan Enrollee and caregiver requests; and
- Physician referrals.

OHCA may also identify Health Plan Enrollees with Special Health Care Needs based on responses to health status screening questions on the SoonerCare eligibility application. The Contractor shall be capable of receiving this data in the manner and format defined by OHCA and shall incorporate these findings into its Risk Stratification Level Framework.

The Contractor's Risk Stratification Level Framework shall identify the extent to which the Contractor will leverage, coordinate or engage with local Provider groups and community agencies currently delivering care coordination or case management to Eligibles. The Contractor's strategies shall be designed to minimize duplication and ensure collaboration with other entities delivering these services to Health Plan Enrollees.

The Contractor shall assign every Health Plan Enrollee to a risk level and deliver interventions in an amount, duration and scope based on its OHCA approved Risk Stratification Level Framework. The Contractor's Risk Stratification Level Framework shall consider factors such as:

- Acuity of any diagnosed health conditions;
- Behavioral health diagnoses;
- Substance use disorder diagnoses;
- Pregnancy status and maternal risk factors;
- Inpatient or emergency department utilization; and
- Social Determinants of Health.

The Contractor shall evaluate Health Plan Enrollees for needed changes in intensity and frequency of care management and population health interventions, based on the Contractor's Risk Stratification Level Framework, when there is a significant change in the Health Plan Enrollee's needs or circumstances, or progress in meeting Care Plan goals.

During Initial Program Implementation, OHCA may, at its sole discretion, provide to the Contractor information on the Health Plan Enrollee's case management or care coordination participation as a SoonerCare Eligible for use by the Contractor in determining assignment according to its Risk Stratification Level Framework.

1.8.1 Health Risk Screening

In accordance with 42 C.F.R. § 438.208(b)(3) and the requirements of this section, the Contractor shall demonstrate a good faith effort to perform a Health Risk Screening on all new Health Plan Enrollees in accordance with the timeline requirements in Section 1.8.1.3: "Timeline for Completion" of this Model Contract and make subsequent attempts to conduct the Health Risk Screening if the initial attempt to contact the Health Plan Enrollee is unsuccessful, in accordance with Section 1.8.1.2: "Methods of Completion" of this Model Contract. The purpose of the Health Risk Screening is to obtain basic health and demographic information, identify any immediate Health Plan Enrollee needs and to assist the Contractor in assigning the Health Plan Enrollee to services in accordance with the Contractor's Risk Stratification Level Framework.

1.8.1.1 Screening Tool

The Contractor shall develop a Health Risk Screening tool for OHCA review and approval. OHCA reserves the right to mandate, with advance notice to the Contractor, a uniform Health Risk Screening to be used by all SoonerSelect MCOs. At minimum, the Health Risk Screening shall include questions about the following:

- Demographic information for verification purposes;
- Current or past physical health and behavioral health conditions;
- Services or treatment the Health Plan Enrollee is currently receiving, including from out-of-state Providers;
- Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another MCO;
- Most recent ER visit, hospitalization, physical exam and medical appointments;
- Current medications; and
- Questions to address Social Determinants of Health.

The Contractor must submit for OHCA review and approval any proposed changes to its Health Risk Screening tool at least 45 days prior to its intended use.

1.8.1.2 Methods of Completion

The Contractor shall propose, for OHCA review and approval, its methodology for contacting Health Plan Enrollees to complete the Health Risk Screening. At minimum, the Contractor's methodology shall include three outreach attempts and other methods to maximize contact with Health Plan Enrollees in order to complete the Health Risk Screening. The Contractor may permit Health Plan Enrollees to complete the Health Risk Screening in person, by phone, electronically through the secure portal described in Section 1.11.6.3: "Health Plan Enrollee Website Portal" of this Model Contract, or by mail. The Contractor shall document all outreach attempts and make the documentation available to OHCA upon request.

1.8.1.3 Timeline for Completion

During Initial Program Implementation, the Contractor shall perform the Health Risk Screening within 90 days of a new Health Plan Enrollee's enrollment effective date. During Steady State Operations, the

Contractor shall perform the Health Risk Screening within 30 days following the new Health Plan Enrollee's enrollment effective date. For purposes of this requirement, a new Health Plan Enrollee is one that has not been enrolled with the Contractor during the prior 12 months.

1.8.1.4 Screening Updates

The Contractor shall conduct an updated Health Risk Screening when a Health Plan Enrollee experiences a change in health status since the initial screening. As part of its Risk Stratification Level Framework, the Contractor shall develop methods to identify when a Health Plan Enrollee has a change in health status requiring an updated Health Risk Screening.

1.8.1.5 Submission of Screening Results to OHCA

In accordance with 42 C.F.R. § 438.208(b)(4), the Contractor shall share with OHCA or other MCOs and the SoonerCare Dental PAHP serving the Health Plan Enrollee the results of the Health Risk Screening to prevent duplication. The results shall be transmitted in the timeframe and format required by OHCA. Contractor must ensure that it maintains and shares, as appropriate, a Health Plan Enrollee health record in accordance with professional standards. Contractor must ensure that in the process of coordinating care, each Health Plan Enrollee's privacy is protected in accordance with all applicable privacy laws, including but not limited to the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E to the extent they are applicable, the requirements of 42 C.F.R. §§ 2.1 – 2.67, the requirements of 43A O.S. § 1-109, and the requirements of 63 O.S. § 1-502.2.

1.8.2 **Comprehensive Assessment**

The Contractor shall conduct a Comprehensive Assessment for each Health Plan Enrollee identified through the Health Risk Screening as having a Special Health Care Need. As part of its Risk Stratification Level Framework, the Contractor shall propose its methodology for determining what responses on the Health Risk Screening trigger the determination a Health Plan Enrollee requires a Comprehensive Assessment. The Contractor shall also identify in its Risk Stratification Level Framework other conditions that will trigger the need for a Comprehensive Assessment. For example, if the Health Plan Enrollee is identified as having an ER visit, Crisis Center visit, hospital admission or change in condition prior to or following completion of the Health Risk Screening such events may be identified as triggers for a Comprehensive Assessment.

In accordance with 42 C.F.R. § 438.208(c)(2), the Comprehensive Assessment will serve as the mechanism to comprehensively assess each Health Plan Enrollee identified as having Special Health Care Needs to identify any ongoing special conditions of the Health Plan Enrollee that require a course of treatment or regular care monitoring.

1.8.2.1 Assessment Tool

The Contractor shall develop a Comprehensive Assessment instrument, subject to OHCA approval. The instrument must assess a Health Plan Enrollee's physical health, behavioral health, community and social support needs. At a minimum, the Comprehensive Assessment shall include questions from the following domains:

- Demographic intake;
- Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content and memory;

- Functional or adaptive deficits/needs (e.g., Activities of Daily Living, Instrumental Activities of Daily Living);
- Behavioral health, including previous psychiatric, addictions and/or substance abuse history, and a behavioral health, depression and substance abuse screen;
- Medical conditions, complications and disease management needs;
- Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;
- Disability history;
- Educational attainment, skills training, certificates, difficulties and history;
- Family/caregiver and social history;
- Medication history and current medications, including name, strength, dosage and length of time on medication;
- Social profile, community and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;
- Advance directives;
- Present living arrangements;
- Health Plan Enrollee strengths, needs and abilities;
- Home environment; and
- Health Plan Enrollee cultural and religious preferences.

Any changes to the Contractor's Comprehensive Assessment instrument must be submitted to OHCA for review and approval at least 45 days prior to its intended use.

1.8.2.2 Methods of Completion

The Contractor shall propose as part of its Risk Stratification Level Framework the methods by which it shall complete the Comprehensive Assessment and what conditions will trigger the determination for when an in-person versus telephonic Comprehensive Assessment is warranted. The Contractor shall ensure that all assessments are conducted in a culturally competent manner and that information and instructions are accessible to individuals with disabilities and persons who have LEP.

1.8.2.3 Timeline for Completion

During Initial Program Implementation, the Contractor shall complete the Comprehensive Assessment within 45 days of the Health Risk Screening. During Steady State Operations, the Contractor shall perform the Comprehensive Assessment within 30 days of the Health Risk Screening.

1.8.2.4 Reassessments

The Contractor shall conduct an annual Comprehensive Assessment on all Health Plan Enrollees identified as having a Special Health Care Need in accordance with the Contractor's Risk Stratification Level Framework. The annual reassessment shall be completed within one year of the Health Plan Enrollee's last assessment date.

The Contractor shall also conduct an updated Comprehensive Assessment when a Health Plan Enrollee experiences a significant change in health status prior to the annual reassessment. As part of its Risk Stratification Level Framework, the Contractor shall propose what constitutes a significant change triggering a reassessment, such as acute illness or deterioration in the Health Plan Enrollee's health,

change in the status of a caregiver (e.g., death or illness), transition from one setting to another (e.g., hospital to home) and change in living arrangements.

1.8.2.5 Direct Access to Specialists

In accordance with 42 C.F.R. § 438.208(c)(4), for Health Plan Enrollees with Special Health Care Needs determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow Health Plan Enrollees to directly access a specialist as appropriate for the Health Plan Enrollee's condition and identified needs.

1.8.3 **Care Plans**

In accordance with 42 C.F.R. § 438.208(c)(3), the Contractor shall produce a Care Plan for Health Plan Enrollees with Special Health Care Needs determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring. The Contractor's Care Plans shall be:

- Approved by the Contractor in a timely manner, if this approval is required by the Contractor;
- Developed in accordance with OHCA quality assurance and utilization review standards; and
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the Health Plan Enrollee's circumstances or needs change significantly, or at the request of the Health Plan Enrollee.

The Contractor shall develop Care Plans within 15 days of completion of the Comprehensive Assessment during both Initial Program Implementation and Steady State Operations.

1.8.4 **Care Management and Population Health Staffing**

1.8.4.1 Staffing Levels

The Contractor shall ensure an adequate number of Care Managers to address the needs of its Health Plan Enrollees in accordance with Contract requirements and the level of services to be delivered under the Contractor's Risk Stratification Level Framework.

The Contractor shall submit an annual Care Management Staffing Plan to OHCA for review and approval. The plan shall be submitted on a schedule and in a format defined by OHCA and shall, at a minimum, address:

- Number of Care Managers, supervisors/managers and support staff;
- Number of care management staff assigned to each of area of the Contractor's Risk Stratification Level Framework;
- Methodology by which the Contractor determined care management staffing levels were sufficient; and
- Process by which the Contractor will ensure the care management staffing levels are sufficient to meet Contract requirements.

1.8.4.2 Care Manager Assignment

The Contractor shall describe in its Risk Stratification Level Framework its proposed methodology for assigning Health Plan Enrollees to a Care Manager, including which levels of care management and population health interventions are assigned a Care Manager. All Care Manager assignments shall be made based on the Health Plan Enrollee's primary need(s) as identified in the Health Risk Screening, Comprehensive Assessment or other Contractor assessment findings. Within ten days of Health Plan

Enrollee designation to a Risk Stratification Level that includes assignment to a Care Manager, the Contractor shall notify the Health Plan Enrollee of the following:

- The assigned Care Manager's name and contact information;
- Procedures to contact the assigned Care Manager if any issues or needs arise; and
- When the Health Plan Enrollee can expect to be contacted by the Care Manager based on the Risk Stratification Level Framework assigned to the Health Plan Enrollee. This communication shall be in writing to the Health Plan Enrollee.

1.8.4.3 Qualifications

The Contractor's Care Managers shall, at a minimum, have the following qualifications:

- Bachelor's degree in social work, psychology, or a related social services field and at least one year of related professional experience with a similar population as those in the SoonerSelect program. Related professional experience includes acting as a Care Manager, rehabilitation specialist, health specialist, social services coordinator or licensed behavioral health professional in the State of Oklahoma; or
- Registered or licensed practical nurse, licensed to practice in the State of Oklahoma, with at least one year of professional experience.

The Contractor shall complete a criminal history and background investigation on all Care Managers prior to their employment or use on a contracted basis. The Contractor shall ensure that care management activities, including but not limited to, screening and assessments, are in line with duties authorized by State licensing boards.

1.8.4.4 Training

The Contractor shall provide Care Managers with initial and ongoing training on topics related to the populations served in the SoonerSelect program. The Contractor shall develop a curriculum and training plan to ensure all Care Managers attend initial and ongoing training sessions. The Contractor shall retain a sufficient level of qualified staff dedicated to performing the training. Attendance at each and every training session shall be documented and stored.

Initial training topics shall include, at a minimum, all the following:

- Orientation to SoonerCare programs;
- Overview of SoonerSelect program population categories;
- SoonerSelect program benefits and services;
- The Contractor's Risk Stratification Level Framework;
- Behavioral health;
- Clinical conditions prevalent among the Contractor's Health Plan Enrollees;
- Instruction on conducting a home visit, as applicable to the Contractor's Risk Stratification Level Framework;
- Health Plan Enrollee outreach and interviewing techniques;
- Completion of a Health Risk Screening and Comprehensive Assessment;
- Reassessment procedures;
- Care planning;

- Identification of risk and risk mitigation techniques;
- How to recognize and report abuse, neglect and Exploitation;
- EVV system and procedures;
- Critical incident reporting;
- Service authorization;
- Service delivery monitoring;
- Care management functions;
- Instruction on locating and arranging community-based services;
- Management of care transitions (e.g., hospital discharge planning);
- Cultural competency;
- Advance directives;
- HIPAA and other privacy laws;
- Disaster planning;
- Care management information system; and
- Documentation of findings in a Health Plan Enrollee's case record.

The Contractor's Care Managers shall successfully complete the Behavioral Health Care Manager certification training provided through the Department of Mental Health and Substance Abuse Services. Care Managers will have six months from the date of hire to successfully complete the training unless otherwise specified in writing by OHCA.

All Care Managers shall receive ongoing training at least annually. Topics to be covered shall be determined by the Contractor based on the populations served and programmatic priority areas identified by OHCA or the Contractor.

1.8.4.5 Care Manager Changes

The Contractor shall allow a Health Plan Enrollee to change a Care Manager if the Health Plan Enrollee desires and there is an alternative Care Manager available. The Contractor shall seek to minimize the number of changes in Care Managers assigned to the Health Plan Enrollee by making an appropriate initial assignment and working to resolve issues before they result in a request for a change.

1.8.4.6 Contractor-Initiated Care Manager Changes

The Contractor may initiate a change in Care Managers in the following circumstances:

- The Care Manager is no longer employed by the Contractor;
- The Care Manager is on temporary leave from employment;
- The Care Manager has a conflict of interest and cannot serve the Health Plan Enrollee; or
- Care Manager caseloads must be adjusted due to the size or acuity of the individual Care Manager's caseload.

The Contractor shall provide advance notice to a Health Plan Enrollee of the change to the extent practicable and shall minimize disruption through adherence to the process described in Section 1.9.7: "Care Manager to New Care Manager" of this Model Contract.

1.8.4.7 Health Plan Enrollee Access to Care Managers

The Contractor shall ensure that Health Plan Enrollees have access to a telephone number to either directly contact their assigned Care Managers or a member of the care management team during normal business hours. A back-up system shall be in place for Health Plan Enrollees when their Care Manager is unavailable, including after hours and holidays. Health Plan Enrollees shall be given an emergency telephone number to call 24 hours per day, seven days per week that is answered by a live voice. Calls that require immediate attention by a Care Manager shall be warm-transferred to an on-call Care Manager so the Health Plan Enrollee's need(s) are addressed as soon as possible. Procedures shall be in place to ensure Health Plan Enrollees, representatives and Providers receive timely communication for calls placed on this line.

1.8.5 **Coordination with Other SoonerCare Programs**

In accordance with 42 C.F.R. §§ 438.208(b)(2)(ii) – (iv), the Contractor shall implement procedures to coordinate services delivered under this Contract with the services the Health Plan Enrollee receives from:

- The Dental PAHP;
- The fee-for-service SoonerCare program; and
- Community and social support providers.

The Contractor's policies and procedures for coordination under this section shall be subject to OHCA review and approval and will be designed to ensure continuity of care and avoid duplication.

1.8.6 **Lock-In Program**

In accordance with 42 C.F.R. § 431.54(e), the Contractor shall have a pharmacy lock-in program that promotes appropriate utilization of health care resources by monitoring potential Abuse or inappropriate utilization of prescription medications. The Contractor shall have a pharmacist on staff to oversee the lock-in program. The Contractor shall develop lock-in criteria as well as policies and procedures for lock-in program referrals, interventions, monitoring, reporting and exceptions for Emergency Services; these shall be reviewed and approved by OHCA prior to adoption and implementation. Health Plan Enrollees may be enrolled in the lock-in program for a minimum of two years and re-evaluated regularly (at least annually). Health Plan Enrollees may change their lock-in pharmacy or prescriber no more than once per year except in extenuating circumstances.

Health Plan Enrollees shall be monitored for excessive use of medications considered to have a high Abuse potential, the use of multiple physicians and pharmacies and the use of medications for diagnoses that raise concern for prescription drug abuse. Health Plan Enrollees enrolled in the pharmacy lock-in program are required to fill all controlled prescriptions for which Medicaid is the primary payer at a single designated pharmacy and by a single designated prescriber and/or Provider group in order to better manage medication utilization.

The Contractor shall monitor and conduct reviews of pharmacy utilization by locked-in Health Plan Enrollees and other Health Plan Enrollees who merit concern, perform case closure activities, and manage all lock-in program correspondence with Health Plan Enrollees and Providers. The Contractor shall be responsible for notifying Health Plan Enrollees and Providers of the lock-in restriction at least ten days in advance of lock-in, including reason for restriction, effective date and length of restriction, name of designated Provider(s), option to change Provider, and Appeal rights. If the Health Plan Enrollee requests to change Providers, the Contractor shall make the change within 30 days of the request. Information on

the Contractor's lock-in program shall be included in the Health Plan Enrollee Handbook, Provider Manual, and other Health Plan Enrollee and Provider educational materials.

The Contractor shall report on the lock-in program in accordance with the Reporting Manual requirements and on a quarterly basis.

The Contractor shall place in its lock-in program any Health Plan Enrollees who were in a lock-in program within fee-for-service Medicaid or another MCO at the time of enrollment with the Contractor.

1.8.7 Monitoring Service Delivery

The Contractor shall develop a comprehensive program to monitor the effectiveness of its care management and population health activities on an ongoing basis. The findings and strategies shall be shared and discussed during the Contractor's Quality Improvement Committee (QIC) meetings.

The Contractor shall immediately remediate all individual findings identified through its monitoring process and shall track and trend such findings and remediation steps to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve care management processes, resolve areas of non-compliance and measure the success of such strategies in addressing identified issues. At a minimum, the Contractor shall ensure the following:

- Care management tools and procedures are consistently and objectively applied and outcomes are continuously measured;
- Health Risk Screenings and Comprehensive Assessments occur within the required timeframes and are submitted to OHCA;
- Care Plans are developed and updated on schedule and in compliance with this Contract;
- Services are delivered in a timely manner and are provided as authorized by the Contractor;
- Care Plans address needs identified in the Comprehensive Assessment and are appropriate and adequate to address a Health Plan Enrollee's needs;
- Service utilization is appropriate;
- Service Gaps are identified and addressed in a timely manner;
- Minimum care management contacts are performed in accordance with the Contractor's Risk Stratification Level Framework;
- Care Manager staffing levels are in compliance with the approved Annual Care Management Staffing Plan submitted to OHCA;
- Health Plan Enrollees assigned risk levels are accurate and conducted in accordance with the Contractor's Risk Stratification Level Framework; and
- Care Manager assignments are performed in a timely and accurate manner.

1.9 Transition of Care

1.9.1 Transition of Care General Provisions

The Contractor shall take all necessary steps to ensure continuity of care when Health Plan Enrollees transition to the Contractor from another MCO or SoonerCare program. The Contractor shall ensure that established Health Plan Enrollee and Provider relationships, current services and existing Prior Authorizations and Care Plans will remain in place during the Continuity of Care Period in accordance with the requirements outlined in this section. Transition to the Contractor shall be as seamless as possible for Health Plan Enrollees and their Providers.

The Contractor shall take special care to provide continuity of care for newly enrolled Health Plan Enrollees who have physical health conditions, behavioral health conditions and/or functional needs and are under the care of existing treatment Providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization or institutionalization, if covered services are disrupted or interrupted.

The Contractor shall make transition of care policies available to Health Plan Enrollees and provide instructions to Health Plan Enrollees on how to access continued services during the Continuity of Care Period. This information shall be available, at minimum, in the Health Plan Enrollee Handbook, new Health Plan Enrollee materials and via Health Plan Enrollee call center representatives. Language used in all forms of communication shall conform with requirements specified in Section 1.11: “Health Plan Enrollee Services” of this Model Contract and 42 C.F.R. § 438.10.

The Contractor shall ensure that all Health Plan Enrollees are held harmless by Providers for payment for any existing covered services, other than required Cost Sharing, during the Continuity of Care period.

1.9.2 Transition of Care Policies and Procedures

The Contractor shall implement a transition of care policy that, at a minimum, is consistent with the requirements in 42 C.F.R. § 438.62(b)(1) and at least meets OHCA’s defined transition of care policy. The Contractor shall have additional transition of care policies and procedures that include at least the following:

- A schedule that ensures that the transition does not create a lapse in service;
- A process for timely information exchange (including transfer of a Health Plan Enrollee record, including the Health Plan Enrollee’s Care Plan as applicable based on the Contractor’s assignment in accordance with its Risk Stratification Level Framework);
- A process for assuring confidentiality;
- A process for allowing Health Plan Enrollees to request and be granted a change of Provider;
- An appropriate schedule for transitioning Health Plan Enrollees from one Provider to another when it is Medically Necessary for ongoing care, including a process for ensuring the Health Plan Enrollee’s new Provider(s) are able to obtain copies of the Health Plan Enrollee’s medical records, as appropriate and consistent with federal and State law;
- A process for transitioning Health Plan Enrollees from one care setting to another; and
- A process for transitioning Health Plan Enrollees from or to another MCO.

The Contractor’s transition of care policy shall also ensure compliance with 42 C.F.R. § 438.62(b)(1)(vi) regarding the process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 C.F.R. § 170.213.

1.9.3 Transition of Prior Authorizations

The Contractor shall ensure all Prior Authorizations for covered benefits in place on the day prior to the Health Plan Enrollee’s enrollment with the Contractor remain in place for 90 days following a Health Plan Enrollee’s enrollment. This requirement applies during both Initial Program Implementation and Steady State Operations. During the 90-day Continuity of Care period, Prior Authorizations may not be denied on the basis that the authorizing Provider is not a Participating Provider. Payment to Non-Participating Providers shall be made at the current Medicaid fee schedule rate, and in accordance with OHCA’s

payment timeliness standards, as outlined in Section 1.14.4.2.1: “Timely Claims Filing Requirements” of this Model Contract, during the Continuity of Care Period.

Notwithstanding the foregoing requirement to honor existing Prior Authorizations for 90 days, the Contractor shall have additional procedures in place that address the continuity of care needs of at least the following populations:

- The Contractor shall be responsible for the costs of pregnant women for continuation of Medically Necessary prenatal care services, delivery and post-natal care, through follow-up checkup within six weeks of delivery, without any form of prior approval and without regard to whether such services are being provided by a Participating or Non-Participating Provider;
- The Contractor shall honor the existing treatment plan until such plan has been completed for Health Plan Enrollees receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for Hepatitis C treatment or who are terminally ill;
- Children receiving private duty nursing services will continue to receive these services until such time as the Contractor has performed a Comprehensive Assessment and determined the appropriate level of private duty nursing services as a component of the Health Plan Enrollee’s overall Care Plan. Children receiving private duty nursing services also will receive specific transition notification and assistance in accordance with Section 1.9.8: “Age Transitions” of this Model Contract;
- The Contractor shall honor OHCA’s negotiated payment rate for Health Plan Enrollees who are receiving out-of-state services and/or meals and lodging assistance;
- Health Plan Enrollees who are receiving services for hemophilia shall continue to receive services by their current hemophilia Providers for up to 90 days;
- Health Plan Enrollees with a treatment plan that contains Behavioral Health Services shall be allowed to remain with the current behavioral health treatment Provider(s) for up to 90 days; and
- If durable medical equipment (DME) or supplies were authorized and ordered prior to enrollment but not received by the time of enrollment, the Contractor shall coordinate and follow through to ensure that Health Plan Enrollees receive the necessary supportive equipment and supplies without undue delay.

1.9.4 Continuity of Provider Assignment

The Contractor shall allow Health Plan Enrollees with an existing relationship with a Participating Provider to retain that Provider during and after transition to the Contractor. The Contractor shall continue to pay a Health Plan Enrollee’s existing Providers until such time as the Contractor can reasonably transfer the Health Plan Enrollee to a Participating Provider without impeding service delivery necessary to the Health Plan Enrollee’s health or to prevent hospitalization or institutionalization. In the event there is no Participating Provider available who meets the Health Plan Enrollee’s needs, the Contractor shall allow the Health Plan Enrollee to retain his/her current Provider until either the current Provider becomes a Participating Provider or a Participating Provider who meets the Health Plan Enrollee’s needs becomes available.

Notwithstanding the foregoing, Health Plan Enrollees shall be permitted to receive care from a Non-Participating Provider if:

- The only Participating Provider available to the Health Plan Enrollee does not, because of moral or religious objections, provide the service the Health Plan Enrollee seeks;
- The Health Plan Enrollee's PCMH Provider or other Provider determines that the Health Plan Enrollee needs related services that would subject the Health Plan Enrollee to unnecessary risk if received separately and not all of these services are available within the network; or
- OHCA determines that other circumstances warrant out-of-network treatment.

1.9.5 Transitions Between MCOs and OHCA

When a Health Plan Enrollee transitions from another MCO to the Contractor, the Contractor shall be responsible for making a request to the surrendering MCO for any data that will facilitate a seamless transition, including but not limited to, Health Risk Screening results, Comprehensive Assessments, Care Plans, utilization data and Provider information. When the Contractor receives requests from an MCO for transition information on a former Health Plan Enrollee, the Contractor shall transmit the information within five days for data which is available electronically, and within 30 days for data which is not stored electronically.

As part of its Risk Stratification Level Framework, the Contractor shall identify additional policies and procedures, based on Health Plan Enrollee risk level, for ensuring the seamless transition of Health Plan Enrollees between MCOs and between the Contractor and OHCA. This includes, but is not limited to, processes for contacting the Health Plan Enrollee's PCMH Provider to coordinate the pending transition and processes to contact the Health Plan Enrollee to assist in the transition.

If the Health Plan Enrollee is hospitalized at the time of Enrollment or Disenrollment from one MCO to another, or from the Contractor to OHCA, the surrendering MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospital as designated by OHCA until the date of discharge. Upon discharge, the Health Plan Enrollee becomes the financial responsibility of the receiving MCO or OHCA.

1.9.6 Terminated Provider to New Provider

The Contractor shall actively assist Health Plan Enrollees in transitioning to another Participating Provider when a current Provider has terminated participation with the Contractor. For Health Plan Enrollees who have a Care Plan in place, this assistance shall be provided by the Health Plan Enrollee's Care Manager.

1.9.7 Care Manager to New Care Manager

The Contractor shall have strategies in place to minimize the number of situations in which a Health Plan Enrollee must be assigned a new Care Manager. However, when the Contractor must assign a new Care Manager to the Health Plan Enrollee, the incoming Care Manager shall have a case conference with the outgoing Care Manager to review the Health Plan Enrollee's Care Plan and transition the Health Plan Enrollee to the new Care Manager. The new Care Manager shall contact the Health Plan Enrollee within five Business Days of assignment to the new Care Manager and shall include the prior Care Manager in the outreach, if possible.

1.9.8 Age Transitions

The Contractor shall monitor the age status of Health Plan Enrollees and offer assistance to Health Plan Enrollees approaching age thresholds that will affect SoonerCare coverage or eligibility, as well as Health Plan Enrollee transitions of care including, but not limited to, transition aged youth, transitioning from the child/adolescent healthcare system to the adult system. The Contractor shall educate these Health Plan

Enrollees or their parents/guardians concerning the upcoming changes in their coverage and shall update Care Plans in advance of the age threshold being reached, to minimize any disruption in care.

1.9.9 Transitions from Inpatient/Residential Settings

In accordance with 42 C.F.R. § 438.208(b)(2)(i), the Contractor shall implement procedures to coordinate services to Health Plan Enrollees between settings of care. This shall include discharge planning techniques and policies and procedures to effectively and appropriately manage the transition of care for Health Plan Enrollees being discharged from hospital and institutional/residential stays. Such techniques shall be designed to control hospital readmissions within 30 days of discharge and shall specifically address behavioral health inpatient/residential stays.

The Contractor shall submit for OHCA review and approval its proposed discharge planning policies and procedures, which shall include the following minimum components:

- Methods for identifying Health Plan Enrollees who are in an inpatient/residential setting;
- Designation of a single point of contact at the Contractor for the Health Plan Enrollee's transition activities;
- Timelines and methods for coordinating with the Health Plan Enrollee, the Health Plan Enrollee's PCMH Provider and other outpatient Providers, hospital discharge planner(s), caregivers and the attending physician to facilitate timely and appropriate discharge planning;
- Procedures for conducting a comprehensive evaluation of the Health Plan Enrollee's health needs and identification of services and supplies required to facilitate transition out of the inpatient setting;
- Processes for ensuring the Health Plan Enrollee is placed in the least restrictive setting post-discharge that will meet the Health Plan Enrollee's needs;
- Methods for evaluating risk of readmission in order to determine the intensity and urgency of follow up required for the Health Plan Enrollee after the date of discharge;
- Areas to be addressed by the discharge plan such as necessary in-home supports, language or cultural needs, medications, home health care needs, DME needs, outpatient service needs, transportation needs, housing needs, income support and follow-up appointments; and
- Timeframes for post-discharge outreach to the Health Plan Enrollee.

1.9.10 Transitions Between Other Settings

The Contractor shall develop policies and procedures to facilitate the sharing of information between settings such as jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service Providers, and the Health Plan Enrollee's PCMH Provider and behavioral health Providers.

1.10 Quality

The Contractor shall comply with all OHCA requirements regarding quality oversight, monitoring and evaluation. The Contractor shall comply with OHCA's comprehensive quality strategy developed in accordance with 42 C.F.R. § 438.340 and with all State and federal regulations.

The Contractor shall provide quality care that includes, at minimum:

- Adequate capacity and service to ensure Health Plan Enrollee choice and timely access to appropriate services and care;

- Effective coordination and continuity of care;
- Protection of Health Plan Enrollee rights and the provision of services in a manner that is sensitive to the cultural needs of Health Plan Enrollees;
- Encouragement and assistance to Health Plan Enrollees in participating in decisions regarding their care;
- Emphasis on health promotion and prevention, as well as early diagnosis, treatment and health maintenance;
- Appropriate utilization of Medically Necessary services; and
- A continuous quality improvement approach.

1.10.1 **Quality Rating System**

OHCA shall develop and implement a Medicaid managed care quality rating system, in accordance with 42 C.F.R. § 438.334, to evaluate the annual performance of all MCOs participating in the SoonerSelect program. The Contractor shall comply with all necessary OHCA reporting requirements for the quality rating system adopted by OHCA.

In accordance with 42 C.F.R. § 438.334(d), OHCA shall issue an annual quality rating to the Contractor based on the performance measures collected. OHCA shall prominently display the quality rating given to the Contractor by OHCA on OHCA's website in accordance with 42 C.F.R. § 438.334(e) and in a manner that complies with the standards at 42 C.F.R. § 438.10(d).

1.10.2 **External Quality Review**

In accordance with 42 C.F.R. § 438.350, the Contractor shall undergo an annual, external independent review (EQR) of the quality, timeliness, and access to the services covered under this Model Contract. To conduct this EQR, OHCA will retain the services of a qualified External Quality Review Organization (EQRO) in accordance with the qualifications for competence and independence at 42 C.F.R. § 438.354. The SoonerSelect program EQRO retained by OHCA shall conduct EQR activities including all necessary audits and review of information in accordance with 42 C.F.R. § 438.358(b), as well as any additional optional audits and review of information outlined in 42 C.F.R. § 438.358(c), that further OHCA's management and oversight of the SoonerSelect program. All EQRO-related quality activities performed by the SoonerSelect program EQRO will comply with all State and federal regulations, including 42 C.F.R. § 438.358. The Contractor shall cooperate fully with the EQRO and demonstrate to the SoonerSelect program EQRO the Contractor's compliance with managed care regulations and quality standards as set forth in federal regulation and OHCA's policy.

The EQRO will conduct the following mandatory activities, in accordance with 42 C.F.R. §438.358(b):

- Validation of the Contractor's Performance Improvement Projects required in accordance with 42 C.F.R. § 438.330(b)(1) that were underway during the preceding 12 months;
- Validation of the Contractor's performance measures required in accordance with 42 C.F.R. § 438.330(b)(2) or Contractor performance measures calculated by the state during the preceding 12 months;
- A review, conducted within the previous three-year period, to determine the Contractor's compliance with the standards set forth in 42 C.F.R. subpart D and the quality assessment and performance improvement requirements described at 42 C.F.R. § 438.330; and

- Validation of the Contractor's network adequacy during the preceding 12 months to comply with requirements set forth in 42 C.F.R. §§ 438.68 and 438.14(b)(1).

OHCA may elect to have the SoonerSelect program EQRO perform the following optional review activities in accordance with 42 C.F.R. §438.358(c):

- Validation of the Contractor's Encounter Data;
- Administration or Validation of Health Plan Enrollee or Provider surveys of quality of care;
- Calculation of performance measures in addition to those reported by the Contractor;
- Performance improvement projects in addition to those conducted by the Contractor;
- Studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and
- Assisting with the quality rating of the Contractor.

The SoonerSelect program EQRO will produce an annual report on quality outcomes, including timeliness of services and access to services covered by the SoonerSelect program. The report will detail, analyze and aggregate the data from all activities conducted in accordance with 42 C.F.R. § 438.358. The report will include the following for each activity conducted:

- Objectives;
- Technical methods of data collection and analysis; and
- Descriptions of data obtained and conclusions drawn from the data.

The information obtained by the SoonerSelect program EQRO will be obtained consistent with protocols established in 42 C.F.R. § 438.352 and the results made available as specified in 42 C.F.R. § 438.364.

The Contractor shall participate with the SoonerSelect program EQRO in various other tasks and projects identified by OHCA to gauge Contractor performance in a variety of areas, including, but not limited to care management and management and treatment of special populations. The Contractor shall ensure that the SoonerSelect program EQRO has sufficient information to carry out this review.

As provided in 42 C.F.R. § 438.358(d), OHCA may also request that the SoonerSelect program EQRO provide technical assistance to the Contractor in conducting activities relating to the mandatory and optional activities described in this section.

OHCA reserves the right, pursuant to 42 C.F.R. § 438.362, to exempt the Contractor from the EQR if all conditions of 42 C.F.R. § 438.362(a) and all other relevant State and federal regulations are met and OHCA determines it is the appropriate course of action.

1.10.3 Quality Assessment and Performance Improvement (QAPI) Program

1.10.3.1 QAPI Program

In accordance with 42 C.F.R. § 438.330(a)(1), the Contractor shall establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes. The Contractor's QAPI program shall comply with all requirements of State and federal law and regulations. The QAPI program shall use standards and guidelines from the Contractor's Accrediting Entity including standards for quality management, quality improvement, and Quality Assessment and Performance Improvement programs.

The QAPI program shall include all of the following, at minimum:

- Performance improvement projects (PIPs) that evaluate clinical and nonclinical areas, in accordance with 42 C.F.R. § 438.330(b)(1) and (d)(1), including all SoonerSelect program population groups, care settings and types of services.
- In accordance with 42 C.F.R. § 438.330(b)(2), collection of and submission of performance measurement data, including the performance measures determined by OHCA as required pursuant to 42 C.F.R. § 438.330(c)(1)(i), or as determined by CMS in the event CMS identifies standard required measures pursuant to 42 C.F.R. § 438(a)(2).
- Mechanisms to detect both underutilization and overutilization of services, in accordance with 42 C.F.R. § 438.330(b)(3).
- Mechanisms to assess the quality and appropriateness of care furnished to Health Plan Enrollees with Special Health Care Needs, in accordance with 42 C.F.R. § 438.330(b)(4). Health Plan Enrollees with Special Health Care Needs will be defined by OHCA in the quality strategy developed pursuant to 42 C.F.R. § 438.340.

OHCA or its designee shall perform oversight and monitoring functions, evaluate the impact and effectiveness of the Contractor's QAPI program, and perform all reporting and SoonerSelect program contractual obligations. The Contractor shall be responsible for the day-to-day performance and operational requirements. The Contractor shall report to the OHCA Quality Assurance Advisory Group. Any changes to the QAPI program structure shall require prior written approval from OHCA, 90 days prior to implementation.

The Contractor shall review outcome data at least quarterly for performance improvement, recommendations and interventions. The Contractor shall include QAPI activities to improve health care disparities identified through data collection.

The Contractor shall use the results of QAPI activities to improve the quality of Health Plan Enrollees physical and behavioral health, with appropriate input from Participating Providers and Health Plan Enrollees. The Contractor shall take appropriate action to address service delivery, Provider and other QAPI issues as they are identified. The Contractor shall make all information about its QAPI program available to Providers and Health Plan Enrollees. The Contractor shall provide technical assistance, corrective action plans and follow-up activities as necessary to Participating Providers to assist them in improving their performance.

The Contractor may be required to conduct special focus studies as determined by OHCA and shall participate in workgroups and agree to establish and implement policies and procedures that are agreed to and described by OHCA in order to address specific quality concerns.

OHCA reserves the right to require the Contractor to develop a process for its own evaluation of the impact and effectiveness of its QAPI program.

1.10.3.2 Oversight of QAPI Program

The Contractor shall have a Quality Department within its organizational structure that is separate and distinct from all other units or departments. The Quality Department shall be accountable to the Contractor's Board of Directors and executive management team, who set strategic direction for the QAPI program and ensure that the QAPI plan is incorporated into the Contractor's operations.

The Contractor shall have a Quality Improvement Committee (QIC), chaired by the Contractor's Chief Medical Officer, that oversees all QAPI functions. Other QIC representatives shall be selected to meet the needs of the Contractor but must include representation from the following functional areas:

- Quality Improvement;
- Grievances and Appeals;
- Care Management;
- Medical Management;
- Credentialing;
- Compliance;
- Health Plan Enrollee Care Support Staff (at least one staff member); and
- Providers, including both physical health and behavioral health Providers.

Individual staff members may serve in multiple roles on the QIC if they also serve in multiple positions within the Contractor's organization. The QIC shall meet no less than quarterly. Its responsibilities shall include the development and implementation of a written QAPI plan, which incorporates the strategic direction provided by the Board of Directors and executive management team.

The QIC shall:

- Direct and review QAPI activities;
- Analyze and evaluate the results of QAPI activities and suggest new or improved activities;
- Ensure that Participating Providers and other stakeholders are involved in the QAPI program;
- Direct task forces or committees in specific improvement areas;
- Publicize findings to appropriate staff and departments within the Contractor's organization;
- Report findings and recommendations to the Contractor's executive management team;
- Direct and analyze periodic reviews of Health Plan Enrollees' service utilization patterns, institute needed action and ensure that appropriate follow-up occurs; and
- Review and approve the QAPI work plan and annual evaluation.

The QIC shall keep written minutes of all committee and sub-committee meetings. A copy of the signed and dated written minutes for each meeting shall be available on file after the completion of the following QIC meeting in which the minutes are approved. Minutes shall be available for review upon request by OHCA and during the annual on-site EQRO review or accreditation review.

1.10.3.3 QAPI Documentation

The Contractor shall submit an annual QAPI program description and associated work plan to OHCA that addresses its strategies for performance improvement and for conducting the quality management activities described in this Section. In addition, the Contractor shall submit an annual evaluation of the previous year's QAPI program to OHCA. The Contractor's QAPI program description, work plan and program evaluation shall be submitted exclusive to Oklahoma Medicaid and shall not contain documentation from any other State Medicaid program(s). The annual QAPI program description, associated work plan and program evaluation shall be submitted in a format specified by OHCA.

The QAPI program description shall include goals, objectives, structure and policies and procedures. At a minimum, the QAPI program description shall include the following:

- Guiding philosophy and strategic direction for the QAPI program;

- Communication mechanism between the Contractor’s executive management team and the QIC;
- QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen;
- Roles of Health Plan Enrollee and Provider representatives on the QIC;
- Process for selecting and directing task forces or subcommittees;
- Types of training, including any quality protocols developed by CMS, provided to quality staff and QIC members;
- Specific components of the QAPI plan;
- Process the QAPI program will use to review and suggest new or improved quality activities;
- Process to report findings to appropriate executive leadership, staff and departments within the Contractor’s organization, as well as relevant stakeholders, such as Participating Providers;
- Methodology for which and how many Participating Providers to profile and how measures for profiling will be selected;
- Process for selecting evaluation and study design procedures;
- How data will be collected and used;
- How the Contractor will ensure that QAPI program activities take place throughout the Contractor’s organization and the procedures to document results;
- The health management information systems that will support the QAPI program;
- Process for reporting findings to OHCA, Participating Providers and Health Plan Enrollees; and
- Process for annual program evaluation.

The annual QAPI work plan shall contain the scope, objectives, planned activities, timeframes and data indicators for tracking performance and other relevant QAPI information.

The annual QAPI program evaluation to OHCA shall include, the following, at minimum:

- A description of ongoing and completed QAPI activities;
- Measures that are trended to assess performance;
- Year-over-year findings that contain an analysis of demonstrable improvements in the quality of clinical care and service;
- Development of future QAPI work plans based on previous year findings;
- Results of QAPI projects and reviews;
- HEDIS, CAHPS and other performance measure results;
- Procedures and measures for assessing the effectiveness of the Contractor’s care management model;
- Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes; and
- Monitoring and evaluation of network quality, including, at minimum:
 - Credentialing and recredentialing processes,
 - Performance improvement projects,
 - Performance measurement,
 - Problem resolution and improvement approach and strategy,
 - Annual program evaluation,
 - Metrics for monitoring the quality and performance of Participating Providers related to their continued participation in the Contractor’s network.

In accordance with 42 C.F.R. § 438.330(e)(1), OHCA or its designees shall annually review the impact and effectiveness of the Contractor's QAPI program. This review shall utilize a variety of methods, including at minimum:

- Reviewing, evaluating and reporting all QAPI Program documents, the Contractor's performance measures and Contractor reports regularly required by OHCA or its designees;
- Reviewing outcomes and trended results of the Contractor's Performance Improvement Projects;
- Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as Health Plan Enrollee choice, rights and protections, services provided to Health Plan Enrollees with Special Health Care Needs, utilization management, care management, network access standards, measurement and improvement standards, Clinical Practice Guidelines and continuity and coordination of care;
- Performing medical records reviews; and
- Conducting on-site reviews to interview the Contractor's staff for clarification, to review records, or to validate implementation of processes and procedures.

The Contractor shall furnish specific data requested in order for OHCA and its designees to conduct evaluations, including medical records, Participating Provider credentialing records, Provider reimbursement records, utilization reports, the Contractor's personnel records and any other documents and files as required by OHCA and its designees.

1.10.4 Surveys

1.10.4.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The Contractor shall conduct annual CAHPS surveys. Annual CAHPS survey reports will be due to OHCA no later than June 15th of each year. The Contractor shall enter into an agreement with a vendor that is certified by NCQA to perform annual CAHPS surveys. The Contractor's vendor shall perform the CAHPS Health Plan Survey 5.0H CHIP, Child, and Adult surveys.

The Contractor shall submit to OHCA by November 1st of each year a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor, sampling methodology, administration protocol, analysis plan and reporting description.

Survey results shall be reported to OHCA separately for each required CAHPS survey listed above. Survey results shall be submitted to OHCA, NCQA, AHRQ, and OHCA's SoonerSelect program EQRO annually as required in Section 1.21: "Reporting" of this Model Contract.

The Contractor shall:

- Use the annual CAHPS results in the Contractor's internal QAPI plan by using areas of decreased satisfaction as areas for targeted improvement;
- Include additional survey questions that are specified by OHCA in addition to the CAHPS;
- Make available results of the surveys to Participating Providers, OHCA, Health Plan Enrollees and families/caregivers;
- Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall survey results; and

- Have mechanisms in place to incorporate survey results in the QAPI plan for program improvements and systems improvements.

At its discretion, OHCA reserves the right to implement additional Mental Health Care Surveys, including, but not limited to, the CAHPS Experience of Care & Health Outcomes (ECHO) Survey. The Contractor shall conduct any additional surveys under the same process, where appropriate, as outlined in this Section.

1.10.4.2 Provider Satisfaction Surveys

The Contractor shall conduct an annual Provider satisfaction survey that is inclusive of all Participating Providers. OHCA will collaborate with the Contractor and other SoonerSelect MCOs to define a uniform set of Provider satisfaction measures and a uniform survey instrument. The Contractor shall conduct the survey and compile and analyze its survey results for submission to OHCA annually.

The survey instrument shall include the following domains:

- Provider relations and communication;
- Clinical management processes;
- Authorization processes, including denials and Appeals;
- Timeliness of claims payment and assistance with claims processing;
- Grievance resolution process; and
- Care management support.

The survey report results shall include a summary of the survey methods and findings for physical health and behavioral health Providers separately, with an analysis of opportunities for improvement.

The Contractor shall provide the survey results to OHCA with an action plan to address the results of the survey in accordance with Section 1.21: "Reporting" of this Model Contract.

1.10.5 **Quality Performance Measures**

The Contractor shall comply with all of OHCA's requirements to improve performance for OHCA-established quality performance measures. Annually, the Contractor shall submit a Quality Performance Measure Report for all quality performance measures established by OHCA pursuant to 42 C.F.R. § 438.330(c)(1)(i) and listed in this Section. Quality performance measures shall:

- Be modified annually by OHCA or CMS and published in advance;
- Be specific to the SoonerSelect program population; and
- Include target performance rates that will increase annually. Required quality performance measures will include measures for both physical health and behavioral health.

The performance measures in Sections 1.10.5.1: "Physical Health Performance Measures" and 1.10.5.2: "Behavioral Health Performance Measures" have been selected to provide evidence of the overall quality of care and specific services provided to each SoonerSelect program population group. The Contractor shall report the performance measures listed below to OHCA at a time and in a format specified by OHCA. The Contractor shall be expected to meet or exceed annual benchmarks/targets for specific performance measures as developed by OHCA prior to Contract implementation.

Annually, the Contractor shall complete the specified measures designated by OHCA as relevant to the Health Plan Enrollees being served in the SoonerSelect program. The Contractor shall contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA

requirements. The Contractor shall submit to OHCA a copy of the signed contract with the NCQA-approved vendor to perform the HEDIS audit. Audited HEDIS results shall be submitted to OHCA, NCQA and OHCA's SoonerSelect program EQRO annually as required in Section 1.21: "Reporting" of this Model Contract.

In addition to OHCA-established quality performance measures, the Contractor shall report EPSDT information utilizing Encounter Data submissions in accordance with specifications for the CMS-416 report. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner and other measures.

The Contractor shall meet OHCA-specified performance targets for all quality performance measures. The performance targets for each of the required measures shall be determined by OHCA in collaboration with the Contractor and other SoonerSelect MCOs.

Although quality performance targets will be updated annually, OHCA, at its discretion, may change these targets and/or change the timelines associated with meeting the targets. The quality performance targets will be incorporated into the comprehensive Uniform Performance Monitoring Data Set described in Section 1.22.2: "Performance-Based Contracting" of this Model Contract.

OHCA shall post information about quality measures and performance outcomes on OHCA's website. This information shall be updated at least annually.

If OHCA determines that the Contractor's performance relative to any of the quality performance targets is not acceptable, OHCA may require the Contractor to submit a corrective action plan in accordance with Section 1.23: "Non-Compliance Remedies" of this Model Contract. OHCA also may impose Non-Compliance Remedies for failure to meet quality performance targets or demonstrate improvement in a measure rate in accordance with Section 1.23.6: "Other Non-Compliance Remedies" of this Model Contract. When considering whether to impose penalties, OHCA may consider the Contractor's cumulative performance on all quality performance measures.

A report, certification or other information required for performance measure reporting is incomplete when it does not contain all data required by OHCA or when it contains inaccurate data. A report that is incomplete or contains inaccurate data shall be considered deficient and each instance shall be subject to Non-Compliance Remedies as described in Section 1.23.6: "Other Non-Compliance Remedies" of this Model Contract.

A report or certification is "false" if completed or made with the knowledge of the preparer or a superior of the preparer that it contains data or information that is not true or not accurate. The Contractor shall submit a detailed explanation for any measure marked as "not reported" (NR). A report that contains an "NR" due to bias for any or all measures by the HEDIS auditor, or is "false," shall be considered deficient and will be subject to Non-Compliance Remedies as described in Section 1.23.6: "Other Non-Compliance Remedies" of this Model Contract.

1.10.5.1 Physical Health Performance Measures

The Contractor shall be responsible for reporting on the physical health performance measures that are provided in the table below. These measures are subject to change.

Physical Health Performance Measures	Frequency	Definition	Data Source
<p>Adult CMS Core Set measures related to physical health:</p> <ul style="list-style-type: none"> • Cervical Cancer Screening • Chlamydia Screening in Women Ages 21 to 24 • Flu Vaccinations for Adults Ages 18 to 64 • Screening for Depression and Follow-Up Plan: Age 18 and Older • Breast Cancer Screening • Adult Body Mass Index Assessment • Controlling High Blood Pressure • Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) • Plan All-Cause Readmissions • Asthma Medication Ratio: Ages 19 to 64 • HIV Viral Load Suppression 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records
<p>Child CMS Core Set measures related to physical health:</p> <ul style="list-style-type: none"> • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Chlamydia Screening in Women Ages 16 to 20 • Childhood Immunization Status • Screening for Depression and Follow-Up Plan: Ages 12 to 17 • Well-Child Visits in the First 15 Months of Life • Immunizations for Adolescents • Developmental Screening in the First Three Years of Life • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Asthma Medication Ratio: Ages 5 to 18 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records

Physical Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> Ambulatory Care: Emergency Department (ED) Visits 			
<p>Prevention Quality Indicators (PQI):</p> <ul style="list-style-type: none"> Diabetes Short-Term Complications Admission Rate Heart failure admission rate Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Asthma in Younger Adults Admission Rate 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility
<p>Maternal and Perinatal Health</p> <ul style="list-style-type: none"> Elective Delivery Prenatal and Postpartum Care: Postpartum Care Contraceptive Care – Postpartum Women Ages 21 to 44 Contraceptive Care – All Women Ages 21 to 44 Cesarean Birth Audiological Diagnosis No Later Than 3 Months of Age Live Births Weighing Less Than 2,500 Grams Prenatal and Postpartum Care: Timeliness of Prenatal Care Contraceptive Care – Postpartum Women Ages 15 to 20 Contraceptive Care – All Women Ages 15 to 20 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records
Preventive care & screening: tobacco use: screening & cessation intervention	Annual	Percentage of patients aged 18 and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation	MMIS, encounter data and medical records, Health Questionnaire Screenings

Physical Health Performance Measures	Frequency	Definition	Data Source
		counseling intervention if identified as a tobacco user	
Tobacco use: screening	Annual	Percentage of patients aged 12+ who were screened for tobacco use at every primary care visit	MMIS, encounter data and medical records
Emergency room (ER) utilization: <ul style="list-style-type: none"> ER visits per 1,000 member months Potentially avoidable ER visits 	Quarterly	Rate of ER visits per 1,000 member months and the number of ER visits that were potentially avoidable	MMIS and encounter data

1.10.5.2 Behavioral Health Performance Measures

The Contractor shall be responsible for reporting on the behavioral health performance measures that are provided in the table below. These measures are subject to change.

Behavioral Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Medical Assistance with Smoking and Tobacco Use Cessation Antidepressant Medication Management Follow-Up After Hospitalization for Mental Illness: Age 18 and Older Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications 	Annual	Adult CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records

Behavioral Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> • Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) • Use of Opioids at High Dosage in Persons Without Cancer • Concurrent Use of Opioids and Benzodiazepines • Use of Pharmacotherapy for Opioid Use Disorder • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence • Follow-Up After Emergency Department Visit for Mental Illness • Adherence to Antipsychotic Medications for Individuals with Schizophrenia 			
<ul style="list-style-type: none"> • Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication • Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 	Annual	Child CMS Core Set Measure Definitions	MMIS, Encounters, Eligibility, Medical Records
Access to Behavioral Health Services	Annual	Number and percentage of Health Plan Enrollees receiving BH services	MMIS and encounter data
Access to substance abuse disorder (SUD) services	Annual	Number and percentage of Health Plan	MMIS and encounter data

Behavioral Health Performance Measures	Frequency	Definition	Data Source
		Enrollees receiving SUD services	
Inpatient care	Annual	Number and percentage of Health Plan Enrollees using inpatient psychiatric services	MMIS and encounter data
Readmission to inpatient care	Annual	Number and percentage of Health Plan Enrollees readmitted to inpatient care within 30 days of discharge	MMIS and encounter data
Depression screening	Annual	Percentage of population aged 12+ who were screened for depression using age-appropriate standardized instruments jointly selected by a primary care provider and behavioral health specialist during the measurement year	MMIS, encounter data and medical records
Depression remission at 12 months	Annual	Percentage of patients age 18 years and older who have reached remission at 12 months (+/- 30 days) after diagnosis or initiating	MMIS, PHQ-9, encounter data and medical records

Behavioral Health Performance Measures	Frequency	Definition	Data Source
		treatment, e.g., had a Patient Health Questionnaire-9 (PHQ-9) score less than five at 12 months (+/- 30 days)	
Screening for alcohol or drug dependence	Annual	Percentage of population aged 12+ who were screened for alcohol or other drug dependence during the measurement year	MMIS, encounter data and medical records
Treatment for alcohol or drug dependence	Annual	Percentage of patients who screened positive for alcohol or other drug dependence and who received treatment and follow-up	MMIS, encounter data and medical records

1.10.6 Performance Improvement Projects (PIPs)

The Contractor shall conduct at least three PIPs annually. For Rating Period one, the Contractor shall propose, subject to OHCA’s approval, one non-clinical, and two clinical PIPs: one that addresses physical health and one that addresses behavioral health. In subsequent years, PIP topics may be identified by CMS, the Contractor, or OHCA. All PIPs are subject to final approval by OHCA.

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Health Plan Enrollee satisfaction, in accordance with 42 C.F.R. § 438.330(d)(2), and must include the following elements set forth at 42 C.F.R. § 438.330(d)(2)(i)-(iv):

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the intervention based on the performance measures collected as part of the PIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

In accordance with 42 § C.F.R. 438.330(d)(3), the Contractor shall report the status and results of each PIP as requested by OHCA, which shall be no less than annually. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes shall be evaluated for statistical significance using a 95% confidence interval. Status reports on PIPs may be requested more frequently by OHCA.

PIPs are subject to annual independent Validation by the SoonerSelect program EQRO to ensure compliance with CMS protocols and OHCA's policy, including timeline requirements.

PIPs that have successfully achieved sustained improvement, as approved by OHCA, shall be considered complete and shall not meet the requirement for one of the number of PIPs required by OHCA, although the Contractor may wish to continue to monitor the performance indicator as part of its overall QAPI program. In this event, the Contractor shall select a new PIP and submit it to OHCA for approval.

1.10.7 Addressing Health Disparities

The Contractor shall participate in, and support OHCA's efforts to reduce health disparities. According to the U.S. Department of Health and Human Services' Office of Minority Health, and for the purposes of this Model Contract, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location). To further advance OHCA's efforts to achieve health equity, the Contractor shall collect and meaningfully use Health Plan Enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify and reduce disparities in health care access, services and outcomes. This includes, where possible, stratifying HEDIS and CAHPS, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities. The Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by: obtaining input from Health Plan Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Health Plan Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

1.10.8 Provider Profiling

The Contractor shall conduct PCMH Provider and other Participating Provider profiling activities at least quarterly. As part of its QAPI Program, the Contractor shall describe the methodology it uses to identify which and how many Participating Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities shall include, without limitation:

- Developing PCMH Provider and other Provider-specific reports that include a multi-dimensional assessment of a PCMH Provider or other Participating Provider's performance using clinical, administrative and Health Plan Enrollee satisfaction indicators of care that are accurate, measurable and relevant to the enrolled population;
- Establishing PCMH Provider, other Participating Provider, group, service area, or regional benchmarks for areas profiled, where applicable; and

- Providing feedback to individual PCMH Providers and other Participating Providers regarding the results of their performance and the overall performance of the Contractor's Participating Provider network.

1.10.9 **Medical Records**

1.10.9.1 Medical Record Standards

As part of its QAPI Program, the Contractor shall establish medical records standards, as well as a record review system to assess and ensure conformity with the standards. The standards shall, at a minimum:

- Require that the medical record be maintained by the Provider;
- Ensure that OHCA's personnel or personnel contracted by OHCA have access to all records, as long as access to the records is needed to perform the duties under this Contract and to administer the Medicaid program;
- Comply with any and all State and federal laws regarding confidentiality;
- Provide OHCA or its designee(s) with prompt access to Health Plan Enrollees' medical records;
- Provide Health Plan Enrollees with the right to request and receive copies of their medical records and to request they be amended; and
- Allow for paper or electronic record keeping.

The Contractor and its Participating Providers shall retain all medical records for a minimum of ten years from the last date of entry in the records. For minors, the Contractor and Participating Providers shall retain all medical records during the period of minority plus a minimum of ten years after the age of majority.

1.10.9.2 Medical/Case Record Audits

The Contractor shall furnish specific data requested in order for OHCA to conduct the medical/case record audit, including audit of Health Plan Enrollee Care Plans, Participating Provider credentialing records, service Provider reimbursement records, utilization reports, the Contractor's personnel records and other documents and files as required under this Model Contract.

If the medical/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of this Model Contract, the Contractor shall correct the problem immediately and may be subject to Non-Compliance Remedies.

1.10.10 **Critical Incident Reporting System**

The Contractor shall develop and implement a Critical Incident reporting and tracking system for behavioral health adverse or Critical Incidents and shall require Participating Providers to report adverse or Critical Incidents to the Contractor, the OHCA Behavioral Health Unit, DHS, and the Health Plan Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). The Contractor shall provide appropriate training and take corrective action as needed to ensure its staff and Participating Providers, as applicable, comply with Critical Incident requirements.

The Contractor shall ensure that any serious incident that harms or potentially harms the Health Plan Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated and corrected, in compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39.

As required by State law, the Contractor shall report abuse, neglect and/or Exploitation on the appropriate form to OHCA within one business day, as well as to DHS and/or law enforcement authorities, in accordance with OAC 317:30-5-97.

The Contractor's staff and Participating Providers shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all Health Plan Enrollees and respond to any emergency needs of Health Plan Enrollees.

The Contractor's Participating Providers shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to the Contractor, the OHCA Behavioral Health Unit, DHS, and the Health Plan Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c) . The Contractor shall review the Participating Provider's report and follow up with the Participating Provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

Critical Incidents shall include, but not be limited to the following when the Health Plan Enrollee is in the care of a behavioral health inpatient, residential or crisis stabilization unit, in accordance with OAC 317:30-5-95.39:

- Suicide death;
- Non-suicide death;
- Death-cause unknown;
- Homicide;
- Homicide attempt with significant medical intervention;
- Suicide attempt with significant medical intervention;
- Allegation of physical, sexual or verbal abuse or neglect;
- Accidental injury with significant medical intervention;
- Use of Restraints/Seclusion (Isolation);
- AWOL or absence from a mental health facility without permission; or
- Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

The Contractor shall identify and track Critical Incidents and shall review and analyze Critical Incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents, including, for example, the number and type of incidents across settings, Participating Providers and Provider types and findings from investigations. The Contractor shall identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of care to Health Plan Enrollees.

The Contractor shall submit reports of Critical Incidents in accordance with Reporting Manual requirements that provide the number and types of incidents that occurred during the reporting period, the timeliness of incident reporting, the results of the Contractor's investigations and the strategies the Contractor developed and implemented to improve care and reduce future incidents. The Contractor shall report Critical Incidents to proper oversight entities, including but not limited to, accrediting or licensing entities, DHS, and/or law enforcement agencies, when required by federal or State law.

1.11 Health Plan Enrollee Services

The Contractor shall develop and operate a Health Plan Enrollee Services department with adequate resources and qualified staff to deliver responsive, person-centered customer care to Health Plan Enrollees, including those with visual, hearing, functional or cognitive impairments.

The Contractor shall ensure that, through its written materials, Health Plan Enrollee Services Call Center and other Health Plan Enrollee Services activities, it provides timely and accurate information to Health Plan Enrollees and pursuant to 42 C.F.R. § 438.10(c)(7) has appropriate mechanisms for helping Health Plan Enrollees and Eligibles to understand the benefits and requirements of the SoonerSelect program and the Contractor's services.

1.11.1 Accessibility of Health Plan Enrollee Information

Pursuant to 42 C.F.R. § 438.10(c)(1), the Contractor must provide all required information to Health Plan Enrollees and Eligibles in a manner and format that may be understood easily and is readily accessible by such Health Plan Enrollees and Eligibles. All accommodations for the Health Plan Enrollee's special needs or reading proficiency must be provided to the Health Plan Enrollee free of cost. The Contractor shall develop and submit to OHCA a plan to assist Health Plan Enrollees with Limited English Proficiency (LEP) and visually impaired Health Plan Enrollees to understand all Health Plan Enrollee materials. The plan shall be reviewed as part of the Readiness Review.

1.11.1.1 Prevalent Non-English Languages

The Contractor shall make all Health Plan Enrollee materials available in English and Spanish and other prevalent non-English languages identified by OHCA. This includes, but is not limited to, the following written materials that are critical to obtaining services:

- The provider directory described in Section 1.11.13: "Provider Directory" of this Model Contract;
- The Health Plan Enrollee Handbook described in Section 1.11.5.2: "Health Plan Enrollee Handbook" of this Model Contract;
- Grievance and Appeals notices; and
- Denial and termination notices.

The Contractor shall also identify additional languages that are prevalent among Health Plan Enrollees. For purposes of this requirement, prevalent language is defined as any language spoken by at least five percent of the general population in the Contractor's service area.

OHCA will provide information about the Health Plan Enrollee's spoken language on the ANSI ASC X 12 834 electronic transactions. The Contractor shall utilize this information to ensure written materials are distributed in the appropriate prevalent non-English language.

When the Contractor learns the Health Plan Enrollee requires a prevalent non-English language, a note shall be made in the Health Plan Enrollee record and all Contractor correspondence thereafter shall be provided in both English and the required non-English language. If a non-English language is preferred, the Contractor must notify OHCA in a manner to be specified by OHCA so it may note the preferred language in their records.

1.11.1.2 Interpretation Services

Pursuant to 42 C.F.R. § 438.10(d)(4), the Contractor shall make interpretation services available to Health Plan Enrollees at no cost. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD

and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that that OHCA identifies as prevalent.

Interpreters shall be made available both in-person, including at Provider's offices, and through the telephone. For telephonic assistance, the Health Plan Enrollee may not be made to disconnect and call a different number. The Contractor shall provide information to its Participating Providers regarding how to access interpretation services for Health Plan Enrollees and shall notify Providers they shall not suggest or require that Health Plan Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters.

1.11.1.3 Auxiliary Aids and Alternative Formats

Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall make written Health Plan Enrollee materials available in alternative formats and via auxiliary aids and services upon request of the Health Plan Enrollee or Eligible at no cost. Alternative formats include, but are not limited to, braille, large font letters, audiotape and verbal explanations of written materials.

1.11.1.4 Health Plan Enrollee Notification of Interpretation Services and Alternative Formats

Pursuant to 42 C.F.R. § 438.10(d)(5)(i) - (iii), the Contractor shall notify Health Plan Enrollees of the following:

- That oral interpretation is available for any language;
- Written translation is available in prevalent languages;
- That auxiliary aids and services are available upon request and at no cost for Health Plan Enrollees with disabilities; and
- How to access those services.

1.11.1.5 Taglines

Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall include in its written materials taglines in each prevalent non-English language in the State, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY number of the Contractor's Health Plan Enrollee services call center. Large print means printed in a font size no smaller than 18 point.

1.11.2 **Cultural Competency**

Pursuant to 42 C.F.R. § 438.206(c)(2), the Contractor shall participate in OHCA's efforts to promote the delivery of services in a culturally competent manner to all Health Plan Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

The Contractor shall develop a cultural competency and sensitivity plan for review and approval by OHCA at the time of Readiness Review. The plan shall include guidelines for evaluating and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:

- Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way;

- Incorporate cultural competence into the Contractor’s medical, behavioral health, and care management programs, including outreach and referral methods;
- Recruit and train culturally diverse staff that will be able to operate fluently with all Health Plan Enrollee communities throughout the State;
- Ensure Health Plan Enrollee assessments inquire about language preference;
- Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter;
- Ensure cultural competence outcomes through internal audits and performance improvement targets;
- Develop a set of cultural competency standards designed to help all parts of the care management process deliver culturally sensitive care;
- Identify and develop intervention strategies for high-risk health conditions found in certain cultural groups; and
- Provide annual training to Care Managers, Participating Providers and Health Plan Enrollee facing staff (e.g., Health Plan Enrollee Services) to ensure the delivery of culturally and linguistically appropriate care.

1.11.3 **Written Material Guidelines**

1.11.3.1 General Guidelines

In accordance with 42 C.F.R. § 438.10(d)(6), all written materials the Contractor provides to Health Plan Enrollees and Eligibles shall:

- Use easily understood language and format;
- Use a font size no smaller than 12 point;
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Health Plan Enrollees or Eligibles with disabilities or LEP;
- Be written at a reading level no higher than sixth grade using the Flesch-Kincaid readability test; and
- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats free of cost. Large print means printed in a font size no smaller than 18 point.

1.11.3.2 Prior Approval Process

The Contractor shall submit to OHCA for review and prior written approval templates of all materials that will be distributed to Health Plan Enrollees and all Marketing Materials. The Contractor must develop and include a Contractor-designated inventory control number on all Health Plan Enrollee and Marketing Materials. The purpose of this inventory control number is to facilitate OHCA’s review and approval of Health Plan Enrollee and Marketing Materials and document its receipt and approval of original and revised documents. All submitted content must also include a clearly marked date issued or date revised and a reading level assessment, using the Flesch-Kincaid readability test. All materials translated into a non-English language shall be submitted to OHCA with a certificate of translation, that shall include an official statement in which the translator confirms that he or she has accurately translated the document.

Should the Contractor contract with either a Subcontractor or its Participating Providers to create and/or distribute Health Plan Enrollee or Marketing Materials, the materials shall not be distributed to Health

Plan Enrollees unless the materials have been submitted to OHCA by the Contractor for review and prior written approval.

OHCA will review the submitted materials and either approve or deny them. In the event OHCA does not approve the materials, OHCA may provide written comments, and the Contractor shall resubmit the Health Plan Enrollee or Marketing Materials for review. OHCA will either approve or deny the resubmission.

1.11.3.3 Modifications to Approved Health Plan Enrollee Materials

The Contractor shall not make substantive changes to materials developed for use by or distribution to Health Plan Enrollees without OHCA's review and prior approval.

Health Plan Enrollee materials developed by a Subcontractor or Participating Provider operating on the Contractor's behalf, shall not be substantively changed without OHCA's review and prior written approval.

OHCA will review the modified Health Plan Enrollee and Marketing Materials and either approve or deny them. In the event OHCA does not approve the materials, OHCA may provide written comments, and the Contractor shall resubmit the Health Plan Enrollee materials for review.

1.11.3.4 Discontinuation of Use/Modifications to Materials After Approval

OHCA reserves the right to notify the Contractor to discontinue or modify Health Plan Enrollee or Marketing Materials after approval.

1.11.3.5 Oklahoma Department of Libraries

The Contractor shall be held responsible for providing OHCA-approved documents to OHCA for submission to the Department of Libraries, in a method, format, and timing decided by OHCA.

1.11.3.6 Distribution Guidelines

The Contractor shall distribute Health Plan Enrollee materials in the preferred mode of the Health Plan Enrollee, either via mail or electronically. Mailed materials shall be sent to the Health Plan Enrollee's address as provided in the ANSI ASC X 12 834 electronic transactions. The name of the Contractor and its logo shall be prominently featured, once per item, on each piece of Health Plan Enrollee mail. It should solicit updates to any information, including address.

Pursuant to 42 C.F.R. § 438.10(c)(6), the Contractor may distribute Health Plan Enrollee materials in an electronic format instead of a paper copy with a Health Plan Enrollee's express consent. Health Plan Enrollee materials shall not be provided electronically by the Contractor unless all the following are met:

- The format is readily accessible;
- The information is placed in a location on the Contractor's website that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements specified in Section 1.11.1: "Accessibility of Health Plan Enrollee Information" of this Model Contract, including Section 508 guidance and guidelines that provide greater accessibility to individuals with disabilities; and

- The Contractor informs the Health Plan Enrollee that the information is available in paper form without charge upon request and shall be provided to the Health Plan Enrollee upon request within five days.

1.11.3.7 Guidelines for Email

The Contractor may attempt to contact Health Plan Enrollees through email unless the Health Plan Enrollee does not have access to email or opts out of email. The Contractor shall not attempt to disseminate information about its program through purchased or rented email lists. The Contractor shall not email Health Plan Enrollees through email addresses obtained by referrals and shall provide an opt-out process for Health Plan Enrollees to no longer be contacted via email. If the email address provided for the Health Plan Enrollee is non-existent, invalid or becomes invalid or otherwise undeliverable, the Contractor shall switch back to paper correspondence and notify OHCA the email address is no longer valid, in a manner to be specified by OHCA.

1.11.3.8 Guidelines for Text

The Contractor is permitted to utilize text messaging in communicating with its Health Plan Enrollees. If the Contractor elects to correspond with the Health Plan Enrollee by text messaging, it shall ensure compliance with the Telephone Consumer Protection Act, and all HIPAA requirements as outlined in Section 1.1.15: "Confidentiality; HIPAA and Business Associate Requirements" of this Model Contract, and shall provide indemnification in Section 1.1.15.3: "Obligations of the Contractor" of this Model Contract.

1.11.3.9 Updates to Health Plan Enrollee Contact Information

The Contractor shall use and regularly update a record of the modalities used to reach the Health Plan Enrollee, and shall:

- Update the record based on changes in OHCA's registered addresses and record returned mail and re-mail attempts;
- Call any telephone number maintained in OHCA's records or any publicly available phone book or directory;
- Notify OHCA, through a method to be specified by OHCA, if the Contractor learns of a new address for the Health Plan Enrollee.

1.11.3.10 Monitoring Effectiveness of Contractor Materials

The Contractor shall monitor and evaluate the effectiveness of its Health Plan Enrollee and Eligible materials and distribution as directed by OHCA. The Contractor may be responsible for tracking, at minimum, website hits and returned mail rates.

1.11.4 **OHCA Developed Health Plan Enrollee Materials**

Pursuant to 42 C.F.R. § 438.10(c)(4), the Contractor shall utilize OHCA-developed definitions for managed care terminology as described in Section 1.11.4.1: "Defined Terms" of the Model Contract, the model Health Plan Enrollee Handbook as described in Section 1.11.5.2: "Health Plan Enrollee Handbook" of this Model Contract and Health Plan Enrollee notices. The model materials developed by OHCA may include translations of Health Plan Enrollee materials into prevalent non-English languages.

The Contractor shall be responsible for producing and distributing written materials for Health Plan Enrollees, in addition to OHCA-developed model materials.

1.11.4.1 Defined Terms

For consistency in the information provided to Health Plan Enrollees and pursuant to 42 C.F.R. § 438.10(c)(4)(i), OHCA will develop and require the Contractor to use standardized definitions for managed care terminology, including:

- Appeal;
- Copayment;
- Durable medical equipment, prosthetics/orthotics and supplies;
- Emergency medical condition;
- Emergency medical transportation;
- Emergency room care;
- Emergency services;
- Excluded services;
- Grievance;
- Habilitation services and devices;
- Health insurance;
- Home health care;
- Hospice services;
- Hospitalization;
- Hospital outpatient care;
- Medically necessary;
- Network;
- Non-participating provider;
- Participating provider;
- Physician services;
- Plan;
- Preauthorization;
- Premium;
- Prescription drug coverage;
- Prescription drugs;
- Primary care physician;
- Primary care provider (i.e. PCMH Provider);
- Provider;
- Rehabilitation services and devices;
- Skilled nursing care;
- Specialist; and
- Urgent care.

1.11.5 **New Health Plan Enrollee Materials and Outreach**

The Contractor shall provide the following information to new Health Plan Enrollees:

- Health Plan Enrollee Handbook in accordance with the timing and content requirements of Section 1.11.5.2: “Health Plan Enrollee Handbook” of this Model Contract;
- Health Plan Enrollee ID card in accordance with the timing and content requirements of Section 1.11.5.3: “Health Plan Enrollee ID Card” of this Model Contract; and

- Information regarding how to access a Provider Directory as described in Section 1.11.13: “Provider Directory” of this Model Contract.

Additionally, the Contractor shall make all reasonable efforts during Initial Program Implementation to contact Health Plan Enrollees within 90 days of initial Health Plan Enrollee enrollment and within ten days of a Health Plan Enrollee’s enrollment effective date during Steady State Operations. Reasonable effort is defined as at least three attempts to contact the Health Plan Enrollee with at least one of those attempts by telephone. The three attempts by the Contractor shall not be made within the same day. Telephone attempts should be staggered between different times of the day in an effort to increase the likelihood of making contact with the Health Plan Enrollee.

Upon contacting a new Health Plan Enrollee, the Contractor shall:

- Inquire about any urgent health needs or previously scheduled services or advise the Health Plan Enrollee how to contact the Contractor to provide this information;
- Conduct a Health Risk Screening, in accordance with the requirements outlined in Section 1.8.1: “Health Risk Screening” of this Model Contract, or inform the Health Plan Enrollee that he or she will be contacted at a later time for this purpose;
- Inform the Health Plan Enrollee about his or her right to continue certain existing services, as applicable, in accordance with Section 1.9: “Transition of Care” of this Model Contract;
- Review with the Health Plan Enrollee what to do in an emergency;
- Inform the Health Plan Enrollee about the Contractor’s policies with respect to obtaining covered services;
- Assist the Health Plan Enrollee in selecting a PCMH Provider in accordance with Section 1.11.11: “PCMH Selection and Assignment” of this Model Contract;
- Provide the Health Plan Enrollee with the Contractor’s telephone numbers and website address;
- Advise the Health Plan Enrollee about opportunities available for learning about Contractor policies and benefits in greater detail; and
- Confirm the Health Plan Enrollee knows how to access the Contractor’s Provider Directory.

1.11.5.1 Failure to Contact

The Contractor shall report to OHCA all Health Plan Enrollees that it has failed to contact during the first 90 days of initial Health Plan Enrollee enrollment and within ten days of a Health Plan Enrollee’s enrollment effective date during Steady State Operations, the days of enrollment and the nature and disposition of its contact attempts. OHCA will specify the reporting format and timelines in the Reporting Manual.

1.11.5.2 Health Plan Enrollee Handbook

1.11.5.2.1 Distribution Timeframe

The Contractor shall provide each Health Plan Enrollee a Health Plan Enrollee Handbook within ten days after receiving notice of a Health Plan Enrollee’s enrollment on the ANSI ASC X 12 834 electronic transaction and within ten days of the Health Plan Enrollee’s request for a new Health Plan Enrollee Handbook. The Health Plan Enrollee Handbook serves as a summary of benefits and coverage. Pursuant to 42 C.F.R. § 438.10(g)(4), the Contractor shall give each Health Plan Enrollee notice of any change that OHCA defines as significant in the information provided in the Health Plan Enrollee Handbook. The notice shall be provided at least 30 days before the intended effective date of the change.

1.11.5.2.2 Distribution Methods

Pursuant to 42 C.F.R. § 438.10(g)(3)(i)-(iv), the Contractor shall be considered to have provided a Health Plan Enrollee Handbook to the Health Plan Enrollee if one of the following distribution methods is used:

- Mailing a printed copy of the Health Plan Enrollee Handbook to the Health Plan Enrollee's mailing address;
- Providing the information by email after obtaining the Health Plan Enrollee's agreement to receive the Handbook by email;
- Posting the information on the Contractor's website and advising the Health Plan Enrollee in paper or electronic form that the information is available on the Contractor's website. The Contractor shall include the applicable URL address provided that Health Plan Enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- Providing the information by any other method that can reasonably be expected to result in the Health Plan Enrollee receiving that information.

The Contractor shall develop strategies and policies to ensure that Health Plan Enrollee Handbooks may be delivered to homeless Health Plan Enrollees and submit these policies to OHCA for review and approval.

1.11.5.2.3 Number of Health Plan Enrollee Handbooks

If the Health Plan Enrollee Handbook is mailed and there are two or more related Health Plan Enrollees registered to the same address, the Contractor is permitted to mail one copy to that address. The Contractor shall provide information to the Health Plan Enrollee about how to request additional copies of the Health Plan Enrollee Handbook.

Every Health Plan Enrollee that opts to receive information via email shall receive an electronic version of the Health Plan Enrollee Handbook.

1.11.5.2.4 Health Plan Enrollee Handbook Content

Pursuant to 42 C.F.R. § 438.10(c)(4)(ii), the Contractor shall use OHCA's model Health Plan Enrollee Handbook content in developing a Contractor-specific Handbook for OHCA's review and approval. The content of the Health Plan Enrollee Handbook shall include information that enables the Health Plan Enrollee to understand the MCO and SoonerSelect. This information shall include at a minimum:

- A table of contents;
- Information about how to update any personal information;
- Information about what managed care is, with emphasis placed on Participating versus Non-Participating Providers;
- The amount, duration and scope of benefits provided by the Contractor in sufficient detail to ensure that Health Plan Enrollees understand the benefits to which they are entitled, including information about the EPSDT benefit and how to access component services;
- Procedures for obtaining benefits, including any policies, procedures and requirements for Service Authorizations and/or referrals for specialty care and for other benefits not furnished by the Health Plan Enrollee's PCMH Provider;
- Information required AI/AN-specific policies and procedures, including:
 - Opt-in policies, and

- Rights in accessing care as described in Section 1.15: “American Indian/Alaska Native Population and Indian Health Care Providers” of this Model Contract;
- Limitations or exclusions to benefits;
 - In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor must inform Health Plan Enrollees that the service is not covered and how the Health Plan Enrollee can obtain information from OHCA about how to access those services,
- Information on how to access all services, including but not limited to EPSDT, transportation (both emergency and non-emergency), behavioral health, and pharmacy;
- Information on how to access services when out-of-state;
- How and where to access any benefits provided by OHCA and the Dental PAHP, including any Cost Sharing and how transportation is provided;
- Cost Sharing on any benefits,
- The toll-free telephone number and hours of operation for the:
 - Health Plan Enrollee Services Call Center,
 - Behavioral Health Services Hotline,
 - Medical management, and
 - Any other Contractor unit providing services directly to Health Plan Enrollees;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an Emergency Medical Condition and Emergency Services,
 - The fact that Prior Authorization is not required for Emergency Services,
 - The fact that, the Health Plan Enrollee has a right to use any hospital or other setting for emergency care,
 - Identifying how to determine emergency status if the Health Plan Enrollee is unsure;
- Any restrictions on the Health Plan Enrollee’s freedom of choice among Participating Providers;
- The process for selecting and changing the Health Plan Enrollee’s PCMH Provider;
- The extent to which, and how, Health Plan Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers. This includes an explanation that the Contractor shall not require a Health Plan Enrollee to obtain a referral before choosing a family planning Provider;
- An assurance of non-discrimination of services;
- Health Plan Enrollee rights and responsibilities, including the Health Plan Enrollee’s right to:
 - Receive information on Health Plan Enrollee and plan information,
 - Be treated with respect and with due consideration for dignity and privacy,
 - Receive information on available treatment options and alternatives, presented in a manner appropriate to the Health Plan Enrollee’s condition and ability to understand,
 - Participate in decisions regarding his or her health care, including the right to refuse treatment,
 - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation,
 - Request and receive a copy of their medical records and request that they be amended or corrected, and
 - Obtain available and accessible Health Care Services covered under the Contract;
- Grievance, Appeal and State Fair Hearing procedures and timeframes, including:

- The right to file Grievances and Appeal,
- Requirements and timeframes for filing a Grievance or Appeal,
- The availability of assistance in the filing process,
- The right to request a State Fair Hearing after the Contractor has made a determination on the Health Plan Enrollee's Appeal which is adverse to the Health Plan Enrollee,
- The fact that, when requested by the Health Plan Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Health Plan Enrollee files an Appeal or requests a State Fair Hearing within the timeframes specified for filing. The Health Plan Enrollee may, consistent with State policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Health Plan Enrollee;
- How to exercise an Advance Directive;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- Information on how to report suspected Fraud or Abuse;
- The process of selecting and changing the Health Plan Enrollee's PCMH Provider;
- Explanation of the role of the PCMH Provider;
- An explanation of how Health Plan Enrollee care needs, conditions and geographic location will factor into the assignment of a PCMH Provider;
- Transition of care policies for Health Plan Enrollees and Eligibles;
- The role of the Care Manager/care management department and how to contact this individual or department;
- Explanation of circumstances in which the Health Plan Enrollee may be billed for services or fees;
- General health and wellness literacy information;
- Explanation about how to disenroll from the Contractor's plan; and
- Any other content required by OHCA.

The Health Plan Enrollee Handbook shall also explicitly outline the following Health Plan Enrollee responsibilities:

- Checking OHCA/Contractor's information; correcting inaccuracies; and allowing government agencies, employers and Providers to release records to OHCA/Contractor;
- Notifying OHCA/Contractor within ten days if there are changes in income, the number of people living in the home, address or mailbox changes or health insurance changes;
- Transferring, assigning and authorizing to OHCA all claims the Health Plan Enrollee may have against health insurance, liability insurance companies or other third parties. This includes payments for medical services made by OHCA for the Health Plan Enrollee's dependents;
- Working on requests for assistance from the Office of Child Support Services;
- Allowing SoonerCare to collect payments from anyone who is required to pay for medical care;
- Sharing necessary medical information with any insurance company, person or entity who is responsible for paying the bill;
- Inspecting any medical records to see if claims for services can be paid;
- Obtaining permission for Oklahoma DHS or OHCA to make payment or overpayment decisions;
- Storing his or her identification card and knowing his or her Social Security number to receive health care services or prescriptions;

- Confirming that any care received is covered;
- Understanding Health Plan Enrollee responsibility as it pertains to securing NEMT and the timeframes required to receive NEMT services;
- Cost Sharing; and
- Ensuring all information provided to OHCA/Contractor is complete and true upon penalty of fraud or perjury.

1.11.5.3 Health Plan Enrollee ID Card

The Contractor shall distribute Health Plan Enrollee ID cards to each SoonerSelect-enrolled individual in a household within seven days of receiving the ANSI ASC X 12 834 electronic transactions from OHCA.

If the Health Plan Enrollee loses his or her Health Plan Enrollee ID card, or the Health Plan Enrollee's information changes, the Contractor shall update and reissue the Health Plan Enrollee ID card within seven days of receiving notification of the change. The Health Plan Enrollee must also be able to access and print a new card through the Health Plan Enrollee Portal described in Section 1.11.6.3: "Health Plan Enrollee Website Portal" of this Model Contract.

The Health Plan Enrollee ID card must be made out of durable material suitable for everyday use, such as durable plastic or laminated paper.

Each Health Plan Enrollee ID card must include sufficient information to identify the Health Plan Enrollee's identity, and Contractor information to facilitate claims filing for all Participating Providers.

The Contractor must submit a sample Health Plan Enrollee ID card as part of the Readiness Review for OHCA review and approval.

1.11.6 **Health Plan Enrollee Website**

1.11.6.1 General Website Requirements

The Contractor shall develop a Health Plan Enrollee website. In developing the Health Plan Enrollee website, the Contractor shall:

- Maintain a separate and distinct section on its website for SoonerSelect information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each webpage with the date the page was last updated;
- Clearly label any links;
- Notify individuals that they will leave the Contractor's SoonerSelect website if there is a link that will take individuals to non-SoonerSelect information or to a different website;
- Comply with HIPAA when providing Health Plan Enrollee eligibility or Health Plan Enrollee identification on the website, including the Health Plan Enrollee and Provider portal(s);
- Ensure website content can be viewed via mobile devices; and
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

1.11.6.2 Website Content

As part of Readiness Review activities, the Contractor must submit all website pages and content related to the SoonerSelect program to OHCA for review and approval before making the content public. At a minimum, the Contractor shall include the following information on its website:

- Contractor’s contact information, including address, Health Plan Enrollee Services Call Center toll-free number and TTY/TDD number;
- Contractor’s office hours/days, including availability of customer service;
- Provider directory and information on how to find a Participating Provider near the Health Plan Enrollee’s residence;
- Description of any restrictions on the Health Plan Enrollee’s freedom of choice among Participating Providers, as well as the extent to which Health Plan Enrollees may obtain benefits from Non-Participating Providers;
- The preferred drug list, including:
 - Which generic and brand name medications are covered;
 - Whether the drug requires Prior Authorization; and
 - What tier each medication is in.
- Link to OHCA website and/or other pages within the website, as specified by OHCA;
- The amount, duration and scope of benefits available by the Contractor in sufficient detail to ensure that Health Plan Enrollees are informed of the services to which they are entitled, including Service Authorization requirements;
- Procedures for obtaining benefits, including authorization requirements;
- Health Plan Enrollee Handbook;
- Accreditation information in accordance with Section 1.3.2: “Accreditation” of this Model Contract; and
- Grievance, Appeals and State Fair Hearing processes.

The Contractor may include the following information on its website:

- Marketing Materials specific to OHCA-approved Value-Added Benefits and/or quality rating reports; and
- Materials intended to be read by Health Plan Enrollees or Eligibles, such as newspaper articles and news releases, with prior approval from OHCA.

Following SoonerSelect Initial Program Implementation, the Contractor shall request updates to website content in accordance with Section 1.11.3.2: “Prior Approval Process” of this Model Contract.

1.11.6.3 Health Plan Enrollee Website Portal

The Contractor must provide a Health Plan Enrollee portal on its website with a single sign-on process that can be accessed on a variety of electronic devices, including a computer or mobile device. The Health Plan Enrollee portal must at least:

- Allow Health Plan Enrollees to access and print Health Plan Enrollee ID cards; and
- Provide Explanation of Benefits (EOB) information.

1.11.6.4 508 Compliance

The Contractor shall ensure that all electronic information and services will be compliant with all language, formatting and accessibility standards such as Section 508 guidelines or guidelines that provide greater accessibility to individuals with disabilities. The Contractor shall notify Health Plan Enrollees that materials are available in paper form and through auxiliary aids and services upon request and at no cost.

1.11.6.5 Website Translation

The Contractor shall ensure that website content will also be available in the prevalent non-English languages, in accordance with the requirements of Section 1.11.1.1: “Prevalent Non-English Languages” of this Model Contract. The Contractor shall receive approval of the translation from OHCA before publishing it online in accordance with the requirements of Section 1.11.3.2: “Prior Approval Process” of this Model Contract.

1.11.6.6 Machine Readable Data

The Contractor shall post its provider directories and formularies on its website in a machine-readable file and format specified by the DHHS Secretary.

1.11.6.7 Social Media and Mobile Applications

The Contractor shall utilize social media platforms and mobile applications to provide Health Plan Enrollees with health topic information and SoonerSelect information. OHCA will work with Contractors on any proposed initiatives. Social media shall be used to maximize Contractor’s communication with Health Plan Enrollees.

The Contractor shall receive approval from OHCA before utilizing a new social media platform. OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

1.11.7 **Health Plan Enrollee Services Call Center**

1.11.7.1 Health Plan Enrollee Services Call Center Availability

The Contractor shall operate a toll-free Health Plan Enrollee Services Call Center in accordance with the location requirements outlined in Section 1.3.5: “Oklahoma Presence” of this Model Contract and aimed at addressing questions from Health Plan Enrollees and their representatives. The Contractor may operate an overflow call center within the United States for the purposes of meeting the Health Plan Enrollee Services Call Center performance requirements described in Section 1.11.7.2: “Health Plan Enrollee Services Call Center Performance Standards” of this Model Contract.

The Contractor shall ensure the Health Plan Enrollee Services Call Center is staffed and operational, at minimum, from 8:00 am to 5:00 pm Central Time on Monday through Friday, except for State Holidays.

The Contractor shall operate an after-hours system for fielding calls outside of Call Center operating hours. This system shall record any message the Health Plan Enrollee leaves, his or her name and telephone number. The Contractor shall ensure that all calls are returned during the next business day. Notwithstanding the foregoing, the Contractor shall ensure Health Plan Enrollee access to Care Managers in accordance with Section 1.8.4.7: “Health Plan Enrollee Access to Care Managers” of this Model Contract.

The Contractor shall record all calls and emails received and store them in a searchable database. The Contractor shall have the ability to retrieve these calls and emails within one business day. The Contractor

shall also maintain a remote monitoring system that OHCA may be able to use to assess the Contractor and Health Plan Enrollee interaction.

1.11.7.2 Health Plan Enrollee Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Health Plan Enrollee Services Call Center activities and performance. The Contractor shall ensure the Call Center meets the following minimum performance requirements:

- Call abandonment rate shall be less than five percent;
- 85% of calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed 30 seconds;
- Blocked call rate shall not exceed one percent; and
- The overflow call center must not receive more than five percent of all incoming calls to the Call Center.

The Contractor shall have the capability to track these Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Health Plan Enrollee Services Call Center reporting shall break down performance by:

- The Contractor's main Health Plan Enrollee Services Call Center;
- Overflow call center, if applicable; and
- Applicable Subcontractors.

The Contractor shall also have the capability to track Grievances received in the Health Plan Enrollee Services Call Center by volume and type. The Contractor shall have the capability to compare and report its Oklahoma Call Center's performance to the performance of its affiliate health plans in other states, if it has affiliate health plans, and if similar performance standards are tracked.

At the end of each Contract year, the Contractor shall issue to the OHCA an annual report detailing performance of the Call Center and mapping out improvement strategies for the following year.

1.11.7.3 Call Center Training

The Contractor shall develop a program to train newly hired Health Plan Enrollee Services Call Center staff and to conduct ongoing training for all Call Center staff. This training program shall address topics that include, at least:

- The populations covered under the SoonerSelect program;
- Covered and non-covered services;
- Enrollment and Disenrollment;
- Fielding eligibility questions;
- Accessing services in- and out-of-network;
- Care management;
- Services for AI/AN Health Plan Enrollees;
- Cultural and linguistic competency;
- Out-of-state services; and
- Filing a Grievance or Appeal.

The training program shall teach Call Center staff to interact with Health Plan Enrollees efficiently, patiently and respectfully. The staff shall be trained so that they are equipped to recognize situations where a Health Plan Enrollee has LEP or is hearing impaired and to direct them to the appropriate resources.

Call Center staff shall receive training quarterly, or more frequently, through instructor-led training or staff meetings. The staff shall also be retrained immediately upon a major change in service delivery or covered services.

The Contractor shall submit its Call Center training program to OHCA during Readiness Review and annually for review and approval.

1.11.7.4 Multilingual Representatives

The Contractor shall have multilingual Health Plan Enrollee Services Call Center representatives able to field calls for every prevalent non-English language. The Contractor shall also submit a plan for identifying Health Plan Enrollees with LEP and providing these Health Plan Enrollees with the translation or interpretation services necessary to have their question or issue resolved in a timely manner. The Contractor's plan must comply with the minimum requirements of Section 1.11.1.2: "Interpretation Services" of this Model Contract.

1.11.7.5 Redetermination Assistance

The Contractor is permitted via the Health Plan Enrollee Services Call Center to provide assistance to Health Plan Enrollees with questions regarding the SoonerCare annual eligibility redetermination process. The Contractor is permitted to answer questions about the redetermination process and assist the Health Plan Enrollee in obtaining the required documentation necessary to complete the process. In providing assistance for eligibility redeterminations, the Contractor is prohibited from the following:

- Discriminating against Health Plan Enrollees, particularly high-cost Health Plan Enrollees or Health Plan Enrollees that have indicated a desire to change MCOs;
- Talking to Health Plan Enrollees about changing MCOs. If a Health Plan Enrollee has questions or requests to change MCOs, the Contractor shall refer the Health Plan Enrollee to OHCA or its designee;
- Providing any indication as to whether the Health Plan Enrollee will be eligible, as this decision is at the sole discretion of OHCA;
- Engaging in or supporting fraudulent activity in association with helping the Health Plan Enrollee complete the redetermination process; or
- Signing or sending any redetermination forms on behalf of the Health Plan Enrollee.

1.11.8 **Behavioral Health Services Hotline**

The Contractor shall operate a toll-free Behavioral Health Services Hotline staffed by trained personnel 24 hours a day, seven days a week, 365 days a year. The Behavioral Health Services Hotline staff must include or have access to qualified behavioral health professionals to assess, triage and address Health Plan Enrollee behavioral health emergencies.

The Contractor shall ensure the Behavioral Health Services Hotline meets the following minimum performance requirements:

- Call abandonment rate shall be less than five percent;

- 99% of calls are answered by the fourth ring;
- No incoming calls receive a busy signal;
- The system can immediately connect to the local suicide hotline’s telephone number and other crisis response systems; and
- Have patch capabilities to 911 emergency services.

The Contractor shall not impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Health Plan Enrollee. The Contractor shall ensure the Behavioral Health Services Hotline meets the oral interpretation and auxiliary aid requirements under Section 1.11.1.2: “Interpretation Services” of this Model Contract.

The Contractor shall have the capability to track required Behavioral Health Services Hotline metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual.

1.11.9 Health Plan Enrollee Rights

Pursuant to 42 C.F.R. § 438.100, the Contractor shall have written policies guaranteeing each Health Plan Enrollee’s right to:

- Receive information on the SoonerSelect program and the Contractor.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Health Plan Enrollee’s condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.

Pursuant to 42 C.F.R. §§ 438.100(a)(1) and 438.100(c), each Health Plan Enrollee is free to exercise his or her rights without the Contractor or its Participating Providers treating the Health Plan Enrollee adversely.

Health Plan Enrollee rights will at least appear in the Health Plan Enrollee Handbook, described in Section 1.11.5.2: “Health Plan Enrollee Handbook” of this Model Contract.

1.11.10 Advisory Board

The Contractor shall establish a standing Advisory Board that includes Health Plan Enrollees, Health Plan Enrollee representatives (e.g., family members and caregivers), advocates and Participating Providers. Health Plan Enrollees and Health Plan Enrollee representatives shall constitute a majority of the Board, which shall include at least ten persons in total. The Board, in its composition, shall reflect the Contractor’s total membership in terms of geography, aid category, race and ethnicity and shall specifically include Health Plan Enrollees who receive Behavioral Health Services, or other individuals representing the Health Plan Enrollees.

The Contractor shall submit the proposed Advisory Board membership to OHCA for review and approval, prior to convening the first meeting. The Contractor shall keep OHCA advised of changes in membership as they occur.

The Contractor shall convene meetings at least quarterly and shall consult the Advisory Board on matters affecting Health Plan Enrollee and Provider experience, including but not limited to:

- Health Plan Enrollee outreach and educational activities and materials;
- Provider outreach and educational activities and materials;
- Quality improvement plan, including;
 - Selection of Performance Improvement Project topics and sharing of results,
 - Identification of measures to be evaluated for the purpose of documenting the Contractor's performance in both the short- and long-term; and
- Strategies for addressing operational deficiencies, as identified through Grievance and Appeal trends, Health Plan Enrollee satisfaction data, Health Plan Enrollee appointment wait times, ER utilization trends and other quality data.

The Advisory Board shall meet at least quarterly, with the first meeting to be held no later than 90 days after initial Health Plan Enrollee enrollment into the SoonerSelect program. The Contractor shall inform OHCA at least 30 days in advance of each meeting and shall permit OHCA to send representative(s) to observe the meeting, if OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the Health Plan Enrollee and the family member or other person assisting the Health Plan Enrollee to each meeting, to facilitate attendance by board members and their representatives. The Contractor may offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Advisory Board meetings and Board activities and results. The Contractor shall submit the record in a manner and format specified by OHCA upon OHCA request.

1.11.10.1 Behavioral Health Advisory Board

In addition to the Advisory Board required under Section 1.11.10: "Advisory Board" of this Model Contract, the Contractor shall establish a Behavioral Health Advisory Board to enhance the delivery of Behavioral Health Services under the Contract, including substance use disorder services. The Behavioral Health Advisory Board shall include representation by behavioral health Participating Providers, peer recovery specialists, Health Plan Enrollees who are consumers of Behavioral Health Services, and Health Plan Enrollee representatives. Health Plan Enrollees and Health Plan Enrollee representatives shall constitute a majority of the Behavioral Health Advisory Board.

At minimum, the Behavioral Health Advisory Board shall have input into the Contractor's policy development, planning for services, service evaluation, and Health Plan Enrollee, family member and Provider education.

The Behavioral Health Advisory Board shall meet at least quarterly, with the first meeting to be held no later than 90 days after initial Health Plan Enrollee enrollment into the SoonerSelect program. The Contractor shall inform OHCA at least 30 days in advance of each meeting and shall permit OHCA to send representative(s) to observe the meeting, if OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the Health Plan Enrollee and the family member or other person assisting the Health Plan Enrollee to each meeting, to facilitate attendance by Health Plan Enrollees and their representatives. The Contractor may offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Behavioral Health Advisory Board meetings, activities and results. The Contractor shall submit the record in a manner and format specified by OHCA upon OHCA request.

1.11.11 PCMH Selection and Assignment

Pursuant to 42 C.F.R. § 438.208(b)(1), the Contractor shall implement procedures to ensure that each Health Plan Enrollee has an ongoing source of care appropriate to their needs. The Contractor shall formally designate a PCMH Provider to all Health Plan Enrollees to be primarily responsible for coordinating services accessed by the Health Plan Enrollee. The Contractor shall allow each Health Plan Enrollee to choose his or her PCMH Provider to the extent possible and as appropriate and in accordance with Section 1.11.11.2: “Assignment Requirements” of this Model Contract. The Contractor shall have procedures for serving Health Plan Enrollees and reimbursing Provider claims from the first day of Health Plan Enrollee enrollment with the Contractor, whether or not the Health Plan Enrollee has selected or been assigned a PCMH Provider.

1.11.11.1 Eligible Provider Types

The Contractor shall limit PCMH Provider types to those specified in Section 1.12.4.1: “PCMH Provider Standards” of this Model Contract. A Health Plan Enrollee whose PCMH site is a multi-provider clinic can be assigned either to the clinic or a specific practitioner within the clinic to serve as his or her PCMH Provider.

1.11.11.2 Assignment Requirements

In accordance with 42 C.F.R. § 438.3(l), each Health Plan Enrollee shall be allowed to choose his or her PCMH Provider to the extent possible and appropriate. The Contractor shall implement procedures to assist Health Plan Enrollees in selecting a PCMH Provider upon enrollment with the Contractor. The Contractor shall educate Health Plan Enrollees on factors to consider in making a PCMH Provider selection, such as travel distance, special healthcare needs and Providers seen by family members.

If a Health Plan Enrollee does not select a PCMH Provider within 30 days of his or her enrollment effective date, the Contractor shall assign one. All Contractor-initiated PCMH Provider assignments shall:

- Be within the time and distance standards of the Health Plan Enrollee’s residence as specified in Section 1.12.4: “Time and Distance and Appointment Access Standards” of this Model Contract;
- Be made to an age, gender and culturally-appropriate Provider;
- Consider the following factors:
 - Previous or current relationship the Health Plan Enrollee has with a Provider;
 - Previous or current relationship the Health Plan Enrollee’s family members have with a Provider;
 - Any special medical needs of the Health Plan Enrollee, including pregnancy; and
 - Any Health Plan Enrollee language needs made known to the Contractor.

Pursuant to 42 C.F.R. § 438.208(b)(1), within three days of the Health Plan Enrollee’s selection or Contractor’s assignment to a PCMH Provider, the Contractor shall notify the Health Plan Enrollee, in writing, of the name and contact information of the PCMH Provider.

OHCA intends to provide the Contractor with Health Plan Enrollees’ historical PCMH assignments from the SoonerCare fee-for-service delivery system to facilitate the Contractor’s assignment of Health Plan Enrollees to a PCMH Provider during Initial Program Implementation.

1.11.12 PCMH Changes

1.11.12.1 Health Plan Enrollee-initiated PCMH Changes

The Contractor must permit Health Plan Enrollees to change PCMH Providers, without cause. If the Contractor has made an initial assignment, the Contractor must permit the Health Plan Enrollee to change during the first month, effective the following business day. The Contractor may limit the effective date of changes after the first month of enrollment to the beginning of the following month.

The Contractor must ensure that Health Plan Enrollees have at least two age- and gender-appropriate PCMH Providers within the travel time and distance standards specified in Section 1.12.4: "Time and Distance and Appointment Access Standards" of this Model Contract, from which to select.

1.11.12.2 Contractor-initiated PCMH Changes

The Contractor may initiate a change in PCMH Providers only under the following circumstances:

- Health Plan Enrollee requires specialized care for an acute or Chronic Condition and the Health Plan Enrollee and the Contractor agree that reassignment to a different Participating Provider is in the Health Plan Enrollee's interest;
- Health Plan Enrollee's place of residence has changed such that he or she has moved beyond the PCMH Provider travel time and distance standard;
- Health Plan Enrollee's PCMH Provider ceases to participate in the Contractor's network;
- Health Plan Enrollee's behavior toward his or her PCMH Provider is disruptive to the extent that the Provider cannot effectively manage their care, and the PCMH Provider has made all reasonable efforts to accommodate the Health Plan Enrollee; or
- Health Plan Enrollee has taken legal action against the Provider.

Whenever initiating a change, the Contractor must offer affected Health Plan Enrollees the opportunity to select a new PCMH Provider. The Contractor shall notify the Health Plan Enrollee within three days of the name and contact information of the new Contractor-assigned or Health Plan Enrollee-selected PCMH Provider.

1.11.12.3 Notification of PCMH Termination

Pursuant to 42 C.F.R. § 438.10(f)(1), the Contractor shall make a good faith effort to give written notice of termination of a Participating Provider to each Health Plan Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. The Contractor shall provide notice to a Health Plan Enrollee no more than 15 Calendar Days after receipt or issuance of the termination notice and earlier if appropriate to ensure quality of care.

"Regular basis," at a minimum, shall be construed to mean any Provider delivering care on a routine basis as defined in the Health Plan Enrollee's Care Plan, as applicable. When clinically appropriate, the Contractor shall conduct immediate outreach and support for Health Plan Enrollees to select alternative Providers. For Health Plan Enrollees who are receiving treatment for a chronic or ongoing medical condition, the Contractor shall ensure that there is no disruption in services.

1.11.13 Provider Directory

1.11.13.1 Format and Distribution

The Contractor shall have a provider directory available in electronic and paper formats. The directory shall be distributed to Health Plan Enrollees at least annually in paper format or through a reminder

notification to Health Plan Enrollees of its availability on the Contractor's website. If the Contractor does not routinely distribute paper copies, the Contractor shall distribute a paper copy if requested by a Health Plan Enrollee.

1.11.13.2 Content

Pursuant to 42 C.F.R. §§ 438.10(h)(1)(i)-(viii) and 438.10(h)(2), the provider directory shall contain the following information about the Contractor's Participating Providers:

- Provider's name as well as any group affiliation, including the following Provider types:
 - Physicians, Physician Assistants, and Advanced Practice Registered Nurses, including specialists,
 - Hospitals,
 - Pharmacies,
 - Behavioral health Providers,
 - Other Providers required under this Contract;
- Street address(es);
- Telephone number(s);
- Website URL, as appropriate;
- Specialty, if appropriate;
- Gender;
- Whether the Provider will accept new Health Plan Enrollees (necessary only in the online version);
- Mapping capabilities (necessary only in the online version);
- Provider's cultural and linguistic capabilities, including languages (including ASL) offered by the Provider or by skilled medical interpreter at the Provider's office and whether the Provider has completed cultural competence training; and
- Whether the Provider's office/facility has accommodations for persons with disabilities, including offices, exam room(s) and equipment.

1.11.13.3 Submission Process and OHCA Approval

The Contractor shall submit its provider directory to OHCA for review and approval at least 30 days prior to distribution. The open panel status of the Provider shall be updated online as it changes. Review from OHCA is not necessary to change the open panel status.

1.11.13.4 Updates

The Contractor shall update its provider directory at the following timeframes:

- At least monthly for the paper directory; and
- No later than three Business Days after the Contractor receives updated Provider information for the online version of the directory.

1.11.13.5 Website Publication

In accordance with 42 C.F.R. § 438.10(h)(4), the Contractor shall make the provider directory available on its website without a login requirement, and in a machine readable file and format as specified by the Secretary.

1.11.14 Physician Incentive Plan Notification

Pursuant to 42 C.F.R. §§ 438.10(f)(3), if the Contractor uses physician financial incentive plans, the Contractor must make available, upon request, information about the incentive program. The Contractor shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions and any such incentive plans must comply with all applicable laws, including, without limitation 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R §417.479.

1.11.15 Marketing and Outreach

Marketing is any communication from the Contractor to an Eligible who is not enrolled with the Contractor that can reasonably be interpreted to try to influence the Eligible to:

- Enroll in the Contractor’s Medicaid product; or
- Either not enroll in, or disenroll from, another MCO.

Marketing does not include:

- Communication to an Eligible from the issuer of a Qualified Health Plan (QHP), as defined in 45 C.F.R. § 155.20, about the QHP; and
- Communication related to educating Health Plan Enrollees about Contractor operations or educating Health Plan Enrollees as part of care management activities.

Marketing Materials are materials that are produced in any medium, by or on behalf of the Contractor and can reasonably be interpreted by OHCA or its designee as intended to market the Contractor (or its employees, Participating Providers, agents or Subcontractors) to Eligibles. Marketing Materials include verbal presentation and written materials as well as advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts and electronic messages.

1.11.15.1 Policies and Procedures

The Contractor shall develop and maintain written policies and procedures governing the development, implementation and distribution of Marketing activities and materials that, among other things, includes methods for quality control to ensure materials are accurate and do not mislead, confuse or defraud Health Plan Enrollees, OHCA or the State.

1.11.15.2 Training Curriculum

The Contractor shall develop training curriculum and provide training for Marketing representatives, including the Contractor’s staff and Subcontractors. The Contractor shall maintain documentation of training efforts and provide such documentation upon request to OHCA.

1.11.15.3 Literacy/Format

The Contractor shall ensure that its Marketing activities and materials are designed to meet the informational needs, relative to Marketing, of the cultural and physical diversity of the SoonerSelect population. All Marketing Materials shall be in compliance with the information requirements in 42 C.F.R. § 438.10 to ensure that, before enrolling, an Eligible receives accurate oral and written information needed to make an informed decision on whether to enroll.

For further instruction on the requirements for written materials, refer to Section 1.11.3: “Written Material Guidelines” of this Model Contract.

1.11.15.4 OHCA Review and Approval Process

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall not distribute Marketing Materials without first obtaining OHCA approval. OHCA shall consult with the Medical Care Advisory Committee established under 42 C.F.R. § 431.12 on the Marketing Material review process.

The Contractor shall submit Marketing Materials to OHCA for review and approval in accordance with the requirements of Section 1.11.3.2: "Prior Approval Process" of this Model Contract at least 60 days prior to expected use and distribution. The Contractor shall not change any approved materials without the consent and approval of OHCA.

1.11.15.5 Use of State Agency Logos

The Contractor shall not refer to or use OHCA or other State agency name or logo in its Marketing Materials without prior written approval. Any approval given for the name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the state program logo(s) in its Marketing Materials upon the request of OHCA.

1.11.15.6 Service Area Distribution

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall distribute Marketing Materials to its entire service area as indicated in the Contract.

1.11.15.7 Marketing Plan

The Contractor shall develop and implement a plan that details the Marketing activities the Contractor will undertake and Marketing Materials the Contractor will create during the Contract period. The Marketing plan shall comply with the Marketing activity standards listed in 42 C.F.R. § 438.104 and include, at a minimum, the following information:

- Marketing goals and strategies;
- Details of proposed Marketing activities and events, including calendar of planned outreach activities and events for the first Contract year, distribution methods and schedules. This includes any proposed advertising campaigns, website development and launch, social media platform development and launch and printed materials development and distribution;
- Process for removing outdated materials;
- How the Contractor shall meet the informational needs, relative to Marketing, of the cultural and physical diversity of its membership;
- Summary of Value-Added Benefits, if applicable;
- List of all Subcontractors engaged in Marketing activities for the Contractor;
- Copy of training curriculum for Marketing representatives, including employees and Subcontractors;
- Procedures for monitoring and enforcing compliance with Marketing guidelines;
- Methods for tracking Marketing contacts, including (but not limited to) website visits and social media interactions;
- Process for responding to unsolicited direct contact from Health Plan Enrollees or Eligibles; and
- Details regarding the basis the Contractor uses for awarding bonuses or increasing the salary of Marketing representatives or any other employees involved in Marketing activities.

The Contractor shall submit the plan to OHCA for review and approval as part of Readiness Review activities, on a schedule to be defined by OHCA. The Contractor shall submit any changes to OHCA for

review and approval a minimum of 30 days before intended implementation of the Marketing activity. The plan also shall be updated quarterly and submitted to OHCA for review.

1.11.15.8 Allowable Marketing Activities

The Contractor and its Subcontractors are allowed to perform the following Marketing activities (either written or verbal):

- Distributing general information through mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets);
- Responding to verbal or written requests for MCO-specific information made by a Health Plan Enrollee;
- Organizing or attending activities/events that are designed to benefit the entire community, such as health fairs or other health education and promotion activities which have been prior approved by OHCA;
- Attending events at the request of OHCA to disseminate or share information about the Contractor, its services and outcomes; and
- Offering Eligibles and Health Plan Enrollees tokens or gifts of nominal value, as long as the Contractor acts in compliance with all Marketing provisions provided for in 42 C.F.R. § 438.104, which addresses Marketing activities and other State and federal laws, regulations and guidance regarding inducements.

1.11.15.9 Prohibited Marketing Activities

Pursuant to 42 C.F.R. § 438.104, the Contractor and its Subcontractors are prohibited from engaging in the following Marketing activities (either written or verbal):

- Distributing Marketing Materials or attending/organizing Marketing events that have not received prior approval from OHCA;
- Engaging in direct or indirect door-to-door, telephone, email, texting or other Cold-call Marketing techniques or activities;
- Influencing enrollment in conjunction with the sale or offering of any private insurance, except as provided in 42 C.F.R. § 438.104;
- Distributing plans and materials or making any statement that OHCA determines to be inaccurate, false, misleading or intended to defraud Health Plan Enrollees, Eligibles or OHCA. This includes statements that mislead or falsely describe covered services, membership or availability of Participating Providers or Participating Providers' qualifications or skills;
- Asserting that an Eligible must enroll in the Contractor to obtain benefits or to not lose benefits;
- Asserting that the Contractor is endorsed by CMS, the State or federal government or similar entity, including any other governmental entity;
- Assisting with enrollment or improperly influencing MCO selection;
- Designing a Marketing plan that discourages or encourages MCO selection based on health status or risk (however, this provision does not preclude the Contractor from proclaiming expertise or excellence with a specific subpopulation enrolled in the SoonerSelect program); and
- Conducting any other Marketing activity prohibited by OHCA during the term of the Contract.

OHCA reserves the right to prohibit additional Marketing activities at its discretion.

1.11.15.10 Marketing in Provider Offices

The Contractor may distribute brochures and display posters at Provider offices and clinics that inform patients that the Provider/clinic is part of the Contractor's network, provided that all MCOs in which the provider/clinic participates have an equal opportunity to be represented.

The Contractor is prohibited from:

- Requiring Providers to distribute Contractor-prepared Marketing and educational communications to patients;
- Providing incentives or giveaways to Providers to distribute them to Health Plan Enrollees or Eligibles;
- Allowing Providers to solicit Enrollment or Disenrollment with the Contractor or another MCO; and
- Conducting Marketing activities or distributing Health Plan Enrollee materials in areas where patients primarily receive health care services or are waiting to receive health care services.

The Contractor shall instruct Providers on permissible and prohibited Marketing activities and obtain the written consent of the Provider when conducting any form of Marketing in a Provider's office. The Contractor shall maintain records of the instruction and consent.

1.11.15.11 Media Contacts

The Contractor shall not provide information to the media or participate in media interviews without the prior consent of OHCA. In circumstances where time is of the essence, OHCA will make a good faith effort to review the Contractor's request and respond within one business day. The Contractor shall refer to OHCA any contacts by the media or entity/individual not directly related to the program.

1.12 **Provider Network Development**

1.12.1 **General Network Development and Contracting Standards**

1.12.1.1 Contractor Approach, Policies and Procedures for Provider Contracting

1.12.1.1.1 Approach

The Contractor shall develop and utilize a standardized approach to contracting with Providers for participation in the Contractor's Participating Provider network. This approach shall incorporate, at a minimum, the following elements as further described in this Section:

- Credentialing and recredentialing process.
- A written Provider Agreement that lists the contractual obligations between the Contractor and the Participating Provider.

1.12.1.1.2 Policies and Procedures

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 42 C.F.R. 438.214(a), the Contractor shall maintain written policies and procedures on:

- Participating Provider selection;
- Retention and termination of a Participating Provider's participation with the Contractor;
- Responding to changes in the Contractor's network of Participating Providers that affect access and ability to deliver services in a timely manner; and
- Access standards.

All policies and procedures required under Section 1.12 of this Contract shall be made available to OHCA upon request and will be reviewed during the Readiness Review.

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(c), the Contractor's written policies and procedures on Participating Provider selection, retention and termination shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Contractor shall develop and follow written policies and procedures for Provider contracting and network development, including at minimum:

- Provider selection, retention and termination;
- Network participation outreach activities;
- Network participation application and processing;
- Network changes impacting access standards and the Contractor's ability to deliver services under this Contract in a timely manner;
- Credentialing and recredentialing processes;
- Nondiscrimination of Providers;
- Excluded Providers;
- Provider Agreements; and
- Provider Payment.

1.12.1.2 Adequate Network

In accordance with 42 C.F.R. § 438.206(b)(1), the Contractor shall maintain and monitor a network of appropriate Participating Providers, supported by a signed Provider Agreement that is sufficient to provide adequate access and availability to all services covered under this Contract for all Health Plan Enrollees, including those with LEP or physical or mental disabilities. The Contractor shall provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for Emergency Medical Conditions and shall make arrangements with, or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Contract can be furnished promptly and without compromising the quality of care, in accordance with 42 C.F.R. § 438.3(q)(1) and (q)(3).

In developing an adequate network of Participating Providers, the Contractor shall:

- Meet and require its Participating Providers to meet State standards for timely access to care and services, as specified in this Model Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).
- Ensure that its Participating Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to other SoonerCare populations, if the Participating Provider serves only SoonerCare Eligibles, in accordance with 42 C.F.R. § 238.206(c)(1)(ii);
- Make services included in this Contract available 24 hours a day, seven days a week, when Medically Necessary, in accordance with 42 C.F.R. § 438.206(c)(1)(iii);
- Establish mechanisms to ensure compliance of with timely access requirements by Participating Providers, in accordance with 42 C.F.R. § 438.206(c)(1)(iv);

- Monitor Participating Providers regularly to determine compliance with timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(v); and
- Take corrective action if the Contractor, or its Participating Providers, fail to comply with the timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(vi).

The Contractor shall be able to demonstrate the Contractor's ongoing activities and efforts to comply with these standards. OHCA shall monitor and review the Contractor's compliance with these standards as part of its ongoing oversight activities.

Section 1.12.4: "Time and Distance and Appointment Access Standards" of this Model Contract provides a listing of the minimum required components of network access standards. This is not meant to be an all-inclusive listing of Provider types and components of the Participating Provider network. The Contractor's Participating Provider network for other service Providers must be adequate to ensure that care is available timely and geographically accessible. In addition, the Contractor shall add additional Participating Providers based on the needs of Health Plan Enrollees or due to changes in State or federal requirements.

In accordance with 42 C.F.R. § 438.206(b)(4), if the Contractor is unable to provide necessary medical services covered under this Contract to a particular Health Plan Enrollee, the Contractor shall adequately and timely cover the services provided out-of-network by a Non-Participating Provider, for as long as the Contractor is unable to provide the services within the Contractor's network of Participating Providers. The Contractor shall coordinate payment with Non-Participating Providers and ensure that the cost to the Health Plan Enrollee is no greater than it would be if the services were furnished by a Participating Provider, in accordance with 42 C.F.R. § 438.206(b)(5).

As described in Section 1.6.21: "Delivery Network" of this Model Contract:

- If a female Health Plan Enrollee's designated PCMH Provider is not a women's health specialist, the Contractor shall provide the Health Plan Enrollee with direct access to a women's health specialist within the Contractor's Participating Provider network for covered routine and preventive women's health care services, in accordance with 42 C.F.R. § 438.206(b)(2); and
- The Contractor shall provide for a second opinion from a Participating Provider, or arrange for the Health Plan Enrollee to obtain a second opinion outside the Contractor's Participating Provider network, at no cost to the Health Plan Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).

1.12.1.3 Additional Network Contracting Requirements and Limitations

1.12.1.3.1 Non-Discrimination

In accordance with 42 C.F.R. § 438.12(a)(1), the Contractor may not discriminate in the participation, reimbursement or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

1.12.1.3.2 Written Notice of Decision not to Contract

If the Contractor declines to include individual or groups of Providers in its network of Participating Providers, it must give the affected Providers written notice of the reason for its decision in accordance with 42 C.F.R. § 438.12(a)(1).

1.12.1.3.3 Limits on Network Contracting Requirements in this Contract

Notwithstanding other language in this Model Contract, the Contractor:

- In accordance with 42 C.F.R. § 438.12(b)(1), shall not be required to execute a Provider Agreement beyond the number necessary to meet the needs of its Health Plan Enrollees;
- In accordance with 42 C.F.R. § 438.12(b)(2), shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- In accordance with 42 C.F.R. § 438.12(b)(3), shall not be precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Health Plan Enrollees.

1.12.1.3.4 Compliance with OHCA-Determined Provider Selection Requirements

The Contractor shall comply with any and all additional Participating Provider network selection requirements established by OHCA or the State, in accordance with 42 C.F.R. §§ 438.12(a)(2) and 42 C.F.R. 438.214(e). This shall include all requirements included in this Contract and any amendments thereto, along with all other OHCA guidance on Participating Provider selection along with any applicable state law during the term of this Model Contract.

1.12.1.4 Screening, Enrollment and Periodic Revalidation

1.12.1.4.1 SoonerCare Participation

In accordance with the Provider disclosure, screening, and enrollment requirements at 42 C.F.R. §§ 438.608(b), 455.100-107 and 455.400-470, the Contractor shall require Providers seeking to become Participating Providers to be enrolled as a contracted Provider with SoonerCare. OHCA shall screen, enroll and periodically revalidate all Participating Providers as a Provider with SoonerCare, in accordance with 42 C.F.R. 438.602(b)(1).

1.12.1.4.2 Provider Agreement Execution Pending SoonerCare Enrollment

In accordance with 42 C.F.R. § 438.602(b)(2), the Contractor may execute a Provider Agreement pending the outcome of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to 60 days, but must terminate a Participating Provider immediately upon notification from the State that the Participating Provider cannot be enrolled with SoonerCare, or the expiration of one 60 day period without enrollment of the Provider with SoonerCare, and notify affected Health Plan Enrollees.

1.12.1.5 Provider Network Development and Management Plan

In accordance with 42 C.F.R. § 438.207(a), the Contractor shall provide assurances to OHCA and provide a Provider Network Development and Management Plan, in a manner and format to be specified by OHCA, that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with OHCA's standards for access to care and in accordance with 42 C.F.R. §§ 438.68 and 438.206(c)(1).

As part of the Provider Network Development and Management Plan, the Contractor shall demonstrate that:

- It offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Health Plan Enrollees for the service area, in accordance with 42 C.F.R. § 438.207(b)(1);
- It maintains a network of Participating Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Health Plan Enrollees in the service area, in accordance with 42 C.F.R. § 438.207(b)(2);
- The Participating Provider network includes sufficient family planning Providers to ensure timely access to Family Planning Services and Supplies, in accordance with 42 C.F.R. § 438.206(b)(7); and
- It requires its Participating Providers to meet requirements for access to services as set forth at Section 1.12.4: “Time and Distance and Appointment Access Standards” of this Model Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).

The Provider Network Development and Management Plan shall contain, at a minimum, information on the following:

- Summary of Participating Providers, by provider type and geographical location in the State;
- An attestation that the Contractor’s network of Participating Providers is sufficient to provide adequate access to all services covered under the Contract for all Health Plan Enrollees, including but not limited to those with LEP or physical or mental disabilities;
- Demonstration of monitoring activities to ensure that OHCA-defined network access standards, including time and distance, are met;
- Summary of capacity of the Contractor’s network of Participating Providers and network adequacy issues by type of Provider, service and county and efforts to address those issues; and
- Ongoing activities for Participating Provider development and expansion considerations.

At a minimum, the Plan shall be submitted to OHCA at the following timeframes in accordance with 42 C.F.R. § 438.207(b) - (c):

- At the time the Contractor enters into a Contract with OHCA;
- On an annual basis; and
- At any time there has been a significant change, as defined by OHCA, in the Contractor’s operations that would affect adequacy of capacity of services, including changes in the Contractor’s services, benefits, geographic service area, composition of or payments to its network of Participating Providers or enrollment of a new population in the Contractor’s MCO.

OHCA shall review and approve the Contractor’s Provider Network Development and Management Plan. Once approved, OHCA shall submit an assurance of compliance to CMS that the Contractor meets OHCA’s requirements for availability of services, as set forth in 42 C.F.R. §§ 438.68 and 438.206. The submission to CMS shall include documentation of an analysis that supports the assurance of the adequacy of the Contractor’s network of Participating Providers. OHCA shall make available to CMS, upon request, all documentation collected by OHCA from the Contractor.

1.12.1.6 Participating Provider Network Listing

The Contractor shall supply to OHCA, no later than five Business Days before the end of each month, an up-to-date listing of all Participating Providers. The Contractor's up-to-date listing must include open capacity for PCMH Providers. The listing shall be provided in a format specified by OHCA. OHCA reserves the right to request Participating Provider listing data on a basis more frequently than monthly.

1.12.1.7 Providers Prohibited from Participating Provider Status

The Contractor shall conduct background checks and similar activities as required under state and federal law on all Providers before entering into a Provider Agreement with the Provider.

In accordance with 42 C.F.R. § 438.610, the Contractor shall not knowingly have a relationship with and shall have a proactive method to prevent relationship(s) with entities specified in Section 1.24.1.7: "Termination for Debarment" of this Model Contract.

1.12.1.8 Use of OHCA Provider Identification

A list of all Provider types and Provider sub-specialties enrolled by OHCA is included in Appendix 1C of this Model Contract. The Contractor shall utilize the same respective identifiers, and any updates thereto, for the Contractor's Participating Providers to ensure appropriate data interfaces with OHCA.

1.12.2 **Provider Agreement Requirements**

1.12.2.1 General Requirements

In all Provider Agreements, the Contractor shall comply with all requirements specified in 42 C.F.R. §§ 438.12, 438.214, and 489.1 through 489.35. The Contractor shall maintain policies and procedures that reflect these requirements.

All Provider Agreements shall be executed in accordance with all applicable State and federal statutes, regulations, policies, procedures and rules. The Contractor shall identify and incorporate the applicable terms of this Contract and any amendments by or incorporated documents from the State, including the Solicitation for this Model Contract. Under the terms of the Provider Agreement, the Participating Provider shall agree that all applicable terms and conditions set out in this Model Contract, any incorporated documents, the Solicitation for this Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of the Participating Provider with regard to the provision of services to SoonerSelect program Health Plan Enrollees.

If any requirement in the Provider Agreement is determined by OHCA to conflict with this Model Contract, such requirement shall be null and void and all other provisions of the Provider Agreement shall remain in full force and effect.

1.12.2.2 Minimum Content Requirements

All Provider Agreements shall contain the following provisions, at minimum:

- *Parties to the Provider Agreement.* Identify the parties of the Provider Agreement and each party's legal basis of operation in the State of Oklahoma.
- *Term of Provider Agreement.* Include provisions describing when the Provider Agreement shall become effective and expire.
- *Termination of the Provider Agreement.* Include the procedures and specific criteria for:
 - Reasons for termination;

- The Contractor's ability to deny, refuse to renew or terminate any Provider Agreement in accordance with the terms of this Contract and any applicable statutes and regulations;
 - Written notice requirements;
 - In the event of termination of the Provider Agreement, the Provider shall immediately make available to OHCA or its designated representative in a usable form any or all records whether medically or financially related to the terminated Participating Provider's activities undertaken pursuant to the Provider Agreement and that the provision of such records shall be at no expense to OHCA;
 - OHCA reserves the right to direct the Contractor to terminate any Participating Provider if OHCA determines that termination is in the best interest of the State.
- *Independent Contractor.* Specify that the Participating Provider is not a third party beneficiary to the Contract between the Contractor and the State and that the Participating Provider is an independent contractor performing services as outlined in this Contract between the Contractor and the State.
 - *Scope of Work.* Identify the services, activities and reporting responsibilities to be performed by the Participating Provider.
 - *NPI.* Require that any Provider, including Providers ordering or referring a covered service, have an NPI, to the extent such provider is not an atypical provider as defined by CMS.
 - *Credentialing and Recredentialing.* The Contractor shall maintain all Provider Agreements in accordance with 42 C.F.R. § 438.214.
 - *Health Plan Enrollee Rights and Responsibilities.* Require all Participating Providers to abide by Health Plan Enrollee rights and responsibilities denoted in this Model Contract.
 - *Display Notices of Health Plan Enrollee Rights to Grievances, Appeals and State Fair Hearings.* Require that the Participating Provider display notices in public areas of the Participating Provider's facility/facilities in accordance with all State requirements and any subsequent amendments.
 - *Physical Accessibility.* Require Participating Providers to provide physical access, reasonable accommodations, and accessible equipment for Health Plan Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3).
 - *Interpreter Presence.* Require Participating Providers to accommodate the presence of interpreters.
 - *Emergency Services.* Provide that Emergency Services be rendered without the requirement of Prior Authorization.
 - *Confidentiality.* Require that Health Plan Enrollee information be kept confidential, as defined by State and federal laws, regulations and policy.
 - *Record Keeping.* Require Participating Providers to maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Health Plan Enrollees and their representatives shall be given access to and can request copies of the Health Plan Enrollees' medical records to the extent and in the manner provided under State or federal law.

- *Record Availability.* Require Participating Providers to maintain all records related to services provided to Health Plan Enrollees for a ten year period. In addition, require Providers to make all Health Plan Enrollee medical records or other service records available for any quality reviews that may be conducted by the Contractor, OHCA or its designated agent(s) during and after the term of the Provider Agreement.
- *Professional Standards for Health Records.* In accordance with 42 C.F.R. § 438.208(b)(5), require Participating Providers furnishing services to Health Plan Enrollees to maintain and share Health Plan Enrollee health records in accordance with professional standards.
- *Vaccines for Children, as applicable.* If the Participating Provider is eligible for participation in the Vaccines for Children program, the Contractor shall require the Provider to comply with all program requirements as defined by OHCA.
- *Facility and Record Access for Evaluation, Inspection or Auditing Purposes.* Include a provision that authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Provider Agreement.
- *Release of Information for Monitoring Purposes.* Include a provision that the Participating Provider shall release to the Contractor any information necessary to monitor Participating Provider performance on an ongoing and periodic basis.
- *Health Plan Enrollee Cost Sharing.* Specify the Participating Provider's responsibilities and prohibited activities regarding SoonerSelect program Cost Sharing. When the covered service provided requires a Copayment, as allowed by the Contractor, the Participating Provider may charge the Health Plan Enrollee only the amount of the allowed Copayment, which cannot exceed the Copayment amount allowed by OHCA. The Participating Provider shall accept payment made by the Contractor as payment in full for covered services, and the Participating Provider shall not solicit or accept any surety or guarantee of payment from the Health Plan Enrollee, OHCA or the State.
- *Third Party Liability.* Include a provision for Participating Provider responsibility with respect to Third Party Liability, including:
 - The Participating Provider's obligation to identify Health Plan Enrollee Third Party Liability coverage, including Medicare and long-term care insurance as applicable; and
 - Except as otherwise required, the Participating Provider shall seek such Third Party Liability payment before submitting claims to the Contractor.
- *Reimbursement Rates and Risk Assumptions.* Include the reimbursement rates and risk assumptions, if applicable.
- *Claims Submission and Payment.* Provide for prompt submission of claims information needed to make payment within six months of the covered service being provided to a Health Plan Enrollee.
- *Performance-based Provider Payments/Incentive Plans.* Describe, as applicable, any performance-based Provider payment(s)/incentive plan(s) to which the Participating Provider is subject.
- *QM/QI Participation.* The Contractor shall monitor utilization of the quality of services delivered under the Provider Agreement. The Provider Agreement shall require the Participating Provider's participation and cooperation in any internal and external QM/QI monitoring, utilization review,

peer review and/or appeal procedures established by OHCA and/or the Contractor and require the Participating Provider's participation in any corrective action processes that will be taken where necessary to improve quality of care.

- *Data and Reporting.* Provide for the timely submission of all reports, clinical information and Encounter Data required by the Contractor and OHCA.
- *Indemnify and Hold Harmless.* Specify that at all times during the term of the Provider Agreement, the Participating Provider shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by the Provider pursuant to the Provider Agreement.
- *Non-discrimination.* Require Participating Providers to:
 - Agree that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of the Contractor's program or otherwise subjected to discrimination in the performance of the Provider Agreement with the Contractor or in the employment practices of the Participating Provider;
 - Identify Health Plan Enrollees in a manner which will not result in discrimination against the Health Plan Enrollee in order to provide or coordinate the provision of covered services; and
 - Not use discriminatory practices with regard to Health Plan Enrollees such as separate waiting rooms, separate appointment days or preference to private pay patients.
- *Access and Cultural Competency.* Require Participating Providers to take adequate steps to promote the delivery of services in a culturally competent manner to Health Plan Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.
- *Database Screening and Criminal Background Check of Employees.* Require Participating Providers to comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Health Plan Enrollees and/or access to Health Plan Enrollees' Protected Health Information. Participating Providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed at Section 1.18.10: "Prohibited Affiliations and Exclusions" of this Model Contract. The Contractor shall require Participating Providers to conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. The Participating Provider shall be required to immediately report to the Contractor any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate a Provider Agreement with a Participating Provider as provided under State and/or federal law.

OHCA reserves the right to amend these requirements as it deems necessary.

1.12.2.3 Network Provider Agreement Limitations/Restrictions and Assurances

The Contractor shall not include any of the following limitations or restrictions in any Provider Agreement:

- *Non-Compete Clause.* Prohibit a Participating Provider from entering into a contractual relationship with another MCO or IMCE (i.e., no covenant-not-to-compete) or include any

compensation terms (i.e., incentive or disincentive) that encourages a Participating Provider not to enter into a contractual relationship with another MCO or IMCE.

- *Interference with Provider-Patient Relationship.* In accordance with § 1932(b)(3)(A) of the Act and 42 C.F.R. § 438.102(a)(1)(i)-(iv), the Provider Agreement shall not contain any provisions that prohibit or otherwise restrict Participating Providers acting within the scope of the Participating Provider’s license from advising or advocating on behalf of Health Plan Enrollees for the following:
 - Health Plan Enrollee health status, medical care or treatment options, including any alternative treatment that may be self-administered;
 - Any information a Health Plan Enrollee needs to decide among all relevant treatment options;
 - The risks, benefits and consequences of treatment or non-treatment; or
 - The Health Plan Enrollee’s right to participate in decisions regarding the Health Plan Enrollee’s health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- *The right to request resolution or support to file a Grievance or Appeal on behalf of a Health Plan Enrollee if authorized by the Health Plan Enrollee to do so.* The Contractor must include assurances in any Provider Agreement, including single case agreements in Section 1.12.2.5: “Single Case Agreements” of this Model Contract that it will take no punitive action against a Provider who either requests an expedited resolution or supports a Health Plan Enrollee’s Appeal.

1.12.2.4 Provider Agreement Requirements for Specific Provider Types

The Contractor shall include the following provisions in its Provider Agreements, as applicable to the specific Provider types in this Section.

1.12.2.4.1 PCMH Provider Agreements

In addition to the minimum Provider Agreement requirements in Sections 1.12.2.2: “Minimum Content Requirements” and 1.12.2.3: “Network Provider Agreement Limitations/Restrictions and Assurances” of this Model Contract, the Contractor shall include PCMH responsibilities in all Agreements with PCMH Providers. At a minimum, PCMH responsibilities specified in the Provider Agreement shall include:

- Delivering primary care services and follow-up care;
- Utilizing and practicing evidence-based medicine and clinical decision supports;
- Making referrals for specialty care and other covered services and, when applicable, working with the Contractor to allow Health Plan Enrollees to directly access a specialist as appropriate for a Health Plan Enrollee’s condition and identified needs;
- Maintaining a current medical record for the Health Plan Enrollee;
- Using health information technology to support care delivery;
- Providing care coordination in accordance with the Health Plan Enrollee’s Care Plan, as applicable based on the Contractor’s Risk Stratification Level Framework, and in cooperation with the Health Plan Enrollee’s Care Manager;
- Ensuring coordination and continuity of care with Providers, including but not limited to specialists and behavioral health Providers;

- Engaging active participation by the Health Plan Enrollee and the Health Plan Enrollee’s family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and Care Plan development;
- Providing access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other Providers, clinics and/or local hospitals;
- Providing enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
- Participating in continuous quality improvement and voluntary performance measures established by the Contractor and/or OHCA.

1.12.2.4.2 Behavioral Health Providers

In addition to the minimum Provider Agreement requirements in Sections 1.12.2.2: “Minimum Content Requirements” and 1.12.2.3: “Network Provider Agreement Limitations/Restrictions and Assurances” of this Model Contract, the Contractor shall require that all Provider Agreements with behavioral health Providers identified in Section 1.12.4.4: “Behavioral Health Provider Standards” of this Model Contract include the following requirements:

- Requirement that Participating Providers providing inpatient psychiatric services to Health Plan Enrollees schedule the Health Plan Enrollee for outpatient follow-up or continuing treatment prior to discharge from the inpatient setting with the outpatient treatment occurring within seven Calendar Days from the date of discharge.
- Requirement that Participating Providers Complete OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under this Model Contract.
- Requirement that Participating Providers provide treatment to pregnant Health Plan Enrollees who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.
- Agreement that the Contractor will obtain the appropriate Health Plan Enrollee releases to share clinical information and Health Plan Enrollee health records with community-based behavioral health Providers, as requested, consistent with all State and federal confidentiality requirements and in accordance with Contractor policy and procedures.

1.12.2.4.3 Laboratory Testing Sites

In addition to the minimum Provider Agreement requirements in Sections 1.12.2.2: “Minimum Content Requirements” and 1.12.2.3: “Network Provider Agreement Limitations/Restrictions and Assurances” of this Model Contract, the Contractor shall require that all Provider Agreements with laboratory testing sites providing services under this Contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

The Contractor shall maintain a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Health Plan Enrollees.

Providers performing laboratory tests are required to be certified under the CLIA. OHCA will continue to update the provider file with CLIA information. This will make laboratory certification information available to the Contractor on the Medicaid provider file.

1.12.2.5 Single Case Agreements

The Contractor may enter into a single case agreement with any Provider performing covered services who is not willing to become a Participating Provider with the Contractor. The Contractor must ensure that the Provider is an OHCA Provider. In instances where a single case agreement is needed, and the Provider is not an OHCA Provider, OHCA must approve the single case agreement prior to contract execution.

1.12.3 **Credentialing**

The Contractor shall demonstrate that all Participating Providers are credentialed as required under 42 C.F.R. § 438.214. In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(b), the Contractor shall follow OHCA's uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorder Providers, and follow a documented process for credentialing and recredentialing of all Participating Providers.

For purposes of this requirement, OHCA has determined, in accordance with OHCA's SoonerCare program credentialing and recredentialing policy, the Contractor shall credential Providers based on requirements of the applicable Accrediting Entity with whom the Provider is accredited. Additionally, the Contractor shall utilize the uniform credentialing application required by OHCA during the credentialing process.

1.12.3.1 Credentialing and Recredentialing Timeframes

The Contractor shall ensure that credentialing of all Providers applying for Participating Provider status shall be completed as follows, or according to any stricter credentialing timeliness requirements as may be required by the applicable Accrediting Entity with whom the Provider is accredited:

- All applications must be credentialed within 45 days of receipt of a completed application.

In the event the Contractor delegates credentialing activities to a delegated credentialing agency, the Contractor shall ensure all credentialed Providers are loaded into the Contractor's Provider files and claims system within 15 Calendar Days of receipt from the delegated entity.

1.12.3.2 Ongoing Monitoring

The Contractor shall complete ongoing monitoring of Provider sanctions, Grievances and quality issues between recredentialing cycles. The Contractor shall collect and review relevant information and take appropriate and prompt action against Providers when the Contractor identifies occurrences of poor quality.

1.12.3.3 Non-Licensed Providers

When individuals providing services under this Contract are not required to be licensed or certified, the Contractor shall ensure, based on applicable State regulations, rules and/or program standards, that the individuals are appropriately educated, trained, qualified and competent to perform their job responsibilities. In addition, the Contractor shall perform background checks and database screening in accordance with State and federal laws to ensure the Provider has not been excluded or debarred from participation in Medicare, Medicaid or any federal health care program or employed/contracted with an individual/entity that has been excluded or debarred from these health care programs. This provision also applies to agency Providers that employ or hire non-licensed staff.

1.12.4 Time and Distance and Appointment Access Standards

In accordance with 42 C.F.R. § 438.68(a), OHCA has developed and shall enforce the time and distance standards set forth in this Section. In developing the time and distance standards, OHCA considered all applicable requirements of 42 C.F.R. § 438.68(c). The Contractor shall meet the time and distance standards developed by OHCA in accordance with 42 C.F.R. § 438.68(b)(1) set forth in this Section in all geographic areas in which the Contractor operates, with standards varying for Urban and Rural Areas, as required pursuant to 42 C.F.R. § 438.68(b)(3), for the following types of Participating Providers:

- Adult PCPs;
- Pediatric PCPs;
- Obstetrics and Gynecology (OB/GYN) Providers;
- Adult mental health Providers;
- Adult Substance Use Disorder Providers;
- Pediatric mental health Providers;
- Pediatric Substance Use Disorder Providers;
- Adult specialist providers;
- Pediatric specialist providers;
- Hospitals; and
- Pharmacies.

PCPs, as indicated in federal regulations, are known as PCMH Providers throughout this Model Contract. The standards in Section 1.12.4.1: “PCMH Provider Standards” of this Model Contract below are intended to correspond to the adult and Pediatric PCP standards required under 42 C.F.R. § 438.68.

OHCA has determined that time and distance standards for additional Provider types are necessary to promote the goals of the SoonerSelect program and has set forth minimum access requirements for Providers as outlined in Section 1.12.4.7.2: “Essential Community Providers” of this Model Contract below. OHCA reserves the right to set time and distance standards for additional Provider types that it determines necessary to improve Health Plan Enrollee access and further the goals of the SoonerSelect program.

1.12.4.1 PCMH Provider Standards

The Contractor shall provide and maintain an adequate network of PCMH Providers, to ensure that Health Plan Enrollees have access to all primary care services in SoonerSelect program benefit package. The Contractor shall ensure that each SoonerSelect program Health Plan Enrollee has a PCMH Provider.

PCMH Providers include the following Provider types:

- Physicians licensed in the state where they practice and who are engaged in a general practice or in family medicine, general internal medicine or general pediatrics;
- IHCPs;
- Advanced practice nurses licensed in the state where they practice and have prescriptive authority;
- Physician assistants licensed in the state where they practice; and
- FQHC and RHC Provider groups, physicians, advanced practice nurses and physician assistants who meet the descriptions above and are authorized within their scope of practice under state law to provide these services.

The Contractor may allow SoonerSelect program Health Plan Enrollees to select a specialist or subspecialist as the Health Plan Enrollees’ PCMH Provider, where medically appropriate, and provided that the selected specialist Provider is willing to perform all responsibilities of a PCMH Provider.

The Contractor shall meet the following access standards for PCMH Providers:

Provider Type	Measure	Standard
Distance		
Adult PCMH Pediatric PCMH	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence
Adult PCMH Pediatric PCMH	Rural Distance	Within 45 miles of a Health Plan Enrollee’s residence
Appointment Time		
Adult PCMH Pediatric PCMH	<ul style="list-style-type: none"> • Not to exceed 30 days from date of the Health Plan Enrollee’s request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. • Each PCMH shall allow for at least some same-day appointments to meet acute care needs. 	

1.12.4.2 Obstetrics and Gynecology (OB/GYN) Provider Standards

The Contractor’s Participating Provider network shall include a sufficient number of OB/GYN Providers to ensure that Health Plan Enrollees have access to all OB/GYN services in the SoonerSelect program benefit package and to meet program access standards for adequate capacity.

The Contractor shall meet the following access standards for OB/GYN Providers:

Provider Type	Measure	Standard
Distance		
OB/GYN	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence
OB/GYN	Rural Distance	Within 45 miles of a Health Plan Enrollees residence
Appointment Time		
OB/GYN	<ul style="list-style-type: none"> • Not to exceed 30 days from date of the Health Plan Enrollee’s request for routine appointment. • Within 72 hours for Non-Urgent Sick Visits. • Within 24 hours for Urgent Care. <p>Maternity Care:</p> <ul style="list-style-type: none"> • First Trimester – Not to exceed 14 Calendar Days • Second Trimester – Not to exceed seven Calendar Days • Third Trimester – Not to exceed three Business Days 	

1.12.4.3 Specialty Provider Standards

The Contractor’s Participating Provider network shall include a sufficient number and type of adult and Pediatric specialty Providers to ensure that Health Plan Enrollees have access to all specialty care services in the SoonerSelect program benefit package and to meet program access standards for adequate capacity. The Contractor shall provide Health Plan Enrollees with access to network care for at least the following specialty provider types:

- Physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package;
- Anesthesiologist assistants;
- Audiologists;
- Nutritionists;
- Opticians;
- Optometrists;
- Podiatrists; and
- Therapists to provide specialty care services as required in the SoonerSelect benefit package.

This is not intended to be an all-inclusive list. The Contractor shall analyze the clinical needs of the enrolled membership to identify additional specialty Provider types to include as part of the Contractor’s network.

The Contractor shall meet the following access standards for Specialty Providers:

Provider Type	Measure	Standard
Distance		
Adult Specialty Pediatric Specialty	Urban Distance	Within 15 miles of a Health Plan Enrollee’s residence
Adult Specialty Pediatric Specialty	Rural Distance	Within 60 miles of a Health Plan Enrollee’s residence
Appointment Time		
Adult Specialty Pediatric Specialty		<ul style="list-style-type: none"> • Not to exceed 60 days from date of the Health Plan Enrollee’s request for routine appointment. • Within 24 hours for Urgent Care.

1.12.4.4 Behavioral Health Provider Standards

The Contractor’s Participating Provider network shall include a sufficient number and type of behavioral health Providers to ensure that Health Plan Enrollees have access to all Behavioral Health Services in the benefit package outlined in Section 1.6.2: “Behavioral Health Benefits” of this Model Contract and to meet program access standards. To further Health Plan Enrollee access to behavioral health Providers, the Contractor shall develop incentive plans to recruit and retain behavioral health professionals and medical practitioners in the Contractor’s network. The Contractor also shall provide for the delivery of Behavioral

Health Services via Telehealth, if Health Plan Enrollee requested, to the extent possible for OHCA-defined services that are reimbursable through Telehealth.

Upon award of this Contract, the Contractor shall extend an offer for all OHCA-enrolled behavioral health Providers to become a Participating Provider, with reimbursement for services at OHCA FFS rates, and any updates thereto, at minimum. If the Provider agrees to contract with the Contractor, after one year, continued status as a Participating Provider may be based, in part, on Provider performance in measures to be developed by the Contractor and approved by OHCA.

The Contractor’s network shall include all the following Medicaid behavioral health Provider types:

- Acute and Residential Treatment;
- Case Management and Psychosocial Rehabilitation Services;
- MAT providers;
- Community Mental Health Centers (CMHCs);
- Certified Community Behavioral Health Clinics (CCBHCs);
- Inpatient Psychiatric Hospitals;
- Licensed Behavioral Health practitioners;
- Licensure Candidates;
- Opioid Treatment Programs;
- Crisis Intervention and Crisis Stabilization Facilities;
- Behavioral Health Urgent Care Centers;
- Outpatient Behavioral Health Agencies, Clinics and Facilities;
- Programs of Assertive Community Treatment (PACT);
- Psychiatrists and Psychologists;
- Substance Use Disorder Treatment;
- First Episode Psychosis (RAISE) Providers; and
- Therapeutic Behavioral Services, Family Support and Training and Peer Recovery Support.

The Contractor shall meet the following access standards for Behavioral Health Providers, including adult and Pediatric mental health and adult and Pediatric Substance Use Disorder Providers, in accordance with 42 C.F.R. § 438.68(b). The Contractor shall document and make available to OHCA, upon request, any waiting lists preventing the Contractor’s network from admitting a Health Plan Enrollee to treatment in the prescribed timeframe, if applicable.

Provider Type	Measure	Standard
Distance		
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use	Urban Distance	<ul style="list-style-type: none"> • Within ten miles of a Health Plan Enrollee’s residence for outpatient visits • Within 60 miles of a Health Plan Enrollee’s residence for all other

Provider Type	Measure	Standard
Distance		
		treatment settings
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use	Rural Distance	<ul style="list-style-type: none"> • Within 30 miles of a Health Plan Enrollee’s residence for outpatient visits • Within 90 miles of a Health Plan Enrollee’s residence for all other treatment settings
Appointment Time		
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use		<ul style="list-style-type: none"> • Not to exceed 30 days from date of the Health Plan Enrollee’s request for routine appointment. • Within seven days of hospitalization. • Within 24 hours for Urgent Care.

1.12.4.5 Pharmacy Provider Standards

The Contractor’s Participating Provider network shall include a sufficient number of pharmacies to ensure that Health Plan Enrollees have access to all prescription drug and pharmacy-based medical supplies in the SoonerSelect program benefit package and to meet program access standards.

The Contractor shall not require as a condition for participation in its pharmacy network any limitations that would exclude independent retail pharmacies. The Contractor or its PBM shall not steer or require any Providers or Health Plan Enrollees to use a specific pharmacy for regular prescriptions, refills, or specialty drugs. The Contractor’s pharmacy network under this Contract must be contracted and administered separately from the Contractor’s or Subcontractor’s commercial network.

In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the Pharmacist in Charge must also be licensed by the Oklahoma State Board of Pharmacy.

The Contractor may utilize mail-order pharmacies in its Participating Provider network but shall not require or incentivize Health Plan Enrollees to use a mail-order pharmacy, including through different Health Plan Enrollee Cost Sharing. Health Plan Enrollees who elect to use this service must not be charged fees, including postage and handling fees.

The Contractor or their Subcontractor shall not require patients to use pharmacies that are directly or indirectly owned by the PBM or Contractor, including all regular prescriptions, refills or specialty drugs regardless of day supply.

The Contractor or their Subcontractor shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other Providers unless it specifically lists all pharmacies, hospitals and Providers participating in the pharmacy network.

The Contractor shall meet the following access standards for Pharmacy Providers, in accordance with the Oklahoma Patient’s Right to Pharmacy Choice Act at 36 O.S. § 6958 *et seq.* Mail-order pharmacies shall not be used to meet these standards.

Provider Type	Measure	Standard
Distance		
Pharmacies	Urban service area, meaning a five digit zip code in which the population density is greater than 3,000 individuals per square mile	At least 90% of Health Plan Enrollees reside within two miles of a retail pharmacy participating in the PBM's retail pharmacy network
	Suburban service area, meaning a five digit zip code in which the population density is between 1,000 and 3,000 individuals per square mile	At least 90% of Health Plan Enrollees reside within five miles of a retail pharmacy in the PBM's retail pharmacy network
	Rural service area, meaning a five digit zip code in which the population density is less than 1,000 individuals per square mile	At least 70% of Health Plan Enrollees reside within 15 miles of a retail pharmacy in the PBM's retail pharmacy network
Mail Order Pharmacy	Not applicable	Not applicable
Appointment Time		
Pharmacies	Not applicable	

1.12.4.6 Indian Health Care Provider Standards

The Contractor shall comply with the network adequacy requirements of Section 1.15.4: “Indian Healthcare Providers (IHCPs)” of this Model Contract.

1.12.4.7 Hospitals and Essential Community Provider Standards

1.12.4.7.1 Hospitals

The Contractor’s network shall include a sufficient number and type of hospitals and essential community Providers to ensure that Health Plan Enrollees may access a range of covered physical and mental health services in the setting most appropriate for the Health Plan Enrollee’s’s treatment needs.

Hospitals include the following Provider types:

- Disproportionate share hospital (DSH) and DSH-eligible hospitals;
- Children’s hospitals;
- Sole community hospitals; and
- Critical access hospitals (CAHs).

The Contractor shall demonstrate sufficient access to Essential Hospital Services to serve the expected enrollment and to meet, at minimum, the following:

Provider Type	Measure	Standard
Distance		
Hospitals	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence
Hospitals	Rural Distance	Within 45 miles of a Health Plan Enrollee’s residence
Appointment Time		
Hospitals	Not applicable	

1.12.4.7.2 Essential Community Providers

Essential community providers include the following Provider types:

- FQHCs and RHCs;
- Family planning Providers (Title X family planning clinics and Title X “look-alike” family planning clinics);
- IHCPs;
- Government-funded/operated community mental health centers/certified community behavioral health clinics;
- Government-operated state mental health hospitals;
- State agencies, including but not limited to, OJA, OSDH, and DHS;
- Local, regional, and state educational services agencies;
- Local health departments;
- Long Term Care Hospitals Serving Children (LTCHs-C); and
- Other entities certified by CMS as an essential community provider.

The Contractor shall contract with essential community providers in the Contractor’s service area to the extent possible and practical. If the Contractor is unable to Contract with essential community providers as required below, the Contractor shall demonstrate to OHCA that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the Contractor’s service area without contracting with essential community providers. The Contractor shall demonstrate that its Participating Provider network includes sufficient family planning Providers to ensure timely access to covered services.

Provider Type	Measure	Standard
Distance		
Essential Community Providers	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence

Provider Type	Measure	Standard
Distance		
Essential Community Providers	Rural Distance	Within 45 miles of a Health Plan enrollee’s residence
Appointment Time		
Essential Community Providers	Not specified	

1.12.4.8 Department of Health

Upon award of this Contract, the Contractor shall extend an offer to all Oklahoma State Department of Health (OSDH) County Health Departments, including any applicable OSDH mobile clinics, to become a Participating Provider with reimbursement for services at OHCA FFS rates, and any updates thereto, at minimum.

In accordance with Title 63, Section 1-105e, when OSDH provides a covered service to any Health Plan Enrollee, the OSDH may submit a claim for said service to the Contractor. Upon receipt of the claim, the Contractor shall reimburse OSDH for the service provided in accordance with OHCA FFS rates and any updates thereto, at minimum. The Contractor shall recognize the public health service delivery model utilized by OSDH as an appropriate provider of services for reimbursement.

1.12.5 Network Adequacy Exception Process

OHCA shall allow a Contractor to submit to OHCA a formal written request for a waiver of the distance standards in Section 1.12.4: “Time and Distance and Appointment Access Standards” of this Model Contract where there are no Participating Providers within the required driving distance or the Contractor is unable to enter into a Provider Agreement with a particular Provider type. In such situations, OHCA may waive the applicable requirement in its entirety or expand the driving distance by considering community standards for accessing care and the availability of Telehealth. In accordance with 42 C.F.R. § 438.68(d)(1)(ii), the standard by which the exception will be evaluated and approved by OHCA, at minimum, will be based on the number of Providers in that specialty in which the Contractor is requesting the waiver that are practicing in the Contractor’s service area and the extent to which Health Plan Enrollees within the impacted geographic area or needing a particular Provider type are able to access services via the Contractor’s network via Telehealth.

In accordance with 42 C.F.R. § 438.68(d)(2), OHCA will monitor Health Plan Enrollee access to the Provider type for which any waiver is granted on an ongoing basis and include the findings to CMS in the managed care program assessment report required under 42 C.F.R. § 438.66.

1.12.6 Provider Agreement Termination

1.12.6.1 Participating Provider Contract Termination

The Contractor and its Participating Providers shall have the right to terminate the contracts entered into with each other via a Provider Agreement. The Contractor and its Participating Providers may terminate the Provider Agreement for cause with 30 days’ advance written notice to the other party and without cause with 60 days’ advance written notice to the other party.

The Contractor shall terminate its Provider Agreement with the Participating Provider immediately under the following circumstances:

- To protect the health and safety of Health Plan Enrollees;
- Upon credible allegation of Fraud on the part of the Participating Provider;
- When the Participating Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the Provider to provide services under this Contract; or
- Upon request of OHCA.

If OHCA terminates a Provider from SoonerCare participation, OHCA shall notify the Contractor. The Contractor shall be responsible for monitoring all relevant State registries to review any Participating Providers that are terminated by OHCA and subsequently excluded from participation in the Contractor's Participating Provider network.

The Contractor shall follow a process to be defined by OHCA for notification, facilitation of Health Plan Enrollee records transfer and any other assistance necessary for an orderly transition of health care from a Provider whose Provider Agreement has been terminated.

1.12.6.2 Notification of Participating Provider Network Changes

1.12.6.2.1 Notification to OHCA of Participating Provider Network Changes

The Contractor shall notify OHCA when a Provider Agreement is terminated with:

- A hospital, FQHC, IHCP, facility or any practitioner who is actively serving 100 or more of the Contractor's SoonerSelect program Health Plan Enrollees; or
- Any Participating Provider whose termination has the potential to compromise the Contractor's ability to meet one or more network access standards under this Model Contract.

In such an event, the Contractor shall provide OHCA with a corrective action plan. OHCA reserves the right to allow Health Plan Enrollees affected by the termination of the Provider to disenroll from the Contractor's MCO in accordance with the provisions of Section 1.23: "Non-Compliance Remedies" of this Model Contract.

The Contractor shall work with the terminated Provider to ensure that any Health Plan Enrollee records and information are provided to the Contractor to facilitate an orderly transition of Health Plan Enrollee care.

1.12.6.2.2 Notification to Authorities of Provider Agreement Termination

If the Contractor terminates a Provider Agreement, the Contractor must report the Provider's termination to the appropriate authorities, including the National Practitioner Data Bank (NPDB), State licensing agencies, and any other entity designated by OHCA.

1.12.6.2.3 Notification to Health Plan Enrollees of Participating Provider Network Changes

The Contractor shall notify Health Plan Enrollees of Provider disenrollment in accordance with Section 1.11.12.3: "Notification of PCMH Termination" of this Model Contract.

1.12.6.3 Participating Provider Contract Termination Appeal Rights

The Contractor shall handle Provider Appeals of Provider Agreement terminations using a process substantially the same as the process and requirements set forth in OAC 317:2-1-12. The Contractor shall

develop, implement and maintain a system for tracking Appeals related to Provider Agreement contracting issues. Within this process, the Contractor shall respond fully and completely to each Provider's Appeal and establish a tracking mechanism to document the status and final disposition of each. Such documentation shall be made available to OHCA upon request.

OHCA reserves the right to include an independent review process established by OHCA for final determination on these disputes.

1.12.7 Submission of Provider Enrollment and Disenrollment Data to OHCA

The Contractor shall submit Participating Provider enrollment data to OHCA in an electronic format and timeframe specified by OHCA.

The Contractor shall notify OHCA, in a manner specified by OHCA, of the Contractor's intent to disenroll a Participating Provider at least ten Business Days in advance of sending the notice of disenrollment to the impacted Provider. The Contractor shall also notify OHCA within five days of the Contractor's receipt of notice from a Participating Provider that the Provider intends to disenroll from the Contractor's network.

1.12.8 Direct Access to Specialists

In accordance with 42 C.F.R. § 438.208(c)(4), the Contractor shall have a mechanism in place to allow Health Plan Enrollees with Special Health Care Needs determined through a Comprehensive Assessment to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the Health Plan Enrollee's condition and identified needs.

1.13 Provider Services

The Contractor shall develop and implement a comprehensive Provider services function within the Contractor's organization that shall include responsibility for, at minimum, the Provider communication and training requirements outlined in this Section of the Contract.

1.13.1 Policies and Procedures

The Contractor shall develop and maintain written policies and procedures, which shall be reviewed by OHCA during Readiness Review and made available to OHCA upon request, on the following Provider services topics, at minimum:

- Provider services call center policies and procedures that address, at minimum:
 - Call center staffing;
 - Call center staff training;
 - Call center hours of operation;
 - Call center access and response standards, monitoring of calls and compliance with standards;
- Provider website policies and procedures that address, at minimum:
 - Website content;
 - Frequency of website updates; and
 - Ongoing monitoring of accuracy information provided on the website;
- Provider manual content, review and distribution;
- Provider training and education, including targeted training and education for Behavioral Health Services; and
- Provider Complaint System, including Provider reconsiderations and appeals.

1.13.2 **Provider Services Call Center**

1.13.2.1 Availability

The Contractor shall maintain a Provider Services Call Center in accordance with the location requirements outlined in Section 1.3.5: “Oklahoma Presence” of this Model Contract. The Provider Services Call Center shall operate a toll-free telephone line to respond to Provider questions, comments, inquiries and requests for Prior Authorizations.

The Contractor may operate an overflow call center within the United States for the purposes of meeting the performance requirements listed in this Contract for the Provider Services Call Center.

The Contractor shall ensure that the Provider services call center is staffed adequately to respond timely to Providers’ questions at a minimum from 8:00 am to 5:00 pm Central Time, Monday through Friday, except for State Holidays.

A pharmacy call center shall be available at a minimum from 8:00 am to 7:00 pm Central Time, Monday through Friday, 9:00 am to 5:00 pm Central Time Saturday, and 11:00 am to 4:00 pm Central Time Sunday, except for the following holidays: New Year’s Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. The pharmacy call center must be able to connect Providers with qualified, licensed medical professionals (e.g., pharmacists, nurses, physicians) to discuss medication therapy options.

The Contractor shall have an automated system available during business and non-business hours. The automated system shall include, at minimum, information on how to obtain after hours Prior Authorization and a voice mailbox for callers to leave messages. In addition, the Contractor shall return all messages on the next business day.

1.13.2.2 Provider Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Provider Services Call Center activities and performance. The Contractor shall ensure the Call Center meets the following minimum performance requirements:

- Call abandonment rate shall be less than five percent;
- 85% of all calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed 30 seconds;
- Blocked call rate shall not exceed one percent; and
- The overflow call center shall not receive more than five percent of all incoming calls to the Provider Services Call Center.

The Contractor shall have the capability to track these Provider Services Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Provider Services Call Center reporting shall break down performance by:

- The Contractor’s main Provider Services Call Center;
- Overflow call center, if applicable;
- Pharmacy call center; and
- Applicable Subcontractors.

At the end of each Contract year, the Contractor shall issue to OHCA an annual report that details performance of the Provider Services Call Center and maps out improvement strategies for the following year.

1.13.2.3 Provider Services Call Center Training

The Contractor (or its contracted PBM) shall develop a program to train newly hired staff and retrain current Provider Services Call Center staff. This training program shall address topics that include, at minimum:

- The populations covered under the SoonerSelect program;
- SoonerSelect program Covered and non-covered services;
- Prior Authorization requirements and processes;
- Claims submission requirements and processes, including a focus on how to correct claims that have been denied due to Provider submission errors;
- Care management;
- Access to Behavioral Health Services including the Contractor's Prior Authorization requirements that comport with requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. § 438.910(d);
- Common billing concerns and issues that may be specific to behavioral health Providers;
- Services for AI/AN Health Plan Enrollees;
- Cultural and linguistic competency;
- Out-of-state services;
- How to triage any calls related to pharmacy benefits and implement first call resolution when possible;
- Filing a Provider Complaint; and
- Filing a Grievance or Appeal on behalf of a Health Plan Enrollee.

OHCA reserves the right to amend these requirements as it deems necessary.

1.13.3 **Provider Website**

1.13.3.1 General Website Requirements

The Contractor shall maintain a website that is accessible to Providers. The Contractor shall:

- Ensure the website is accessible via mobile devices;
- Maintain a separate and distinct section on its website for its SoonerSelect program information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each page within the website with the date the page was last updated;
- Clearly label any links;
- Comply with HIPAA requirements and all other State and federal statutory and regulatory privacy when providing Health Plan Enrollee eligibility or Health Plan Enrollee identification on the website, including Provider portal(s); and
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

1.13.3.2 Website Content

The website shall include all pertinent information including, at least, the following:

- Provider Manual;
- Sample Provider Agreements;
- How to contact the Contractor and its Provider services department;
- Functionality to allow Providers to make inquiries and receive responses from the Contractor regarding care for Health Plan Enrollees, including real-time eligibility information and electronic Prior Authorization request and approval;
- Prior Authorization forms and criteria for medications;
- How to track the status of claims online;
- Grievances, Appeals and State Fair Hearing processes; and
- How to file Provider Complaints, including policies and procedures on Provider reconsiderations and appeals.

1.13.4 **Provider Manual**

1.13.4.1 General Provider Manual Requirement

The Contractor shall develop, provide, and maintain a written Provider Manual for use by the Contractor's Participating Provider network. The Contractor shall issue a Provider Manual at time of Provider application. The Provider Manual shall be made available electronically, and in hard copy format (upon Provider request), to all Participating Providers, without cost.

1.13.4.2 Provider Manual Content

The Provider Manual shall include, at minimum, the following topics:

- Requirements for updating Participating Provider demographic data, including the process and timeframes for updating;
- Expectations for appointment access standards, by Provider type, as outlined in Section 1.12.4: "Time and Distance and Appointment Access Standards" of this Model Contract;
- Requirements for tracking and following-up on referrals for other services (e.g., specialist referrals);
- Benefits provided by the Contractor;
- Coordination of benefits with other Providers, any Subcontractors and OHCA's contractors;
- How and where to access any benefits provided by the State, including any Cost Sharing, and how transportation is provided;
- In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, what benefits are not covered and how Health Plan Enrollees can obtain information on and access to those services;
- Prior Authorization, utilization management, second opinion and referral processes, which shall include the Contractor's mechanism to allow Health Plan Enrollees to directly access a specialist as appropriate for a Health Plan Enrollee's condition and identified needs;
- For female Health Plan Enrollees, direct access to a women's health specialist within the Contractor's Participating Provider network for covered care necessary to provide women's

routine and preventive health care services. This is in addition to the Health Plan Enrollee's designated source of primary care if that source is not a women's health specialist;

- The extent to which, and how, Health Plan Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers;
- Medical necessity standards and Clinical Practice Guidelines;
- The extent to which, and how, after-hours and emergency coverage are provided;
- Any restrictions on the Health Plan Enrollee's freedom of choice among Participating Providers;
- Cost Sharing and the Contractor's tracking systems for aggregate limits;
- Health Plan Enrollee rights and responsibilities;
- Confidentiality and privacy requirements, including, but not limited to HIPAA, with which the Provider must comply;
- Provider rights for advising and advocating on behalf of Health Plan Enrollees, including the right to file a Grievance or Appeal on behalf of a Health Plan Enrollee as his or her Authorized Representative;
- Provider non-discrimination information;
- The process of selecting and changing the Health Plan Enrollee's PCMH Provider;
- Grievance, Appeal and State Fair Hearing procedures and timeframes;
- How to file Provider Complaints, including policies and procedures for filing Provider reconsiderations and appeals;
- Advance Directives;
- How to access auxiliary aids and services, including additional information in alternative formats or languages for patients;
- The Contractor and State contact information, including addresses and phone numbers;
- Information on how to report any potential Fraud, Waste and Abuse;
- Information on how to report any potential cases of neglect, abuse and Exploitation of Health Plan Enrollees;
- Critical Incident reporting;
- Policies and procedures for Third Party Liability and other collections;
- Protocols for Encounter Data reporting and records applicable to Providers for whom the Contractor reimburses via a capitated arrangement;
- Claims submission/filing protocols and standards;
- Payment policies;
- Credentialing/recredentialing information;
- Performance standards;
- Information about the Contractor's care management model;
- The Contractor's Quality Assessment and Performance Improvement (QAPI) program; and
- Requirements regarding use of the Contractor's EVV system and Provider's responsibility in monitoring and immediately addressing service gaps, including the use of back-up staff.

OHCA reserves the right to amend these requirements as necessary.

1.13.5 **Provider Education, Training and Technical Assistance**

The Contractor shall establish and maintain a Participating Provider training, education and technical assistance plan. The Contractor shall update the plan annually and shall submit the plan and updates to OHCA. The Contractor shall maintain a record of its training, education and technical assistance activities and shall make this information available to OHCA upon request.

1.13.5.1 Training Frequency

The Contractor shall provide initial and ongoing, at a minimum semi-annual, education and training to its Participating Provider network. The Contractor shall provide trainings in varying geographic locations based on Participating Provider network concentration and need.

1.13.5.2 Training Content

The Contractor shall provide the following information, at minimum, in Participating Provider trainings and educational materials and upon request of a Participating Provider:

- Conditions of participation with the Contractor;
- Participating Provider responsibilities to the Contractor and to Health Plan Enrollees;
- Prior Authorization, utilization management, second opinion and referral processes, including the Contractor's mechanism to allow Health Plan Enrollees to directly access a specialist as appropriate for a Health Plan Enrollee's condition and identified needs;
- For female Health Plan Enrollees, direct access to a women's health specialist within the Contractor's Participating Provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Health Plan Enrollee's designated source of primary care if that source is not a women's health specialist;
- The extent to which, and how, Health Plan Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers;
- Behavioral Health Services, including
 - how Participating PCMH Providers shall screen Health Plan Enrollees for and identify behavioral health disorders and conditions,
 - the Contractor's referral process for Behavioral Health Services and
 - clinical coordination requirements for Behavioral Health Services;
- How to update the Participating Provider's demographic or facility information with the Contractor and under what timeline;
- Billing requirements, rate structures and amounts;
- Claims submission and dispute resolution processes;
- Encounter submission and encounter rejection remediation process for Providers for whom the Contractor reimburses via a capitated arrangement;
- Cultural and linguistic competency and resources, including AI/AN cultural competency;
- Critical Incident reporting requirements and timeframes;
- Credentialing and recredentialing processes;
- Grievance, Appeals and State Fair Hearing processes;
- Policies and procedures surrounding Provider Complaints;
- Information on how to report any potential cases of abuse, neglect and Exploitation of Health Plan Enrollees;
- Advance Directives;

- Information about the Contractor’s care management model;
- Information, as applicable, about the SoonerSelect program and SoonerSelect Provider responsibilities, including but not limited to care management responsibilities;
- The Contractor’s Quality Assessment and Performance Improvement (QAPI) program; and
- Other training and education as required/requested by OHCA or any other State or federal agency.

1.13.5.3 Provider Technical Assistance

The Contractor shall provide technical assistance to Participating Providers when determined necessary by the Contractor or OHCA or as requested by Participating Providers. Technical assistance includes, but is not limited to, in-person and telephonic one-on-one meetings. All technical assistance shall be provided in a culturally competent manner.

The Contractor shall have targeted technical assistance for Participating Behavioral Health Services Providers that request technical assistance or that are identified by the Contractor as having significant issues with claims submission requirements or other billing concerns in order to educate the Provider and assist in resolving potential ongoing billing issues. The Contractor shall ensure that it provides a sufficient number of dedicated representatives to conduct office visits and training to address this targeted behavioral health technical assistance requirement.

1.13.5.4 State Sponsored Provider Outreach Activities

OHCA reserves the right to require that the Contractor coordinate with OHCA and ODMHSAS for State-sponsored Provider outreach activities.

1.13.6 **Provider Complaint System**

A Participating or Non-Participating Provider who is not satisfied with the Contractor’s policies and procedures or a decision made by the Contractor that does not impact the provision of services to Health Plan Enrollees may file a Provider Complaint. The Contractor shall have written policies and procedures, approved by OHCA, for receiving, tracking, dating, storing, responding to, reviewing, reporting and resolving Provider Complaints. The Contractor shall establish a Provider Complaint system to track the receipt and resolution of Provider Complaints, including requests for reconsideration or appeals, as detailed in Sections 1.13.6.1: “Provider Reconsiderations” and 1.13.6.2: “Provider Appeals” of this Model Contract, respectively. The Contractor shall:

- Have sufficient ability to receive Provider Complaints by telephone, in writing or in person;
- Have staff designated to receive, process and resolve Provider Complaints;
- Thoroughly investigate each Provider Complaint;
- Ensure an escalation process is in place;
- Furnish the Provider timely written notification of resolution or results; and
- Maintain a tracking system capable of generating reports to OHCA on Provider Complaint volume and resolution, in accordance with reporting requirements specified in Section 1.21: “Reporting” of this Model Contract.

1.13.6.1 Provider Reconsiderations

The Contractor shall operate a reconsiderations process whereby Providers may request the Contractor reconsider the decision the Contractor has made or intends to make that is adverse to the Provider. At

minimum, this shall include reconsiderations of Program Integrity Provider audit findings and Provider Agreement termination. Such policies and procedures shall be provided in writing:

- In the Provider Manual detailed in Section 1.13.4: “Provider Manual” of this Model Contract;
- On the Contractor’s website detailed in Section 1.13.3: “Provider Website” of this Model Contract;
- At the time the Provider enters into a Provider Agreement or subcontract with the Contractor;
- and
- Upon Provider request.

The Contractor shall require the Provider to submit a request for reconsideration within the timeframe determined by OHCA. The Contractor shall resolve all requests for reconsideration within OHCA-determined timeframe. The Contractor shall send a reconsideration resolution notice to the Provider within the timeframe determined by OHCA and including the following, at minimum:

- The date of the notice;
- The action the Contractor has made or intends to make;
- The reasons for the action;
- The date the action was made or will be made;
- If the action is based upon a statute, regulation, policy or procedure, the Contractor shall provide the statute, regulation, policy or procedure supporting the action;
- An explanation of the Provider’s ability to submit an appeal request to the Contractor within 30 Calendar Days of the date of the notice;
- The address and contact information for submission of an appeal;
- The procedures by which the Provider may request an appeal regarding the Contractor’s action;
- The specific change in federal or State law that requires the action, if applicable;
- The Provider’s ability to submit a State Fair Hearing request following completion of the Provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State Fair Hearing will be granted; and
- Any other information required by Oklahoma statute or regulation, if applicable.

1.13.6.2 Provider Appeals

The Contractor shall implement and operate a system for Provider appeals of the Contractor’s audit findings related to Program Integrity efforts and for cause and immediate Provider Agreement termination.

The Contractor shall operate a process whereby Providers may appeal a decision the Contractor has made or intends to make that is adverse to the Provider. Such policies and procedures shall be provided in writing:

- In the Provider Manual detailed in Section 1.13.4: “Provider Manual” of this Model Contract;
- On the Contractor’s website detailed in Section 1.13.3: “Provider Website” of this Model Contract;
- At the time the Provider enters into a Provider Agreement or subcontract with the Contractor;
- and
- Upon Provider request.

The Contractor shall require the Provider to submit an appeal request in writing within the timeframe determined by OHCA. The Contractor shall resolve all appeals within OHCA-determined timeframe. The

Contractor shall send an appeal resolution notice to the Provider within the timeframe determined by OHCA and including the following, at minimum:

- The date of the notice of appeal resolution;
- The results of the resolution process;
- The date of the appeal resolution; and
- For decisions not wholly in the Provider’s favor:
 - An explanation of the Provider’s ability to request a State Fair Hearing following receipt of the Contractor’s notice of appeal resolution;
 - How to request a State Fair Hearing;
 - An explanation that any request for a State Fair Hearing must be requested within 30 Calendar Days of the notice of appeal resolution;
 - The address and contact information for submission of the State Fair Hearing request;
 - Details on the right to be represented by counsel at the State Fair Hearing;
 - The ability to submit a State Fair Hearing request following completion of the Contractor’s Provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State Fair Hearing will be granted; and
 - Any other information required by Oklahoma statute or regulation, if applicable.

The Contractor shall furnish a litigation summary to OHCA including all information to be specified by OHCA within 15 Calendar Days of a Provider’s request for a State Fair Hearing.

1.14 Provider Payment

1.14.1 Provider Payment Rates

1.14.1.1 Participating Provider Payment

The Contractor shall ensure that rates for Participating Providers are reasonable to ensure Health Plan Enrollee access to services, specified at Section 1.12.4: “Time and Distance and Appointment Access Standards” of this Model Contract, and that they comply with all State and federal provisions regarding rate setting. The Contractor may adopt the current SoonerCare fee schedule in the absence of a separate payment rate and methodology negotiated with a Participating Provider.

The Contractor shall adhere to State and federal requirements pertaining to payments of specific Provider types as described in Sections 1.14.1.4 through 1.14.1.9 of this Model Contract.

The Contractor’s Provider rate setting in the aggregate must align with the provisions of Section 1.22.2: “Performance-Based Contracting.”

1.14.1.2 Payment to Non-Participating Provider

If the Contractor is unable to provide covered services to a Health Plan Enrollee within the Contractor’s network of Participating Providers, the Contractor must adequately and timely arrange for the provision of these services by Non-Participating Providers, in accordance with 42 C.F.R. § 438.206(b)(4). Pursuant to 42 C.F.R. § 438.206(b)(5), the Contractor shall ensure that, if applicable, the cost to the Health Plan Enrollee is no greater than it would have been if the services were furnished by a Participating Provider. Except as otherwise precluded by law and/or specified for IHCPs, FQHCs, RHCs and CCBHCs, the Contractor shall reimburse Non-Participating Providers for covered services provided to SoonerSelect program Health Plan Enrollees at a maximum of 95% of the current Medicaid fee schedule/payment rate, unless the Contractor and the Non-Participating Provider agree to a different reimbursement amount.

1.14.1.3 Balance Billing

In accordance with § 1932(b)(6) of the Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), the Contractor shall ensure that a Health Plan Enrollee is held harmless by the Provider for the costs of covered services except for any applicable Copayment amount allowed by OHCA. The Contractor shall ensure no balance billing by Providers, referral Providers and Subcontractors to any SoonerSelect program Health Plan Enrollees for services covered under this Model Contract.

1.14.1.4 Payment for Emergency Services

The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating or Non-Participating Provider, in accordance with federal requirements at § 1932(b)(2) of the Act and 42 C.F.R. § 438.114(c)(1)(i). In accordance with § 1932(b)(2)(D) of the Act, the Contractor shall pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid by OHCA under FFS.

1.14.1.5 Payments to IHCPs

The Contractor shall reimburse IHCPs in accordance with the requirements of Section 1.15.4.3: “Payments to IHCPs.”

1.14.1.6 Payments to FQHCs and RHCs

Notwithstanding the provisions of Section 1.14.1.1: “Participating Provider Payment,” the Contractor shall provide payment for the provision of covered services provided by Participating FQHC and RHC Providers at the Prospective Payment System (PPS) Rate and methodology as employed by OHCA for Eligibles not enrolled in the SoonerSelect program, unless a separate payment rate and methodology is negotiated between the Contractor and the Participating Provider and is approved by OHCA. The Contractor’s payment to a Participating FQHC or RHC shall not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider that is not a FQHC or RHC, in accordance with § 1903(m)(2)(A)(ix) of the Act.

1.14.1.7 Payments to Pharmacy Providers

Notwithstanding the provisions of Section 1.14.1.1: “Participating Provider Payment,” the rate paid to Participating Pharmacy Providers shall use the FFS payment rate employed by OHCA for the SoonerCare program. The Contractor or PBM drug pricing file should be updated to reflect current pricing at least every seven days.

The Contractor or their Subcontractor shall not engage in Spread Pricing and all payments to pharmacies will follow a transparent, pass-through model. Contractor or their Subcontractor will not retroactively deny or retroactively reduce reimbursement to Providers through the use of direct or indirect fees or clawbacks or other methods after adjudication of the claim unless the claim was fraudulent, billed incorrectly or otherwise identified as incorrect through an audit.

The Contractor or their Subcontractor shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for: (i) the submission of a claim; (ii) enrollment or participation in a retail pharmacy network; or (iii) the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network.

The Contractor or their Subcontractor shall not reimburse a pharmacy or pharmacist in the State an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the

pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy.

The Contractor or their Subcontractor may not deny a pharmacy the opportunity to participate in any pharmacy network if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies.

The Contractor or Subcontractor will not retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless: (i) the original claim was submitted fraudulently; or (ii) to correct errors identified in an audit, so long as the audit was conducted in compliance with Sections 356.2 and 356.3 of Title 59 of the Oklahoma Statutes.

The Contractor or Subcontractor will not fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a PBM network.

1.14.1.8 Payment for Physician Administered Drugs

Physician Administered Drugs shall be reimbursed at the FFS payment rate employed by OHCA for the SoonerCare program.

1.14.1.9 Payments to CCBHCs

Notwithstanding the provisions of Section 1.14.1.1: "Participating Provider Payment" of this Model Contract, the Contractor shall provide payment for the provision of covered services provided by Participating CCBHC Providers at the Prospective Payment System (PPS) Rate and methodology as employed by OHCA for Eligibles not enrolled in the SoonerSelect program. These rates will be maintained by OHCA and sent to Contractor on an ongoing basis, as updates are made.

1.14.1.10 Performance-Based Provider Payments

Performance-based payment arrangements between the Contractor and its network of Participating Providers are essential to advancing SoonerSelect program quality and outcome objectives. The Contractor shall develop and implement performance-based payments that:

- Include mechanisms to advance and encourage both high-quality care and cost savings and that are appropriate to the different components of the Contractor's network; and
- Include, but are not limited to, PCMH Providers, other medical Providers and behavioral health Providers.

The Contractor's performance-based payments may be made using any combination of the following models:

- Bundled payments, in which the Contractor reimburses Participating Providers for a set of services related to a procedure or health condition rather than for each service separately;
- Pay-for-performance, in which Participating Providers are rewarded for meeting quality or outcome goals, including with respect to service accessibility, service utilization, clinical outcomes, Health Plan Enrollee/patient satisfaction and/or cost of care;
- Payment penalties, for failure to meet quality or outcomes goals, Participating Provider deviation from evidence-based practice standards or when Participating Provider care is connected to sub-standard outcomes such as certain health care acquired conditions;

- Shared savings, in which the Contractor sets a cost target and Participating Providers share in savings of avoided costs if the Contractor meets or exceeds the target(s);
- Shared savings and shared risk, in which the Participating Provider also is put at financial risk if costs exceed the defined target threshold;
- Global capitation in which the Contractor gives a Participating Provider, provider group or health system a single per-patient payment with the intention that the Participating Provider or health system will provide all necessary services to that patient during the Contract period; and/or
- Other models that conform to the objectives and standards of this Section of the Contract.

OHCA reserves the right to develop State-required components the Contractor must implement in its performance-based payment arrangements, such as the following:

- Targeted outcome goals;
- Targeted health conditions; and
- Other components OHCA determines necessary to further the goal of high-quality care or cost savings.

In accordance with 42 C.F.R. § 438.3(i) and Section 1903(m)(2)(A)(x) of the Act, such performance-based payment arrangements, as applicable, must meet the physician incentive plan requirements of 42 C.F.R. §§ 422.208 and 422.210, including:

- The Contractor shall not make a payment, directly or indirectly, to a Participating Provider as an inducement to reduce or limit covered services furnished to a Health Plan Enrollee; and
- If the Contractor's performance-based payment arrangement puts a physician/physician group at substantial financial risk, as determined at 42 C.F.R. § 422.208(d), for services not provided by the physician/physician group, the Contractor must ensure that the physician/physician group has adequate stop-loss protection.

By year three of this Contract, at least 80% of the Contractor's payments to Participating Providers, shall be to Participating Providers whose Provider Agreement includes a performance-based component. The 80% threshold will be calculated using a numerator consisting of total payments to these Participating Providers (performance-based and other) and a denominator consisting of all Participating Provider payments. Pharmacy, FQHC and RHC Provider payments, will be excluded from the calculation.

The Contractor shall submit an annual Performance-Based Payment Plan to OHCA in a format and on a schedule to be defined by OHCA. The Performance-Based Payment Plan shall detail the Contractor's strategy and good faith efforts for reaching the 80% target in the third year of this Contract, including specifying the Contractor's intermediate targets in year one and year two of this Contract. The Performance-Based Payment Plan also shall describe the Contractor's methodology or methodologies by type of Participating Provider. The Performance-Based Payment Plan shall be submitted to OHCA for review and approval by OHCA prior to implementation. The Contractor shall submit performance-based payment reports on a quarterly basis to OHCA in a format defined by OHCA and detailing the specific payments for that quarter.

1.14.1.11 Payments to LTCHs-C

Notwithstanding the provisions of Section 1.14.1.1: "Participating Provider Payment" of this Model Contract, the Contractor shall, at a minimum, provide payment for the provision of covered services

provided by LTCHs-C at the rate based on the methodology approved in the Oklahoma Medicaid State Plan.

1.14.2 Prohibited Payments

1.14.2.1 Overpayments

The Contractor shall report Overpayments to OHCA and recover Overpayments the Contractor identifies from its Participating Providers as specified in Section 1.18.6: “Reporting Overpayments” of this Model Contract.

1.14.2.2 Suspension of Payments

The Contractor shall suspend payments to a Participating Provider for which the State determines there is a credible allegation of Fraud in accordance with Section 1.18.7: “Suspension of Payments for Credible Allegation of Fraud” of this Model Contract and in accordance with 42 C.F.R. § 455.23.

1.14.2.3 Providers Ineligible for Payment

The Contractor shall ensure that no payments using Medicaid funds are made for services or items as provided in Section 1.18.10: “Prohibited Affiliations and Exclusions” of this Model Contract.

1.14.2.4 Provider-Preventable Conditions

In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the Contractor shall not make any payment to a Provider for Provider-preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-preventable Conditions for which payment shall not be made include:

- Health- acquired conditions occurring in any inpatient hospital setting, identified as a health-acquired condition by the Secretary of DHHS under § 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients; and
- Conditions meeting the following criteria:
 - Is identified in the State Plan;
 - Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
 - Has a negative consequence for the Health Plan Enrollee;
 - Is auditable; and
 - Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

1.14.3 Payment Assurance

Pursuant to 42 C.F.R. § 438.60, OHCA ensures that no payment is made to a Participating Provider other than by the Contractor for services covered under this Contract, except when these payments are specifically required to be made by the State in Title XIX of the Act, Title 42 of the C.F.R., or when OHCA makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan. OHCA reserves the right to review any and all Contractor policies and procedures to ensure compliance with this assurance.

1.14.4 Claims Processing

1.14.4.1 Claims Processing System and Methodology

The Contractor shall maintain a claims payment system capable of processing and paying claims in an accurate and timely manner and in full compliance with all State and federal law, including but not limited to, HIPAA requirements. The Contractor's claim processing system shall comport with all the information exchange provisions outlined in Section 1.19: "Information Technology" of this Model Contract.

The Contractor shall ensure that either Provider claims submissions or checks/warrants payable be printed, in boldface type, with the language specified in 42 C.F.R. § 455.18 or 42 C.F.R. § 455.19, respectively.

This system shall store claim information in accordance with the record retention requirements at Section 1.1.14: "Inspection and Audit Rights" of this Model Contract. At a minimum, these records shall include:

- The identity of the Provider submitting the claim;
- Date stamp of day received;
- Type of claim;
- Amount billed;
- All adjustments;
- Dates of all relevant action taken on the claim, including payment and denial;
- Amount paid;
- Service code;
- Provider involved in claim, including ordering, referring and rendering;
- Service location;
- Application of coordination of benefits and subrogation of claims; and
- Information on the units of service rendered so that OHCA may collect information for the purposes of utilization management.

The claims processing system used by the Contractor shall be equipped to receive and adjudicate claims submitted electronically and by mail, within a timeframe established by OHCA. The Contractor shall ensure that the electronic claims submission process is usable with a standard internet connection. Providers must be able to track the status of submitted claims online and contact a representative of the Contractor for resolution of claims questions.

The Contractor's and Subcontractors' payment cycle for newly submitted claims shall run at least weekly, on the same day each week, as determined by the Contractor and approved in writing by OHCA.

The claims processing system shall be equipped with system edits for the following, at minimum:

- Confirming Health Plan Enrollee eligibility as claims are submitted on the basis of the eligibility information provided by OHCA applicable to the period in which the charges on the claim were incurred;
- Ensuring that claims are only paid if received from Providers that are eligible to render the services for which the claim was submitted;
- Reviewing for Third Party Liability and reducing claims payment based on payments by a third party for any part of a service;
- Reviewing for duplicate claims and flagging possible duplicate claims for further review or denial;

- Reviewing for PA requirement, and, if applicable to the service(s) for which the claim is submitted, PA approval;
- Reviewing for medical necessity, including that services are appropriate in amount, duration and scope;
- Verifying that the service is a covered service under this Contract and is eligible for payment;
- Ensuring that Health Plan Enrollee benefit limits are factored into the claim adjudication and payment determination;
- Ensuring compliance with NCCI editing;
- Ensuring that the date(s) of service on the claim are valid, including, but not limited to:
 - Date(s) are not in the future; and
 - Date of admission is earlier than date of discharge;
- Identifying missing, invalid, or mismatched Provider NPIs, CLIA certifications, and/or TINs/EINs.

OHCA reserves the right to add additional minimum required system edits, at its discretion.

Each financial adjustment to each claim shall be recorded, including Third Party Liability adjustments, interest and Copayments.

The Contractor's claims processing system shall track the error rates in claims and Encounter Data received from the Provider or a third party prior to a claim or encounter being adjudicated and submitted to OHCA.

1.14.4.2 Timely Claims Filing and Processing

1.14.4.2.1 Timely Claims Filing Requirements

The Contractor shall adjudicate Provider claims in accordance with timely filing limits specified in OAC 317:30-3-11. The Contractor shall require the Provider to submit all claims within six months from the date of service. The Contractor shall require claims to be resubmitted, when applicable, within an additional six months from the date of service. The only exceptions to the resubmission deadline are the following:

- Administrative correction or action by the Contractor taken to resolve a dispute;
- Reversal of eligibility determination;
- Investigation for Fraud or Abuse of the Provider; or
- Court order or hearing decision.

1.14.4.2.2 Timely Payment Requirements

OHCA has set the following timely payment requirements, which have been developed in accordance with the requirements at 42 C.F.R. §§ 447.45(d)(2)-(3) and 447.46 and §§ 1902(a)(37)(A) and 1932(f) of the Act. The Contractor shall observe the following requirements in adjudicating Clean Claims:

- Ensure that 90% of Clean Claims received from all Providers are paid within 14 days of receipt; and
- Ensure that 99% of Clean Claims received from all Providers are paid within 90 days of receipt.

In accordance with 42 C.F.R. § 447.45(d), all claims shall be paid within 12 months of date of receipt by the Contractor, except in the following cases:

- The time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;
- The time limitation does not apply to claims from Providers under investigation for Fraud and Abuse; and
- The Contractor may make payments at any time in accordance with a court order, to carry out hearing decisions or OHCA/Contractor corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action or court order to others in the same situation as those directly affected by it.

The Contractor shall develop policies and procedures governing the processing of claims. At minimum, these policies and procedures should cover the format in which claims are to be submitted, the speed with which the Participating Provider or Subcontractor can expect them to be processed and compliance with State and federal law.

The Contractor shall pay its Participating Providers and Subcontractors consistent with Section 1902(a)(37)(A) of the Act.

1.14.4.2.3 Date of Receipt and Date of Payment

The following definitions shall apply for the purpose of determining timely payment of Clean Claims in accordance with §§ 1902(a)(37)(A) and 1932(f) of the Act:

- In accordance with 42 C.F.R. §§ 447.45(d)(5) and 447.46(c)(1), the date of receipt, for purposes of Section 1.14.4.2: “Timely Claims Filing and Processing” of this Model Contract, shall be the date the Contractor received the claim as indicated by its date stamp on the claim.
- In accordance with 42 C.F.R. §§ 447.45(d)(6) and 447.46(c)(1), the date of payment, for purposes of Section 1.14.4.2: “Timely Claims Filing and Processing” of this Model Contract, shall be considered to be the date of the check or other method of payment to the Provider from the Contractor.

1.14.4.2.4 Interest Payment for Delayed Adjudication of Clean Claims

The Contractor shall pay a monthly interest rate of 1.5 percent on all Clean Claims that are not adjudicated within 45 days of receipt by the Contractor, in accordance with 62 O.S. 34.72. This interest rate shall be prorated on a daily basis.

1.14.4.2.5 Treatment of Unclean Claims

If the Contractor receives a claim submission that does not include all the necessary documentation or information to be determined a Clean Claim in order to pay the claim, resulting in a denial or partial denial of the claim, the Contractor may notify the Provider who submitted the claim in writing within seven days of receipt and explain what further documentation is needed for the Contractor to adjudicate the claim. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

1.14.4.2.6 Claim Corrections and Resubmissions

Any corrections or resubmissions of existing, paid claims shall be submitted as adjustments to the existing claim.

1.14.4.3 Claims Format

The Contractor shall accept HIPAA-compliant formats for electronic claims submission. The Contractor shall comply with the following standardized paper billing forms and formats, and any updates thereto:

- Professional claims: CMS 1500 claim form
- Institutional claims: CMS 1450/UB04

The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These shall include, but not be limited to, HIPAA-based standards and federally required safeguard requirements.

1.14.4.4 Remittance Advice

The Contractor shall send a remittance advice with the claim payment unless payment is executed electronically. If the payment is electronic, the Contractor shall send the remittance advice the same day either electronically in 835 format or via download on Provider portal.

1.14.4.5 Claims Inquiries and Disputes

The Contractor shall develop policies and procedures governing claims inquiries and disputes. The claims dispute resolution process developed by the Contractor shall include at least two levels for Providers to dispute the nature of medical necessity, with the second level including review by a medical professional with the same or similar specialty to the medical area that is the topic of the dispute. The Contractor shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

1.15 **AI/AN Population and Indian Health Care Providers**

OHCA is committed to preserving the protections afforded to AI/AN Health Plan Enrollees under federal law, while expanding access to person/family-centered care coordination. OHCA is also committed to preventing disruption in payments to IHCPs, while encouraging opportunities for creative partnerships between the Contractor and IHCP community.

OHCA and the Contractor will pursue these objectives and maintain open communication with AI/AN stakeholders through the processes outlined in this section and in compliance with the State Plan.

1.15.1 **Tribal Government Liaison**

As a part of Key Staff, the Contractor shall employ a full-time Tribal Government Liaison (as described in Section 1.3.6.2) to conduct outreach to the AI/AN community and to serve as a resource for Health Plan Enrollees and Providers with questions or issues. The Tribal Government Liaison will develop policy and lead tribal consultation with tribal governments and tribal health care Providers in Oklahoma. The Contractor shall develop an outreach plan for OHCA's review and approval for submission during the Readiness Review. The Tribal Government Liaison will also be responsible for communicating with and advising Contractor's Key Staff on topics regarding issues and concerns raised by IHCPs and AI/AN Health Plan Enrollees including but not limited to, reimbursement, claims payments, access to care, and enrollment. The Tribal Government Liaison will also coordinate cultural competency training for Contractor's staff.

1.15.2 **OHCA Tribal Government Relations Unit**

OHCA Tribal Government Relations unit acts as an AI/AN liaison between OHCA and CMS, Indian Health Service, Urban Indian facilities and Indian Tribes of Oklahoma for State and national level issues, including

(without implied limitation) AI/AN work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. The Contractor's Tribal Government Liaison shall serve as a single point-of-contact for OHCA Tribal Government Relations unit and shall attend AI/AN consultative meetings held by OHCA.

1.15.3 AI/AN Health Plan Enrollees

1.15.3.1 Enrollment and Disenrollment

OHCA or its designee will provide Choice Counseling and OHCA's enrollment materials will advise eligible AI/AN Health Plan Enrollees that they have the option to enroll in the SoonerSelect program. Health Plan Enrollees who opt-in will be subject to the enrollment provisions specified in Section 1.5: "Enrollment and Disenrollment" of this Model Contract, except that AI/AN Health Plan Enrollees may disenroll from the SoonerSelect program without cause. If an AI/AN Eligible elects not to enroll or enrolls and then chooses to disenroll from the SoonerSelect program, the AI/AN Eligible shall have a new opportunity to enroll at the next Open Enrollment Period.

1.15.3.2 IHCP as Patient Centered Medical Home (formerly Primary Care Provider)

In accordance with 42 C.F.R. § 438.14(b)(3), unless the Contractor is an Indian Managed Care Entity (ICME), the Contractor shall permit AI/AN Health Plan Enrollees to receive services from an IHCP primary care provider who is a Participating Provider and to choose that IHCP as the AI/AN Health Plan Enrollee's PCMH if that Provider has capacity to provide the services.

1.15.3.3 Access to Out-of-Network IHCPs and Referrals under Purchase and Referred Care

Pursuant to 42 C.F.R. § 438.14(b)(4), the Contractor shall permit AI/AN Health Plan Enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the AI/AN Health Plan Enrollee is otherwise eligible to receive such services. In accordance with 42 C.F.R. § 438.14(b)(6), the Contractor shall also permit an out-of-network IHCP to refer an AI/AN Health Plan Enrollee to a Participating Provider. This includes services furnished by an out-of-network IHCP or through referral under purchase and referred care.

1.15.3.4 Health Plan Enrollee Cost Sharing

AI/AN Health Plan Enrollees are exempt from Cost Sharing in accordance with the requirements of Section 1.17.2: "Cost Sharing Exempt Populations" of this Model Contract.

1.15.3.5 Care Management

The Contractor shall include AI/AN Care Managers within its care management staffing. The Contractor shall inquire of AI/AN Health Plan Enrollees as to their preference, if any, and shall offer AI/AN Health Plan Enrollees the option of receiving care management from an AI/AN Care Manager, to the extent practicable.

1.15.4 Indian Health Care Providers (IHCPs)

1.15.4.1 Sufficient IHCP Participation

In accordance with 42 C.F.R. § 438.14(b)(1), the Contractor shall demonstrate there are sufficient IHCPs participating in the Contractor's network to ensure timely access to services available under the Contract from such Providers for AI/AN Health Plan Enrollees who are eligible to receive services. The Contractor shall provide OHCA with network accessibility reports that are specific to its AI/AN Health Plan Enrollees and IHCP network, in accordance with Reporting Manual requirements.

1.15.4.2 Timely Access to IHCPs

If timely access to covered services cannot be ensured due to few or no IHCPs in the State, the Contractor will be considered to have met the IHCP network requirement if AI/AN Health Plan Enrollees are permitted by the Contractor to access out-of-state contracted IHCPs.

This circumstance shall also be deemed to be good cause for Disenrollment from both the Contractor and the SoonerSelect program in accordance with 42 C.F.R. § 438.56(c).

1.15.4.3 Payments to IHCPs

All Contractor payments to IHCPs shall be made in accordance with 42 C.F.R. § 438.14. OHCA will reimburse for services that are eligible for 100% federal reimbursement and are provided by an IHS or 638 tribal facility to AI/AN Health Plan Enrollees who are eligible to receive services through an IHS or 638 tribal facility. Encounters for SoonerCare services billed by IHS or 638 tribal facilities and eligible for 100% federal reimbursement will not be accepted by OHCA or considered in capitation rate development. The Contractor shall make payment to IHCPs for covered services not eligible for 100% federal reimbursement and provided to Health Plan Enrollees who are eligible to receive services through the IHCP regardless of whether the IHCP is a Participating Provider. The Contractor may negotiate a rate for the services provided by an IHCP or, in the absence of a negotiated rate, the Contractor shall reimburse the IHCP for its services at a rate not less than the level and amount the Contractor would pay to the same type of Participating Provider that is not an IHCP.

The Contractor shall pay for all services not eligible for 100% federal reimbursement to all Non-Participating IHCPs enrolled in SoonerCare as an FQHC an amount equal to the amount the Contractor would pay a network FQHC that is not an IHCP, as further described in Section 1.14.1.6: "Payments to FQHCs and RHCs" of this Model Contract, including any supplemental payment from OHCA to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under fee-for-service.

The Contractor shall pay for all services not eligible for 100% federal reimbursement to an IHCP that is not enrolled in SoonerCare as an FQHC, regardless of network status with the Contractor, at minimum, at the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS). In the absence of a published encounter rate, the Contractor shall pay, at minimum, the amount the IHCP would receive if the services were provided under the State Plan fee-for-service methodology. In the event the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under fee-for-service or the applicable encounter rate published annually in the Federal Register by the IHS, the Contractor shall make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under fee-for-service or the applicable encounter rate.

The Contractor shall timely pay all I/T/U Participating Providers in accordance with the requirements of Section 1.14.4.2: "Timely Claims Filing and Processing" of this Model Contract.

In accordance with CMS State Health Official Letter #16-002, IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal Providers to furnish certain services for AI/AN Eligibles and Health Plan Enrollees and such services are eligible for 100% federal funding. The Contractor shall provide reporting in the timeframe and format required by OHCA to facilitate the state's collection of 100% federal funding for these services. The Contractor shall also facilitate the development of care coordination

agreements between IHCP and other non-IHS/Tribal Providers as necessary to support the provision of services for AI/AN Health Plan Enrollees.

1.15.5 Indian Managed Care Entity

Pursuant to 42 C.F.R. § 438.14(d), an IMCE may restrict its enrollment to AI/ANs in the same manner as Indian Health Programs may restrict the delivery of services to AI/ANs, without being in violation of the requirements in 42 C.F.R. § 438.3(d).

1.16 Health Plan Enrollee Grievances and Appeals

1.16.1 General Requirements

1.16.1.1 Health Plan Enrollee Grievances and Appeals System

In accordance with 42 C.F.R. §§ 438.402 and 438.228(a), the Contractor shall operate a Health Plan Enrollee Grievances and Appeals System to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them. The Health Plan Enrollee Grievances and Appeals System shall comply with the requirements in all applicable State and federal laws, regulations and guidance. In accordance with the requirements of 42 C.F.R. § 438.402, the Contractor's Grievances and Appeals System shall:

- Have only one level of Appeal for Health Plan Enrollees;
- Allow a Health Plan Enrollee to file a Grievance and request an Appeal with the Contractor, with the ability for the Health Plan Enrollee to request a State Fair Hearing after receiving notice pursuant to 42 C.F.R. § 438.408, and Section 1.16.2: "Adverse Benefit Determinations" of this Model Contract, that the Adverse Benefit Determination is upheld;
- Allow a Health Plan Enrollee to file a Grievance with the Contractor, either orally or in writing, at any time;
- Provide that a Health Plan Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have 60 Calendar Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to the Contractor, which may be filed either orally or in writing;
- Unless the Health Plan Enrollee is requesting an expedited resolution, as described in Section 1.16.4: "Appeals" of this Model Contract, require an oral request for an Appeal to the Contractor to be followed by a written, signed request for an Appeal, with the filing date being the date that the oral request for Appeal was made.

As provided under State law and 42 C.F.R. § 438.402(c)(2)(ii), the Contractor and OHCA shall allow an Authorized Representative to request an Appeal, file a Grievance, or request a State Fair Hearing, on behalf of a Health Plan Enrollee with the written consent of the Health Plan Enrollee. When the term "Health Plan Enrollee" is used throughout Section 1.16: "Health Plan Enrollee Grievances and Appeals" of this Model Contract, it includes Authorized Representatives, and Providers designated as Authorized Representatives for the sole purpose of pursuing Appeals or Grievances on behalf of Health Plan Enrollees. However, Providers shall not be allowed to request continuation of benefits as specified in 42 § 438.420(b)(5) and Section 1.16.6: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Model Contract.

The Contractor shall maintain written policies and procedures on its Health Plan Enrollee Grievances and Appeals System that shall be approved by OHCA in writing prior to implementation during the Readiness Review.

1.16.1.2 Information About Grievance and Appeals System

The Contractor shall provide information about the Grievances and Appeals System and State Fair Hearing procedures and timeframes to Health Plan Enrollees, Providers and Subcontractors consistent with all applicable State and federal law, regulation and guidance.

1.16.1.2.1 Information to Providers and Subcontractors

In accordance with 42 C.F.R. §§ 438.414 and 438.10(g)(2)(xi) the Contractor shall provide the following information, at minimum, to all Providers and Subcontractors at the time they enter into a contract or Provider Agreement with the Contractor:

- Health Plan Enrollee Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and described in Section 1.16: “Health Plan Enrollee Grievances and Appeals” of this Model Contract;
- The Health Plan Enrollee’s right to file Grievances and Appeals and the requirements and timeframes for filing;
- The availability of assistance to the Health Plan Enrollee with filing Grievances and Appeals;
- The Health Plan Enrollee's right to request a State Fair Hearing after the Contractor has made a determination on a Health Plan Enrollee’s Appeal which is adverse to the Health Plan Enrollee; and
- The Health Plan Enrollee’s right to request continuation of benefits, as described in Section 1.16.6: “Continuation of Benefits Pending Appeal and State Fair Hearing” of this Model Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Health Plan Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor’s determination that is adverse to the Health Plan Enrollee.

At minimum, the Contractor shall include this information in:

- Provider and Subcontractor contracts with the Contractor;
- The Contractor’s Provider Manual;
- Applicable Provider and Subcontractor training materials; and
- Any other materials as required by State or federal law, regulation and guidance.

1.16.1.2.2 Information to Health Plan Enrollees

In accordance with 42 C.F.R. §438.10(g)(2)(xi), the Contractor’s Health Plan Enrollee Handbook shall include Grievance, Appeal and State Fair Hearing procedures and timeframes, consistent with 42 C.F.R. subpart F, in an OHCA-developed description. At minimum, this information shall include:

- Health Plan Enrollee Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and in Section 1.16 of this Contract;
- The Health Plan Enrollee’s right to file Grievances and Appeals and the requirements and timeframes for filing;
- The availability of assistance to the Health Plan Enrollee with filing Grievances and Appeals;

- The Health Plan Enrollee's right to request a State Fair Hearing after the Contractor has made a determination on a Health Plan Enrollee's Appeal which is adverse to the Health Plan Enrollee; and
- The Health Plan Enrollee's right to request continuation of benefits, as described in Section 1.16.6: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Model Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes, although the Health Plan Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor's determination that is adverse to the Health Plan Enrollee.

At a minimum, the Contractor shall include this information in:

- Applicable Health Plan Enrollee written notifications;
- The Contractor's Health Plan Enrollee Handbook; and
- Any other materials as required by State or federal law, regulation and guidance.

1.16.1.3 Expedited Review Process

In accordance with 42 C.F.R. 438.410(a), the Contractor shall establish and maintain an expedited review process for Appeals, for cases in which the Contractor determines, or when the Provider as the Health Plan Enrollee's Authorized Representative indicates that taking the time for a standard resolution could seriously jeopardize the Health Plan Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

1.16.1.4 Reasonable Assistance to Health Plan Enrollees

In accordance with 42 C.F.R. § 438.406(a), the Contractor's Grievance and Appeal System shall include provision of reasonable assistance to Health Plan Enrollees in completing Grievance or Appeals forms and taking other procedural steps related to the Grievance or Appeal. The Contractor's reasonable assistance to the Health Plan Enrollee shall include, at minimum:

- Availability of Health Plan Enrollee Care Support Staff;
- Auxiliary aids and services upon request, such as providing interpreter services; and
- Toll-free numbers that have adequate TTY/TDD and interpreter capability.

1.16.1.5 Availability of Alternative Formats

The Contractor shall ensure that all notices related to Grievances and Appeals are available in the prevalent non-English languages required under Section 1.11.1.1: "Prevalent Non-English Languages" of this Model Contract. Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall ensure that the notices are available in alternative formats for persons with special needs, with auxiliary aids and services made available upon request at no cost.

1.16.1.6 Receipt of Grievances and Appeals

The Contractor shall acknowledge receipt of each Grievance and Appeal of an Adverse Benefit Determination, in accordance with 42 C.F.R. § 438.406(b)(1). The process and timeframe by which the Contractor shall meet this requirement shall be determined by OHCA.

1.16.1.7 Decision Makers on Grievances or Appeals

In accordance with 42 C.F.R. § 438.406(b)(2), the Contractor shall:

- Ensure that any individuals making a decision on a Health Plan Enrollee Grievance or Appeal were not involved in, nor a subordinate of any individual involved in, any previous level of review or decision-making; and
- Ensure that any individual making a decision on a Health Plan Enrollee Grievance or Appeal of an Adverse Benefit Determination are individuals with appropriate clinical expertise, as determined by OHCA, in treating the Health Plan Enrollee's condition or disease when the decision involves the following:
 - An Appeal of a denial that is based on lack of Medical Necessity;
 - A Grievance regarding denial of expedited resolution of an Appeal; or
 - A Grievance or Appeal that involves clinical issues.

The Contractor's decision makers on Health Plan Enrollee Grievances or Appeals shall, in accordance with 42 C.F.R. § 438.406(b)(2)(iii), take into account all comments, documents, records and other information submitted by the Health Plan Enrollee or the Health Plan Enrollee's Authorized Representative without regard to whether such information was submitted or considered by the Contractor in the initial Adverse Benefit Determination.

1.16.1.8 Presentation of Evidence

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(4), provide Health Plan Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the Health Plan Enrollee of the limited time available for this sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b)-(c) for Appeals and expedited Appeals.

1.16.1.9 Access to Health Plan Enrollee Case Files

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(5), provide Health Plan Enrollees and/or Authorized Representative's the Health Plan Enrollee's Case File, including all medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the Contractor's direction, in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b)-(c) for Appeals and expedited Appeals.

1.16.1.10 Parties

In accordance with 42 C.F.R. § 438.406(b)(6), the Contractor's Grievance and Appeals System shall include the following as parties to an Appeal:

- The Health Plan Enrollee and the Health Plan Enrollee's Authorized Representative; or
- The legal representative of a deceased Health Plan Enrollee's estate.

1.16.1.11 Recordkeeping

The Contractor shall, in accordance with 42 C.F.R. § 438.416, maintain records of all Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to OHCA quality strategy. The Contractor shall accurately maintain the records in a manner accessible to OHCA and available upon request to CMS. Except as is established in Section 1.16.5.4: "Contractor State Fair Hearing Support" of this Model Contract, the Contractor shall produce

records to OHCA staff no later than three Business Days after the date of request, in the format (electronic or hard copy) requested. The record of each Grievance or Appeal shall contain, at minimum, the following:

- A general description of the reason for the Grievance or Appeal;
- Date the Grievance or Appeal request was received by the Contractor;
- Date of each review or, if applicable, review meeting;
- Resolution at each level of the Grievance or Appeal, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the Health Plan Enrollee for whom the Grievance or Appeal was filed.

1.16.2 Adverse Benefit Determinations

1.16.2.1 General Requirements

The Contractor shall provide Health Plan Enrollees with timely and adequate written notice of an Adverse Benefit Determination consistent with 42 C.F.R. § 438.404(a). The written notice shall include all information required in Section 1.16.2.2: “Notice Content” of this Model Contract and meet the timing requirements set forth in Section 1.16.2.3: “Timeframes for Notice Adverse Benefit Determination” of this Model Contract.

In accordance with 42 C.F.R. § 438.210(c), the Contractor shall notify the requesting Provider, and give the Health Plan Enrollee written notice meeting the requirements of 42 C.F.R. § 438.404, of any decision the Contractor to deny a Service Authorization (PA) request, or to authorize a service in an amount, duration, or scope that is less than requested.

1.16.2.2 Notice Content

OHCA will work with the Contractor after the award of this Contract to develop model notices of Adverse Benefit Determinations. The written notice shall include, at minimum, the following content set forth at 42 C.F.R. § 438.404(b):

- The Adverse Benefit Determination the Contractor has made or intends to make;
- The reasons for the Adverse Benefit Determination, including the Health Plan Enrollee’s right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Health Plan Enrollee’s Adverse Benefit Determination. Such information shall include necessary criteria, processes, strategies or evidentiary standards in setting coverage limits;
- Information on how to request reasonable access to and copies of all documents, records and other information relevant to the Health Plan Enrollee’s Adverse Benefit Determination;
- The Health Plan Enrollee’s right to request an Appeal of the Contractor’s Adverse Benefit Determination, including information and procedures for exhausting the Contractor’s one level of Appeal and the right to request a State Fair Hearing;
- The circumstances under which an Appeal process can be expedited and how to request it;
- The Health Plan Enrollee’s right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued and the circumstances, consistent with OHCA’s policy, under which the Health Plan Enrollee may be required to pay the costs of these services; and
- The procedures for exercising all rights set for in this Section and in 42 C.F.R. § 438.404(b).

The notice shall comply with all information requirements at 42 C.F.R. § 438.10 and, consistent with 42 C.F.R. § 438.10(d)(3) and Section 1.11.1.5: “Taglines” of this Model Contract, contain taglines in each

State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

1.16.2.3 Timeframes for Notice Adverse Benefit Determination

The Contractor shall mail the written notice of an Adverse Benefit Determination within the following timeframes set forth in Sections 1.16.2.3.1 through 1.16.2.3.5 of this Contract, in accordance with 42 C.F.R. § 438.404(c):

1.16.2.3.1 Termination, Suspension or Reduction of Previously Authorized Covered Services

When the action for which the notice of Adverse Benefit Determination is being provided is a termination, suspension or reduction of previously authorized Medicaid-covered services, the Contractor shall send the written notice at least ten days before the date of action, in accordance with 42 C.F.R. §§ 431.211 and 438.404(c)(1), with certain exceptions indicated below. The Contractor shall also send the written notice of an Adverse Benefit Determination at least ten days before the date of action when the Health Plan Enrollee's location and address is unknown based on returned mail with no forwarding address, in accordance with OAC 317:35-5-67.

Exceptions to the ten day advance written notice requirement for termination, suspension or reduction of previously authorized Medicaid-covered services shall be as follows:

- *Notice Timeframe for Probable Health Plan Enrollee Fraud:* In accordance with 42 C.F.R. §§ 431.214 and 438.404(c)(1), the Contractor may shorten the written notice of Adverse Benefit Determination to as few as five days before the date of action if the Contractor has facts that have been verified, if possible, through secondary sources, indicating that action should be taken because of probable Health Plan Enrollee Fraud.
- *Notice Timeframe for Voluntary or Involuntary Health Plan Enrollee Eligibility or Service Reduction:* In accordance with 42 C.F.R. §§ 431.213 and 438.404(c)(1), the Contractor shall provide Health Plan Enrollees with written notice of an Adverse Benefit Determination no later than the date of the action in the notice in any of the following circumstances:
 - The Contractor has factual information confirming the Health Plan Enrollee's death;
 - The Health Plan Enrollee submits a signed written statement requesting service termination;
 - The Health Plan Enrollee submits a signed written statement including information that requires service termination or service reduction and indicates that the Health Plan Enrollee understands that service termination or service reduction will result from supplying the information;
 - The Health Plan Enrollee has been admitted to an institution in which he or she is ineligible for further services;
 - The Contractor has information establishing that the Health Plan Enrollee has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth;
 - The Health Plan Enrollee's physician prescribes a change in the Health Plan Enrollee's level of medical care; or

- The notice involves an Adverse Benefit Determination with regard to preadmission screening requirements of § 1919(e)(7) of the Act.

1.16.2.3.2 Payment Denial

In accordance with 42 C.F.R. § 438.404(c)(2), when the action for which the notice of Adverse Benefit Determination is being provided is denial of payment, the Contractor shall provide the notice at the time of any action affecting the claim.

1.16.2.3.3 Standard Service Authorization Denial or Limitation

In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d)(1), when the action for which the notice of Adverse Benefit Determination is being provided is standard Service Authorization (PA) decisions that deny or limit services, the Contractor shall provide the notice as expeditiously as the Health Plan Enrollee's condition requires and not to exceed 14 days following receipt of the request for service. The Contractor may extend the 14-day Service Authorization notice timeframe up to 14 additional Calendar Days if:

- The Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor justifies (to OHCA upon request) a need for additional information and how the extension is in the Health Plan Enrollee's interest.

If the timeframe is extended based upon the Contractor justification of a need for additional information and how the extension is in the Health Plan Enrollee's interest, the Contractor shall, in accordance with 42 C.F.R. § 438.404(c)(4), provide the Health Plan Enrollee written notice of the reason for the decision to extend the timeframe, inform the Health Plan Enrollee of the right to file a Grievance if the Health Plan Enrollee disagrees with that decision and issue and carry out its determination as expeditiously as the Health Plan Enrollee's health condition requires and no later than the date the extension expires.

1.16.2.3.4 Expedited Service Authorization Denial

In accordance with 42 C.F.R. §§ 438.404(c)(6) and 438.210(d)(2), for cases in which a Provider indicates, or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the Health Plan Enrollee's life or health or Health Plan Enrollee's ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide oral notice as expeditiously as the Health Plan Enrollee's health condition requires and provide written notice no later than 72 hours after receipt of the request for service. The Contractor may extend the 72-hour time period for written notice by up to 14 days if:

- The Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor justifies (to OHCA upon request) a need for additional information and how the extension is in the Health Plan Enrollee's interest.

1.16.2.3.5 Untimely Service Authorization Decisions

In accordance with 42 C.F.R. § 438.404(c)(5), the Contractor shall give notice on the date that the timeframes expire, when Service Authorization decisions are not reached within the applicable timeframes for either standard or expedited Service Authorizations as set forth in Sections 1.16.2.3.3 and 1.16.2.3.4 of this Contract.

1.16.3 **Grievances**

1.16.3.1 Authority, Format and Timeframe for Filing Grievance

As detailed in Section 1.16.1.1: “Health Plan Enrollee Grievances and Appeals System” of this Model Contract, a Health Plan Enrollee may file a Grievance with the Contractor, either orally or in writing at any time.

1.16.3.2 Requirement to File Grievance with Contractor

The Health Plan Enrollee shall be required to file a Grievance directly with the Contractor and shall not file with OHCA, in accordance with OHCA’s policy as allowed under 42 C.F.R. §438.402(c)(3).

1.16.3.3 Timeframe for Resolution of Grievance

The Contractor shall resolve each Grievance and provide notice, as expeditiously as the Health Plan Enrollee’s health condition requires, which shall be within 30 Calendar Days from the date the Contractor receives the Grievance, in accordance with 42 C.F.R. § 438.408(a) and (b)(1).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon its request) that there is a need for additional information and how the delay is in the Health Plan Enrollee’s interest.

If the Contractor extends the timeframe for resolution of a Grievance, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(ii):

- Make reasonable efforts to give the Health Plan Enrollee prompt oral notice of the delay; and
- Give the Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two Calendar Days and inform the Health Plan Enrollee of the right to file a Grievance if the Health Plan Enrollee disagrees with that decision.

1.16.3.4 Grievance Resolution Notice Format and Content

The Contractor shall provide written notice of resolution of a Grievance to the impacted Health Plan Enrollee within three Calendar Days of the resolution of the Grievance. In accordance with 42 C.F.R. § 438.408(d)(1) and Section 1.11.4: “OHCA Developed Health Plan Enrollee Materials” of this Model Contract, OHCA shall establish the content the Contractor must include in the notice. The notice shall be in a format and language that, at a minimum, meet the requirements of 42 C.F.R. § 438.10, including taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

1.16.4 **Appeals**

1.16.4.1 Authority and Format for Requesting Appeal

As detailed in Section 1.16.1.1: “Health Plan Enrollee Grievances and Appeals System” of this Model Contract, a Health Plan Enrollee may file an Appeal with the Contractor orally or in writing. In accordance with 42 C.F.R. § 438.402(c)(3), an oral request must be followed by a signed, written request unless the Health Plan Enrollee is requesting an expedited resolution.

1.16.4.2 Timeframe for Requesting Appeal

In accordance with 42 C.F.R. § 438.402(c)(2)(ii), the Contractor shall allow the Health Plan Enrollee to file an Appeal to the Contractor within 60 Calendar Days from the date on the Adverse Benefit Determination notice.

1.16.4.3 Timeframe for Standard Appeal Resolution

The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Health Plan Enrollee's health condition requires, which shall be within 30 Calendar Days from the date the Contractor receives the Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(2).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon its request) that there is a need for additional information and how the delay is in the Health Plan Enrollee's interest.

If the Contractor extends the timeframe for resolution of an Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

- Make reasonable efforts to give the Health Plan Enrollee prompt oral notice of the delay;
- Give the Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two Calendar Days and inform the Health Plan Enrollee of the right to file a Grievance if the Health Plan Enrollee disagrees with that decision; and
- Resolve the Appeal as expeditiously as the Health Plan Enrollee's health condition requires and no later than the date the extension expires.

Notwithstanding the foregoing, the Contractor shall resolve Step Therapy Appeals according to the following:

- Step Therapy Appeals in Exigent Circumstances shall be resolved within 24 hours of receipt of the Appeal request; or
- Within 72 hours for all other Step Therapy Appeals requests. However, if the timeframe for resolution falls on a weekend, or on any other day the Contractor is closed or closes early, including but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall not run until the close of the next full business day.

1.16.4.4 Timeframe for Expedited Resolution

The Contractor shall resolve each expedited Appeal and provide notice, as expeditiously as the Health Plan Enrollee's health condition requires, which shall be within 72 hours from the date the Contractor receives the Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(3).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to 14 Calendar Days if:

- The Health Plan Enrollee or Provider as Authorized Representative requests an extension; or
- The Contractor shows (to the satisfaction of OHCA, upon its request) that there is a need for additional information and how the delay is in the Health Plan Enrollee's interest.

If the Contractor extends the timeframe for resolution of an expedited Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Health Plan Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

- Make reasonable efforts to give the Health Plan Enrollee prompt oral notice of the delay;
- Give the Health Plan Enrollee written notice of the reason for the decision to extend the timeframe within two Calendar Days and inform the Health Plan Enrollee of the right to file a Grievance if the Health Plan Enrollee disagrees with that decision; and
- Resolve the Appeal as expeditiously as the Health Plan Enrollee's health condition requires and no later than the date the extension expires.

1.16.4.5 Appeal Resolution Notice Format and Content

For all Appeals, the Contractor shall provide written notice of resolution to the impacted Health Plan Enrollee, in accordance with 42 C.F.R. § 438.408(d)(2), in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10. The notice shall contain taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

In accordance with 42 C.F.R. § 438.408(d)(2)(ii), the Contractor, in addition to the written notice requirements of the preceding paragraph, shall also make reasonable efforts, as determined by OHCA, to provide oral notice to the Health Plan Enrollee for resolution of an expedited Appeal.

OHCA intends to work with the Contractor to develop model notices upon award of this Contract. In accordance with 42 C.F.R. § 438.408(e)(1)-(2), the notice shall include the results of the resolution process and the date it was completed, and for Appeals not resolved wholly in favor of the Health Plan Enrollee, the notice shall include the following:

- The right to request a State Fair Hearing;
- How to request a State Fair Hearing;
- The right to request and receive benefits while the State Fair Hearing is pending, as detailed in 1.16.6: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Model Contract;
- How to request benefits while the State Fair Hearing is pending; and
- Notice that the Health Plan Enrollee may, consistent with OHCA policy, be held liable for the cost of those benefits if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination.

1.16.5 **Access to State Fair Hearings and Contractor Role**

1.16.5.1 Authority and Timeline for State Fair Hearing Request

Pursuant to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1), a Health Plan Enrollee may request a State Fair Hearing under Subpart E of 42 C.F.R. Part 431 only after receiving notice from the Contractor upholding an Adverse Benefit Determination. The Health Plan Enrollee shall have 120 days from the date of the Adverse Benefit to request a State Fair Hearing.

1.16.5.2 Deemed Exhaustion of Appeals Process

If the Contractor fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the Health Plan Enrollee is deemed to have exhausted the Contractor's Appeal process and the Health Plan Enrollee may initiate a State Fair Hearing, pursuant to 42 C.F.R. §§438.402(c)(1)(i)(A) and 438.408(f)(1)(i).

1.16.5.3 Parties to State Fair Hearing

In accordance with 42 C.F.R. § 438.408(f)(3), parties to the State Fair Hearing shall include the Contractor and the Health Plan Enrollee and the Health Plan Enrollee's representative or the representative of a deceased Health Plan Enrollee's estate.

1.16.5.4 Contractor State Fair Hearing Support

The Contractor shall maintain a sufficient level of trained staff to provide support in the State Fair Hearing process, including all of the following, at minimum:

- The Contractor shall provide the State with a summary setting forth the following information:
 - Name and address of the Health Plan Enrollee, which includes the Health Plan Enrollee's Authorized Representative, if applicable;
 - A summary statement concerning why the Health Plan Enrollee is filing a request for a State Fair Hearing;
 - A brief chronological summary of the Contractor's action in relationship to the Health Plan Enrollee's request for a State Fair Hearing;
 - A statement of the basis of the Contractor's decision;
 - A citation of the applicable policies relied upon by the Contractor;
 - A copy of the notice which notified the Health Plan Enrollee of the decision in question;
 - Any applicable correspondence; and
 - The name and title of the Contractor's staff who will serve as witnesses at the State Fair Hearing.
- This summary must be received by OHCA within: 24 hours after notification of the request for a State Fair Hearing relating to a Step Therapy Appeal; or within 15 Calendar Days after notification of the request for a State Fair Hearing, in all other instances.
- Summarizing the arguments presented by the Health Plan Enrollee, which includes the Health Plan Enrollee's Authorized Representative, if applicable, and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Health Plan Enrollee and Contractor are clearly identified. The Contractor shall state the legal basis upon which any dismissal requests are based and include regulations or statutes in support.
- Ensuring timely delivery to the Health Plan Enrollee, which includes the Health Plan Enrollee's Authorized Representative, if applicable, the State and the Office of Administrative Hearings State Fair Hearing documentation, as required.

OHCA reserves the right to amend the Contractor State Fair Hearing responsibilities, including setting performance targets for State Fair Hearing requests that are resolved upholding the Contractor's original determination, as it deems necessary and appropriate under this Model Contract.

1.16.6 Continuation of Benefits Pending Appeal and State Fair Hearing

1.16.6.1 When the Contractor Shall Continue Benefits

In accordance with 42 C.F.R. § 438.420 and OAC 317:2-1-2.6, the Contractor shall continue a Health Plan Enrollee's benefits under the Contract when all of the following occur:

- The Health Plan Enrollee files the request for an Appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);
- The Appeal involves the termination, suspension, or reduction of previously authorized services;
- The services were ordered by an authorized Provider;
- The period covered by the original authorization has not expired; and
- The Health Plan Enrollee timely files for continuation of benefits, meaning on or before the later of the following:
 - Within ten Calendar Days of the Contractor sending the notice of Adverse Benefit Determination; or
 - The intended effective date of the Contractor's proposed Adverse Benefit Determination.

If the Health Plan Enrollee fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten Calendar Days of the Adverse Benefit Determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

- The Health Plan Enrollee has exceeded the limit applicable to the service;
- When a request for a Prior Authorization is denied for a prescription drug, with the exception of the 72-hour emergency supply or a step therapy exception request made by a Provider;
- When coverage of a prescription drug or service is denied because it is not covered by SoonerCare;
- When coverage of a prescription drug is denied because the Health Plan Enrollee has been locked-in in accordance with Section 1.8.6: "Lock-In Program" of this Model Contract; or
- When a Provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

1.16.6.2 Duration of Continued or Reinstated Benefits

If the Contractor continues or reinstates the Health Plan Enrollee's benefits at the Health Plan Enrollee's request while the Appeal or State Fair Hearing is pending, the benefits must be continued until one of following occurs:

- The Health Plan Enrollee withdraws the Appeal or request for State Fair Hearing;
- The Health Plan Enrollee fails to request a State Fair Hearing and continuation of benefits within ten Calendar Days after the Contractor sends the notice of an adverse resolution to the Health Plan Enrollee's Appeal under 42 C.F.R. § 438.408(d)(2); or
- A State Fair Hearing officer issues a hearing decision adverse to the Health Plan Enrollee.

1.16.7 Contractor Recovery

The Contractor may, in accordance with 42 C.F.R. § 438.420(d), recover from the Health Plan Enrollee costs of services furnished to the Health Plan Enrollee while an Appeal or State Fair Hearing was pending, to the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420

or § 431.230(b) and the final resolution of the Appeal or State Fair Hearing upholds the Contractor's Adverse Benefit Determination.

1.16.8 Effectuation of Reversed Health Plan Enrollee Appeal Resolutions

1.16.8.1 Authorization of Services Not Furnished While Health Plan Enrollee Appeal is Pending

In accordance with 42 C.F.R. § 438.424(a), when services are not furnished to the Health Plan Enrollee while the Health Plan Enrollee's Appeal or State Fair Hearing is pending, and the Contractor or State Fair Hearing officer reverses the decision to deny, limit or delay services, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Health Plan Enrollee's health condition requires. This shall be no later than 72 hours from the date the Contractor receives notice reversing the initial determination to deny, limit or delay the services.

1.16.8.2 Payment for Services Furnished While Health Plan Enrollee Appeal is Pending

In accordance with 42 C.F.R. § 438.424(b), the Contractor shall pay for disputed services received by the Health Plan Enrollee while the Health Plan Enrollee's Appeal or State Fair Hearing was pending and the Contractor or State Fair Hearing officer reverses the initial decision to deny authorization of the services. Payment shall be made in accordance with the terms of this Model Contract.

1.17 Cost Sharing

1.17.1 Compliance with State Plan Requirements

Any Cost Sharing imposed by the Contractor shall be in accordance with Medicaid FFS requirements as outlined in OHCA State Plan and 42 C.F.R. §§ 447.50 through 447.56.

1.17.2 Cost Sharing Exempt Populations

The Contractor shall not impose premiums on any Health Plan Enrollees. In accordance with 42 C.F.R. § 447.56, the Contractor shall not impose Cost Sharing upon any of the following:

- Health Plan Enrollees under age 21;
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in Foster Care and individuals receiving benefits under Part E of that title, without regard to age;
- Pregnant Women for Pregnancy-Related Services during the pregnancy and through the 60-day postpartum period;
- Any Health Plan Enrollee whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;
- Health Plan Enrollees receiving hospice care, as defined in section 1905(o) of the Act;
- An AI/AN Health Plan Enrollee who is eligible to receive or has received an item or service furnished by an IHCP or through referral under purchase and referred care is exempt from premiums. AI/AN Health Plan Enrollees who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under purchase and referred care are exempt from all Cost Sharing; and
- Health Plan Enrollees receiving Medicaid due to a diagnosis of breast or cervical cancer in accordance with 42 C.F.R. § 435.213.

1.17.3 Cost Sharing Exempt Services

In accordance with 42 C.F.R. § 447.56, the Contractor shall implement processes to ensure Cost Sharing is not imposed on any of the following services:

- Emergency Services;
- Family Planning Services and Supplies;
- Preventive Services, which includes, at minimum the services specified at 42 C.F.R. § 457.520 provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics;
- Pregnancy-Related Services; and
- Provider-Preventable Services.

1.17.4 Claims Payment Reductions

The Contractor shall reduce the payment made to a Provider by the amount of the Health Plan Enrollee's Cost Sharing obligation, regardless of whether the Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, the Contractor shall not reduce payments to Providers, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing.

1.17.5 Five Percent Cost Sharing Limit

In accordance with 42 C.F.R. § 447.56(f), Health Plan Enrollee's total Cost Sharing shall not exceed five percent of the Health Plan Enrollee's household income applied on a monthly basis. The Contractor shall report Health Plan Enrollee Cost Sharing to the MMIS according to a process defined by OHCA. The MMIS will aggregate the Contractor's Cost Sharing data with household Cost Sharing and Health Plan Enrollee Cost Sharing incurred for any Excluded Benefits and will notify the Contractor via the ANSI ASC X 12 834 electronic transaction when a Health Plan Enrollee has met the five percent aggregate limit. Upon receipt of the ANSI ASC X 12 834 electronic transaction, the Contractor shall ensure that Copayments are not deducted from Provider claims reimbursement through the end of the month. The Contractor shall notify the Health Plan Enrollee and Providers when the aggregate limit has been met and that Cost Sharing will not apply for the remainder of the month. The Contractor shall reinstate Health Plan Enrollee Cost Sharing effective the first of the following month for any Health Plan Enrollees who exceeded the aggregate limit in the previous month.

1.18 Program Integrity

1.18.1 General Program Integrity and Compliance Requirements

The Contractor and its Subcontractors shall comply with all State and federal laws and regulations related to program integrity, compliance and disclosure requirements. This includes all current State and federal laws and regulations as well as any future laws and regulations that may be required.

1.18.1.1 Administrative and Management Arrangements and Procedures

The Contractor and its Subcontractors shall implement and maintain administrative and management arrangements or procedures that are designed to detect and prevent Fraud, Waste and Abuse. The Contractor's Fraud, Waste and Abuse policies and procedures shall be coordinated with those of OHCA's Program Integrity and Accountability Unit. In accordance with 42 C.F.R. § 438.608(a), the arrangements, policies and procedures must include, but not be limited to, the following, as further detailed in this Section 1.18 of this Contract:

- A compliance program, as described in Section 1.18.2: "Compliance Program" of this Model Contract;

- Prompt referral of any potential Fraud, Waste or Abuse to OHCA’s Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA, as described in Section 1.18.1.2: “Referral to OHCA Program Integrity and Accountability Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)” of this Model Contract;
- Prompt notification to OHCA regarding changes in a Health Plan Enrollee’s circumstances that may affect SoonerSelect program eligibility, as described in Section 1.18.3.1: “Reporting Health Plan Enrollee Changes in Circumstance” of this Model Contract;
- Notification to OHCA regarding changes in a Provider’s circumstances that may affect SoonerSelect program eligibility, as described in Section 1.18.3.2: “Reporting Provider Changes in Circumstance” of this Model Contract;
- Method to verify Health Plan Enrollees’ receipt of covered services, as described in Section 1.18.4: “Verifying Delivery of Services” of this Model Contract;
- Written policies and procedures to prevent Fraud, Waste and Abuse and employee whistleblower protections, as described in Section 1.18.5: “False Claims Act Policies and Whistleblower Protection” of this Model Contract;
- Prompt reporting of all Overpayments, as described in Section 1.18.6: “Reporting Overpayments” of this Model Contract; and
- Suspending payments to Participating Providers where there is a credible allegation of Fraud, as described in Section 1.18.7: “Suspension of Payments for Credible Allegation of Fraud” of this Model Contract.

1.18.1.2 Referral to OHCA Program Integrity and Accountability Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)

In accordance with 42 C.F.R. § 438.608(a)(7), the Contractor shall make a prompt referral of any potential Fraud, Waste, or Abuse that the Contractor, or a Subcontractor to the extent that a Subcontractor is delegated responsibility for coverage of services and payment of claims, identifies to OHCA’s Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA. The referral shall be made within three Business Days of the Contractor’s identification of the activity at issue.

1.18.1.3 Collaboration with OHCA and MFCU

The Contractor shall collaborate with the Oklahoma Medicaid Fraud Control Unit (MFCU) and OHCA as necessary to ensure integrity of the SoonerSelect program. At minimum, the Contractor shall:

- Participate in good faith at monthly program integrity meetings held jointly with the MFCU and OHCA;
- Provide responses to specific requests made by the MFCU within three Business Days of receipt of the request; and
- Provide the MFCU access to the Contractor’s claims payment data and other applicable records.

OHCA reserves the right to amend these requirements or timeframes as necessary to address program integrity concerns identified by OHCA, MFCU or the Contractor.

1.18.1.4 Audit Requirements and Provider Rights

The Contractor shall cooperate in any audit activity performed by OHCA, the OHCA’s Program Integrity and Accountability Unit, Medicaid recovery audit contractor, CMS and/or Payment Error Rate Management and CMS audit Medicaid integrity contractors. The Contractor, its Subcontractors and Participating Providers shall, upon request, make available any and all administrative, financial and

medical records relating to the delivery of items or services for which State or federal monies are expended, unless otherwise provided by law.

Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2.

1.18.2 Compliance Program

In accordance with 42 C.F.R. § 438.608(a)(1)(i)-(vii) and OHCA policy, the Contractor, as well as its Subcontractors that are delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall have a compliance program that includes, at minimum, all of the following elements:

- Written policies, procedures and standards of conduct that articulate the Contractor or Subcontractor's commitment to comply with all applicable requirements and standards under this Contract and all applicable State and federal requirements;
- The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Chief Executive Officer and the Board of Directors;
- The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor or Subcontractor's compliance program and its compliance with requirements under this Model Contract;
- At a minimum, the Contractor shall utilize a full-time, single Lead Investigator based in Oklahoma to identify risk and guard against Fraud, Waste and Abuse, monitor aberrant Providers, and refer potential Fraud, Waste and Abuse to OHCA by conducting Fraud, Waste and Abuse investigations, and preparing investigatory reports.
 - The Lead Investigator shall be dedicated solely to OHCA program integrity work and meet the following qualifications:
 - A minimum of two years in health care field working in Fraud, Waste and Abuse investigations and audits;
 - A Bachelor's degree or an Associate's degree with an additional two years working in health care Fraud, Waste and Abuse investigations and audits. OHCA will accept experience and certifications commensurate with the educational requirements. OHCA will evaluate the experience and certifications in lieu of educational requirements; and
 - Ability to understand and analyze health care claims and coding.
 - The Lead Investigator shall collaborate with the OHCA Program Integrity and Accountability Unit and OHCA Legal Unit in areas such as Fraud referrals, audits and investigations, overpayments, Provider terminations, as well as attend any required meetings as prescribed by OHCA, including, but not limited to, OHCA's monthly Program Integrity meeting with MFCU.
 - In addition to the Lead Investigator, the Contractor shall, at a minimum, utilize one full-time investigator for every 75,000 SoonerSelect program Health Plan Enrollees. These investigators shall be based in Oklahoma to identify risk and guard against Fraud, Waste and Abuse, monitor aberrant Providers, and refer potential Fraud, Waste and Abuse to

OHCA by conducting Fraud, Waste and Abuse investigations, and preparing investigatory reports;

- A system for training and education for the Compliance Officer and Lead Investigator, the organization's senior management and the organization's employees for the State and federal standards and requirements under this Contract, as described in Section 1.18.2.2: "Compliance Education and Training" of this Model Contract;
- Effective lines of communication between the Compliance Officer and the organization's employees;
- Enforcement of standards through well-publicized disciplinary guidelines; and
- The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract;
- The establishment and implementation of procedures for proactive specific controls in place to detect Fraud, Waste and Abuse and erroneous payments, including review of Provider records and technology used to identify:
 - Aberrant billing patterns,
 - Pre/post-payment claims edits,
 - Post-processing review of claims,
 - Provider profiling and credentialing used to aid program and payment integrity reviews,
 - Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of covered services,
 - Provisions in Subcontractor and Provider Agreements that ensure integrity of Provider credentials, and
 - Health Plan Enrollee record reviews;
- The establishment of policies and procedures for reporting all allegations of Fraud, Waste and Abuse to the OHCA's Program Integrity and Accountability Unit and Legal Unit, in writing using a form as prescribed by OHCA, including:
 - Designating the Contractor's staff members responsible for reporting Fraud to the OHCA's Program Integrity and Accountability Unit,
 - Providing a process for timely, complete and consistent exchange of information and collaboration with the OHCA's Program Integrity and Accountability Unit, designated agents and contracted EQRO;
- The development of policies and implementation of a process to:
 - Timely suspend all Provider payments, as outlined in Section 1.18.7: "Suspension of Payments for Credible Allegation of Fraud" of this Model Contract, when notified by the OHCA Legal Unit and other State/federal agencies to suspend payments because of credible allegation(s) of Fraud,

- Comply with requests from the OHCA Program Integrity and Accountability Unit, OHCA Legal Unit and other State/federal agencies to access and receive copies of any records kept by the Contractor;
- Staff that are qualified and adequate in number and training to effectively monitor this Contract;
- Development and implementation of a process for the confidential reporting of Contractor violations, including:
 - Hotline and/or electronic method for reporting violations, as described in Section 1.18.2.3: “Compliance Hotline” of this Model Contract;
 - Designation of an individual to receive reports of violations;
 - Independent reporting paths for the reporting of violations so that such reports cannot be diverted by any supervisors or other personnel;
- Establishment of protections to ensure that:
 - No individual who reports cases or suspected cases of a program integrity violation, Fraud, Waste or Abuse is retaliated against by anyone who is employed by or contracted with the Contractor,
 - The identity of the individual(s) reporting violations or suspected violations be kept confidential to the extent possible;
- Development and implementation of an internal and external process for conducting investigations and follow-up of any suspected or confirmed Fraud, Waste or Abuse or compliance violations;
- Coordination with OHCA and other MCOs contracted with OHCA on proactive detection of Fraud, Waste and Abuse and erroneous payments, including:
 - Providing a monthly and quarterly list of audit activities to OHCA, in writing in a form as prescribed by OHCA, in order to reduce or prevent overlap;
 - Participating in monthly meetings with OHCA Program Integrity and Accountability Unit to discuss all active referrals, investigations and audits;
 - Reporting audit activities and audit outcomes to OHCA in order to facilitate OHCA follow-up on the audit activity as needed;
 - Timely correspondence necessary with MCOs contracted with OHCA as directed by OHCA to prevent or detect potential Fraud, Waste, or Abuse of Medicaid funds under the SoonerSelect program; and
 - Monthly check for exclusions of the Contractor’s employees, owners and agents and database to capture identifiable information.

1.18.2.1 Compliance Plan

The Contractor shall have a written compliance plan that addresses, at minimum, the items described in Section 1.18.2: “Compliance Program” of this Model Contract. The Contractor shall submit a copy of the compliance plan to the OHCA’s Program Integrity and Accountability Unit for review and approval a minimum of 60 days prior to the Contract start date and annually thereafter by July 1st. The initial compliance plan must be approved by the OHCA’s Program Integrity and Accountability Unit prior to implementation by the Contractor.

The Contractor shall submit any request(s) for revision(s) to the compliance plan for review to the OHCA's Program Integrity and Accountability Unit a minimum of 60 days prior to the requested implementation date of the revision(s). Revisions must be approved by the OHCA's Program Integrity and Accountability Unit prior to implementation by the Contractor.

1.18.2.2 Compliance Education and Training

The Contractor shall educate and train all employees, including management, and any Subcontractors/agents about:

- Provisions of 42 C.F.R. § 438.610 regarding prohibited Contractor affiliations and all relevant State and federal laws, regulations, policies procedures and guidance, including updates and amendments to these documents or any such standards;
- The Contractor's compliance program, as described in Section 1.18.2: "Compliance Program" of this Model Contract;
- The Contractor's code of conduct; and
- Privacy and security, including but not limited to HIPAA.

The Contractor shall conduct training for new hires within 30 days of employment and conduct training annually for all employees. The Contractor shall maintain evidence of completed education and training efforts. The Contractor shall provide such evidence upon request by OHCA.

1.18.2.3 Compliance Hotline

The Contractor shall maintain a toll-free compliance hotline number. The Contractor's hotline and OHCA's hotline shall be accessible by employees, Subcontractors/agents, Participating Providers and Health Plan Enrollees to report compliance concerns, including suspected Fraud, Waste and Abuse. The Contractor shall ensure that the Contractor's hotline number and OHCA's hotline number, as well as an explanatory statement, are distributed to its employees, Subcontractors/agents, Participating Providers and staff.

1.18.3 **Reporting Changes in Circumstance**

1.18.3.1 Reporting Health Plan Enrollee Changes in Circumstance

The Contractor shall promptly notify OHCA, in a notification manner approved by OHCA, when the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, receives information about changes in a Health Plan Enrollee's circumstances that may affect the Health Plan Enrollee's SoonerSelect program eligibility, in accordance with 42 § C.F.R. 438.608(a)(3) and in accordance with the provisions of Section 1.5.8: "Health Plan Enrollee Status Changes" of this Model Contract. Changes required to be promptly reported include, at minimum, all of the following:

- Changes in the Health Plan Enrollee's residence or notification of the Health Plan Enrollee's mail that is returned as undeliverable; and
- Death of the Health Plan Enrollee.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within five Business Days of the Contractor's receipt of the information.

1.18.3.2 Reporting Provider Changes in Circumstance

In accordance with 42 C.F.R. § 438.608(a)(4), the Contractor shall promptly notify OHCA, in a notification manner approved by OHCA, when the Contractor, or its Subcontractor to the extent the Subcontractor is

delegated responsibility for coverage of services and payment of claims, receives information about a change in a Provider's circumstances that may affect the Provider's eligibility to participate in the SoonerSelect program, including termination of the Provider Agreement with the Contractor.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three Business Days of the Contractor's receipt of the information. The Contractor shall provide the information required under this Section inclusive of, at minimum, the Provider's name, address and NPI to an OHCA designated email.

1.18.4 Verifying Delivery of Services

1.18.4.1 General Requirement

In accordance with 42 C.F.R. § 438.608(a)(5), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall have a method to verify whether services that have been represented to have been delivered by Participating Providers were actually received by Health Plan Enrollees. The Contractor may conduct verification by telephone, electronic correspondence or writing. The Contractor shall report the results of this monitoring to OHCA on a quarterly basis in a manner prescribed by OHCA.

1.18.4.2 Explanation of Benefits (EOBs)

The Contractor shall develop and distribute EOBs to verify the delivery of services consistent with the requirements of 42 C.F.R. § 438.608(a)(5). The EOBs shall be distributed using a methodology approved by OHCA that ensures all services and Provider types are sampled regularly.

The EOB developed and distributed by the Contractor shall conform to all requirements of 42 C.F.R. §§ 455.20 and 433.116. The Contractor shall ensure that EOBs are accessible electronically via the Health Plan Enrollee Portal as set forth at Section 1.11.6.3: "Health Plan Enrollee Website Portal" of this Model Contract and shall also ensure telephonic, written or other electronic EOB access for Health Plan Enrollees unable to access the Health Plan Enrollee Portal. The EOB should list the services delivered, name of the Provider claiming the service, date on which it was claimed to have been delivered, service location and amount of payment. A Health Plan Enrollee shall be instructed to call the listed phone number if the services are incorrect. In the event the Contractor receives notice from a Health Plan Enrollee that services listed on the EOB were not received, the Contractor shall follow the requirements of this Section 1.18: "Program Integrity" to determine if referral due to potential Fraud is necessary.

The Contractor shall oversample if a specific service or class of provider justifies closer oversight.

1.18.5 False Claims Act Policies and Whistleblower Protection

In accordance with 42 C.F.R. § 438.608(a)(6), the Contractor shall establish and implement written policies for all employees, including management, and any Subcontractor or agent of the Contractor's that provide detailed information about preventing and detecting Fraud, Waste and Abuse in federal health care programs. This information shall include, at minimum:

- The False Claims Act;
- Other federal and state laws described in § 1902(a)(68) of the Act and 42 U.S.C. 1396a;
- Administrative remedies for false claims and statements;
- State laws pertaining to civil or criminal penalties for false claims and statements, including 63 O.S. § 5053 through 63 O.S. § 5054;

- Whistleblower protection under such laws, including the rights of employees to be protected as whistleblowers; and
- The Contractor's policies and procedures for detecting and preventing Fraud, Waste and Abuse.

In addition, the Contractor shall include this information in its employee handbook. These policies shall be made available to OHCA upon request and reviewed during Readiness Review.

1.18.6 Reporting Overpayments

In accordance with 42 C.F.R. § 438.608(a)(2), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall promptly report all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, to OHCA in a manner and format to be specified by OHCA.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three Business Days of the Contractor's identification or recovery of the Overpayment.

1.18.7 Suspension of Payments for Credible Allegation of Fraud

The Contractor, or its Subcontractor, to the extent the Subcontractor is delegated claims payment responsibility, shall timely suspend payments to a Participating Provider for which OHCA determines there is a credible allegation of Fraud in accordance with 42 C.F.R. §§ 438.608(a)(8) and 455.23. OHCA shall determine whether payments should be suspended or if an exception is appropriate. OHCA shall notify the Contractor of payment suspensions, and the Contractor must then immediately suspend further payments to the Provider. The Contractor must ensure that no Medicaid dollars are received by a Provider whose payments have been suspended or that has been terminated by OHCA.

After a credible allegation of Fraud, unless prior written approval is obtained from OHCA, the Contractor may not take any of the following actions:

- Contact the subject of the investigation concerning any matter related to the investigation;
- Institute any interventions, sanctions or remedial procedures toward the subject of the investigation, including but not limited to hearings, suspension or termination;
- Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the Provider;
- File any civil action based upon the suspected Fraud against the subject of the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the suspected Fraud;
- or
- Accept any money or other thing of value offered by the subject of the investigation in connection with suspected Fraud.

If the Contractor thinks that it is appropriate to initiate a recoupment or withholding action against a Provider under these circumstances, the Contractor shall consult with OHCA and the OHCA's Program Integrity and Accountability Unit to ensure whether such action is permissible. In the event that the Contractor obtains funds from an action when recoupment or withholding is prohibited, the Contractor shall return the funds to the Provider.

1.18.8 Provider Screening and Enrollment

In accordance with 42 C.F.R. § 438.608(b), the Contractor shall ensure that all of the Contractor's Participating Providers are enrolled with OHCA as a Medicaid Provider and periodically revalidated

consistent with the Provider disclosure, screening and enrollment requirements of 42 C.F.R. §§ 438.602, 455.100-106 and 455.400 - 470.

1.18.9 **Written Disclosures**

The Contractor shall submit the following disclosures and reports, as set forth at 42 C.F.R. § 438.608(c):

- Written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610, as detailed in Section 1.18.10: “Prohibited Affiliations and Exclusions” of this Model Contract;
- Written disclosures of information on ownership and control required under 42 C.F.R. § 455.104, as detailed in Section 1.18.9.1: “Required Ownership, Controlling Interest and Managing Employee Disclosures” of this Model Contract;
- Report to OHCA within 30 Calendar Days when the Contractor has identified the Capitation Payments or other payments in excess of amounts specified in this Contract, as detailed in Section 1.2.3: “Report of Capitation Overpayment” of this Model Contract.

1.18.9.1 Required Ownership, Controlling Interest and Managing Employee Disclosures

In accordance with the requirements at 42 C.F.R. §§ 438.604(a)(6), 438.608(c)(2) and 455.104, the Contractor shall submit to OHCA the following information:

- The name of any Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- The address of a Person with an Ownership or Control Interest in the Contractor or its Subcontractors, which, for corporations shall include, as applicable, the following:
 - Primary business address,
 - Every business location, and
 - Post Office box address;
- The date of birth of any individual Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- The Social Security Number of any individual Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- Other tax identification number of any corporate Person with an Ownership or Control Interest in the Contractor or its Subcontractors;
- Tax identification number of any Subcontractor in which the Contractor has a five percent or more interest;
- Information on whether a Person with an Ownership or Control Interest in any Subcontractor in which the Contractor has a five percent or more interest is related to another Person with Ownership or Control interest in the Contractor as a spouse, parent, child, or sibling;
- The name of any Other Disclosing Entity in which an owner of the Contractor is a Person with an Ownership or Control Interest; and
- The name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

1.18.9.1.1 Persons with an Ownership or Control Interest

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2) and 455.100-455.104, as well as §§ 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Act, the Contractor and its Subcontractors shall disclose to OHCA, and OHCA shall review the submitted disclosures, any Persons with an Ownership or Control Interest in the Contractor that:

- Has a Direct Ownership Interest, Indirect Ownership Interest, or any other Ownership Interest of five percent or more of the Contractor's equity;
- Owns five percent or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent of the value of the Contractor's assets;
- Is an officer or director of the Contractor if the Contractor is organized as a corporation;
- Is a partner in the Contractor if the Contractor is organized as a partnership; or
- Is a member or manager of the Contractor if the Contractor is organized as a limited liability company.

1.18.9.1.2 When Disclosures of Persons with An Ownership or Control Interest Are Required

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2), 455.100-455.103 and 42 C.F.R. 455.104(c)(3), as well as §§ 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Act, the Contractor and its Subcontractors shall make the disclosures required in Section 1.18.9.1: "Required Ownership, Controlling Interest and Managing Employee Disclosures" of this Model Contract at the following times:

- When the Contractor submits a Proposal in accordance with the State's procurement process;
- When the Provider or Disclosing Entity submits a Provider application;
- When the Provider or Disclosing Entity executes a Provider Agreement with OHCA;
- Upon request of the State during revalidation of Provider enrollment;
- When the Contractor executes a Contract with OHCA;
- When OHCA renews or extends this Contract; and
- Within 35 days after any change in ownership of the Contractor or of the Disclosing Entity.

1.18.10 Prohibited Affiliations and Exclusions

1.18.10.1 Providers Excluded from Participation in Federal Health Care Programs

The Contractor, in accordance with 42 C.F.R. § 438.214(d)(1), shall not employ or contract with Providers excluded from participation in federal health care programs.

1.18.10.2 Sanctioned Individual

The Contractor shall not allow a sanctioned individual under § 1128(b)(8) of the Act to have Control Interest in the Contractor, in accordance with 42 C.F.R. § 438.808 and § 1903(i)(2) of the Act.

1.18.10.3 Other Prohibited Affiliations

The Contractor:

- Shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly:
 - with an individual convicted of crimes described in § 1128(b)(8)(B) of the Act, in accordance with 42 C.F.R. § 438.808(a), 438.808(b)(2) and § 1903(i)(2) of the Act;
 - with any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), 438.610(a) and § 1903(i)(2) of the Act; or

- with any individual or entity that is excluded from participation in any Federal health care program under § 1128 or 1128A of the Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2) 438.610(b) and 1903(i)(2) of the Act.
- Shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services:
 - with any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is, debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), 438.610(a) and § 1903(i)(2) of the Act; or
 - with any individual or entity that is excluded, or would provide those services through an individual or entity who is excluded, from participation in any Federal health care program under § 1128 or 1128A of the Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), 438.610(b), and § 1903(i)(2) of the Act.

1.18.10.4 Written Disclosure

In accordance with 42 C.F.R. § 438.608(c), the Contractor shall provide written disclosure of all prohibited relationships between the Contractor and any individual, entity or Affiliate identified in Section 1.18.10: “Prohibited Affiliations and Exclusions” of this Model Contract.

1.18.10.5 State Identification of Prohibited Relationships

In accordance with 42 C.F.R. § 438.610(d), if OHCA finds that the Contractor is not in compliance with the requirements for prohibited affiliations at 42 C.F.R. § 438.610(a)-(c), set forth in this Section of the Contract, OHCA shall notify the Secretary of DHHS of the Contractor’s noncompliance. OHCA may continue an existing agreement with the Contractor unless the Secretary directs otherwise. OHCA shall not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary of DHHS provides to OHCA and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the Contractor’s prohibited affiliations.

1.18.11 **Overpayments to Providers**

1.18.11.1 Treatment of Recoveries Made by Contractor of Overpayments to Providers

The Contractor shall provide the following policies, procedures, timelines and documentation to OHCA prior to the Contractor’s Readiness Review:

- Retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste or Abuse;
- The process, timeframes and documentation required for reporting the recovery of all Overpayments; and
- The process, timeframes and documentation required for payment of recoveries of Overpayments to OHCA in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

This Subsection does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

If an Overpayment to a Provider made by the Contractor is identified by OHCA rather than by the Contractor, OHCA may recover the Overpayment directly from the Provider, or OHCA may require the Contractor to recover and send the Overpayment to OHCA as directed by the OHCA Program Integrity and Accountability Unit.

If a Fraud referral from the Contractor generates an investigation and/or legal action results in a recovery, the Contractor will be entitled to share in recovery following final resolution of the action (settlement agreement/final court judgment) and payment of recovered funds to OHCA. The State shall retain its costs of pursuing the action and its actual documented loss. The State will pay the remainder of the recovery, not to exceed the Contractor's actual documented loss, to the Contractor. If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the settlement. If final resolution of a matter does not occur until after this Contract has expired, these policies shall survive expiration.

If OHCA makes a recovery where the Contractor has sustained a documented loss, but the case did not result from a referral made by the Contractor, OHCA shall not be obligated to repay any monies recovered to the Contractor, but may do so at its discretion.

1.18.11.2 Overpayment Reporting Mechanism for Participating Providers

In accordance with 42 C.F.R. § 438.608(d)(2), the Contractor shall have a mechanism for a Participating Provider to report to the Contractor when the Participating Provider has received an Overpayment, to return the Overpayment to the Contractor within 30 days after the date on which the Overpayment was identified and to notify the Contractor in writing of the reason for the Overpayment. The Contractor shall require Participating Providers to use this reporting mechanism.

1.18.12 Fraudulent or Abusive Health Plan Enrollee Conduct

Fraudulent or abusive Health Plan Enrollee conduct may include, but is not limited to, the following:

- Overutilization, such as:
 - Concurrently obtaining services from two or more Providers of the same specialty, not in the same group practice, with no referrals;
 - Using two or more emergency facilities for non-emergent diagnosis;
 - Concurrently using two or more prescribing physicians to obtain drugs from the same therapeutic class of medication;
 - Two or more occurrences of having prescriptions for the same therapeutic class of medication filled two or more times on the same or subsequent day by the same or different Providers; or
 - Concurrently using two or more pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer's maximum recommended dosage as approved by the Food and Drug Administration (FDA);
- Fraud, such as:
 - Purchasing drugs on a forged prescription;

- Loaning the Health Plan Enrollee’s SoonerSelect card to another individual to obtain Medicaid-reimbursed services; and
- Engaging in threatening or abusive conduct to Providers.

Health Plan Enrollees may be identified through utilization management, chart review or by referral from Participating Providers. The Contractor shall notify OHCA of Health Plan Enrollees who have been identified as participating in fraudulent or abusive conduct within three Business Days of the Contractor identifying or being informed of the Health Plan Enrollee’s conduct.

The Contractor shall also take additional steps in accordance with OHCA’s guidance. OHCA shall work with the Contractor and the Health Plan Enrollee based on the specific circumstances of the fraudulent or abusive activity.

The Contractor, with OHCA’s approval, shall provide the Health Plan Enrollee with written notification and supporting documentation of the identified fraudulent or abusive behavior. The Contractor shall provide education to the Health Plan Enrollee regarding the Health Plan Enrollee’s behavior. The Contractor shall document all efforts.

The Contractor may request initiation of Disenrollment of Health Plan Enrollees for fraudulent behavior in accordance with the provisions of Section 1.5.7.1: “Contractor Request” of this Model Contract.

1.18.13 Transactions with Parties in Interest

1.18.13.1 Reporting Transactions

In accordance with §1903(m)(4)(A) of the Act, the Contractor shall report to OHCA and, upon request, to the Secretary of DHHS, the Inspector General of DHHS, and the Comptroller General a description of transactions between the Contractor and a Party in Interest, as defined in §1318(b) of the Public Health Service Act, (Party in Interest) the following transactions:

- Sale or exchange, or leasing of any property between the Contractor and a Party in Interest;
- Furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a Party in Interest, not including salaries paid by the Contractor to employees for services provided in the normal course of employment; and
- Lending of money or an extension of credit between the Contractor and any Party in Interest.

1.18.13.2 Availability of Reports

In accordance with § 1903(m)(4)(B) of the Act, the Contractor shall make any reports of transactions identified in Section 1.18.13.1: “Reporting Transactions” of this Model Contract between the Contractor and Parties in Interest that are provided to OHCA, the Secretary, the Inspector General of DHHS, or the Comptroller General or other agencies available to Health Plan Enrollees upon reasonable request.

1.19 Information Technology

1.19.1 General Requirements

The Contractor shall maintain a management information system in full compliance with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), requirements set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH) in 42 U.S.C. 17931, § 6504(a) of the Affordable Care Act and all other applicable state and federal laws and regulations.

In accordance with 42 C.F.R. § 438.242, the Contractor's management information system shall collect, analyze, integrate and report data as set forth in this Contract. The Contractor shall make all information and data collected by the Contractor's management information system available (in usable format as specified) to OHCA and, upon request, to CMS, in accordance with 42 C.F.R. § 438.242(b)(4). Pursuant to 42 C.F.R. § 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act, which requires the state claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of the Act.

At minimum, the Contractor's management information system shall:

- Collect data on Health Plan Enrollee and Provider characteristics as specified in Section 1.19 and any subsequent OHCA requirements, and on all services furnished to Health Plan Enrollees through an Encounter Data system, described in Section 1.19.4: "Health Plan Enrollee Encounter Data" of this Model Contract;
- Ensure that data received from Providers is accurate and complete by:
 - Verifying the accuracy and timeliness of reported data, including data from Participating Providers the Contractor is compensating on the basis of capitation payments;
 - Screening the data for completeness, logic, and consistency; and
 - Collecting data from Participating Providers in a standardized format or formats, to the extent feasible and appropriate, including secure information exchanges and technologies utilized for SoonerSelect program quality improvement and care coordination efforts.
- Implement an Application Programming Interface (API) as specified in 42 C.F.R. § 431.60 as if such requirements applied directly to Contractor and include all Encounter Data, including Encounter Data from any Participating Providers Contractor is compensating on the basis of capitation payments and adjudicated claims and Encounter Data from any Subcontractors.
- Implement and maintain a publicly accessible standards-based API described in 42 C.F.R. § 431.70, which must include all information specified in 42 C.F.R. § 438.10(h)(1) and (2).
- The Contractor shall conform to HIPAA-compliant standards for information exchange and demonstrate this capability at Readiness Review. Batch and online transaction types are as follows:
 - Batch transaction types:
 - ASC X12N 820 Premium Payment
 - ASC X12N 834 Benefit Enrollment and Maintenance
 - ASC X12N 835 Claims Payment Remittance Advice
 - ASC X12N 837I Health Care Claim: Institutional
 - ASC X12N 837P Health Care Claim: Professional
 - NCPDP D.0 Pharmacy Claim
 - Online transaction types:
 - ASC X12N 270/271 Eligibility Coverage or Benefit Inquiry/Response
 - ASC X12N 274 Healthcare Provider Information
 - ASC X12N 276/277 Health Care Claim Status Inquiry/Response
 - ASC X12N 278 Health Care Services Review Inquiry/Response
 - NCPDP D.0 Pharmacy Claim

As a part of its management information system solution, the Contractor shall provide for an electronic document management system, ensuring that documents received from Health Plan Enrollees or

Providers maintain logical relationships to certain key data such as Health Plan Enrollee identification and Provider identification numbers when the Contractor houses indexed images of documents used by Health Plan Enrollees and Providers to transact with the Contractor.

The Contractor shall also be required to demonstrate sufficient data analysis and ability to interface with OHCA systems. The Contractor shall ensure medical information will be kept confidential at all times, through security protocol, and with heightened sensitivity as data relates to personal identifiers and sensitive services.

The Contractor shall ensure that its management information system is compliant with any future State or federal regulations within the timeframe stipulated by the respective regulatory body. This includes, but is not limited to, all requirements for Medicaid Managed Care Plans from the “21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program” final rule (ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the Federal Register on May 1, 2020.

In accordance with 42 C.F.R. §438.242(c)(3), the Contractor shall collect and submit all data required for State T-MSIS reporting and other CMS required reporting.

1.19.1.1 Electronic Visit Verification Requirements

OHCA contracts with an Electronic Visit Verification (EVV) vendor to monitor services under this Contract including home health Services and State Plan Personal Care Services as detailed at Section 1.6.5: “State Plan Personal Care Services” of this Model Contract in accordance with §12006(a) of the 21st Century Cures Act. The Contractor shall contract with OHCA’s existing EVV vendor to continue the statewide EVV system to monitor Health Plan Enrollee receipt and utilization of home health services and State Plan Personal Care Services. The Contractor shall ensure that all Participating Providers who provide services subject to EVV are participating in the EVV system, unless granted an OHCA approved written exception.

The Contractor shall be responsible for any additional costs needed to support the Contractor’s operations or reporting capabilities related to EVV. The EVV vendor will interface daily with the Contractor and send claims in the electronic 837 claims format for processing. The Contractor, as a part of its claims processing system, shall ensure system functionality to comply with all requirements for EVV detailed in the EVV requirements of the 21st Century Cures Act, including, but not limited to, the ability to:

- Log the arrival and departure of the Provider delivering the service;
- Verify, in accordance with business rules, that services are being delivered in the correct location (e.g., the Health Plan Enrollee’s home);
- Verify the identity of the individual Provider providing the service to the Health Plan Enrollee;
- Match services provided to a Health Plan Enrollee with services authorized in the Health Plan Enrollee’s Care Plan;
- Ensure that the Provider delivering the service is authorized to deliver such services; and
- Reconcile paid claims with service authorizations (PA), as applicable.

The Contractor shall monitor and use information from the EVV system to verify that services are provided as specified in the Health Plan Enrollee’s Care Plan; in accordance with the established schedule, including the amount, frequency, duration, and scope of each service; that services are provided by the authorized Provider; and to identify and immediately address service gaps, including, but not limited to late and

missed visits. The Contractor shall monitor services any time a Health Plan Enrollee is receiving services, including after the Contractor's regular business hours.

1.19.1.2 Care Management Requirements

The Contractor shall interface with the OHCA Care Management system to enable data sharing between OHCA and the Contractor for transition of care events or at the request of OHCA. The Contractor will provide bi-directional interface(s) with the OHCA Care Management system to share care management case data, continuity of care documents, and predictive analytics information. The interfaces shall utilize standard clinical and administrative data formats.

1.19.1.3 Ongoing Maintenance of IT Solutions

The Contractor shall maintain its management information system as reviewed and approved during the Readiness Review process described at Section 1.3.10: "Readiness Review" of this Model Contract during the life of this Model Contract. The Contractor shall timely correct any defects identified and will notify OHCA if the defects impact Provider or Health Plan Enrollee portals or any functionality that supports the delivery of Health Plan Enrollee or Provider services. The Contractor shall submit a report of such defect corrections to OHCA monthly, at minimum. During Readiness Review, the Contractor shall submit an IT Maintenance and Operations plan for OHCA review and approval.

The Contractor shall develop and maintain an IT Roadmap, which shall show any planned upgrades to any component of the IT solution proposed. The IT Roadmap shall be delivered to OHCA at a minimum twice per year. The Contractor shall notify OHCA at least 60 days in advance of: 1) any proposed release upgrades for any Commercial Off the Shelf (COTS) products in use; and 2) any changes to non-COTS products requiring custom coding to address a system issue or enhance existing system functionality. The notification shall include an impact statement including what the upgrade will provide and the risks associated with the implementation. OHCA reserves the right to require a delay of no more than 60 days in the implementation of any planned upgrades.

The Contractor shall participate in OHCA Information Technology Defect resolution meetings with OHCA-contracted MMIS vendor(s) as required by OHCA.

1.19.2 **Operations**

The Contractor's management information system shall integrate information and data components across the Contractor's operations, ensuring all data collection and exchange capabilities are in compliance with the requirements of 42 C.F.R. § 438.242.

The Contractor's management information system shall support all aspects of a managed care operation, which shall include modules/subsections that capture and provide information on the following operational areas, at minimum, as determined by OHCA and in accordance with 42 C.F.R. § 438.242(a):

- Health Plan Enrollee information, including:
 - Disenrollment for reasons other than the loss of Medicaid eligibility; and
 - Grievances and Appeals;
- Third Party Liability;
- Provider;
- Reference;
- Encounter processing;
- Claims processing;

- Financial;
- Care Management, specifically addressing data related to:
 - Health Risk Screenings;
 - Comprehensive assessments;
 - Medical history
 - Past and current Care Plans and Prior Authorizations;
 - Care management contacts and interventions; and
 - Reporting and analysis systems for medical management purposes.
- Utilization Management;
- Quality Improvement;
- Reporting; and
- Program Integrity.

The Contractor shall have the ability to process, receive and send data on these areas, and any other areas necessary for SoonerSelect program operations in a HIPAA-compliant format where applicable.

The Contractor's data management and records system shall have protocols for managing duplicative records for individual Health Plan Enrollees or specific SoonerSelect program populations.

In accordance with 42 C.F.R. § 438.242(b) and Section 1.19.1: "General Requirements" of this Model Contract, the Contractor shall ensure the accuracy and completeness of all data submitted to OHCA, including data from Participating Providers receiving compensation from the Contractor, and all data shall be screened for completeness, logic, consistency and be collected from Providers in standardized formats to the extent feasible and appropriate.

1.19.3 Communications with OHCA

The Contractor shall transmit all data directly to OHCA in accordance with 42 C.F.R. § 438.242. If the Contractor utilizes Subcontractors for services, the Contractor shall ensure all data from the Subcontractors is provided to the Contractor and the Contractor shall transmit the Subcontractors' data to OHCA in a format specified by OHCA. The Contractor's management information system shall be capable of utilizing formats specified by OHCA and shall be capable of sharing information directly with OHCA's systems. The Contractor shall be responsible for ensuring a working interface between OHCA's and the Contractor's system to facilitate exchange of relevant Health Plan Enrollee and Provider data.

The Contractor shall operate a functional email server that is compatible with the systems maintained by OHCA and OHCA's contracted fiscal agent. This server shall be capable of sending and receiving confidential encrypted messages.

The Contractor meet OHCA's security standards in all communication, including encryption of confidential data and materials.

1.19.4 Health Plan Enrollee Encounter Data

In accordance with the terms of this Contract, 42 C.F.R. § 438.242(c), and all applicable State and federal laws, the Contractor shall collect and maintain sufficient Health Plan Enrollee Encounter Data to identify the Provider who delivers any items(s) or service(s) to Health Plan Enrollees under this Contract. In accordance with 42 C.F.R. § 438.818(a)(1), the Contractor shall have a comprehensive automated and integrated Encounter Data system that complies with HIPAA standards and is capable of meeting the requirements in the subsections below.

1.19.4.1 Encounter Data Detail and Format

The Contractor shall submit complete, accurate and timely HIPAA-compliant Encounter Data in the level of detail and format to be specified by OHCA. The Contractor's Encounter Data shall be submitted to the State MMIS in the standard HIPAA transaction formats, including the ASC X12N 837 transaction formats (P – Professional, I – Institutional) and, for pharmacy services, in the NCPDP format. Contractor paid amounts shall be provided.

The Contractor shall collect, and submit to the State MMIS, Health Plan Enrollee service level Encounter Data for all covered, not covered, and denied services. Encounter data will include servicing Provider data.

The Contractor shall be held responsible for errors or noncompliance resulting from its actions or the actions of an agent authorized to act on its behalf for all submission of data including Encounter Data.

Encounter Data shall be certified and submitted in accordance with 42 C.F.R. § 438.606 and Section 1.21.1.3: "Certification Requirements" of this Model Contract. The Encounter Data shall include fully adjudicated claims from the previous seven days as well as any corrections from previous encounter submissions. OHCA reserves the right to alter the level of detail or format in which the Encounter Data is submitted. Should this occur, the Contractor shall comply with any such changes. The Contractor's Health Plan Enrollee Encounter Data submitted to OHCA shall meet all requirements and include all information that the State is required to report to CMS under 42 C.F.R. § 438.818 and shall be submitted to OHCA in the Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP) formats and the ASC X12N 835 format, as appropriate. Collection, maintenance, submission and specifications of Health Plan Enrollee Encounter Data shall be compliant with 42 C.F.R. § 438.242.

The Contractor and its Provider network shall accept and use the State assigned Provider IDs for Encounter Data submissions. The Contractor and its Provider network shall accept and use State eMPI/ Medicaid IDs for SoonerCare Eligibles. The Contractor will provide unique MCO identifiers for Encounter Data submission.

Specific to Drug Rebates, the Contractor must, in accordance with 42 C.F.R. § 438.3(s)(2) and § 1927(b)(1)(A) of the Act, report:

- Drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 30 Calendar Days after the end of each quarterly rebate period. Data will include drugs billed under the prescription drug program and physician administered drugs.
- Drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the Contractor.

Claims for drug products obtained and/or administered in an office/clinic or other non-institutional setting and processed via the Contractor's medical benefit shall contain a valid 11-digit NDC and all other necessary information, including HCPCS codes and appropriate billable units for the actual drug and quantity administered to allow for State submission of rebates for these products.

1.19.4.2 Timely Submission and Reconciliation

The Contractor shall require all Providers and any delegated Subcontractors to submit Encounter Data and claims data in sufficient detail to support detailed utilization tracking and financial reporting. The Contractor shall submit all Encounter Data to OHCA and the State HIE. The Contractor shall collect and

submit Encounter Data to the state HIE within three Business Days of adjudication. All adjusted encounters must be submitted within three Business Days of adjustment. OHCA reserves the right to alter the frequency of required data submission. Should this occur, the Contractor shall comply with any such changes.

The Encounter Data submitted by the Contractor to OHCA shall include the Encounter Data from all Subcontractors and be sufficient to determine which Provider provided a service(s) or item(s) to a Health Plan Enrollee. Data submitted regarding a Provider interaction shall include the appropriate NPI and service location code. Encounter Data shall be submitted for all of the following types of claims processed by the Contractor or Subcontractors:

- Paid;
- Denied;
- Corrected;
- Voided; and
- Zero dollars paid.

The Contractor shall submit Encounter Data for 100% of encounters within three Business Days of adjudication. This includes all claim types indicated in the immediately preceding paragraph.

1.19.4.3 OHCA Review of Encounter Data

In accordance with 42 C.F.R. § 438.242(d), OHCA shall review and validate that the Encounter Data collected, maintained, and submitted to OHCA by the Contractor meets the requirements of 42 C.F.R. § 438.242. If OHCA determines that the Contractor Encounter Data submission does not meet accuracy and completeness standards or is denied by OHCA for another reason, it shall require the Contractor to correct the Encounter Data and resubmit it to OHCA within 30 days. OHCA may audit the data for accuracy at any time. The Contractor shall support OHCA's Encounter Data Validation activities.

The Contractor acknowledges that complete and validated Encounter Data is critical for OHCA to meet CMS reporting and rate setting requirements. Contractor shall collaborate with OHCA and OHCA's designated technology vendor(s) to make adjustments to the Contractor's Encounter Data processing system to meet the requirements of the technology vendor(s).

1.19.4.4 Health Information Exchange

As required by OHCA, the Contractor shall participate in the State's designated health information exchange (HIE) initiatives for submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery in numerous ways, including: reducing medical errors; decreasing duplicative or unnecessary services; improving data quality for public health research; promoting population health management, reducing manual, labor-intensive monitoring and oversight; and reducing Fraud and Abuse.

The Contractor shall develop, implement and participate in health information technology (HIT) and data sharing initiatives in order to improve the quality, efficiency and safety of health care delivery in the State. The Contractor shall assign staff to participate in a technical workgroup as scheduled by OHCA and the State HIE vendor. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality, and completeness of the Encounter Data submission to the State HIE.

The Contractor shall be required to enter into data sharing agreements with any health information technology entity that the State enters into data sharing agreement with to operate the statewide HIE.

The Contractor's participation shall include bi-directional interfaces to gather and send clinical data to the HIE. The Contractor shall require its Providers with CMS certified Electronic Health Records (EHR) systems to connect to the State HIE for the purpose of bi-directional health data exchange. Providers who do not have a certified EHR shall be required to use the State HIE provider portal to query patient data for enhanced patient care.

If the Provider does not have an EHR, they must still sign a participation agreement with the State HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other Providers in their community of care.

The Contractor's Participating Providers shall sign a participation agreement with the State HIE within one month of contract signing. Providers shall engage with the State HIE for the purpose of connecting their EHR system to the HIE to share their patient electronic records. The ultimate objective is to facilitate improved care coordination resulting in higher quality care and better outcomes.

The Contractor's network hospitals, long term care facilities and emergency departments (EDs) shall be required to send electronic patient event notifications of a patient's admission, discharge, and/or transfer (ADT) to the state HIE. This will improve care coordination by allowing a receiving Provider, facility, or practitioner to reach out to the patient and deliver appropriate follow-up care in a timely manner.

The Contractor shall submit a monthly report to OHCA regarding Contractor's Provider network and Provider EHR, HIE connectivity status.

The Contractor shall be responsible for establishing connectivity to the Statewide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable State policies, standards and guidelines.

The Contractor shall collect, and submit to the State HIE, Health Plan Enrollee service level Encounter Data for all covered, not covered, and denied services. Encounter Data will include servicing Provider data as required by 42 C.F.R. § 242(c)(1). The Contractor's Encounter Data shall be submitted to the State HIE in the standard HIPAA transaction formats, including the ASC X12N 837 transaction formats (P – Professional, I – Institutional, and D – Dental) and, for pharmacy services, in the NCPDP format. Contractor paid amounts shall be provided.

The Contractor shall convert all information that enters its claims system via hard copy paper claims, or other proprietary formats, to Encounter Data to be submitted in the appropriate HIPAA-electronic compliant formats.

The Contractor and their network of Participating Providers shall accept and use the State assigned Provider IDs for Encounter Data submissions.

The Contractor and their network of Participating Providers shall accept and use State eMPI/ Medicaid IDs for SoonerCare Eligibles. The Contractor(s) will provide unique MCO identifiers for their Encounter Data submissions.

The Contractor shall collect and submit Encounter Data to the State HIE within three Business Days of adjudication. All adjusted encounters must be submitted within three Business Days of adjustment.

1.19.5 Enrollment Data

The Contractor shall maintain an eligibility and enrollment subsystem that is continuously updated with information both received from OHCA and received directly from a Health Plan Enrollee. This subsystem shall have the ability to interface with the Contractor's claims processing and care management systems and maintain information at a detail level to be specified by OHCA. The Contractor shall be responsible for verifying Health Plan Enrollee eligibility data and reconciling with Capitation Payments for each eligible Health Plan Enrollee. The Contractor shall reconcile its eligibility and capitation records monthly. OHCA shall determine the terms for reconciling eligibility and underpayments of capitation back to the Contractor. The Contractor shall be financially responsible for the Health Plan Enrollee's SoonerSelect program covered benefits that are the responsibility of the Contractor under this Contract if the Contractor receives either enrollment information or a Capitation Payment. OHCA reserves the right to alter the frequency of required eligibility and capitation record reconciliation. Should this occur, the Contractor shall comply with any such changes.

The Contractor shall accept enrollment data in electronic format, via secure file transfer protocol ("SFTP"), as directed by OHCA and as detailed in the OHCA Program Companion Guide – 834 Contractor Benefit Enrollment and Maintenance Transaction (834 Companion Guide), which shall be updated by OHCA or its designated third party MMIS vendor. OHCA reserves the right to amend the 834 Companion Guide. The Contractor shall be responsible for loading all eligibility information into its system within one Business Day of receipt.

The Contractor's database shall have the capability to identify an individual Health Plan Enrollee across multiple demographic and clinical data sets. The system must also be able to utilize a unique Oklahoma based Master Patient Index (MPI).

The Contractor shall develop and maintain policies and procedures to ensure the accuracy and completeness of the data submitted to OHCA. The Contractor shall continuously update the subsystem with data submitted by OHCA and the Health Plan Enrollee. OHCA reserves the right to audit data submitted by the Contractor for validity and completeness at any time. The Contractor shall screen the data for completeness, logic and consistency. The Contractor's system shall maintain audit trails for this purpose.

1.19.6 Preferred Drug List

OHCA shall make available a file of preferred drugs, prior authorized drugs, and drugs with step therapy on a monthly basis for the Contractor or the Subcontractor's use in processing prescription drug claims. This file shall be loaded by the Contractor or its Subcontractor for claims processing within 24 hours of receipt.

OHCA will develop a file of preferred physician-administered drugs for use by the Contractor or its Subcontractor in paying medical benefit drug claims.

1.19.7 State MAC List

OHCA will provide a Maximum Allowable Cost (MAC) file in a frequency to be determined by OHCA for use in processing prescription drug claims. This file shall be loaded by the Contractor or its Subcontractor for claims processing within 24 hours of receipt.

1.19.8 System Security

The Contractor shall maintain systems, policies and procedures that ensure State and federal standards for compliance and security are met and to protect the integrity of all business and technical components

of the Contractor's operations under this Model Contract. This includes, but is not limited to, a requirement that Contractor must comply with the most current version of the suite of documents entitled the Minimum Acceptable Risk Standards for Exchanges ("MARS-E"). Alternatively, Contractor agrees to implement and maintain standards that at all times meet or exceed the most current MARS-E requirements. For example NIST 800-53 rev 4 (moderate system) would meet the requirements of the current MARS-E. Contractor further agrees to maintain a level of security that is commensurate with the risk and magnitude of the harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest security levels. If at any time, Contractor plans to implement and maintain security standards other than MARS-E or the most current applicable NIST standards, Contractor must submit the specific details of the planned change to OHCA for approval not later than 60 days before the date of planned implementation. Contractor is prohibited from implementing different security standards that would reduce the level of protection provided or that would cause OHCA to fall out of compliance with any applicable laws, regulations, or requirements of government agencies with jurisdiction or enforcement authority over OHCA.

The Contractor shall ensure access to data systems is restricted by employing an access management function that restricts individual access to data in a tiered structure based on the security clearance of the individual accessing the data. The Contractor shall ensure access to information is based on job function with the overarching concept of access to information on the minimum basis required for adequate performance of the job function (e.g., users permitted inquiry privileges only will not be permitted to modify information if not applicable to the requirements of the job the individual is performing).

The Contractor shall ensure every point of data receipt and processing has appropriate security and data integrity protocols in place. The Contractor shall be responsible for providing physical safeguards to its data processing center, operations center and any related information or systems. These safeguards shall remain in place for the duration of the Contractor's relationship with OHCA. The Contractor shall grant authorized OHCA and CMS personnel and any designees access to its facilities upon request.

Contractor shall be maintain data online for no less than three years and shall retain additional archive history for no less than ten years, and the Contractor shall ensure such data is retrievable within 48 hours.

The Contractor shall provide OHCA with a list of all staff with access to identifying Health Plan Enrollee data upon request from OHCA.

The Contractor shall make available identifying Health Plan Enrollee data to authorized and designated State and federal employees and designees.

The Contractor shall immediately (in any event, not later than within one hour of Discovery) notify OHCA in the event of an information security breach, including unintentional security issues caused by the Contractor's employees. The Contractor shall maintain audit trails on individual Health Plan Enrollee documentation and have the ability to determine who has accessed or viewed a Health Plan Enrollee's personal medical information.

The Contractor shall abide by the current State of Oklahoma Security Standards at: <https://www.ok.gov/cio/documents/InfoSecPPG.pdf> and any updates thereto. Contractor recognizes that it may be necessary for OHCA to require Contractor to adhere additional or modified security standards which may be more stringent than the State of Oklahoma Security Standards, in order to maintain compliance with applicable laws, rules, regulations, legal requirements, and industry best

practices. In the event OHCA determines additional or modified security standards to be necessary, it will give Contractor at least 60 days advance written notice of any changes in requirements, and Contractor agrees to timely implement and comply with the same.

In addition, the Contractor shall complete and attest to meeting all Security Specifications in Form 8070001240-V-MCO Security Specifications located in the Bidder's Library. An annual SOC 2 Type II of the MCO system is required as is annual penetration testing of the system conducted by independent pen test practitioner. Contractor will provide copies of the annual SOC 2 Type II Report, all penetration testing reports, and any additional independent assessment or audit completed to attest to Contractor's security controls upon OHCA's request. The Contractor shall require Multi-Factor-Authentication (MFA) for all privileged users, defined as those users that have access to PHI across all of the Contractor's systems.

Contractor shall complete Form 8070001240-W-OMES Cloud Computing Certification located in the Bidder's Library, based on proposed system environment as a part of Proposal submission.

To the extent Contractor requests to use a third-party hosting vendor, that vendor is subject to OHCA's approval and must satisfactorily complete the State's Certification and Accreditation Review and any supplemental requests by OHCA. Contractor agrees not to migrate OHCA's data or otherwise utilize a different third-party hosting vendor in connection with key business functions that are Contractor's obligations under the Contract until OHCA approves the third-party hosting vendor's State Certification and Accreditation Review. In the event the third-party hosting vendor is not approved by OHCA, Contractor acknowledges and agrees it may not utilize such third-party vendor in connection with key business functions that are Contractor's obligations under the Contract, until such third party meets OHCA requirements.

1.19.9 Disaster Preparation and Data Recovery

The Contractor shall submit a plan that addresses disaster recovery and business continuity related to emergency situations to OHCA for review and approval during Readiness Review detailed in Section 1.3.10: "Readiness Review" of this Model Contract and on an annual basis thereafter.

The plan shall include the following aspects of disaster recovery, at minimum:

- Communications;
- Physical plant security;
- Data security; and
- Fire/disaster prevention and recovery procedures.

Each aspect included within the disaster recovery plan must describe both the Contractor and OHCA's responsibilities. For purposes of this requirement, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its Subcontractors' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Disasters may include natural disasters, human error/malfeasance/neglect, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall take all steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. OHCA and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status.

The Contractor shall notify OHCA, at a minimum, within two hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims processing, eligibility and enrollment processing, Service Authorization (PA) management, Provider enrollment and data management, Encounter Data management, and any other processing affecting the Contractor's capability to interface with OHCA or OHCA's contractors. If all information required herein is not available within the required time frame for reporting, Contractor shall not delay the initial report, but shall provide as much information as is available at the time and shall continue to update OHCA with additional information at least every four hours until complete information is provided. OHCA, in its discretion, may require the Contractor to provide a detailed plan for resuming operations.

The Contractor shall develop information system contingency planning in accordance with the requirements of this Section and with 45 C.F.R. § 164.308, which relates to administrative safeguards. Contingency plans shall include: data backup plans, disaster recovery plans and emergency mode of operation plans. The Contractor shall address Application and Data Criticality analysis and testing and revisions procedures within the Contractor's contingency plan documents. The Contractor shall be responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within 24 hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software and shall back up on tape or optical disk and store its data in an off-site location approved by OHCA.

The Contractor shall have the capability to continue receiving, processing and disseminating data and reports within 24 hours of a disaster situation. In the event of a catastrophic or natural disaster, including, but not limited to: fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities, the Contractor shall resume normal business functions at the earliest possible time, not to exceed 30 Calendar Days from the date of the catastrophic event or natural disaster. In the event of any other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's scope of control including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply, the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten Calendar Days.

The Contractor may include resources outside Oklahoma but within the United States as part of this plan. If applicable, the plan must satisfy all requirements for federal certification.

The plan shall be maintained and updated by the Contractor throughout the term of this Contract and shall be available for review by State or federal officials on request. The Contractor shall certify to OHCA that the disaster recovery plan has been tested at least annually and has passed all aspects of testing.

The Contractor shall have a disaster preparation and recovery plan specific to operating information systems in a disaster situation.

The data system shall be accessible remotely and offsite. The offsite system shall be capable of providing basic system functions in the event of a disaster incapacitating another system site.

The Contractor and its Subcontractors' responsibilities include, but are not limited to:

- Supporting immediate restoration and recovery of lost or corrupted data or software;
- Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation;
- Demonstrating an ability to meet back-up requirements by submitting and maintaining data backup and disaster recovery plans that address:
 - Checkpoint and restart capabilities and procedures;
 - Retention and storage of back-up files and software;
 - Hardware back-up for the servers;
 - Hardware back-up for data entry equipment;
 - Network back-up for telecommunications; and
 - Developing coordination methods for disaster recovery activities with OHCA and its contractors to ensure continuous eligibility, enrollment and delivery of services; and
- Providing OHCA with business resumption documents, reviewed and updated at least annually, but not limited to:
 - Disaster recovery plans;
 - Business continuity and contingency plans;
 - Facility plans; and
 - Any other related documents as identified by OHCA.

At no additional charge to OHCA, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery plan (BCDR) with respect to the system and services it provides to OHCA under this Model Contract. The BCDR plan will, at a minimum, meet the requirements of National Institute of Standards and Technology (NIST) SP800-34 and its successor publications once made final.

The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:

- At a minimum, the Recovery Time Objectives will be no more than 48 hours; and
- At a minimum, the Recovery Point Objectives will be no more than 24 hours.

These Objectives will be reviewed and, as necessary, modified on an annual basis.

The Contractor shall coordinate its BCDR plan with OHCA's IT business continuity/disaster recovery plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery.

The Contractor agrees to coordinate the development, updating, and testing of its BCDR plan with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

The BCDR plan will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated no less than annually by the Contractor, reflecting technological changes, Contractor business changes, OHCA business operations changes and other appropriate factors agreed upon by the Contractor and OHCA.

The Contractor shall test its BCDR plan no less than annually, with such testing being comprehensive in nature and scope assuring point-to-point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.

The first test of the Contractor's BCDR plan shall be performed within 90 Calendar Days of the award of this Contract.

The Contractor will provide the State with an annual report regarding the Contractor's annual, at minimum, testing and updating of its BCDR plan, including the results of the test, failure points and corrective action plans.

OHCA retains the right to veto, change or request revisions to all plans required under this Section 1.19.9.

1.19.10 Back-up Plan

The Contractor shall develop a back-up plan for maintaining provisional functionality of the information technology and data management systems in the event of any failure that incapacitates main systems. The plan shall articulate the data management strategy in place to ensure the Contractor can meet the Recovery Point Objectives mentioned in the BCDR plan as required pursuant to Section 1.19.9: "Disaster Preparation and Data Recovery" of this Model Contract.

The Contractor shall submit this back-up plan to OHCA for review during the Readiness Review at Section 1.3.10: "Readiness Review" of this Model Contract. OHCA retains the right to veto, change or request revisions to the back-up plan.

1.19.11 Accessibility

The Contractor shall ensure that Health Plan Enrollees and Providers have continuous access to information to be designated by OHCA. Internet accessibility shall comply with requirements in Section 1.11: "Health Plan Enrollee Services" of this Model Contract, Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. The Contractor shall ensure information is available 24 hours a day, seven days per week via the Health Plan Enrollee portal, Provider portal, and/or toll-free phone-based functions including, but not be limited to: confirmation of enrollment, electronic claims management, Health Plan Enrollee services and Provider services. The exceptions to this requirement include during periods of scheduled system unavailability for maintenance or updates during specific time periods agreed upon by OHCA and the Contractor and unavailability caused by events outside of the Contractor's scope of control.

The Contractor shall ensure that all system functions used for enrollment, disenrollment, claims or transaction submission/receipt/processing, transaction viewing or searches, and interfacing/exchanging data for Health Plan Enrollees, providers and State staff are accessible between 7:00 am and 7:00 pm Central Time, Monday through Friday with the exception of State Holidays.

The Contractor shall submit the URL for the Contractor's public website to OHCA to embed in agency websites. The URL may not be changed without OHCA's approval.

The Contractor shall maintain a point of contact with OHCA should OHCA staff require assistance interfacing/exchanging data with Contractor's system.

1.19.11.1 System Performance Requirements

The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm Central Time, Monday through Friday for all applicable system functions except for the following:

- During periods of scheduled downtime agreed upon by OHCA and the Contractor;
- During periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's scope of control; or
- Health Plan Enrollee and Provider portal and phone-based functions, such as Health Plan Enrollee eligibility and enrollment and electronic claims submission that are expected to be available 24 hours a day, seven days a week.

1.19.11.1.1 Record Search Time

The response time shall be within three seconds for 98% of the record searches as measured from a representative sample of OHCA System Access Devices.

1.19.11.1.2 Record Retrieval Time

The retrieval time shall be within three seconds for 98% of the records retrieved as measured from a representative sample of OHCA System Access Devices.

1.19.11.1.3 On-line Adjudication Response Time

The response time shall be within five seconds 99% of the time as measured from a representative sample of user System Access Devices.

1.19.11.1.4 Screen Display Time

The system screen display time shall be within two seconds for 95% of the time as measured from a representative sample of user System Access Devices. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor.

1.19.11.1.5 New Screen Page Time

The new screen page time shall be within two seconds for 95% of the time as measured from a representative sample of user System Access Devices. New screen page time is the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor.

1.19.11.2 System Performance Notification and Reporting

The Contractor shall develop an automated method of monitoring the online performance and responsiveness of all systems, including web portals. The monitoring method shall separately monitor for availability and performance/response time each component of the systems named in Section 1.19.2: "Operations" of this Model Contract.

Upon discovery of any issues within its scope of control that may jeopardize system availability and performance as defined in this Section 1.19, the Contractor shall notify OHCA Business Enterprises in person, via phone and electronic mail, followed by surface mail notification.

The Contractor shall deliver notification as soon as possible, but no later than two hours after the problem occurs.

The Contractor shall resolve unscheduled system unavailability, caused by the failure of systems and telecommunications technologies within the Contractor's scope of control, and shall implement the restoration of services within 30 minutes of the Contractor's discovery of system unavailability. The Contractor shall resolve unscheduled system unavailability to all other Contractor system functions caused by systems and telecommunications technologies outside of the Contractor's scope of control, and shall implement the restoration of services within four hours of the Contractor's discovery of system unavailability.

Cumulative system unavailability caused by systems and telecommunications technologies within the Contractor's scope of control shall not exceed one hour during any continuous five Calendar Day period.

Where the operational problem results in delays in report distribution or problems in on-line access during the business day, the Contractor shall notify OHCA within 15 minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on system unavailability protocols.

The Contractor shall provide to OHCA information on system unavailability events, as well as status updates on problem resolution. These updates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's website.

1.20 Financial Standards and Third Party Liability

1.20.1 Financial Stability

The Contractor shall maintain a financially stable operation in accordance with all State and federal laws, regulations and guidance. The Contractor shall meet and comply with all policies and administration of these processes. The Contractor shall maintain a fiscally solvent operation per federal regulations and Oklahoma Insurance Department (OID) requirements for a minimum net worth and risk-based capital including the following requirements:

- Initial and continuing net worth;
- Paid-in capital;
- Determination of liabilities;
- Risk-based capital investments; and
- Additional reserve or surplus protections as may be required by the OID.

OHCA and the OID will monitor the Contractor's financial performance. OHCA will include OID findings in its monitoring activities. The Contractor shall copy OHCA on required filings with the OID and shall provide separate financial information pertaining to this Contract upon submission. Further responsibilities may also be required following the Contract award date.

1.20.1.1 Insolvency Protection

The Contractor shall comply with State and federal requirements for protection against insolvency, including 42 C.F.R. § 438.106 and Section 1932(b)(6) of the Act. The Contractor shall develop and maintain an Insolvency Plan pursuant to 36 O.S. § 6913(E) and have a process in place to review and authorize contracts established for reinsurance and third-party liability, as applicable. Unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor shall comply with 42 C.F.R. § 438.116, which requires the Contractor:

- Provide satisfactory assurances to OHCA showing that its provision against the risk of insolvency is adequate to ensure that Health Plan Enrollees will not be liable for the Contractor's debts should it become insolvent; and
- Meet the solvency standards established by the HMO Act of 2003, 36 O.S. § 6901, *et. seq.* (OSCN 2016).

In accordance with 42 C.F.R. § 438.106, the Contractor shall also ensure Health Plan Enrollees are not held liable for any of the following:

- The Contractor's debts in the event of the Contractor's insolvency;
- Covered services provided to the Health Plan Enrollee for which OHCA does not pay the Contractor, or for which OHCA or the Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement; and
- Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Health Plan Enrollee would owe if the Contractor covered the services directly.

1.20.1.2 Eligible Investments

The Contractor shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in 36 O.S. § 1601, *et seq.*

1.20.1.3 Modified Current Ratio

The Contractor must maintain current assets, plus long-term investments that can be converted to cash within five Business Days without incurring a penalty of more than 20%, that equal or exceed current liabilities.

If a penalty for conversion of long-term investments is applicable, only the value excluding the penalty may be counted for the purpose of compliance with this requirement. Provided they are not issued by or include an interest in an Affiliate, the types of long-term investments that may be counted, consistent with above requirements, are prescribed in 36 O.S. § 1601, *et seq.*

1.20.1.4 Prior Approval of Payments to Affiliates

The Contractor shall not pay money or transfer any assets to an Affiliate without prior approval from OHCA except for payment of a claim for a medical product or service that was provided to a Health Plan Enrollee and paid in accordance with a written Provider contract and this Contract. To obtain authorization, the Contractor must demonstrate to OHCA that the Contractor:

- Meets specified risk-based capital requirements as of the close of the most recent year for which the due date for filing the annual unaudited OID financial report has passed;
- Complies with the Contract financial stability and solvency protection requirements as of the last day of the most recent quarter for which the due date for filing OID financial reports has passed; and
- Would remain in compliance with the Contract's financial stability and solvency protection requirements following the proposed transaction.

OHCA may require repayment of amounts involved in the transaction if subsequent audit or other adjustments determine that the Contractor did not comply with the Contract's financial stability and solvency protection requirements after the transaction took place.

1.20.2 Medical Loss Ratio

The Contractor shall calculate and report to OHCA its medical loss ratio (MLR) for each MLR Reporting Year in accordance with 42 C.F.R. § 438.8 and the following methodology:

- The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)).
- Each Contractor expense shall be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.
- Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.
- Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
- The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.
- The Credibility Adjustment is added to the reported MLR calculation before calculating any remittances.
- The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.
- If the Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards.
- The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract, with the exception that the Contractor shall separately report the MLR for Expansion Adults.

The Contractor shall submit an MLR report to OHCA in accordance with the Reporting Manual requirements, which shall be within 12 months of the end of the MLR Reporting Year, and that includes for each MLR Reporting Year, the following, in accordance with 42 C.F.R. § 438.8:

- Total incurred claims.
- Expenditures on quality improving activities.
- Expenditures related to activities compliant with program integrity requirements.
- Non-claims costs.
- Premium revenue.
- Taxes.
- Licensing fees.
- Regulatory fees.
- Methodology(ies) for allocation of expenditures.
- Any Credibility Adjustment applied.
- The calculated MLR.
- Any remittance owed to OHCA, if applicable.
- A comparison of the information reported with the audited financial report.

- A description of the aggregation method used to calculate total incurred claims.
- The number of member months.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR Reporting Year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

In the event OHCA makes a retroactive change to the Capitation Payments for an MLR Reporting Year where the MLR report has already been submitted to OHCA, the Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR report.

The Contractor shall attest to the accuracy of the calculation of the MLR when submitting the MLR Report in accordance with the MLR standards delineated in this section and 42 C.F.R. § 438.8.

1.20.2.1 MLR Corridor and MLR Remittance

The Contractor’s total annual Capitation Payments shall be evaluated against a minimum 85% MLR, calculated in accordance with 42 C.F.R. § 438.8. The Contractor’s gains and losses shall be evaluated according to the table below. Note for illustrative purposes the table below uses a Capitation Rate priced-for (target) MLR of 90%. As the Capitation Rates have not yet been developed, this illustrated 90% is subject to change. The corridor will be symmetric. The 85% minimum MLR will not change and neither will the share factors. However, given the change in the priced-for MLR, the 88%, 92%, and 95% will be adjusted to provide a symmetrical corridor. The MLR calculation will be done across all population groups except a separate calculation will be done for the Medicaid Expansion population for federal match claiming purposes.

The following table has been provided for illustrative purposes only:

Medical Loss Ratio Corridor	Contractor Share of Gain/Loss in the Corridor	OHCA/CMS Share of the Gain/Loss in the Corridor
MLR of less than 85%	0%	100%
MLR equal to or greater than 85% and less than 88%	50%	50%
MLR equal to or greater than 88% and less than 92%	100%	0%
MLR equal to or greater than 92% and less than 95%	50%	50%
MLR equal to or greater than 95%	0%	100%

OHCA reserves the right to modify the target MLR and associated corridor in future Contract years, in accordance with Section 1.1.9: “Amendments or Modifications” of this Model Contract. OHCA and the Contractor shall remit to OHCA or the Contractor all applicable refunds in the manner and timeframe

specified by OHCA. This provision shall survive expiration of the Contractor's other duties under the SoonerSelect program, in the event the Contractor is terminated or not renewed.

1.20.3 Risk Adjustment

The Contractor's Capitation Rates will be risk adjusted based on health status. MedicaidRx will be used for the initial Rating Period and model selection will be re-evaluated for later Rating Periods. OHCA will risk adjust existing Medicaid populations using an aggregate risk factor calculation and a retrospective/concurrent factor approach with final adjustment shortly after the end of the first Rating Period. OHCA will use age/gender rating bands for Expansion Adults for the initial Rating Period. Transition limits will be developed and applied as to how much capitation revenue can change due to risk adjustment.

1.20.4 Third Party Liability

The Contractor will be notified of known Health Plan Enrollee third party resources via the ANSI ASC X 12 834 electronic transactions. Health Plan Enrollee third party resource information provided to the Contractor will be based upon information obtained or made available to OHCA at the time of an Applicant or Eligible's eligibility determination or re-determination.

Medicaid shall be the payer of last resort for all covered services in accordance with federal regulations, including 42 C.F.R. 433 Subpart D and 42 C.F.R. § 447.20. The Contractor shall make every reasonable effort to:

- Determine the liability of third parties to pay for services rendered to Health Plan Enrollees;
- Avoid costs which may be the responsibility of third parties; and
- Recover any liability from responsible third-party sources, except for estate recovery and third-party subrogation. Contractor shall calculate amount to be recovered by using their fee schedule for the specific service.

The Contractor shall treat funds recovered from third parties as reductions to claims payment as required under Section 1.14.4.1: "Claims Processing System and Methodology" of this Model Contract and shall report all TPL collections in the manner and timeframe required by OHCA.

1.20.4.1 Third Party Liability Procedures

The Contractor shall develop and implement policies and procedures to meet its obligations regarding Third Party Liability cost avoidance and recovery when the third party pays a benefit to a Health Plan Enrollee.

1.20.4.2 Third Party Payment to Subcontractors

If Third Party Liability exists for part or all of the services provided to a Health Plan Enrollee by a Subcontractor or a Provider, and the third party will make payment within a reasonable time, the Contractor may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's or Provider's allowable claim exceeds the amount of Third Party Liability.

1.20.4.3 Determination of Third Party Payment

If probable existence of Third Party Liability has been established at the time a claim is filed, the Contractor must reject the claim and return it to the Provider for a determination of the amount of any Third-Party Liability. The Contractor shall provide Third Party Liability data to any Provider having a claim denied by the Contractor based upon Third Party Liability.

Notwithstanding the forgoing, in accordance with 42 C.F.R. § 433.139(b), the Contractor shall pay claims for the following and then bill the responsible third party:

- Preventive pediatric services, including EPSDT; and
- For a service provided to a Health Plan Enrollee on whose behalf child support enforcement is being carried out if the third party coverage is through an absent parent and the Provider certifies that, if the Provider has billed a third party, the Provider has waited 100 days from the date of service without receiving payment before billing Medicaid.

1.20.4.4 Third Party Payment Denial

The Contractor shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the Provider or Health Plan Enrollee's failure to follow claims and payment procedures specified by the third party. The basis for such denials may include the failure to obtain Prior Authorization, receive care from a Participating Provider and timely submit claims for payment according to submission procedures.

1.20.4.5 Third Party Payment Recovery

The Contractor shall retain third party payment recoveries, except as otherwise specified in this section. The Contractor shall post all third party payments to claim level detail by Health Plan Enrollee.

1.20.4.6 Estate Recovery Activities

OHCA shall be solely responsible for estate recovery activities and shall retain any funds recovered through these activities.

1.20.4.7 Third Party Subrogation and Recovery

The Contractor shall identify potential subrogation cases using a list of OHCA-approved diagnosis and treatment codes. When subrogation is identified, the Contractor shall notify OHCA in the timeframe and manner required by OHCA. OHCA will be responsible for pursuing subrogation and will retain all subrogation recoveries.

1.20.4.8 Third Party Payment Exclusions

The Contractor shall not consider allowable Health Plan Enrollee Cost Sharing and Health Plan Enrollee payment responsibilities as permitted under the Contract as a Third Party Liability source.

1.20.4.9 Third Party Payment Resource Information

The Contractor must cooperate with OHCA or its cost-recovery vendor, in recovering benefits provided by Health Plan Enrollee's access to other insurance.

OHCA may require a contracted Third Party Liability vendor to review paid claims that are over 120 days old and pursue Third Party Liability (excluding subrogation) for those claims that do not indicate recovery amounts in the Contractor's reported Encounter Data. OHCA has sole right of recovery after 365 Calendar Days. In accordance with 63 O.S. § 5051.2(E), the Contractor shall make appropriate payments to OHCA provided the claim is submitted for consideration within three years from the date the service was furnished. Any action by OHCA to enforce the payment of the claim shall be commenced within six years of the submission of the claim by OHCA.

If the Contractor operates or administers any non-Medicaid MCO, health plan or other lines of business, the Contractor shall assist OHCA in a manner to be specified with identification of Health Plan Enrollees with access to other insurance.

1.21 Reporting

1.21.1 General Reporting Obligations

In accordance with 42 C.F.R. § 438.604(b), the Contractor shall submit any data, documentation or information relating to the Contractor's performance as required by OHCA or the Secretary. OHCA intends to publish a Reporting Manual outlining the Contractor's performance reporting obligations. The Contractor shall comply with all Reporting Manual requirements and submit all requested data completely and accurately within the timeframes and format prescribed by OHCA.

Failure to comply with reporting requirements as outlined in the Reporting Manual, or via ad hoc request from OHCA, may subject the Contractor to Non-Compliance Remedies. At any time that a submitted report is rejected for non-compliance other than timeliness, the Contractor shall revise the report and cure the reason for rejection within five days of notification from OHCA or as otherwise specified. Any revisions to previously submitted reports must be re-submitted in the format specified by OHCA.

If the Contractor delegates any activities or obligations under the Contract, the Subcontractor, individual or entity accepting delegation shall also perform the Contractor's reporting responsibilities and obligations in compliance with the Contract and Reporting Manual.

The Contractor shall provide access to OHCA, upon request, of all source data utilized to generate reports required under the Contract to permit OHCA to validate reports.

1.21.1.1 Modifications to Reporting Requirements

OHCA reserves the right to modify the Reporting Manual at its sole discretion. Additionally, OHCA may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

1.21.1.2 Initial Program Implementation Reporting

OHCA will require more frequent Contractor reporting during Initial Program Implementation to:

- Monitor SoonerSelect program implementation;
- Permit adequate OHCA oversight and corrections of any identified problems as necessary; and
- Ensure satisfactory levels of Health Plan Enrollee and Provider services.

1.21.1.3 Certification Requirements

In accordance with 42 C.F.R. § 438.606(a), all data, documentation, or information submitted by the Contractor to OHCA under 42 C.F.R. § 438.604 shall be certified by one of the following:

- The Contractor's Chief Executive Officer (CEO);
- The Contractor's Chief Financial Officer (CFO); or
- An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

The Contractor shall submit this certification concurrently with the data, documentation or information submission. The certifying officer must attest that, based on the certifying officer's best information, knowledge, and belief, the data, documentation and information submitted are accurate, complete and truthful.

1.21.1.4 Audit Rights and Remedies

OHCA reserves the right to audit the Contractor's self-reported data at any time and may require corrective action or other remedies as specified in Section 1.23: "Non-Compliance Remedies" of this Model Contract for Contractor non-compliance.

1.21.1.5 Continuous Process Improvement

The Contractor shall review all reports submitted to OHCA to identify instances and patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct non-compliance and identify and implement quality improvement activities to improve performance and ensure ongoing compliance.

1.21.2 **Required Data Collection and Reports**

In accordance with 42 C.F.R. § 438.66(c), and as further delineated in the following subsections, the Contractor shall submit data to OHCA on the following:

- Enrollment and Disenrollment data;
- Health Plan Enrollee Grievance and Appeal logs;
- Provider complaint and appeal logs;
- Results of Health Plan Enrollee satisfaction surveys conducted by the Contractor;
- Results of Provider satisfaction surveys conducted by the Contractor;
- Performance on required quality measures;
- Medical management committee reports and minutes;
- Annual quality improvement plan;
- Audited financial and Encounter Data;
- MLR summary reports;
- Customer service performance data; and
- Any other data related to the provision of Long-term services and support (LTSS) not otherwise reported.

OHCA will utilize findings from this data collection to improve the performance of the SoonerSelect program.

1.21.2.1 Contractor Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.2: "Payments to Contractor" of this Model Contract. Contractor payment reports shall include, at minimum:

- *Capitation Reconciliation*: Monthly reconciliation of enrollment and Capitation Payments.
- *Capitation Overpayment*: Report of Capitation Payment Overpayments.

1.21.2.2 Administrative Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.3: "Administrative Requirements" of this Model Contract. Administrative reports shall include, at minimum:

- *Accreditation*: Status reports while undergoing accreditation and copy of accreditation review findings in accordance with requirements of 42 C.F.R. § 438.332(b).

- *Subcontractor Compliance*: Reports documenting known or anticipated value of contracted or subcontracted services, the Contractor's oversight of its Subcontractors and any applicable performance issues or corrective actions.
- *Implementation plan*: Status reports on key implementation activities prior to initial Health Plan Enrollee enrollment.
- *Hiring and Staffing Plan*: Contractor's plan to meet staffing requirements and ongoing reporting of changes in Key Staff.
- *Board of Directors*: Notification of changes in Board of Directors.

1.21.2.3 Enrollment and Disenrollment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.5: "Enrollment and Disenrollment" of this Model Contract. Enrollment and Disenrollment reports shall include, at minimum:

- *Health Plan Enrollee Disenrollment Requests*: Reports documenting volume of and reason for Health Plan Enrollee requests for Disenrollment.

1.21.2.4 Covered Benefits Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.6: "Covered Benefits" of this Model Contract. Benefits reports shall include, at minimum:

- *IMD Waiver*: Data and reporting necessary for OHCA to comply with CMS 1115 IMD demonstration waiver reporting requirements.
- *Drug Rebates*: Pharmacy utilization and other data necessary for OHCA to bill manufacturers for drug rebates.
- *Pharmacy Benefit Financial Disclosures*: Documentation to demonstrate compliance with pharmaceutical transparency and pass-through requirements as outlined in Section 1.6.3.4.3: "Pharmacy Benefit Financial Disclosures" of this Model Contract.
- *Annual DUR Board Report*: Annual report on the operation of the Contractor's DUR program.
- *EPSDT*: Data required to comply with CMS EPSDT performance on the Form CMS-416.
- *Value-Added Benefits*: Report documenting all Value-Added Benefits offered by the Contractor and the utilization rates of each.
- *NEMT Utilization Reports*: Report documenting the number of Health Plan Enrollees who received NEMT, number of trips approved, denied, provided, no shows, waiting time and mileage reimbursement.
- *Social Determinants of Health*: Report documenting Health Plan Enrollee referrals to social services and activities surrounding Contractor partnerships with community-based organizations and social service providers.
- *Immunizations*: Data matching and validation with the Oklahoma State Immunization Information System (OSIIS).

1.21.2.5 Medical Management Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.7: "Medical Management" of this Model Contract. Medical management reports shall include, at minimum:

- *Prior Authorization*: Report documenting PA processing timeliness, approvals, pending requests and denial rates.
- *ER Utilization*: Report documenting the Contractor's ER utilization management activities and outcomes, including utilization breakout by Health Plan Enrollees in different care management levels based on the Contractor's Risk Stratification Level Framework.
- *Medical Management Program*: Report documenting the Contractor's Medical Management Program description, work plan and program evaluation.
- *Utilization Reports*: Reports documenting elements such as inpatient admissions, readmissions, non-emergent use of the ER, drug utilization. The Contractor may be required to provide breakout by Health Plan Enrollees in different care management levels based on the Contractor's Risk Stratification Level Framework.
- *Out of State Services*: Report documenting approved out of State services to include detailed verification of unavailability of in-state services.

1.21.2.6 Care Management and Population Health Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.8: "Care Management and Population Health" of this Model Contract. Care management and population health reports shall include, at minimum:

- *Care Management Staffing Plan*: Report addressing care management staffing plan and staffing levels, by role and care program.
- *Care Management Staffing, actual*: Report addressing actual care management staffing by role, by care program (FTE count/time spent to serve specific populations).
- *Health Risk Screening*: Report documenting timely completion of Health Risk Screenings.
- *Health Risk Screening Unreachable Health Plan Enrollees*: Report documenting Health Plan Enrollees the Contractor was unable to reach to complete the Health Risk Screening, including Health Plan Enrollee name, number of outreach attempts, type of attempt and the Health Plan Enrollee's contact information.
- *Comprehensive Assessment and Reassessment*: Report documenting timely completion of Comprehensive Assessments in accordance with the Contractor's Risk Stratification Level Framework to include type of assessment, mode of assessment, and disposition, for Health Plan Enrollees assessed for care/health management.
- *Health Plan Enrollees in Care Management*: Report documenting new, closed and total cases of Health Plan Enrollee's assigned to care management based on the Contractor's Risk Stratification Level Framework.
- *Care Management Activities*: Report documenting assignment to a Care Manager, caseload, contacts and success based on the Contractor's Risk Stratification Level Framework.
- *Care Plan*: Report documenting the number of Care Plans initiated, revised, completed, reviewed and reduced.
- *Pharmacy Lock-in*: Report addressing activities regarding the Contractor's lock-in program.
- *Ad hoc outreach campaigns*: Report summarizing ad hoc outreach campaigns initiated.

1.21.2.7 Transition of Care Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.9: "Transition of Care" of this Model Contract. Transition of care reports shall include, at minimum, Contractor activity surrounding the following transitions:

- Care manager transitions;
- Age transitions;
- Transitions from inpatient settings; and
- Transitions between MCOs.

1.21.2.8 Quality Improvement Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.10: “Quality” of this Model Contract. The Contractor shall be capable of providing reports broken out by race, ethnicity, or other relevant demographics as directed by OHCA. Quality reports shall include, at minimum:

- *Quality Rating System*: Reporting necessary to comply with the quality rating system required in accordance with 42 C.F.R. § 438.334.
- *Annual QAPI Plan*: An annual QAPI program description and work plan addressing the Contractor’s strategies for performance improvement and quality management activities, which addresses all elements in Section 1.10.3: “Quality Assessment and Performance Improvement (QAPI) Program” of this Model Contract.
- *CAHPS*: Annual reports for each of the audited CAHPS survey required under Section 1.10.4.1: “Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys” of this Model Contract.
- *Provider Satisfaction Survey*: Annual report documenting the results of the annual Participating Provider Survey as described in Section 1.10.4.2: “Provider Satisfaction Surveys” of this Model Contract.
- *Quality Performance Measures*: Reporting on all required measures as described in Section 1.10.5: “Quality Performance Measures” of this Model Contract.
- *Performance Improvement Projects*: Reports on the Contractor’s PIPs as required under Section 1.10.6: “Performance Improvement Projects (PIPs)” of this Model Contract.
- *Provider Profiling*: Provider performance monitoring reports in accordance with Section 1.10.8: “Provider Profiling” of this Model Contract.
- *Critical Incidents*: Reporting on all Critical Incidents as described in Section 1.10.10: “Critical Incident Reporting System” of this Model Contract.

1.21.2.9 Health Plan Enrollee Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.11: “Health Plan Enrollee Services” of this Model Contract. Health Plan Enrollee Services reports shall include, at minimum:

- *Failure to Contact*: Report documenting Health Plan Enrollees the Contractor failed to reach following initial enrollment with the Contractor in accordance with Section 1.11.5: “New Health Plan Enrollee Materials and Outreach” of this Model Contract.
- *Health Plan Enrollee Services Call Center*: Report documenting the performance of the Health Plan Enrollee Services Call Center, such as call volume, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate and overflow call center data. Also includes annual evaluation and planned improvement activities.

- *Health Plan Enrollee Services Call Center Training*: Report documenting the training received by Health Plan Enrollee Services Call Center staff.
- *Behavioral Health Services Hotline*: Report documenting the performance of the Behavioral Health Services Hotline, such as call volume, call abandonment rate, live-voice answer rate and volume of calls patched to 911.
- *Advisory Board*: Reports on activities of the quarterly Advisory Board meetings.
- *Behavioral Health Advisory Board*: Reports on activities of the quarterly Behavioral Health Advisory Board meetings.
- *PCMH Provider Assignments*: Reports on PCMH Provider assignment rates, differentiated by Health Plan Enrollee selection versus Contractor assignment.
- *PCMH Provider Changes*: Reports on the volume of PCMH Provider changes and reasons.
- *Website*: Reports documenting website utilization data.
- *Marketing*: Documents the Contractor's Marketing plan and activities.

1.21.2.10 Provider Network Development Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.12: "Provider Network Development" of this Model Contract. Provider network development reports shall include, at minimum:

- *Network Adequacy*: In accordance with 42 C.F.R. § 438.604, the Contractor shall submit documentation for which OHCA will base its certification that the Contractor has complied with requirements for availability and accessibility of services, including adequacy of the Participating Provider network, as set forth in 42 C.F.R. § 438.206.
- *Geo-Access Reports*: Showing compliance with time and distance standards to Participating Providers as outlined in Section 1.12.4: "Time and Distance and Appointment Access Standards" of this Model Contract.
- *Provider Network Development and Management Plan*: As required in accordance with the requirements of Section 1.12.1.5: "Provider Network Development and Management Plan" of this Model Contract.
- *Provider Enrollment and Disenrollment*: Showing Participating Providers, including enrollments and disenrollments.
- *Provider Application Denials*: Showing all Providers for whom the Contractor has denied request to become a Participating Provider.
- *Credentialing*: Showing the timeliness of all Provider credentialing and recredentialing activities.
- *24-Hour Availability Audit*: Showing Participating Provider's compliance with requirement to be accessible to Health Plan Enrollees 24 hours per day, seven days per week including corrective actions implemented for Participating Providers failing to meet the requirement.
- *Network Adequacy Exceptions Report*: In accordance with Section 1.12.5: "Network Adequacy Exception Process" of this Model Contract, including date of approval, description of the exception, how the Contractor is assuring Health Plan Enrollees residing in the applicable geographic area are receiving the necessary care and Contractor efforts and progress in addressing the deficiency.

1.21.2.11 Provider Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.13: “Provider Services” of this Model Contract. Provider services reports shall include, at minimum:

- *Provider Services Call Center*: Report documenting the performance of the Provider Services Call Center, such as call volume, calls handled, average call handle time, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate, overflow call center data, and customer satisfaction indicators. Also includes annual evaluation and planned improvement activities.
- *Provider Services Call Center Training*: Documents the training received by Provider Services Call Center staff.
- *Participating Provider Training, Education and Technical Assistance Plan*: Documents the training provided including details such as the training topics covered, the date of the training and the participants, by the Contractor to its Participating Providers, in accordance with Section 1.13.5: “Provider Education, Training and Technical Assistance” of this Model Contract.
- *Provider Complaints*: Report documenting the type, volume, timely processing and resolution status of Provider Complaints, reconsiderations and appeals.

1.21.2.12 Provider Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.14: “Provider Payment” of this Model Contract. Provider payment reports shall include, at minimum:

- *Performance-Based Provider Payments*: Documents the plan, volume of and details surrounding performance-based payments made by the Contractor to Participating Providers.
- *Provider-Preventable Conditions*: The Contractor shall require Providers to report Provider-Preventable Conditions associated with claims for payment or Health Plan Enrollee treatments for which payment would otherwise be made. The Contractor shall report all identified Provider-Preventable conditions to OHCA as required under the Reporting Manual.
- *Claims Activity*: Report on claims activities, including the number of claims received, denied and paid, total amount paid and any adjustments or edits to claims.
- *Claims Payment Accuracy*: Report documenting claims payment and denial accuracy by claim type and Provider type. The report shall be compiled by the Contractor through an audit of the accuracy of a random sample of claims payments processed in the relevant reporting period. The report shall document the results of the audit, including the number and percentage of claims and dollars that were paid accurately.
- *Claims Timeliness*: Report on the timeliness of claims paid by claim type and Provider type. The report shall include the number and percentage of claims processed for the reporting period that were paid within 30 days of service date, within 60 days of service date, within 90 days of service date, those left pending, those that were submitted in previous quarters but paid in the reporting quarter and suspended claims.

1.21.2.13 AI/AN Population and IHCPs Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.15: “American Indian/Alaska Native Population and Indian Health Care Providers” of this Model Contract. These reports shall include, at minimum:

- *Network Accessibility*: Reports documenting network accessibility specific to the Contractor’s AI/AN Health Plan Enrollee membership and the IHCP network.

1.21.2.14 Grievances and Appeals Reports

The Contractor shall submit monthly reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.16: “Health Plan Enrollee Grievances and Appeals” of this Model Contract. Health Plan Enrollee Grievances and Appeals reports shall include, at minimum:

- *Health Plan Enrollee Grievances*: Documents the volume, timely processing and reasons for Health Plan Enrollee Grievances.
- *Health Plan Enrollee Appeals*: Documents the volume, timely processing, decision overturn rate and reasons for Health Plan Enrollee Appeals.
- *State Fair Hearings*: Documents the volume of Appeals escalating to the State Fair Hearing process and the rate of Contractor decisions overturned.

1.21.2.15 Cost Sharing Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.17: “Cost Sharing” of this Model Contract. Cost Sharing reports shall include, at minimum:

- *Five Percent Limit*: Reports documenting the volume of Health Plan Enrollees reaching the five percent Cost Sharing limit described in Section 1.17.5: “Five Percent Cost Sharing Limit” of this Model Contract.

1.21.2.16 Program Integrity Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.18: “Program Integrity” of this Model Contract. Program integrity reports shall include, at minimum:

- *Compliance Plan*: The plan developed in accordance with the requirements of Section 1.18.2.1: “Compliance Plan” of this Model Contract, and all associated reporting.
- *Verifying Delivery of Services*: Reports documenting the activities of the Contractor to verify service delivery in accordance with Section 1.18.4: “Verifying Delivery of Services” of this Model Contract. Report shall detail the number of EOBs distributed, Health Plan Enrollee responses and resolution of Health Plan Enrollee responses.
- *Overpayments*: In accordance with 42 C.F.R. § 438.608(d)(3), the Contractor shall report monthly to OHCA on recoveries of Overpayments. Prompt reporting of all Overpayments to occur in accordance with Section 1.18.6: “Reporting Overpayments” of this Model Contract.
- *Transactions with Parties in Interest*: Reporting in accordance with the requirement of Section 1.18.13: “Transactions with Parties in Interest” of this Model Contract.
- *Investigations Opened*: Provides documentation on the program integrity investigations initiated and cases ultimately referred to the State.

1.21.2.17 Information Technology Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual and Section 1.19: “Information Technology” of this Model Contract, to demonstrate compliance with Contract requirements. Information Technology reports shall include, at minimum, the following:

- Encounter Data;
- Encounter Data and Financial Summary Reconciliation;
- Information Security Breach;
- System Performance Reports;
- System Unavailability Reports;
- Disaster Preparation and Recovery Plan;
- BCDR Incidence Reports;
- Back-up Plan;
- Initial and Bi-annual IT Roadmap; and
- Maintenance and Operations Plan.

1.21.2.18 Financial Performance Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.20: “Financial Standards and Third Party Liability” of this Model Contract. Reports shall include, at minimum:

- *Base Data*: In accordance with 42 C.F.R. § 438.604, the Contractor shall submit data on the basis of which OHCA certifies the actuarial soundness of Capitation Rates, including base data generated by the Contractor.
- *Oklahoma Insurance Department Filings*: Copy of all OID required filings provided to OHCA.
- *Audited Financial Reports*: In accordance with 42 C.F.R. § 438.3(m), the Contractor shall submit audited financial reports specific to the Contract on an annual and quarterly basis. The Contractor shall ensure the audit is conducted in accordance with generally accepted accounting principles and standards.
- *Change in Independent Actuary or Independent Auditor*: The Contractor must provide OHCA with notice within ten days of expiration of the Contractor's contract with an independent auditor or actuary. The notice must include: the date and reason for the change or termination; the name of the replacement auditor or actuary; and if the change or termination resulted from a disagreement or dispute, the nature of the disagreement or dispute at issue.
- *Disclosure of Fiduciary Relationships and Bonding Reports*: The Contractor shall disclose each person who qualifies as a fiduciary as defined by 36 O.S. § 6906(A). The Contractor shall provide OHCA with evidence of the Contractor's Fidelity Bond or Certificate of Fidelity Insurance in the manner prescribed by 36 O.S. § 6906(A). The Contractor shall not make payment regarding amounts expended for home health care services provided by any agency or organization, unless the agency or organization provides OHCA with a surety bond as specified in Section 1861(o)(7) of the Act.
- *Third Party Payments*: Reports documenting cost avoidance values, recoveries from third parties, potential subrogation cases and third party resource information.
- *Rate Cell Financial Reports*: Certified financial reports as specified by OHCA reflecting cost experience at the rate cell level.

- *MLR Reports*: Data on the basis of which OHCA will determine the Contractor's compliance with the MLR requirements described in 42 C.F.R. § 438.8 and Section 1.20.2: "Medical Loss Ratio" of this Model Contract.
- *Insolvency Protection*: Data on the basis of which OHCA will determine the Contractor has made adequate provision against the risk of insolvency, as required under 42 C.F.R. § 438.116.

1.22 Contractor Performance Standards

1.22.1 Full Compliance

The performance standards for the Contractor are defined as full compliance with the participation requirements specified in this Model Contract. The Contractor shall be subject to the penalties described in Section 1.23: "Non-Compliance Remedies" of this Model Contract for failure to meet performance standards.

1.22.2 Performance-Based Contracting

The Contractor and OHCA agree that the SoonerSelect program shall be administered in accordance with the tenets of performance-based contracting, including:

- Defining quality of care, quality of life and health outcomes objectives for Health Plan Enrollees;
- Measuring the Contractor's progress in meeting performance objectives; and
- Rewarding the Contractor for achievement of performance objectives and penalizing the Contractor for failure to achieve performance objectives, through the methods described in this section and Section 1.23: "Non-Compliance Remedies" of this Model Contract.

OHCA, the Contractor and other MCOs shall collaborate in development of a uniform performance monitoring data set starting no later than 180 days after the Contract start date. The data set shall incorporate mandatory reports as described in Section 1.21: "Reporting" of this Model Contract and shall include performance benchmarks related to service accessibility and utilization, care management, quality improvement and non-clinical functions. OHCA shall have sole authority for establishing final benchmarks.

1.22.3 Monitoring and Evaluation of Contractor Performance

1.22.3.1 OHCA Monitoring Methods

The Contractor shall cooperate fully to support OHCA's performance of monitoring activities. OHCA will monitor the Contractor's performance and compliance with Contract participation requirements through multiple methods, including but not limited to:

- The Readiness Review;
- Ongoing operational and financial reviews, to be conducted onsite at the Contractor's Oklahoma-based office required under Section 1.3.5: "Oklahoma Presence" of this Model Contract and through desk audits;
- Review of the Contractor's reports required under Section 1.21: "Reporting" of this Model Contract and the Reporting Manual;
- Review of the Contractor's quality improvement measures and performance improvement project outcomes, as described in Section 1.10: "Quality" of this Model Contract;
- Assessment of the Contractor's performance against uniform performance monitoring benchmarks;
- Findings from the annual EQR as described in Section 1.10.2: "External Quality Review" of this Model Contract;

- Quarterly meetings with OHCA and Contractor Key Staff; and
- Additional data concerning the Contractor’s performance gathered directly by OHCA from Health Plan Enrollees, Providers and other SoonerSelect program stakeholders.

1.22.3.2 Contractor Internal Monitoring Methods

The Contractor shall have an internal monitoring process for ensuring compliance with all Contract requirements.

The Contractor shall report to OHCA monthly on its compliance monitoring activities, in a format to be specified by OHCA in the Reporting Manual. The Contractor shall document any self-identified area of non-compliance with Contract requirements and shall describe the actions being taken to correct the deficiency. At its discretion, OHCA may request additional information or require submission of a formal corrective action plan, in accordance with the provisions of Section 1.23: “Non-Compliance Remedies” of this Model Contract.

1.22.3.3 Treatment of Self-Reported Deficiencies in Assessment of Damages

In the event that the Contractor identifies and reports an area of non-compliance (deficiency) that falls within a category for which civil monetary damages apply, as described in Section 1.23: “Non-Compliance Remedies” of this Model Contract, OHCA, at its sole discretion, may waive the damages subject to the Contractor remedying the deficiency in a manner and on a schedule acceptable to OHCA.

OHCA’s standard policy shall be not to waive monetary damages, if applicable, when an area of non-compliance (deficiency) is identified by OHCA without first being reported by the Contractor.

1.22.3.4 Consideration of Contractor Performance in Auto Assignments

It is OHCA’s intent to modify the assignment algorithm in future Contract years of the SoonerSelect program to take into consideration the Contractor’s performance on improving health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.1.9: “Amendments or Modifications” of this Model Contract.

1.22.3.5 Consideration of Contractor Performance in Re-Contracting

It is OHCA’s intent to include data on the Contractor’s performance in any future procurement conducted prior to the expiration of the current Contract, including any extension periods.

1.23 **Non-Compliance Remedies**

The Non-Compliance Remedy imposed by OHCA will be dependent upon the nature, severity and duration of the Contractor’s non-compliance. OHCA shall impose those Non-Compliance Remedies it determines, in its sole discretion, to be appropriate for the deficiencies identified. If OHCA elects not to exercise a Non-Compliance Remedy in a particular instance of Contractor non-compliance, this decision shall not be construed as a waiver of OHCA’s right to pursue future assessment of that performance requirement and associated Non-Compliance Remedy(s), including those that, under the terms of the Contract, may be retroactively assessed.

OHCA may take one or more of the following actions in response to the Contractor’s non-compliance with Contract requirements:

- Require the Contractor to develop a formal corrective action plan submitted to OHCA under signature of the Contractor’s chief executive. The corrective action plan is subject to OHCA approval.

- Suspend full or partial Capitation Payments.
- Suspend auto-assignment of Eligibles to the Contractor. At its sole discretion, OHCA may suspend all auto-assignments or may selectively suspend auto-assignments for a region, county or SoonerCare eligibility group.
- Impose Intermediate Sanctions in accordance with 42 C.F.R. § 438.702 and Section 1.23.3: “Intermediate Sanctions” of this Model Contract.
- Impose other Non-Compliance Remedies in accordance with Section 1.23.6: “Other Non-Compliance Remedies” of this Model Contract.
- Terminate the Contract in accordance with Section 1.24: “Termination” of this Model Contract.

1.23.1 Notification of Non-Compliance Findings

OHCA shall notify the Contractor of any findings of Contract non-compliance in writing and in accordance with Section 1.1.5: “Notices” of this Model Contract. The notice will:

- Describe the nature of the Contract non-compliance;
- Outline required steps to be taken by the Contractor to remedy the non-compliance, including Contractor filing of a corrective action plan, if applicable;
- Provide a date by which the non-compliance must be remedied;
- Describe the method by which the Contractor shall demonstrate it has remedied the area of non-compliance;
- Identify the basis and nature of the Non-Compliance Remedy(s) to be imposed by OHCA, if applicable; and
- Contractor appeal rights as described in Section 1.23.2: “Appeal of Finding of Non-Compliance” of this Model Contract.

1.23.2 Appeal of Finding of Non-Compliance

The Contractor may challenge a finding of non-compliance that results in an Intermediate Sanction, through appeal to OHCA Administrative Law Judge. Such an appeal must be filed in writing with the Administrative Law Judge Docket Clerk within 30 days of the Contractor’s receipt of notice of the Intermediate Sanction. The appeal will be adjudicated in accordance with OHCA’s administrative rules.

1.23.3 Intermediate Sanctions

1.23.3.1 Civil Monetary Penalties

1.23.3.1.1 Failure to Provide Medically Necessary Services

If the Contractor fails to substantially provide Medically Necessary services to a Health Plan Enrollee that the Contractor is required to provide under law or the Contract, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each failure to provide services. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract.

1.23.3.1.2 Imposition of Excess Premiums

If the Contractor imposes premiums or charges on Health Plan Enrollees that are in excess of those permitted in the Medicaid program, OHCA may impose a Civil Monetary Penalty of up to \$25,000 or double the amount of the excess premiums or charges, whichever is greater. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract. If OHCA imposes a Civil Monetary Penalty under this section, OHCA will deduct the amount of the

overcharge from the penalty and return it to the affected Health Plan Enrollee in accordance with 42 C.F.R. § 438.704(c).

1.23.3.1.3 Discrimination on the Basis of Health Status

If the Contractor discriminates among Health Plan Enrollees on the basis of their health status or need for health services, OHCA may impose a Civil Monetary Penalty of up to \$100,000 for each determination of discrimination. OHCA may impose a Civil Monetary Penalty of up to \$15,000 for each Eligible the Contractor did not enroll because of a discriminatory practice, up to the \$100,000 maximum. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract.

1.23.3.1.4 Misrepresentation or Falsification of Information to OHCA or CMS

If the Contractor misrepresents or falsifies information that it furnishes to OHCA or to CMS, OHCA may impose a Civil Monetary Penalty of up to \$100,000 for each instance of misrepresentation. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract.

1.23.3.1.5 Misrepresentation or Falsification of Information to Health Plan Enrollees, Eligibles or Providers

If the Contractor misrepresents or falsifies information that it furnishes to a Health Plan Enrollee, Eligible, or health care Provider, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each instance of misrepresentation. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract.

1.23.3.1.6 Physician Incentive Plan Non-Compliance

If the Contractor fails to comply with the physician incentive plan requirements as described in Section 1.14.1.10: “Performance-Based Provider Payments,” OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each failure to comply. OHCA may also impose sanctions in accordance with Section 1.23.3.2: “Other Intermediate Sanctions” of this Model Contract.

1.23.3.1.7 Improper Distribution of Marketing Materials

If the Contractor distributes Marketing Materials that have not been approved by OHCA or that contain false or misleading information, either directly or indirectly through any agent or independent contractor, OHCA may impose a Civil Monetary Penalty of up to \$25,000 for each distribution.

1.23.3.2 Other Intermediate Sanctions

In accordance with 42 C.F.R. § 438.702, OHCA may impose the following Intermediate Sanctions if it determines the Contractor acts or fails to act in accordance with Sections 1.23.3.1.1 through 1.23.3.1.7.

- Appoint temporary management to the Contractor in accordance with Section 1.23.5: “Appointment of Temporary Management” of this Model Contract.
- Grant Health Plan Enrollees the right to disenroll without cause and notify them of their right to disenroll.
- Suspend all new Enrollments to the Contractor after the date the Secretary or OHCA notifies the Contractor of a determination of a violation of any requirement under §§ 1903(m) or 1932 of the Act.
- Suspend Capitation Payments for new Enrollments to the Contractor until CMS or OHCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

1.23.3.3 Additional Social Security Act Violations

If the Contractor violates any applicable requirements of §§ 1903(m), 1932, or 1905(t) of the Act, or any implementing regulations, other than those violations addressed in Section 1.23.3.1: “Civil Monetary Penalties” of this Model Contract, OHCA may impose the following sanctions:

- Grant Health Plan Enrollees the right to disenroll without cause.
- Suspend all new Enrollments to the Contractor after the date the Secretary or OHCA notifies the Contractor of a determination of a violation of any requirement under §§ 1903(m) or 1932 of the Act.
- Suspend Capitation Payments for new Enrollments to the Contractor until CMS or OHCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

1.23.4 **Denial of Payment for New Health Plan Enrollees**

Capitation Payments to the Contractor will be denied for new Health Plan Enrollees when, and for so long as, payment for those Health Plan Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). CMS may deny payment to OHCA for new Health Plan Enrollees if its determination is not contested timely by the Contractor. OHCA will define in writing to the Contractor the conditions for lifting the payment denials.

1.23.5 **Appointment of Temporary Management**

In accordance with 42 C.F.R. § 438.706, OHCA may impose temporary management of the Contractor when OHCA finds through ongoing monitoring activities such as onsite surveys, Health Plan Enrollee or other complaints, review of the Contractor’s financial status, or any other source:

- There is continued egregious behavior by the Contractor;
- There is substantial risk to Health Plan Enrollee health; or
- The sanction is necessary to ensure the health of the Contractor’s Health Plan Enrollees while improvements are made to remedy violations that require sanctions, or until there is an orderly termination or reorganization of the Contractor.

OHCA must impose temporary management if it finds the Contractor has repeatedly failed to meet substantive requirements in §§ 1903(m) or 1932 of the Act. In accordance with 42 C.F.R. § 438.706(c), OHCA may not delay the imposition of temporary management to provide a hearing. OHCA will not terminate temporary management until it determines, at its sole discretion, that the Contractor can ensure the sanctioned behavior will not recur.

When temporary management is imposed, OHCA will notify and grant Health Plan Enrollees the right to terminate Enrollment with the Contractor without cause, as described in 42 C.F.R. § 438.702(a)(3). If temporary management is imposed, the Contractor shall cooperate fully in the transition process to ensure any disruption to Health Plan Enrollees and Providers is minimized.

OHCA or its designees shall have full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to Health Plan Enrollees pending the Contractor’s termination from the SoonerSelect program or remedying of the underlying deficiency. OHCA shall have the authority to hire staff, execute any instrument in the name of the Contractor and to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party during the temporary management period.

The Contractor shall be responsible for all reasonable expenses related to the direct operation of the health plan, including but not limited to attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor.

1.23.6 Other Non-Compliance Remedies

In accordance with 42 C.F.R. § 438.702(b), OHCA may impose Non-Compliance Remedies, in addition to those outlined in Section 1.23.3: “Intermediate Sanctions” of this Model Contract. Additional Non-Compliance Remedies are outlined in the table below. The Contractor understands and agrees that the liquidated damages described herein are not to be construed as penalties. OHCA retains authority to seek other remedies and take other actions as appropriate to ensure compliance, satisfy contractual obligations and/or safeguard Health Plan Enrollees’ rights and interests.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Section 1.2.2: “Capitation Reconciliation”	The Contractor fails to perform monthly reconciliation of enrollment roster data against Capitation Payments.	<ul style="list-style-type: none"> • Refund of any detected overpayments or duplicate payments as identified through OHCA or federal review and resulting from the Contractor’s failure to properly perform reconciliation. • Liquidated damages of \$5,000 per day that the Contractor remains out-of-compliance with reconciliation requirement.
Section 1.19.4: “Health Plan Enrollee Encounter Data”	The Contractor fails to submit Encounter Data timely.	<ul style="list-style-type: none"> • For failure to submit Encounter Data by the deadline established by OHCA, liquidated damages equal to 15% of capitation paid for the month previous to month in which encounter data was due.
Section 1.19.4: “Health Plan Enrollee Encounter Data”	The Contractor fails to submit Encounter Data in accordance with OHCA accuracy standards, as determined through encounter Validation studies conducted by OHCA or its designee.	<ul style="list-style-type: none"> • For error rate of 5.1 to 7.0 percent: five percent of capitation paid in Validation study period. • For error rate of 7.1 to 10 percent: ten percent of

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		capitation paid in Validation study period. <ul style="list-style-type: none"> For error rate of 10.1 percent or greater: 15% of capitation paid in Validation study period.
Section 1.18.1.3: “Collaboration with OHCA and MFCU”	The Contractor fails to allow OHCA, MFCU, or other authorized State and federal authorities access to claims payment data and other applicable records.	<ul style="list-style-type: none"> Liquidated damages of \$500 per day.
Section 1.18.1.3: “Collaboration with OHCA and MFCU”	Contractor fails to provide information responsive to specific requests made by OHCA, MFCU, or other authorized State and federal authorities (including, but not limited to, requests for records of Health Plan Enrollee and Provider interviews), within three Business Days of said request, unless otherwise agreed upon by OHCA.	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day.
Section 1.18.1.2: “Referral to OHCA Program Integrity and Accountability Unit or Oklahoma Medicaid Fraud Control Unit (MFCU)”	The Contractor fails to refer credible allegations of Fraud to OHCA’s Legal Division in writing within three Business Days of discovery.	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day.
Section 1.18.7: “Suspension of Payments for Credible Allegation of Fraud”	If credible allegation of Fraud exists, the Contractor fails to immediately suspend all payments to the Provider as instructed by OHCA, within 24 hours of receipt of said instruction.	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day.
Section 1.18.1.3: “Collaboration with OHCA and MFCU”	The Contractor fails to participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.	<ul style="list-style-type: none"> Liquidated damages of \$10,000 per meeting.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Section 1.18.2: “Compliance Program”	The Contractor fails to participate in good faith at monthly meetings with the OHCA Program Integrity and Accountability Unit.	<ul style="list-style-type: none"> Liquidated damages of \$10,000 per meeting.
Section 1.18.9.1.2: “When Disclosures of Persons with An Ownership or Control Interest Are Required”	The Contractor fails to disclose any change in ownership and control information to OHCA within 35 Calendar Days in accordance with 42 C.F.R. § 455.104, and Subcontractors as governed by 42 C.F.R. § 438.230.	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day
Section 1.18.9.1.2: “When Disclosures of Persons with An Ownership or Control Interest Are Required”	<p>As required by 42 C.F.R. § 455.105, the Contractor fails to submit to OHCA or DHHS, within 35 Calendar Days of request, full and complete information about:</p> <p>The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and</p> <p>Any significant business transactions between the Contractor and any wholly owned supplier, or between the Provider and any Subcontractor, during the five-year period ending on the date of request.</p>	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day
Section 1.18.2: “Compliance Program”	By close of the last Calendar Day of each month, the Contractor fails to provide a monthly report of all open program integrity related audits and investigations related to Fraud, Waste, and Abuse activities for identifying and collecting potential overpayments, utilization review,	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>and Provider compliance. The report shall include, but is not limited to, audits and investigations performed, overpayments identified, overpayments recovered, and other program integrity actions taken; such as, corrective action plans, Provider education, financial sanctions, and sanctions against a Provider.</p>	
<p>Section 1.21: "Reporting"</p>	<p>The Contractor fails to submit a required report timely and/or accurately.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$2,500 per business day per report that has not been submitted correctly, complete, on time and in the OHCA-defined format. • If reporting non-compliance impacts OHCA's ability to monitor the Contractor's solvency, and the Contractor's financial position requires OHCA to transfer Health Plan Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that would have been paid to the Contractor and the actual rates being paid to the replacement MCO as a result of the Health Plan Enrollee transfer. Additionally, the Contractor shall pay any costs OHCA incurs to

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>accomplish the transfer of Health Plan Enrollees.</p>
<p>Section 1.11.5: “New Health Plan Enrollee Materials and Outreach”</p>	<p>The Contractor fails to distribute a Health Plan Enrollee Handbook or ID Card in the required timeframe.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$500 for each instance where the Contractor fails to distribute a Health Plan Enrollee Handbook within ten days of a Health Plan Enrollee’s Enrollment with the Contractor. • Liquidated damages of \$500 for each instance where the Contractor fails to distribute a Health Plan Enrollee ID Card within seven days of a Health Plan Enrollee’s Enrollment with the Contractor.
<p>Section 1.11.7: “Health Plan Enrollee Services Call Center”</p>	<p>The Contractor fails to meet Health Plan Enrollee Call Center performance standards.</p>	<ul style="list-style-type: none"> • For any calendar month where the call abandonment rate is equal to or greater than five percent, liquidated damages of \$10,000 for each full percentage point equal to or greater than five percent. • For any calendar month where less than 85% of calls are answered by a live voice within 30 seconds of the first ring, liquidated damages of \$10,000 for each full percentage point below 85%. • For any calendar month where the average wait

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>time exceeds two minutes, liquidated damages of \$10,000.</p> <ul style="list-style-type: none"> • For any calendar month where the blocked call rate exceeds one percent, liquidated damages of \$10,000 for each percentage point above one percent.
<p>Section 1.13.2: “Provider Services Call Center”</p>	<p>The Contractor fails to meet Provider Services Call Center performance standards.</p>	<ul style="list-style-type: none"> • For any calendar month where the call abandonment rate is equal to or greater than five percent, liquidated damages of \$10,000 for each full percentage point equal to or greater than five percent. • For any calendar month where less than 85% of calls are answered by a live voice within 30 seconds of the first ring, liquidated damages of \$10,000 for each full percentage point below 85%. • For any calendar month where the average wait time exceeds two minutes, liquidated damages of \$10,000. • For any calendar month where the blocked call rate exceeds one percent, liquidated damages of \$10,000 for each

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		percentage point above one percent.
Section 1.12.3: "Credentialing"	The Contractor fails to meet timeliness standards for Provider credentialing.	<ul style="list-style-type: none"> Liquidated damages of \$500 per Calendar Day where the Contractor fails to credential a Provider within 45 days of receipt of a complete application.
Section 1.14.4.2: "Timely Claims Filing and Processing"	The Contractor fails to meet timely claims payment standards.	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for any calendar month where the Contractor fails to pay 90% or more of clean claims within 14 days for each deficient claim type. Liquidated damages of \$10,000 for any calendar month where the Contractor fails to pay 99% or more of clean claims within 90 days for each deficient claim type. For the purposes of this requirement, there are six claims types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims and pharmacy electronic claims.
Section 1.12.4: "Time and Distance and Appointment Access Standards"	<p>The Contractor fails to meet time and distance standards for network adequacy for any of the following Provider types:</p> <ul style="list-style-type: none"> Adult PCMHs 	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each calendar month, for each Provider type, where the Contractor fails to meet

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<ul style="list-style-type: none"> • Pediatric PCMHs • OB/GYN • Adult mental health • Adult SUD • Pediatric mental health • Pediatric SUD • Adult specialists • Pediatric specialists • Hospitals • Pharmacies • Essential community providers 	<p>the time and distance standards.</p> <ul style="list-style-type: none"> • Submission of corrective action plan to OHCA. • More frequent submission of network adequacy reports at the direction of OHCA until Contractor compliance is demonstrated for 60 consecutive days. • OHCA may require the Contractor to maintain an open network for the Provider type(s) for which the Contractor demonstrates non-compliance. • Non-compliance with network adequacy standards for three consecutive months shall result in auto-assignment suspension until such time as the Contractor successfully demonstrates compliance.
<p>Section 1.16: “Health Plan Enrollee Grievances and Appeals”</p>	<p>The Contractor fails to resolve 98% of Health Plan Enrollee Grievances within 30 Calendar Days from the date the Grievance is received. The Contractor fails to resolve 100% of Health Plan Enrollee Grievances within 60 Calendar Days from the date the Grievance is received.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
<p>Section 1.16: “Health Plan Enrollee Grievances and Appeals”</p>	<p>The Contractor fails to resolve 100% of Health Plan Enrollee Appeals within 30 Calendar Days from the date the Appeal is received.</p> <p>The Contractor fails to resolve 100% of expedited Appeal requests within 72 hours of when the request was received or within the additional 14 Calendar Days if the timeframe is extended.</p> <p>The Contractor fails to resolve 100% of Step Therapy Appeal requests within 24 hours of when the request was received, in exigent circumstances, or 72 hours of when the request was received, in all other circumstances; provided, however, that if the timeframe for response ends on a weekend, or on any other day the Contractor is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day.</p>	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.
<p>Section 1.16: “Health Plan Enrollee Grievances and Appeals”</p>	<p>The Contractor fails to send 100% of notice of standard Service Authorization decisions to the requesting Provider, and the Health Plan Enrollee or the Health Plan Enrollee’s Authorized Representative, within 14 Calendar Days from request for the service, or within 28 Calendar Days, if extended.</p> <p>The Contractor fails to send 100% of notices of expedited service</p>	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>authorizations within 72 hours from the date of request for the service, or within the additional 14 Calendar Days, if extended.</p> <p>The Contractor fails to send 100% of notices of resolution of Step Therapy Appeals within 24 hours of the resolution of the Appeal.</p> <p>The Contractor fails to send 100% of notices of an Adverse Benefit Determination for termination, suspension or reduction of previously authorized services within ten Calendar Days of the effective date of the decision, or within the timeframes specified in 42 C.F.R. §§ 431.214 or 431.213, if applicable.</p> <p>The Contractor fails to send 100% of notices of resolution of Health Plan Enrollee Grievances within three Calendar Days of the resolution of the Grievance.</p>	
<p>Section 1.13.6: “Provider Complaint System”</p>	<p>The Contractor fails to resolve 98% of Provider reconsiderations within 30 Calendar Days of receipt of the request for reconsideration.</p> <p>The Contractor fails to resolve 100% of Provider reconsiderations within 60 Calendar Days of receipt of the request for reconsideration.</p>	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.
<p>Section 1.13.6: “Provider Complaint System”</p>	<p>The Contractor fails to resolve 98% of Provider appeals within 30 Calendar Days of receipt of the appeal.</p>	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>The Contractor fails to resolve 100% of Provider appeals within 60 Calendar Days of receipt of the appeal.</p>	
<p>Section 1.13.6: "Provider Complaint System"</p>	<p>The Contractor fails to send 100% of notices of resolution of Provider reconsiderations within five Calendar Days of resolution of the reconsideration.</p> <p>The Contractor fails to send 100% of notice of resolution of Provider appeals within five Calendar Days of resolution of the appeal.</p>	<ul style="list-style-type: none"> Liquidated damages of \$10,000 for each quarter the Contractor is non-compliant.
<p>Section 1.16.5.4: "Contractor State Fair Hearing Support"</p>	<p>The Contractor fails to maintain a sufficient level of staff training to competently perform the functions, requirements, roles, and duties involved in State Fair Hearing support.</p>	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per day from the time the training deficiency is identified by the State and until the Contractor resolves the situation to the State's approval.
<p>Section 1.16.5.4: "Contractor State Fair Hearing Support"</p>	<p>The Contractor fails to provide the State the required summary information within 24 hours after notification of the request for a State Fair Hearing related to a Step Therapy Appeal, or within 15 Calendar Days after notification of the request for a State Fair Hearing in all other instances.</p>	<ul style="list-style-type: none"> 1-3 months at less than 95%: \$3,000 4-6 months at less than 95%: \$6,000 7-9 months at less than 95%: \$9,000 10-12 months at less than 95%: \$12,000
<p>Section 1.16.5.4: "Contractor State Fair Hearing Support"</p>	<p>The Contractor fails to summarize the arguments presented by the Appellant and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Appellant and Contractor are clearly identified. The Contractor shall state the legal</p>	<ul style="list-style-type: none"> 1-3 months at less than 95%: \$3,000 4-6 months at less than 95%: \$6,000 7-9 months at less than 95%: \$9,000 10-12 months at less than 95%: \$12,000

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	basis upon which dismissal requests are based and include regulations or statutes in support.	
Section 1.16.5.4: “Contractor State Fair Hearing Support”	The Contractor fails to provide timely delivery to the Appellant, the State, and the Office of Administrative Hearings State Fair Hearing documentation, as required.	<ul style="list-style-type: none"> • 1-3 months at less than 95%: \$3,000 • 4-6 months at less than 95%: \$6,000 • 7-9 months at less than 95%: \$9,000 • 10-12 months at less than 95%: \$12,000
Section 1.16: “Health Plan Enrollee Grievances and Appeals”	The State will monitor performance and set performance targets for each Contractor regarding the percentage of State Fair Hearing requests that are resolved without a change to the original determination. When performance targets are identified, the State will inform the Contractor as to the required performance and increment of measurement.	<ul style="list-style-type: none"> • Starting with the quarter following notification, the Contractor is subject to liquidated damage assessment of \$50,000 for each increment of non-compliance with the performance target.
Section 1.3.6.2: “Key Staff”	<p>The Contractor fails to fill Key Staff positions.</p> <p>The Contractor is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles and duties.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$1,000 per Calendar Day for each Key Staff position that remains vacant after 90 days.
Section 1.19.9: “Disaster Preparation and Data Recovery”	The Contractor fails to restore operations in a disaster situation.	<ul style="list-style-type: none"> • If the Contractor’s failure to restore operations requires OHCA to transfer Health Plan Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		<p>would have been paid to the Contractor and the actual rates being paid to the replacement MCO as a result of the Health Plan Enrollee transfer.</p> <ul style="list-style-type: none"> • Additionally, the Contractor shall pay any costs OHCA incurs to accomplish the transfer of Health Plan Enrollees.
<p>Section 1.3.10: “Readiness Review”</p>	<p>The Contractor fails to satisfactorily pass the Readiness Review by the deadline imposed by OHCA.</p>	<ul style="list-style-type: none"> • OHCA may delay Enrollment of Eligibles with the Contractor and/or impose other Non-Compliance Remedies, including, but not limited to, Contract termination. • The Contractor shall be responsible for all costs incurred by OHCA as a result of the delay of Enrollment of Eligibles with the Contractor.
<p>Section 1.3.10: “Readiness Review”</p>	<p>The Contractor fails to submit Readiness Review documentation timely and/or accurately.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$5,000 per business day, per Readiness Review deliverable, that has not been submitted correctly, complete, on time and in OHCA-defined format.
<p>Section 1.1.15: “Confidentiality; HIPAA and Business Associate Requirements ”</p>	<p>The Contractor fails to ensure all data containing Personally Identifiable Information (PII), including but not limited to Protected Health Information (PHI) protected health information (PHI) is secured in</p>	<ul style="list-style-type: none"> • In addition to any remedies available to OHCA pursuant to the terms of this Contract or available at law, if OHCA deems credit monitoring

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>accordance with all applicable State and federal privacy and security requirements, including but not limited to HIPAA, 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109.</p>	<p>and/or identity theft safeguards are needed to protect Health Plan Enrollees whose PII/PHI was placed at risk by the Contractor’s failure to comply with Contract terms, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.</p>
<p>Section 1.7.6.3: “Timeliness Standards”</p>	<p>The Contractor fails to comply with timeliness requirements for processing Prior Authorizations.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$5,000 for each calendar month the Contractor fails to adjudicate all Prior Authorization requests (with the exception of pharmacy and inpatient behavioral health requests) within 72 hours. • Liquidated damages of \$10,000 for each calendar month the Contractor fails to adjudicate all urgent Prior Authorization requests within 24 hours. • Liquidated damages of \$5,000 for each calendar month the Contractor fails to conduct all retrospective reviews within 14 days. • Liquidated damages of \$10,000 for each calendar month the Contractor fails to adjudicate all inpatient/residential

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
		behavioral health Prior Authorization requests within 24 hours. <ul style="list-style-type: none"> • Liquidated damages of \$10,000 for each calendar month the Contractor fails to adjudicate all pharmacy Prior Authorization requests within 24 hours.
Section 1.20: "Financial Standards"	The Contractor fails to comply with Oklahoma Insurance Department requirements for minimum net worth and risk-based capital.	<ul style="list-style-type: none"> • Submission of corrective action plan to OHCA. • If the Contractor fails to meet the financial performance standards or otherwise comply with the corrective action plan by the date specified by OHCA, OHCA may freeze Health Plan Enrollee Enrollment to the Contractor.
Section 1.3.2: "Accreditation"	The Contractor fails to be accredited by an Accrediting Entity within 18 months of Contract award.	<ul style="list-style-type: none"> • Achievement of provisional status shall require a corrective action plan within 30 Calendar Days of receipt of notification from Accrediting Entity and may result in termination of this Contract. • Liquidated damages of \$100,000 per month for every month the Contractor is non-complaint.
Miscellaneous Damages	The State is herein provided an administrative procedure to address general Contract	<ul style="list-style-type: none"> • If the non-compliance is not corrected by the specified date, the State

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
	<p>compliance issues not defined elsewhere in this agreement. The State may identify a condition resulting from the Contractor’s non-compliance with the Contract through monitoring activities. If this occurs, the State will notify the Contractor in writing of the contractual non-compliance. The Contractor shall provide a written response to the notification within five Business Days of receipt of the notice. The State will recommend, when appropriate, a reasonable period of time within which the Contractor shall remedy the non-compliance. This liquidated damage may be independent or combined with any of the liquidated damages listed above.</p>	<p>reserves the right to assess liquidated damages in an amount not to exceed \$500 per business day per occurrence after the due date until the non-compliance is corrected.</p>
<p>Section 1.19.11: “Accessibility”</p>	<p>Contractor fails to provide continuous access to information as required.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$5,000 per day.
<p>Section 1.19.11: “Accessibility”</p>	<p>Contractor fails to ensure that all system functions are accessible as required.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$5,000 per day.
<p>Section 1.19.11: “Accessibility”</p>	<p>Contractor fails to provide its URL to OHCA or changes the URL without OHCA’S approval.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$500 per occurrence.
<p>Section 1.19.11: “Accessibility”</p>	<p>Contractor fails to maintain a point of contact to provide assistance interfacing/exchanging data.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$1,000 per day.
<p>Section 1.19.11.1: “System Performance Requirements”</p>	<p>Contractor fails to satisfy any response, retrieval, or display time requirement.</p>	<ul style="list-style-type: none"> • Liquidated damages of \$1,000 per day.

Contract Requirement	Contractor Non-Compliance	OHCA Non-Compliance Remedies
Section 1.19.11.2: "System Performance Notification and Reporting"	Contractor fails to give OHCA the required notification.	<ul style="list-style-type: none"> Liquidated damages of \$1,000 per occurrence.
Section 1.19.11.2: "System Performance Notification and Reporting"	Contractor fails to resolve unscheduled system unavailability as required.	<ul style="list-style-type: none"> Liquidated damages of \$5,000 per day.
Section 1.1.24: "Compliance with Law"	Contractor fails to meet implementation deadlines for mandates and/or laws as directed by CMS, CDC, or other government entity.	<ul style="list-style-type: none"> Liquidated damages of \$2,500 per day or the total amount of fines, costs, penalties or damages assessed for noncompliance by CMS, CDC, or other government entity, if greater.

1.23.7 Offset

OHCA has the express right to offset any civil monetary penalties, liquidated damages, or other amounts due as a result of non-compliance remedies, together with any amounts due under the Contractor’s indemnification obligations or for breach of this contract, against any payments owed by OHCA to the Contractor under this agreement.

1.24 Termination

1.24.1 Early Termination

The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this section.

Upon termination of this Contract, for any reason, the Contractor shall return to OHCA all items belonging to OHCA. This may include, but is not limited, to computers, equipment, badges, and electronic documents or files.

1.24.1.1 Termination by Mutual Consent

OHCA and the Contractor may terminate the Contract by mutual written agreement.

1.24.1.2 Termination for Convenience

The state may terminate the Contract, in whole or in part, for convenience if it is determined that termination is in the state’s best interest. In the event of a termination for convenience, Contractor will be provided at least 60 days’ written notice of termination. Any partial termination of the Contract shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that remain in effect.

Upon receipt of notice of such termination, Contractor shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Such termination shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any amount paid to Contractor in the form of prepaid fees that are unused when the Contract or certain obligations are terminated shall be refunded. Termination of the Contract under this section, in whole or in part, shall not relieve the Contractor of liability for claims arising under the Contract.

1.24.1.3 Termination for Default

In accordance with 42 C.F.R. § 438.708, OHCA may terminate the Contract, in whole or in part, whenever the Contractor has failed to carry out the terms of the Contract or meet the applicable requirements of §§ 1932, 1903(m) or 1905(t) of the Act. OHCA may assign Health Plan Enrollees to another MCO or provide benefits through other State Plan authority if the Contractor has breached this Contract and is unable or unwilling to cure such breach within the period of time specified by OHCA as provided below.

The Contractor shall also be in default, and the provisions in this section shall apply, if it terminates early without the mutual consent of OHCA.

Upon determination by OHCA that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor shall be notified in writing of the failure and of the time period which has been established by OHCA to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, in accordance with 42 C.F.R. § 438.710, OHCA will provide the Contractor with written notice of its intent to terminate, the reason for termination and the time and place of a pre-termination hearing. After the hearing, OHCA shall provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination. For an affirming decision, OHCA shall give Health Plan Enrollees of the Contractor notice of termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

In the event of termination for default, in full or in part as provided under this clause, OHCA may procure, upon such terms and in such manner as is deemed appropriate by OHCA, supplies or services similar to those terminated and the Contractor shall be liable for any costs associated for such similar supplies or services and all other damages allowed by law. In addition, the Contractor shall be liable to OHCA for administrative costs incurred to procure such similar supplies or services as are needed to continue operations and for administrative costs incurred to transition Health Plan Enrollees from the Contractor.

In the event of a termination for default, the Contractor shall be paid for any outstanding Capitation Payments due less any damages or other amounts assessed or due to OHCA under this Contract. If damages and other amounts owed to OHCA exceed Capitation Payments due to the Contractor, then OHCA shall have the right to collect all such amounts from the Contractor's performance bond, cash deposit, letter of credit or substitute security, as described in Section 1.1.29: "Performance Bond or Substitutes" of this Model Contract.

The rights and remedies of OHCA provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

1.24.1.4 Termination for Unavailability of Funds

In the event funding from federal, State or other sources is not sufficiently appropriated, or is withdrawn, reduced or limited in any way after the effective date of the Contract, OHCA may terminate this Contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.

1.24.1.5 Termination for Lack of Authority

In the event that any necessary federal or State approval or authority to operate the SoonerSelect program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with an MCO for the provision of health care for Eligibles or Health Plan Enrollees, OHCA may terminate this Contract immediately, effective on the close of business on the day specified.

Should any part of the scope of work under this Contract relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The State must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the State paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the Contractor shall return the payment for that work to the State. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

1.24.1.6 Termination for Financial Instability

In the event that OHCA deems, in its sole discretion, that the Contractor is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this Contract, or the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

In the event OHCA elects to terminate the Contract under this provision, the Contractor shall be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise OHCA. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

1.24.1.7 Termination for Debarment

Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The Contractor may not knowingly have an individual or Affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, who has been debarred, suspended or otherwise excluded from

participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The prohibited relationships include:

- A director, officer or partner of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A Subcontractor of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A person with beneficial ownership of five percent or more of the Contractor's equity who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A Participating Provider or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Act;
- Any individual or entity excluded for cause from participation in any State Medicaid program or the Medicare program; or
- Any individual or entity listed on the State or federal excluded Provider lists.

The Contractor shall not have a relationship with an individual that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Act.

OHCA must notify CMS of any prohibited relationship and terminate a Contract with an entity that is found to be out of compliance with 42 C.F.R. § 438.610 if directed by CMS, and OHCA cannot renew or otherwise extend the existing Contract for such an organization unless CMS determines that compelling reasons exist for doing so.

1.24.2 Transition Period Obligations

A Transition Period shall begin upon any of the following triggering events:

- Notice issued by OHCA of intent to terminate the Contract;
- Notice issued by the Contractor or OHCA of intent not to extend the Contract for a subsequent extension period; or
- If the Contract has no remaining extension periods, 180 days before the Contract termination date.

The Contractor shall remain financially responsible for and continue to serve or arrange for the provision of services to Health Plan Enrollees for up to 45 Calendar Days from the Contract termination or expiration date or until the Health Plan Enrollees can be transferred, whichever is longer. The Transition Period ends upon the transition of Health Plan Enrollees to another MCO or OHCA-designated service delivery system. Upon completion of the Transition Period, the Contractor shall comply with all obligations outlined in Section 1.24.3: "Post-Transition Contract Obligations" of this Model Contract.

The Contractor shall submit a written Transition Plan to OHCA for approval. The Transition Plan shall document the Contractor's plan to ensure the orderly transition of Health Plan Enrollees and to meet all Transition Period and Post-Transition obligations. The Contractor shall make revisions to the Transition Plan at the request of OHCA. The Contractor shall execute, adhere to and provide the services set forth in OHCA-approved Transition Plan. All changes to the Transition Plan are subject to OHCA approval.

The Contractor shall cooperate in good faith with OHCA and its employees, agents and independent contractors and comply with all duties and/or obligations under the Contract. During the Transition Period, the Contractor shall:

- Appoint a liaison to serve as the single point of contact for all Transition Period activities.
- Maintain sufficient staffing levels to meet all Contract obligations.
- Transfer all applicable clinical information on file, including but not limited to approved and outstanding Prior Authorization requests and a list of Health Plan Enrollees enrolled in care management in accordance with the Contractor's Risk Stratification Level Framework to OHCA and/or the successor MCO in the timeframe and manner required by OHCA.
- Coordinate the continuation of care for Health Plan Enrollees who are undergoing treatment for an acute condition.
- Notify all Health Plan Enrollees and Participating Providers about the Contract termination or expiration and the process by which Health Plan Enrollees will continue to receive medical care. The notice shall be sent according to a timeline established by OHCA. The Contractor shall be responsible for all expenses associated with Health Plan Enrollee and Participating Provider notification. These notices are subject to OHCA approval.
- Take whatever other actions are necessary to ensure the efficient and orderly transition of Health Plan Enrollees from coverage under this Contract to coverage under any new arrangement developed by OHCA.

1.24.3 **Post-Transition Contract Obligations**

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to Contract termination or expiration. The Contractor shall work in good faith with OHCA to carry out all Post-Transition obligations. Upon any termination or expiration of the Contract, the Contractor shall:

- Appoint a liaison to serve as the single point of contact for all Post-Transition activities.
- Provide OHCA, or its designee, all records related to the Contractor's activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by OHCA. Such records shall be provided at no expense to OHCA or its designee.
- Participate in the External Quality Review, as required in accordance with 42 C.F.R. Part 438, Subpart E, for the final year of the Contract.
- Submit all performance data and reports with a due date following the termination or expiration of the Contract which cover a reporting period prior to termination or expiration. This includes, at minimum, CAHPS and HEDIS data.
- Remain responsible for resolving Grievances and Appeals related to dates of service prior to the Contract termination or expiration.
- Remain responsible for State Fair Hearings related to dates of service prior to the Contract termination or expiration. This includes providing records and representation at State Fair

Hearings. In the event the State Fair Hearing officer reverses the Contractor's decision to deny authorization of services and the Health Plan Enrollee received the disputed services while the State Fair Hearing was pending, the Contractor must pay for those services.

- Remain financially responsible for all claims with dates of services through the day of Contract termination or expiration. The Contractor shall maintain claims processing functions as necessary for a minimum of 12 months in order to adjudicate all claims for services delivered prior to the Contract termination or expiration.
- Remain financially responsible for all inpatient services reimbursed through a DRG methodology for Health Plan Enrollees hospitalized on or before the day of Contract termination or expiration through the date of Health Plan Enrollees discharge from the hospital. This includes the DRG payment and any outlier payments.
- Submit Encounter Data for all claims incurred prior to the Contract termination or expiration.
- Provide OHCA with all outstanding drug rebate disputes with a manufacturer and an action plan to resolve the disputes.
- Comply with the requirements of Section 1.1.15.4: "Obligations of Contractor upon Termination" of this Model Contract, with respect to PHI received from OHCA, or created, maintained or received by the Contractor on behalf of OHCA.

OHCA retains authority to withhold the Contractor's Capitation Payments until the Contractor has received OHCA approval of its Transition Plan and completed the activities set forth in its Transition Plan, and any other OHCA required activities, to the satisfaction of OHCA. OHCA retains sole authority for determining whether the Contractor has satisfactorily completed the Contractor's transition responsibilities.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

CONTRACTOR

By: _____

Date: _____

Title: _____

OKLAHOMA HEALTH CARE AUTHORITY

By: _____

Date: _____

Title: _____

Approved as to Form and Legal Sufficiency:

By: _____

Date: _____

Title: _____

Appendix 1A: Acronyms

ABD – Aged, Blind and Disabled

ABP – Alternative benefit Plan

ACA – Affordable Care Act

ADL – Activities of Daily Living

AHRQ – Agency for Health Care Research and Quality

AI/AN - American Indian/Alaska Native

CAHPS – Consumer Assessment of Healthcare Providers and Systems Survey

CAP – Corrective Action Plan

CCBHC - Certified Community Behavioral Health Clinic

CEO – Chief Executive Officer

C.F.R. – Code of Federal Regulations

CHIP – Children’s Health Insurance Program

CLIA - Clinical Laboratory Improvement Amendments of 1988

CMHC – Community Mental Health Center

CMS – Centers for Medicare & Medicaid Services

CPT – Current Procedural Terminology

CWS – Child Welfare Services

DHS – Oklahoma Department of Human Services

DHHS – The United States Department of Health and Human Services

DIR – Direct and Indirect Remuneration

DSH - Disproportionate Share Hospital

EHR – Electronic Health Records

EOB – Explanation of Benefits

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

EVV – Electronic Visit Verification System

FC – Foster Care Children

FFC – Former Foster Children

FFS – Fee for Service

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Center

HAN – Health Access Network

HCPCS – Health Care Common Procedure Coding System

HEDIS – Healthcare Effectiveness Data and Information Set

HIE – Health Information Exchange

HIPAA – Health Insurance Portability and Accountability Act

HITECH – Health Information Technology for Economic and Clinical Health Act

HMA - Health Management Associates, Inc.

HMO – Health Maintenance Organization

HMP – Health Management Program

IADL – Instrumental Activities of Daily Living

ICF-IID – Intermediate Care Facility for Individuals with Intellectual Disabilities

IHCP – Indian Health Care Provider

IHP – Indian Health Program

IHS – Indian Health Service

IMCE – Indian Managed Care Entity

IID – Individuals with Intellectual Disabilities

I/T/Us – Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization

LOC – Level of Care

LEP – Limited English Proficiency

LTCHs-C – Long Term Care Hospitals Serving Children

MAGI – Modified Adjusted Gross Income

MAT – Medication Assisted Treatment

MCO – Managed Care Organization

MFCU – Medicaid Fraud Control Unit

MLR – Medical Loss Ratio

MMIS – Medicaid Management Information System

NAIC – National Association of Insurance Commissioners

NCCI – National Correct Coding Initiative

NCPDP – National Council for Prescription Drug Programs

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NQTL – Non-Quantitative Treatment Limit

NEMT – Non-Emergency Medical Transportation

NPI – National Provider Identifier

OAC – Oklahoma Administrative Code

ODMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services

ODOC – Oklahoma Department of Corrections

OHCA – Oklahoma Health Care Authority

OID - Oklahoma Insurance Department

OIG – Office of Inspector General

OJA – Office of Juvenile Affairs

OKSHINE – Oklahoma State Health Information Network and Exchange

OMB – Office of Management and Budget

OSDE – Oklahoma State Department of Education

OSDH – Oklahoma State Department of Health

OSIIS – Oklahoma State Immunization Information System

PA – Prior Authorization

PASRR – Preadmission Screening and Resident Review

PBM – Pharmacy Benefit Manager

PCCM – Primary Care Case Management

PCMH – Patient Centered Medical Home

PCP – Primary Care Provider

PDL – Preferred Drug List

PHI – Protected Health Information

PIPs – Performance Improvement Projects

POS – Point of Sale

ProDUR – Prospective Drug Utilization Review

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assurance and Performance Improvement

QHP – Qualified Health Plan

QIC – Quality Improvement Committee

RFP – Request for Proposals

RHC – Rural Health Clinic

SACWIS – Statewide Automated Child Welfare Information System

SDOH – Social Determinants of Health

SED – Serious Emotional Disturbance

SMI – Serious Mental Illness

SSA – Social Security Administration

SSI – Supplemental Security Income

STCs – Special Terms and Conditions

TANF – Temporary Assistance for Needy Families

TFC – Therapeutic Foster Care

TPL – Third Party Liability

TSET – Tobacco Settlement Endowment Trust

TTY/TDD – Telecommunications Device for the Deaf

UCAT – Uniform Comprehensive Assessment Tool

UM – Utilization Management

URAC – Utilization Review Accreditation Commission

URA – Unit Rebate Amount

Appendix 1B: Definitions

B.1.1 Interpretation of Definitions

Listed below are the definitions used in this Model Contract. These terms shall be construed and/or interpreted as follows, unless this Model Contract otherwise expressly requires a different construction and/or interpretation.

Terms used in this Model Contract that are not otherwise explicitly defined shall be understood to have the definition laid out in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

The following terms shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor and Use.

Unsecured Protected Health Information shall have the same meaning as in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

B.1.2 Oklahoma SoonerSelect Contract Definitions

§1915(c) Waiver – Allows states to offer home and community based services to limited groups of Eligibles as an alternative to institutional care. OHCA has administrative authority over six §1915(c) Waivers: ADvantage, Medically Fragile, Community Waiver, Homeward Bound Waiver, In-Home Supports for Adults Waiver and In-Home Supports for Children Waiver.

Abuse – As defined at 42 C.F.R. § 455.2, Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Eligible and Health Plan Enrollee practices that result in unnecessary cost to the Medicaid program.

Accrediting Entity – An entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized Accrediting Entities include AAAHC, NCQA and URAC. To the extent CMS recognizes additional Accrediting Entities, OHCA will also permit the Contractor to achieve accreditation from such entity to meet the requirements of Section 1.3.2: “Accreditation” of the Model Contract.

Act/The Act – Refers to the Social Security Act.

Activities of Daily Living (ADLs) - Activities that reflect the Health Plan Enrollee’s ability to perform self-care tasks essential for sustaining health and safety such as: bathing; eating; dressing; grooming; transferring (includes getting in and out of the tub, bed to chair, etc.); mobility; toileting and bowel/bladder control. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter and protection.

Adult Protective Services (APS) - A program within the Oklahoma Department of Human Services that provides vulnerable adults protection from abuse, neglect or Exploitation.

Advance Directive - Any writing executed in accordance with the requirements of 63 O.S. § 3101.4, which may include a living will, the appointment of a health care proxy or both relating to the provision of health care when an individual is incapacitated.

Adverse Benefit Determination - Pursuant to 42 C.F.R. § 438.400(b), means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by OHCA;
- The failure of the Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (b)(2) regarding the standard resolution of Grievances and Appeals;
- For a resident of a Rural Area with only one MCO, the denial of a SoonerCare Eligible's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the network; or
- The denial of a Health Plan Enrollee's request to dispute a financial liability, including Cost Sharing, Copayments, premiums, deductibles, coinsurance and other Health Plan Enrollee financial liabilities.

Affiliate - Associated business concerns or individuals if, directly or indirectly: (1) either one controls or can control the other; or (2) a third party controls or can control both.

Agent - Any person or entity who has been delegated the authority to obligate or act on behalf of another.

Alternative Benefit Plan – The benefit package delivered to Expansion Adults which is developed by OHCA and approved by the CMS in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

American Indian/Alaska Native – Pursuant to 42 C.F.R. § 438.14, any individual defined at 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12. This means the individual:

- Is a member of a Federally recognized Indian Tribe;
- Resides in an urban center and meets one or more of the four criteria;
 - Is a member of an Indian Tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the State in which they reside or who is a descendant, in the first or second degree, of any such member;
 - Is an Eskimo or Aleut or other Alaska Native;
 - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

Appeal - A review of an Adverse Benefit Determination by the Contractor.

Applicant - An individual who seeks SoonerCare coverage.

Authorized Representative – A competent adult who has the Health Plan Enrollee’s signed, written authorization to act on the Health Plan Enrollee’s behalf during the Grievance, Appeal, and State Fair Hearing process. The written authority to act shall specify any limits of the representation.

Behavioral Health Emergency - A situation in which a Health Plan Enrollee presents as being at imminent risk of behaving in a way that could result in serious harm or death to self or others.

Behavioral Health Services - A wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse and co-occurring disorders.

Business Days - Defined as Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

Calendar Days - Defined as all seven days of the week, including State of Oklahoma holidays.

Capitation Payment - A payment OHCA will make periodically to the Contractor on behalf of each Health Plan Enrollee enrolled under the SoonerSelect program Contract and based on the actuarially sound Capitation Rate for the provision of services under the State Plan. OHCA shall make the payment regardless of whether the particular Health Plan Enrollee receives services during the period covered by the payment.

Capitation Rate - The per- Health Plan Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the Contractor for each Health Plan Enrollee enrolled in the SoonerSelect program for the provision of services during the payment period.

Care Coordination/Care Management - A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the Health Plan Enrollee’s needs using advocacy, communication and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the Health Plan Enrollee, the Care Manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

Care Manager – The Contractor’s staff primarily responsible for delivering services to Health Plan Enrollees in accordance with its OHCA-approved Risk Stratification Level Framework, and meets the qualifications specified in Section 1.8.4.3: “Qualifications” of the Model Contract.

Care Plan - A comprehensive set of actions and goals for the Health Plan Enrollee developed by the Care Manager based on a Health Plan Enrollee’s unique needs. The Contractor shall develop and implement Care Plans for all Health Plan Enrollees with a Special Health Care Need determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3: “Care Plans” of the Model Contract.

Case File - An electronic record that includes Health Plan Enrollee information regarding the management of health care services including but not limited to: Health Plan Enrollee demographics; Health Risk Screening; Comprehensive Assessment (if applicable); Care Plan; reassessments; referrals and authorizations and Health Plan Enrollee case notes.

Certain Children in the Custody of OJA (JJ) - All persons in OJA custody for whom OJA is required to provide services by law or court order.

Certified Community Behavioral Health Clinic (CCBHC) – Entities designed to provide a comprehensive range of mental health and substance use disorder services as defined under the Excellence in Mental Health Act and certified by the Oklahoma Department of Mental Health and Substance Abuse Services.

Child Placing Agency - A private agency that provides social services to children and their families that supplement, support, or substitute parental care and supervision for the purpose of safeguarding and promoting the welfare of children in adoptive homes and foster family homes.

Child Welfare Services (CWS) - The DHS division responsible for administering the State’s child welfare services.

Child Welfare (CW) Specialist - A frontline worker or supervisor position in Child Welfare Services. Child Welfare Specialists may serve in a variety of program areas and case types, including Family Centered Services (Prevention), Child Protective Services (Investigations), Permanency Planning (ongoing foster care cases), Foster Care and Adoptions (supporting foster families) or other specialized programs.

Children – A child under age 19 determined eligible for SoonerCare under 42 C.F.R. § 435.118 or the state’s Medicaid expansion CHIP.

Children Receiving Adoption Assistance – Individuals receiving adoption assistance benefits administered via the DHS. Adoption assistance is designed to provide adoptive families of any economic stratum with needed social services, and medical and financial support to care for children considered difficult to place. Federal and State law provides for adoption assistance benefits including Medicaid coverage, a monthly adoption assistance payment, special services, and reimbursement of non-recurring adoption expenses.

Choice Counseling - The provision of information and services designed to assist Eligibles in making enrollment decisions. It includes answering questions and identifying factors to consider when choosing among MCOs and PCMH Providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO.

Chronic Condition - A condition that is expected to last one year or more and requires ongoing medical attention and/or limits Activities of Daily Living.

Civil Monetary Penalty – A penalty imposed by OHCA which the Contractor must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

Clean Claim - A claim or encounter which can be adjudicated and submitted without obtaining additional information from the Provider of service or a third party. It does not include a claim from a Provider who is under investigation for Fraud or Abuse or a claim under review for Medical Necessity.

Clinical Practice Guidelines – Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The Contractor shall adopt Clinical Practice Guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of Providers in the particular field; consider the needs of Health Plan Enrollees; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

Cold-call Marketing - Any unsolicited personal contact by the Contractor with an Eligible for the purpose of Marketing.

Confidential Information - Information in any medium (e.g., visual, written, numeric, verbal) that is in some capacity restricted in disclosure or distribution. This includes medical information of individuals or Health Plan Enrollees, information given by OHCA to the Contractor that is indicated to be proprietary, non-public information exchanged between the Contractor and its Subcontractors, or others.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - A survey administered to healthcare recipients to report on and evaluate their experiences with a particular health care system.

Continuity of Care Period – The 90 day period immediately following a Health Plan Enrollee’s enrollment with the Contractor whereby established Health Plan Enrollee and Provider relationships, current services and existing Prior Authorizations and Care Plans shall remain in place in accordance with the requirements of Section 1.9: “Transition of Care” of the Model Contract.

Contract - As a result of receiving an award from OHCA and successfully meeting all Readiness Review requirements, the agreement between the Contractor and OHCA where the Contractor will provide Medicaid services to SoonerSelect Health Plan Enrollees, comprising of the Contract and any Contract addenda, appendices, attachments or amendments thereto, and be paid by OHCA as described in the terms of the agreement.

Contract Dispute - A circumstance whereby the Contractor and OHCA are unable to arrive at a mutual interpretation of the requirements, limitations or compensation for performance of the Contract.

Contract Officer - A designated employee of the Contractor authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to the implementation of the Contract.

Contractor – An MCO with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect program Health Plan Enrollees as specified in the Contract. The term “Contractor” includes all of such Contractor’s Affiliates, Agents, Subsidiaries, any Person with an Ownership or Control Interest, officers, directors, managers, employees, independent contractors and related parties working for or on behalf of the Contractor and other parties required to be disclosed at Section 1.18.9 “Written Disclosures” of this Model Contract.

Copayment - A fixed amount that a Health Plan Enrollee pays for a covered health care service when the Health Plan Enrollee receives the service.

Cost Sharing - When the State requires that Health Plan Enrollees bear some of the cost of their care through mechanisms such as Copayments, deductibles and other similar charges.

Credibility Adjustment - An adjustment to the MLR for a Partially Credible Contractor to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Crisis Center - Any certified community mental health center, comprehensive community addiction recovery center or facility operated by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), which is established and maintained for the purpose of providing community-based mental health and substance abuse crisis stabilization services including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance

abuse treatment services. Qualified providers must be certified by the Oklahoma of Department of Mental Health and Substance Abuse Services pursuant to OAC 450:23.

Crisis Intervention Services - Face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress and/or danger of alcohol or drug relapse.

Critical Incident - Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a SoonerSelect program Health Plan Enrollee.

Days - Calendar days unless otherwise specified.

Deemed Newborn - Children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

Direct Ownership Interest – Pursuant to 42 C.F.R. § 455.101 means possession of equity in the capital, the stock, or the profits of the Disclosing Entity.

Disclosing Entity – Pursuant to 42 C.F.R. § 455.101 means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Disenrollment - The removal of a Health Plan Enrollee from participation in the Contractor's MCO.

Dual Eligible Individuals - Individuals eligible for both Medicaid and Medicare.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Screening and diagnostic services to determine physical or mental defects in Eligibles or Health Plan Enrollees under age 21 and health care, treatment, and other measures to correct or ameliorate any existing defects and/or Chronic Conditions discovered.

Electronic Visit Verification (EVV) System - An electronic system that documents the time that Providers begin and end the delivery of services to Health Plan Enrollees and the location of services. The EVV System shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

Eligible – An individual who has SoonerCare coverage.

Emergency Medical Condition - A medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

Emergency Services - Health Care Services that are furnished by a Provider qualified to furnish such services and needed to evaluate, treat, or stabilize an Emergency Medical Condition.

Encounter Data - Information relating to the receipt of any item(s) or service(s) by a Health Plan Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

Enrollment - The process by which an Eligible becomes a Health Plan Enrollee with the Contractor.

Essential Hospital Services - Tertiary care hospital services to which it is essential for the Contractor to provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

Excluded Benefits – Medicaid-covered services that are not the responsibility of the Contractor as specified in Section 1.6.4: “Excluded Benefits” of the Model Contract.

Excluded Populations - Populations that are excluded from participation in the SoonerSelect program as specified in Section 1.4.5: “Excluded Populations” of the Model Contract.

Exigent Circumstances – Circumstances in which a delay in receiving a prescription drug will jeopardize the Health Plan Enrollee’s life or health or ability to attain, maintain, or regain maximum function.

Expansion Adult – Refers to an Eligible or Health Plan Enrollee age 19 or older and under age 65, with income at or below 138% FPL determined eligible in accordance with 42 C.F.R. § 435.119.

Exploitation - An unjust or improper use of the resources of a vulnerable Health Plan Enrollee for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable Health Plan Enrollee through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

External Quality Review (EQR) - The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that the Contractor furnishes to Health Plan Enrollees.

External Quality Review Organization (EQRO) - An organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs External Quality Review and other EQR-related activities as set forth in 42 C.F.R. § 438.358.

Facility Based Crisis Stabilization Services - Emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment and medical assessment. Qualified providers must be certified by the Oklahoma Department of Mental Health and Substance Abuse Services pursuant to OAC 450:23.

Family Foster Care – Provides 24-hour-a-day substitute temporary care and supportive services in a home environment for children in DHS custody, from birth to 18 years of age.

Family Planning Services and Supplies – Services and supplies described in § 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which OHCA claims or could claim federal match at the enhanced rate under § 1905(a)(5) of the Act.

Federally Qualified Health Center (FQHC) - An organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors.

Former Foster Children (FFC) – Individuals under age 26 determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age 18 or aging out of foster care.

Foster Care - Planned, goal-directed service that provides 24-hour-a-day substitute temporary care and supportive services in a home environment for children birth to 18 years of age in OKDHS custody.

Foster Care and Adoption Association of Oklahoma (FCAO) – Advocacy organization that supports foster and adoptive parents. This group meets with DHS leadership quarterly, and has a very active Facebook group with over 6,000 members.

Foster Care Children (FC) - Children in Foster Care include children and youth who are in State custody due to abuse or neglect.

Full Credibility or Fully Credible - A standard for which the experience of the Contractor is determined to be sufficient for the calculation of an MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. A Contractor that is assigned Full Credibility (or is Fully Credible) will not receive a Credibility Adjustment to its MLR.

Fraud - Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Grievance - A Health Plan Enrollee expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee or failure to respect the Health Plan Enrollee's rights regardless of whether remedial action is requested. A Grievance includes a Health Plan Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Grievance and Appeal System - The processes the Contractor implements to handle Health Plan Enrollee Grievances and Appeals of Adverse Benefit Determinations, as well as the processes to collect and track information about them.

Health Care Services - All Medicaid services provided by the Contractor in any setting, including but not limited to medical care, behavioral health care and pharmacy.

Healthcare Effectiveness Data and Information Set (HEDIS) - A tool supplied by the NCQA and used by health plans to measure performance on important dimensions of care and service. This information set contains a number of measures designed to evaluate quality of care in a standardized fashion that allows for comparison between health plans.

Health Passport - A collaborative effort between DHS, OHCA and OSDE. Each child in the custody of the DHS, has an individual electronic Passport that includes information specific to the child. Child's Passport contains case plan information including but not limited to:

- Medical;
- Education;
- Date of next court hearing;
- Contact information for child's worker, supervisor and attorney;
- List of known family/kin;
- Reason child came into care;
- General behaviors of the child; or

- Disabilities.

Health Plan Enrollee – A SoonerCare Eligible who has been enrolled in a SoonerSelect MCO.

Health Plan Enrollee Handbook - A guidebook that explains the SoonerSelect program that the Contactor shall distribute to every Health Plan Enrollee. It shall be designed to help the Health Plan Enrollee understand the MCO, the SoonerSelect program and the rights and responsibilities that come with membership in the program.

Health Risk Screening - A screening tool developed by the Contractor, and approved by OHCA, to obtain basic health and demographic information, identify any immediate needs a Health Plan Enrollee may have and assist the Contractor to assign a risk level for the Health Plan Enrollee in order to determine the level of care management needed.

Indian Health Care Provider (IHCP) - A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

Indian Health Programs – As defined in 25 U.S.C. § 1603(12): (a), any health program administered directly by the Indian Health Service; (b) any tribal health program; and (c) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to 25 U.S.C. § 47.

Indian Managed Care Entity (IMCE) - An MCO, PIHP, PAHP, PCCM or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization (each as defined in 25 U.S.C. § 1603) which may be composed of one or more I/T/Us and which also may include the Indian Health Service.

Indian Tribe - As defined in 25 U.S.C. § 1603.

Indirect Ownership Interest – Pursuant to 42 C.F.R. § 455.101 means a Direct Ownership Interest in an entity that has a Direct Ownership Interest in the Disclosing Entity. This term includes a Director Ownership Interest in any entity that has an Indirect Ownership Interest in the Disclosing Entity.

Initial Program Implementation – The 90 day period following OHCA initially enrolling all Eligibles who meet criteria for the SoonerSelect program with an MCO.

Intermediate Sanction – The sanctions described in 42 C.F.R. § 438.702 which OHCA may impose for the Contractor's non-compliance for any of the conditions in 42 C.F.R. § 438.700.

Juvenile Justice Involved - All persons in OJA custody or under its supervision for whom OJA is required to provide services by law or court order.

Key Staff – The following staff positions dedicated full time to the SoonerSelect program and based in the Contractor's Oklahoma office: CEO; CFO; Compliance Officer; Care Management Director; Information Systems Director; Chief Medical Officer; Health Plan Enrollee Services Director; Provider Services Director; Utilization Management Director; Quality Management Director; Behavioral Health Director; Data Compliance Manager; Pharmacy Director; Health Plan Enrollee Advocate; Grievances and Appeal Manager; Claims Manager; Transition Coordinator; Tribal Government Liaison; Program Integrity Lead Investigator; and Internal Audit Director.

Limited English Proficiency (LEP) – Eligibles and Health Plan Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient (LEP) and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Major Subcontractor - A Major Subcontractor is defined as:

- Major administrative Subcontractors are entities anticipated to be paid \$2,000,000 or more for Health Plan Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing and Health Plan Enrollee/Provider education; or
- Major health service Subcontractors are entities not including Participating Providers, that have an executed agreement to deliver or arrange for the delivery of any physical health, behavioral health or pharmacy benefit covered under the Contract in accordance with Section 1.6: “Covered Benefits” of the Model Contract.

Maltreatment in Care - Any instances of “abuse” or “neglect” as defined in 10A O.S. 1-1-105.

Managed Care Organization (MCO) - A health plan that has a Contract to participate in the SoonerSelect program and to deliver benefits and services to Health Plan Enrollees.

Managing Employee – Pursuant to 42 C.F.R. § 455.101 means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Marketing - Any communication from the Contractor to an Eligible that can reasonably be interpreted as intended to influence the Eligible to enroll in the Contractor’s SoonerSelect product, or either to not enroll in, or to disenroll from, another MCO’s SoonerSelect product. Marketing does not include communication to an Eligible from the issuer of a QHP about the QHP.

Marketing Materials - Materials that are produced in any medium by or on behalf of the Contractor (including its employees, Participating Providers, agents or Subcontractors) and can reasonably be interpreted as intended to market the Contractor to Eligibles.

Medical Management Program - Consists of a series of activities undertaken by Providers and the Contractor to maintain and improve quality and Medically Necessary (or similar) service levels and respond to accreditation and regulatory requirements.

Medically Necessary - A standard for evaluating the appropriateness of services. Medical necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

- Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;
- Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the Health Plan Enrollee’s need for the service;
- Treatment of the Health Plan Enrollee’s condition, disease or injury must be based on reasonable and predictable health outcomes;

- Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the Health Plan Enrollee, family or medical provider;
- Services must be delivered in the most cost-effective manner and most appropriate setting; and
- Services must be appropriate for the Health Plan Enrollee's age and health status and developed for the Health Plan Enrollee to achieve, maintain or promote functional capacity or age-appropriate growth and development.

Also aligning with federal standards, "Medically Necessary services" are no more restrictive than the State Medicaid program including Quantitative (QTL) and Non-Quantitative Treatment Limits (NQTL), as indicated in State statutes and regulations, the State Plan, and other State policies and procedures. The Contractor shall cover Medically Necessary services related to the ability for a Health Plan Enrollee to attain, maintain, or regain functional capacity.

Medicare Savings Program – Provides assistance to Eligibles in paying Medicare premium and cost sharing.

MLR Reporting Year - A period of 12 months consistent with the Rating Period.

National Provider Identifier (NPI) - A unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

No Credibility or Non-Credible - A standard for which the experience of the Contractor is determined to be insufficient for the calculation of an MLR. A Contractor that is assigned No Credibility (or is Non-Credible) will not be measured against any MLR requirements.

Non-Claims Costs - Those expenses for administrative services that are not: Incurred claims (as defined in 42 C.F.R. § 438.8(e)(2)); expenditures on activities that improve health care quality (as defined in 42 C.F.R. § 438.8(e)(3)); licensing and regulatory fees, or federal and State taxes (as defined in 42 C.F.R. § 438.8(f)(3)).

Non-Compliance Remedy – An action taken by OHCA in response to the Contractor's failure to comply with a Contract requirement or performance standard. Remedies include, but are not limited to: the requirement for the Contractor to develop a formal corrective plan; Capitation Payment suspension; auto-assignment suspension; Intermediate Sanctions; Contract termination and the remedies under Section 1.23.6: "Other Non-Compliance Remedies" of the Model Contract.

Non-Participating Provider - A physician or other Provider who has not contracted with or is not employed by the Contractor to deliver services under the SoonerSelect program.

Non-Urgent Sick Visit - Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of Non-Urgent Sick Visits include cold symptoms, sore throat and nasal congestion. Requires face-to-face medical attention within 72 hours of Health Plan Enrollee notification of a non-urgent condition, as clinically indicated.

Office of Juvenile Affairs (OJA) – The OJA provides, with its community partners, prevention, educational and treatment services, as well as secure facilities for juveniles in order to promote public safety and reduce juvenile delinquency.

OJA Specialists - Individuals employed by the OJA who provide services in the areas of rehabilitation of juvenile offenders and protection of the public through clinical and case management activities in the areas of juvenile intake, probation, parole and custodial responsibility for delinquent children and their families.

OK Care - Members are Oklahoma children’s agencies and residential providers. Includes the contracted foster home providers, therapeutic foster care (TFC) providers, and congregate/residential providers.

Oklahoma Association of Youth Services – An organization of 39 youth services agencies that provide a variety of community based services and also emergency shelters. The contracts for OAYS services occur through the Office of Juvenile Affairs (OJA).

Oklahoma Department of Corrections (ODOC) – The mission of the ODOC is to protect the public, promote a safe working environment for staff, and encourage positive change in offender behavior by providing rehabilitation programs to enable successful reentry.

Oklahoma Department of Human Services (Oklahoma DHS) - The Oklahoma DHS is the largest state agency in Oklahoma. Oklahoma DHS provides a wide range of assistance programs to help Oklahomans in need including: food benefits (SNAP); temporary cash assistance (TANF); services for persons with developmental disabilities and persons who are aging; Adult Protective Services; child welfare programs; child support services and child care assistance, licensing and monitoring. DHS also handles applications and eligibility for SoonerCare’s aged, blind, and disabled population, and long-term care.

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) - The ODMHSAS is responsible for providing services to Oklahomans who are affected by mental illness and substance abuse. The mission of the ODMHSAS is to promote healthy communities and provide the highest quality care to enhance the well-being of all Oklahomans.

Oklahoma Health Care Authority (OHCA) - The single state Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect program.

Oklahoma State Department of Education (OSDE) – The OSDE is the state education agency of the State of Oklahoma charged with determining the policies and directing the administration and supervision of the public school system of Oklahoma.

Oklahoma State Department of Health (OSDH) - The OSDH, through its system of local health services delivery, is ultimately responsible for protecting and improving the public's health status through strategies that focus on preventing disease. Three major service branches, Community & Family Health Services, Prevention & Preparedness Services and Protective Health Services, provide technical support and guidance to 68 county health departments as well as guidance and consultation to the two independent city-county health departments in Oklahoma City and Tulsa.

Open Enrollment Period - The annual period, as defined by OHCA, when Health Plan Enrollees and Eligibles can enroll in an MCO for the SoonerSelect program.

Other Disclosing Entity – Pursuant to 42 C.F.R. § 455.101, any other Medicaid Disclosing Entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, Rural Health Clinic, or health maintenance organization that participates in Medicare;
- Any Medicare intermediary or carrier; and
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Outcomes - Changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Overpayment – Any payment made to a Participating Provider by the Contractor to which the Participating Provider is not entitled or any payment to the Contractor by a state to which the Contractor is not entitled to under Title XIX of the Act and under the SoonerSelect program.

Parent and Caretaker Relative – An individual determined eligible under 42 C.F.R. § 435.110.

Partial Credibility or Partially Credible - A standard for which the experience of the Contractor is determined to be sufficient for the calculation of an MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A Contractor that is assigned Partial Credibility (or is Partially Credible) will receive a Credibility Adjustment to its MLR.

Participating Provider - A physician or other Provider who has a contract with or is employed by the Contractor to provide services to Health Plan Enrollees under the SoonerSelect program.

Past Performance Information – The Bidder’s experience, expertise, and performance in connection with prior contracts, including its performance in the areas of cost, quality, schedule, compliance with plans and specifications, and adherence to the applicable laws and regulations.

Patient Centered Medical Home (PCMH) - OHCA implemented a PCMH primary care delivery system in January 2009 for SoonerCare Choice Eligibles. This model incorporated a managed care component with traditional fee-for-service and incentive payments for medical homes. For the purposes of this Contract, the term “PCMH” shall be used instead of “primary care provider.” PCMH Providers include the provider types listed in Section 1.12.4.1: “PCMH Provider Standards” of the Model Contract.

Pediatric – Children from birth through age 21.

Performance Improvement Projects (PIPs) - A concentrated effort on a problem, consistent with 42 C.F.R. § 438.330, and designed to achieve significant improvement, sustained over time, in health outcomes and Health Plan Enrollee satisfaction and must include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

Person-Centered Care - A health delivery system that provides care that is respectful of and responsive to Health Plan Enrollee's preferences, needs and values. Person-centered care ensures that a Health Plan Enrollee's values guide all clinical and quality of life decisions.

Personal Care Services - Assistance to an individual in carrying out Activities of Daily Living, such as bathing, grooming and toileting, or in carrying out instrumental Activities of Daily Living, such as preparing meals and doing laundry or errands directly related to the Health Plan Enrollee's personal care needs, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. The Personal Care Service requires a skilled nursing assessment of need, development of a Care Plan to meet identified personal care needs, Care Plan oversight and periodic re-assessment and updating, if necessary, of the Care Plan. Personal Care services do not include technical services such as, tracheal suctioning, bladder catheterization, colostomy irrigation and operation of equipment of a technical nature.

Person with Ownership or Control Interest – Pursuant to 42 C.F.R. § 455.101 means a person or corporation that:

- Has a Direct Ownership Interest totaling five percent or more in a Disclosing Entity;
- Has an Indirect Ownership Interest equal to five percent or more in a Disclosing Entity;
- Has a combination of Direct and Indirect Ownership Interests equal to five percent or more in a Disclosing Entity;
- Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity if that interest equals at least five percent of the value of the property or assets of the Disclosing Entity;
- Is an officer or director of a Disclosing Entity that is organized as a corporation; or
- Is a partner in a Disclosing Entity that is organized as a partnership.

Pharmacy Benefit Manager (PBM) - A third party responsible for operating and administering the Contractor's pharmacy program. Pursuant to 59 O.S. § 358, PBMs transacting business in Oklahoma are required to apply for and obtain a license from the Oklahoma Insurance Department.

Pinnacle Plan - The DHS plan to improve the safety, permanency, and wellbeing of children served by the child welfare system.

Post-Stabilization Care Services - Covered services related to an Emergency Medical Condition that are provided after a Health Plan Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R.. § 438.114 (e), to improve or resolve the Health Plan Enrollee's condition.

Post-Transition - The time period that begins upon conclusion of the Transition Period and ends upon the Contractor's successful completion, as determined at the sole discretion of OHCA, of all post-Contract expiration or termination obligations.

Pregnancy-Related Services – In accordance with 42 C.F.R. § 440.210, services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having become pregnant. OHCA considers all services received by a Health Plan Enrollee or Eligible that is pregnant to be a Pregnancy-Related Service.

Pregnant Women – A women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

Presumptive Eligibility – A period of temporary SoonerCare eligibility provided to individuals determined by a qualified entity, on the basis of Applicant self-attested income information, to meet the eligibility requirements for a MAGI eligibility group.

Primary Care Provider (PCP) - A Provider under contract with the Contractor to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and Prior Authorizations. For the purposes of this Contract, the term “PCMH” shall be used instead of “PCP.”

Prior Authorization/Service Authorization - A requirement that a Health Plan Enrollee obtain the Contractor’s approval before a requested medical service is provided or before services by a Non-Participating Provider are received. Prior Authorization is not a guarantee of claims payment; however, failure to obtain Prior Authorization may result in denial of the claim or reduction in payment of the claim. For the purposes of this Contract, the term “Prior Authorization” shall be used instead of “pre-authorization.”

Program of Assertive Community Treatment (PACT) Services - Services delivered within an assertive community-based approach to provide treatment, rehabilitation and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with Serious Mental Illness with a self-contained multi-disciplinary team. Qualified PACT programs must be certified by the Oklahoma Department of Mental Health and Substance Abuse Services pursuant to OAC 450:55.

Proposal – The response submitted by the Contractor during the RFP process detailing its approach to meeting terms of the Contract and serving the SoonerSelect program.

Protected Health Information - Information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

Provider – Includes both Participating and Non-Participating Providers.

Provider Agreement - An agreement between the Contractor and a Participating Provider that describes the conditions under which the Participating Provider agrees to furnish covered services to Health Plan Enrollees.

Provider Complaint - A verbal or written expression by a Provider involving dissatisfaction with the Contractor’s policies, procedures, communication or other action by the Contractor.

Provider-Preventable Conditions - A condition occurring in any inpatient hospital setting, identified by the Secretary under Section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in Section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients. Also includes a condition occurring in any health care setting that is identified in the State Plan, has been found by OHCA, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines; has a negative consequence for the Health Plan Enrollee or Eligible; is auditable; and includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and any surgical or other invasive procedure performed on the wrong patient.

Psychiatric Consultation Program - Psychiatric consultation which occurs through the clinical team at Child Welfare is primarily aimed at assisting Child Welfare Specialists with ensuring that the needs of children and youth in foster care are met, educating staff on diagnoses and treatment and answering general questions. It is NOT typically aimed at making specific medication recommendations, dosing, etc. for a specific child.

Quality Assessment and Performance Improvement (QAPI) - A process designed to address and continuously improve Contractor quality metrics. The QAPI activities will provide the Contractor with data which it shall use, in conjunction with input from Health Plan Enrollees and other stakeholders, to improve the delivery of care and care outcomes. The program shall evaluate all SoonerSelect program population groups, care settings and types of services, including physical health services, Behavioral Health Services and pharmacy benefits. The Contractor's QAPI program shall comply with every aspect of State and federal law, including 42 C.F.R. § 438.330 in its entirety.

Quality Improvement Committee (QIC) - A committee within the Contractor's organizational structure that oversees all QAPI functions. The Contractor's Chief Medical Officer shall chair the committee.

Rating Period – The time period selected by OHCA for which the actuarially sound Capitation Rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a).

Readiness Review - The on-site and desk review process required in accordance with 42 C.F.R. § 438.66. The Contractor is required to meet Readiness Review requirements to the satisfaction of OHCA prior to receiving Health Plan Enrollee enrollment.

Report Period – The measurement period used for the performance withhold program described in Appendix 1D: "Performance Withhold Program." The Report Period is a calendar year.

Reporting Manual – OHCA-developed manual outlining the Contractor's performance reporting obligations, including required reporting, data definitions, frequency and formats.

Residential Child Care Program - A 24-hour residential program where children live together with, or are supervised by, adults other than their parents or relatives. Types of residential programs may also include:

- Children's Shelters - A non-secure public or private residential program that provides temporary care and supervision for children.
- Residential Treatment Programs – Provides medical care for children with emotional, psychological or mental disorders.
- Secure Care Programs – A program that cares for and supervises adjudicated children in a building where entering and exiting is prohibited through the use of internal and external locks or through secure fencing around the perimeter.

Risk Stratification Level Framework - OHCA-approved Contractor methodology for determining the intensity and frequency of care management and population health interventions received by Health Plan Enrollees in accordance with the requirements of Section 1.8: "Care Management and Population Health" of the Model Contract.

Runaway - A child in the care and custody of the State is considered to have runaway if they have been away from their home or placement for more than one night without knowledge and/or permission.

Rural Area - A county with a population of less than 50,000 people.

Rural Health Clinic - Clinics meeting the conditions to qualify for Rural Health Clinic reimbursement as stipulated in Section 330 of the Public Health Services Act. Rural Health Clinics (RHCs) certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. Rural Health Clinics may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare) or independent (freestanding), and may include Indian Health Clinics. To participate, a Rural Health Clinic must have a current contract on file with OHCA.

Science of HOPE - The Science of Hope is a framework developed by Dr. Chan Hellman that is based on more than 2,000 articles that have been published on Hope and its impact to social and well-being outcomes.

Secretary – Refers to the Secretary of the U.S. Department of Health and Human Services.

Serious Emotional Disturbance (SED) - A condition experienced by persons from birth to age 18 that show evidence of points of: (a) The disability must have persisted for six months and be expected to persist for a year or longer; (b) a condition or Serious Emotional Disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable Serious Emotional Disturbance; and (c) the child must exhibit either of the following items below:

- Psychotic symptoms of a Serious Mental Illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
- Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):
 - Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs;
 - Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system;
 - Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults;
 - Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent); or
 - Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

Serious Mental Illness - A condition experienced by persons age 18 and over that show evidence of points of: (a) the disability must have persisted for six months and be expected to persist for a year or longer; (b) a condition or Serious Mental Illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable Serious Mental Illness; and (c) the adult must exhibit either of the following items below:

- Psychotic symptoms of a Serious Mental Illness (e.g., schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
- Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level);
 - Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs;
 - Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system;
 - Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers;
 - Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations); or
 - Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

Service Gap - A delay in initiating any service and/or a disruption of a scheduled, ongoing service that was not initiated by a Health Plan Enrollee, including late or missed visits.

Shall - A verb used to designate duties that will be a required condition of the Contract. Failure of a Contractor to perform a duty required as a condition of the Contract will be considered breach of Contract.

Social Determinants of Health – Conditions in the places where a Health Plan Enrollee lives, learns, works and plays that affect the Health Plan Enrollee’s health and quality-of-life risks and outcomes.

SoonerCare – The Oklahoma Medicaid program.

SoonerCare Dental PAHP – Refers to the vendor with whom OHCA contracts to provide SoonerCare covered dental benefits.

SoonerSelect Specialty Children’s Plan - The single statewide managed care plan that will coordinate and deliver SoonerSelect benefits in a highly coordinated manner, including physical health, behavioral health and pharmacy for the specialty children’s population. The specialty population includes Medicaid Eligibles who are Former Foster Children (FFC), select juvenile justice involved (OJA), in foster care (FC), children with an open prevention services case (PSC) through CWS or receiving adoption assistance (AA).

Soon-To-Be-Sooner – Oklahoma’s separate CHIP program providing coverage to unborn children of families earning up to and including 185% of the FPL. This program allows coverage of pregnancy related services under Title XXI.

Special Health Care Needs – Individuals who have or are at risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health or related services of a type or amount beyond that generally required.

Spread Pricing – Any amount charged or claimed by a Pharmacy Benefit Manager to OHCA that is in excess of the amount the Pharmacy Benefit Manager paid to the pharmacy that filled the prescription.

Standing Referral - A referral from a PCMH Provider or the Contractor for a Health Plan Enrollee needing access to multiple appointments with the specialist over a set period of time, such as a year, without seeking multiple referrals.

State - When not otherwise specified, refers to a government entity or entities within the State of Oklahoma.

State Holidays – Includes New Year’s Day, Martin Luther King, Jr. Day, Presidents’ Day, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving Day and the following day, Christmas Eve and Christmas Day, or any updates thereto based on executive order of the Governor of Oklahoma.

State Plan – An agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

State Plan Benefits – The SoonerCare benefits available to all Health Plan Enrollees, with the exception of Expansion Adults.

State Fair Hearing - The process set forth in Subpart E of 42 C.F.R. Part 431.

Statewide Automated Child Welfare Information System (SACWIS) - Known as KIDS, is a database of statistical information pertaining to Children and Family Service Reviews.

Steady State Operations- The time period beginning 90 days after Initial Program Implementation.

Step Therapy Appeal – An Appeal filed by a Health Plan Enrollee related to a Prior Authorization requirement to begin medication with the most cost-effective drug therapy prior to progressing to another drug therapy.

Subcontractor - An individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor’s obligations under its Contract with the State. A Participating Provider is not a Subcontractor by virtue of the Provider Agreement with the Contractor.

Subsidiary or Subsidiaries – A company that is owned or controlled by another company or entity.

Telehealth - Means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telehealth visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic

mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

Therapeutic Foster Care (TFC) - A Residential Behavioral Management service provided in foster home settings. TFC is designed to serve children ages three to 18 with special psychological, social, behavioral and emotional needs who can accept and respond to the close relationships within a family setting, but whose special needs require more intensive or therapeutic services than are found in traditional foster care.

Third Party Liability (TPL) – All or part of the expenditures for a Health Plan Enrollee’s medical assistance furnished under the OHCA State Plan that may be the liability of a third party individual, entity or program.

Transition Period – The time period which begins upon any of the following triggering events: notice issued by OHCA of its intent to terminate the Contract; notice issued by the Contractor or OHCA to not extend the Contract; or if the Contract has no remaining extension periods, 180 days before the Contract termination date. The Transition Period ends upon the transition of Health Plan Enrollees to another MCO or OHCA-designated service delivery system.

Transition Plan – The plan developed by the Contractor and approved by OHCA documenting how the Contractor will ensure the orderly transition of Health Plan Enrollees and meet the Transition Period and Post-Transition obligations upon Contract expiration or termination.

Trauma Informed Care - An approach to the delivery of health, behavioral health, developmental, educational, and social services that recognizes the science of trauma and adversity, understands the impact of trauma to the brain and health across the lifespan, and views behavior through a lens of “what happened to you” rather than “what is wrong with you.”

Tribal Foster Care - Provides services to AI/AN children and families in compliance with federal and State regulations. DHS seeks to ensure compliance with the federal and State Indian Child Welfare Acts in all program areas. Oklahoma Indian Tribes are responsible for certifying tribal foster homes.

Uniform Comprehensive Assessment Tool (UCAT) - The evaluation instrument used by the Contractor to determine whether a Health Plan Enrollee has a need for Personal Care Services in accordance with OAC 317:35-15-4.

Urban Area – A county with a population of 50,000 people or more.

Urgent Care - Medical care provided for 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 layperson could expect that the absence of medical attention within 24 hours could result in:

- 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;
- Serious impairment to bodily function; or
- A serious dysfunction of any body organ or part.

Value-Added Benefit - Any benefit or service offered by the Contractor that is not a covered benefit. These benefits are subject to change annually as determined by the Contractor and OHCA.

Validation - The review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis.

Wraparound Approach - A team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than service.

Waste - The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Youth Advocacy Board – Former foster youth who serve as advocates and interface with CWS Oklahoma Successful Adulthood Program.

Appendix 1C: OHCA Provider types and Provider sub-specialties

Provider Type	Sub-Specialty
Advance Practice Nurse	Clinical Nurse Specialist
	Certified Nurse Practitioner
	Certified Registered Nurse Anesthetist (CRNA)
	Certified Nurse Midwife
Anesthesiologist Assistant	
Ambulatory Surgical Center (ASC)	
Audiologist	
Case Manager (Targeted)	
Certified Diabetic Educator	
Chiropractor	
Clinic	Federally Qualified Health Clinic (FQHC)
	Rural Health Clinic (RHC)
	Group
	ITU Outpatient Clinic
	Dental Clinic
	OT/PT/ST/RT Group
	Pediatric Clinic
	Applied Behavior Analysis Group
	Speech/Hearing Clinic
	Hospital Based Rural Health Clinic
	Free Standing Rural Health Clinic
	Podiatry Group
	Optometry Group
	Audiology Group
	Psychiatry Group
	Radiology Group
	Behavioral Health Group
	Urgent Care
	Oncology Clinic
	Ophthalmology
	Emergency Medicine Group
	Anesthesia/Pain Management Group
	OB/GYN Group
Laboratory Group	
Diagnostic Sleep Study Clinic	
Dentist	Endodontist
	General Dentistry Practitioner
	Oral Surgeon
	Orthodontist
	Pediatric Dentist
	Periodontist
Oral Pathologist	

Provider Type	Sub-Specialty
	Prosthodontist
	General Dentist with Orthodontic Privileges
DME/Medical Supply Dealer	
End-Stage Renal Disease (RSD) Clinic	
Extended Care Facility	Nursing Facility
	ICF/IID
	Skilled Nursing Facility
Foster Care Agency	RBMS Room and Board
	RBMS Therapeutic Foster Care
	Intensive Treatment Family Care
Home Health Agency	Home Health Agency
	Specialized Home Nursing Services
Hospice	
Hospital	Acute Care
	Psychiatric
	Rehabilitation
	Critical Access
	Children's Rehab Specialty
	ITU Hospital
	Hospital Based Psych
Inpatient Psychiatric Facility	Psychiatric Residential Treatment Facility
	Community Based Extended PRTF
	Psychiatric Hospital
	Acute Psych Level II
Laboratory	Independent Lab
	County Health Department Lab
Licensed Behavioral Health Practitioner	Certified Nurse Practitioner
	Licensed Clinical Social Worker
	Licensed Professional Counselor
	Licensed Behavioral Practitioner
	Under Supervision
	Licensed Marital and Family Therapist
	Licensed Alcohol and Drug Counselor
Mental Health Provider	Partial Hospitalization
	Outpatient Mental Health Clinic
	Community Mental Health Center (CMHC)
	Psychologist
	PACT
	Family Counseling
	Substance Use Disorders
	Family Training
	Para Professional
Mid-Level Practitioner	Physician Assistant

Provider Type	Sub-Specialty
Mobile X-Ray/IDTF	Independent Diagnostics Testing Facility
	Mobile X-Ray
Nurse	Registered Nurse
	Public Health Nurse
Nutritionist	
Optician	
Optometrist	
Other Service Provider	Genetic Counselor
	Lactation Consultant
Pharmacy	
Physician	Oral Surgeon
	Allergist
	Anesthesiologist
	Cardiologist
	Cardiovascular Surgeon
	Dermatologist
	Emergency Medicine Practitioner
	Family Practitioner
	Gastroenterologist
	General Practitioner
	General Surgeon
	Geriatric Practitioner
	Hand Surgeon
	Internist
	Neonatologist
	Nephrologist
	Neurological Surgeon
	Neurologist
	Nuclear Medicine Practitioner
	Obstetrician/Gynecologist
	Oncologist
	Ophthalmologist
	Orthopedic Surgeon
	Otologist, Laryngologist, Rhinologist
	Pathologist
	Pediatric Surgeon
	Maternal Fetal Medicine
	Physical Medicine and Rehabilitation Practitioner
	Plastic Surgeon
	Psychiatrist
	Pulmonary Disease Specialist
	Radiologist
	Thoracic Surgeon

Provider Type	Sub-Specialty
	Urologist
	General Internist
	General Pediatrician
	Dispensing Physician
	Radiation Oncologist
	Abdominal Surgery
	Adolescent Medicine
	Critical Care
	Endocrinology
	Geriatric Psychiatry
	Gynecological Oncology
	Hematology
	Hematology Oncology
	Immunology
	Infectious Diseases
	Laryngology
	Maxillofacial Surgery
	Neurology Child
	Occupational Medicine
	Pain Medicine
	Pediatric Critical Care Medicine
	Pediatric Emergency Med (Pediatrics)
	Pediatric Endocrinology
	Pediatric Gastroenterology
	Pediatric Hematology Oncology
	Pediatric Infectious Disease
	Pediatric Nephrology
	Pediatric Ophthalmology
	Pediatric Orthopedics
	Pediatric Otolaryngology
	Pediatric Pathology
	Pediatric Pulmonology
	Pediatric Rheumatology
	Pediatrics Allergy
	Pediatrics Cardiology
	Pediatric Surgery (Neurology)
	Pediatric Urology
	Psychiatry Child
	Pulmonary Diseases
	Rheumatology
	Rhinology
	Sports Medicine
	Surgery Colon and Rectal

Provider Type	Sub-Specialty
	Surgery Head and Neck
	Surgery Traumatic
	Transplant Surgery
	Neonatal Perinatal Medicine
	Sleep Medicine
	Medical Resident In Training
	Family Practice Obstetrics
	Addiction Medicine
Podiatrist	
Public Health Agency	County Health Department
Room and Board	
School Corporation	School Corporation
	School Based Para Professional
State Employed Physicians	Allergist
	Anesthesiologist
	Cardiologist
	Cardiovascular Surgeon
	Dermatologist
	Emergency Medicine Practitioner
	Family Practitioner
	Gastroenterologist
	General Surgeon
	Geriatric Practitioner
	Internist
	Neonatologist
	Nephrologist
	Neurological Surgeon
	Neurologist
	Nuclear Medicine Practitioner
	Obstetrician/Gynecologist
	Oncologist
	Ophthalmologist
	Orthopedic Surgeon
	Otologist, Laryngologist, Rhinologist
	Pathologist
	Pediatric Surgeon
	Maternal Fetal Medicine
	Physical Medicine and Rehabilitation Practitioner
	Plastic Surgeon
	Psychiatrist
	Pulmonary Disease Specialist
	Radiologist
	Thoracic Surgeon

Provider Type	Sub-Specialty
	Urologist
	General Pediatrician
	Adolescent Medicine
	Critical Care
	Endocrinology
	Gynecological Oncology
	Hematology
	Hematology Oncology
	Infectious Diseases
	Neurology Child
	Pain Medicine
	Pediatric Critical Care Medicine
	Pediatric Emergency Med (Pediatrics)
	Pediatric Endocrinology
	Pediatric Gastroenterology
	Pediatric Hematology Oncology
	Pediatric Infectious Disease
	Pediatric Nephrology
	Pediatric Orthopedics
	Pediatric Otolaryngology
	Pediatric Pathology
	Pediatric Pulmonology
	Pediatric Rheumatology
	Pediatrics Cardiology
	Pediatric Surgery (Neurology)
	Pediatric Urology
	Psychiatry Child
	Rheumatology
	Sports Medicine
	Surgery Colon and Rectal
	Surgery Traumatic
	Neonatal Perinatal Medicine
	Family Practice Obstetrics
Therapist	Physical Therapist
	Physical Therapist Assistant
	Occupational Therapist
	Occupational Therapist Assistant
	Speech/Hearing Therapist
	Speech/Hearing Therapist Assistant
	Speech/Hearing Therapist Fellow
	Board Certified Behavior Analyst
	Board Certified Assistant Behavior Analyst
	Registered Behavior Technician

Provider Type	Sub-Specialty
Transportation Provider	Ambulance
	Air Ambulance

Appendix 1D: Performance Withhold Program

1.0 Overview

OHCA is committed to the delivery of high quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets and appropriately rewards advancement of quality goals. In furtherance of these objectives, OHCA will withhold a portion of the Contractor’s Capitation Payments, as set forth in this Appendix. The Contractor shall be eligible to receive some or all of the withheld Capitation Payments based on the Contractor’s performance in the areas outlined in Section 1.2 of this Appendix.

1.1 Performance Withhold

OHCA will withhold a portion of the Contractor’s Capitation Payments according to schedule outlined in the table below.

Contract Rating Period	Withhold Percentage	Reporting Year	Measurement Year	Reporting of Measures Due from MCO
One--SFY 2022 (Oct 1, 2021-Jun 30, 2022)	1.0	2023	CY 2022	June 15, 2023
Two--SFY 2023 (Jul 1, 2022-Jun 30, 2023)	1.5	2024	CY 2023	June 15, 2024
Three--SFY 2024 (Jul 1, 2023-Jun 30, 2024)	2.0	2025	CY 2024	June 15, 2025
Four--SFY 2025 (Jul 1, 2024-Jun 30, 2025)	2.5	2026	CY 2025	June 15, 2026
Five--SFY 2026 (Jul 1, 2025-Jun 30, 2026)	3.0	2027	CY 2026	June 15, 2027

1.1.1 Frequency

Contractor performance will be assessed annually per the timeframes listed in the table above. OHCA will issue one assessment and payment, if applicable, per MCO per State fiscal year (SFY).

1.1.2 Report Period

The measurement period used for the performance withhold measures is by each calendar year (CY), according to the following:

- Measurement Year One: CY 2022
- Measurement Year Two: CY 2023
- Measurement Year Three: CY 2024
- Measurement Year Four: CY 2025

- Measurement Year Five: CY 2026

1.1.3 Potential Payout

The potential payout for this determination is equal to the amount withheld during each Contract Rating Period.

OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Model Contract Section 1.1.9: “Amendments or Modifications.”

1.2 Outcome Measures and Payment Structure

During the first Contract Rating Period, the Contractor shall be eligible to receive withheld Capitation Payments based on performance in CY 2022 on the five outcome measures and targets outlined in the table below. Withhold payment opportunities have been established based on OHCA priority areas.

Each measure will be compared to the previous year’s performance for OHCA rate among all MCOs submitting data. For the first year only, comparisons will be made to CY 2019. The Contractor shall report all performance withhold measures based on the hybrid methodology when the measure specifications provide that option. To ensure that a proper baseline is set, the Contractor shall utilize the hybrid methodology for all Quality Performance Measures outlined in Section 1.10.5: “Quality Performance Measures” when the measure specification provides that option.

Measure	Measurement Set	Amount of Capitation Withhold	OHCA Baseline Rate	Annual Target Criteria
Adolescent Well-Care Visits	CMS Core Set Hybrid Methodology	0.2%	CY2019: 42.84%	The target will be a two percent increase over OHCA overall rate for CY2019. For future years, the target will be a two percent increase over the most recent calendar year data.
Concurrent Use of Opioids and Benzodiazepines	CMS Core Set Administrative Methodology	0.2%	CY2019: 21.25%	The target will be a two percent decrease from OHCA overall rate for CY2019. For future years, the target will be a two percent decrease from the most recent calendar year data.
Ambulatory Care: Emergency Department (ED) Visits	CMS Core Set Administrative Methodology	0.2%	CY2019: 82.36%	The target for the first year will be a decrease in the most recent OHCA rate. In future years, the benchmark

Measure	Measurement Set	Amount of Capitation Withhold	OHCA Baseline Rate	Annual Target Criteria
				will be the rate of the MCO that performed the best for the prior year.
Plan All-Cause Readmissions	CMS Core Set Administrative Methodology	0.2%	CY2019: 89.92%	The target for the first year will be a decrease in the most recent OHCA rate. In future years, the benchmark will be the rate of the MCO that performed the best for the prior year.
Weight Assessment for Children/Adolescents	CMS Core Set Hybrid Methodology	0.2%	CY2019: 5.24%	The target for the first year will be the lowest reported rate by states reporting this measure utilizing a hybrid methodology. For future years, the target will be a two percent increase over OHCA overall rate.

OHCA reserves the right to adjust the measures, number of measures, weighting of measures and performance targets in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Model Contract Section 1.1.9: “Amendments or Modifications.”

1.3 Timing of Quality Withhold Determination

OHCA will make its best efforts to distribute a report identifying Contractor performance and eligibility for payment of withheld Capitation Payments within six months of the end of each established Report Period, as defined in Section 1.1.2 “Performance Withhold” of this Appendix. Given that unforeseen circumstances may impact the timing of this determination, OHCA reserves the right to revise the timeframe in which this report is issued.

1.4 Federal Compliance

In accordance with 42 C.F.R. § 438.6, the performance withhold program:

- Will not be renewed automatically;
- Will be made available to both public and private SoonerSelect MCOs under the same terms of performance;
- Does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements;

- Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives specified in the State’s managed care quality strategy required under 42 C.F.R. § 438.340; and
- Will measure performance for a fixed period of time during the Rating Period under the Contract in which the incentive arrangement is applied.

1.5 Contractor Eligibility

The Contractor may, in OHCA’s sole discretion, lose eligibility for its compensation under the performance withhold program if:

- OHCA has suspended, in whole or in part, Capitation Payments or enrollment to the Contractor;
- OHCA has assigned, in whole or in part, the membership and responsibilities of the Contractor to another participating SoonerSelect MCO;
- OHCA has assumed or appointed temporary management with respect to the Contractor;
- The Contract has been terminated;
- The Contractor has, based on the sole determination of OHCA, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in the Model Contract Section 1.24.3: “Post-Transition Contract Obligations;” or
- OHCA has imposed upon the Contractor a Non-Compliance Remedy during the Report Period.

OHCA may, at its discretion, reinstate the Contractor’s eligibility for participation in the SoonerSelect performance withhold program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract and the OHCA has satisfactory assurances of acceptable future performance.

2 Appendix 2: SoonerSelect Specialty Children’s Plan

The provisions of Appendix 2 are intended to implement and support the Oklahoma SoonerSelect Specialty Children’s Plan. The goals and requirements described herein are in addition to the goals and requirements described in the RFP and Model Contract for the SoonerSelect program unless otherwise indicated. To the extent that any provisions in this Appendix conflict with provisions related to the SoonerSelect program Model Contract, for the populations served through the SoonerSelect Specialty Children’s Plan, the provisions of Appendix 2: Addendum shall control.

2.1 SoonerSelect Specialty Population

The specialty population includes Medicaid Eligibles who are Former Foster Children (FFC), (select) Juvenile Justice Involved (JJ), in Foster Care (FC), Children receiving prevention services, or Children Receiving Adoption Assistance (AA). The Contractor shall be responsible for coordinating and delivering SoonerSelect benefits in a highly coordinated manner, including physical health, behavioral health, and pharmacy.

2.2 SoonerSelect Specialty Children’s Plan Goals

The goal of the SoonerSelect Specialty Children’s Plan is to Contract with one managed care plan that:

- Has the willingness and capability to partner with the OHCA, the Department of Human Services (DHS) and Office of Juvenile Affairs (OJA) to develop a care management program that supplements, closely aligns, and coordinates with the:
 - Targeted case management (TCM) services that will continue to be provided by community-based DHS Child Welfare (CW) Specialists and OJA Targeted Case Managers (TCM);
 - DHS Child Welfare Services (CWS) leadership responsible for compliance with the Oklahoma Pinnacle Plan, the state’s plan to achieve improvements in the child welfare system per the settlement agreement reached in the case of DG vs. Yarbrough (08-CV-074);
 - CWS team of clinical and social specialists which provides intensive oversight, planning, and coordination for children with chronic conditions and/or complex healthcare needs; and
 - OJA leadership responsible for coordinating the state’s response to young person’s at-risk of involvement or involved with the juvenile justice system.
- Has utilization management expertise that supports access to services that promote the most holistic and effective combination of interventions necessary to reverse trauma, build resilience, and prepare Health Plan Enrollees for successful adulthood;
- Has demonstrated expertise with the specialty populations including:
 - Managing their unique needs (behavioral, physical, emotional, and/or developmental);
 - Coordinating care across a system of care that includes multiple state agencies and the judicial system;
 - Implementing innovative solutions that:
 - Support home-based treatments;
 - Result in placement stability;
 - Result in increased numbers of family-based treatment providers such as Therapeutic Foster Care (TFC) Providers;
 - Expand access to evidence-based treatments;

- Result in trauma informed, and HOPE centered practices;
- Result in improved health outcomes; and
- Leverage the existing system of care.
- Has data management tools, systems, and/or innovative solutions that:
 - Enable maximum data sharing capabilities across systems (OHCA, DHS and OJA); and
 - Have role-based security capabilities, that include a mechanism to provide limited or full access to Health Plan Enrollee (i.e., FC and JJ) information based on type of user (case worker vs. foster parent).
- Through their response portrays:
 - An understanding of Oklahoma’s current system of care for children receiving prevention services, or in the custody of DHS or OJA;
 - The ability to facilitate compliance with the Pinnacle Plan and associated strategies; and
 - Willingness to actively participate/support in the revision, implementation and monitoring of future Pinnacle Plan strategies.

2.3 Bidder’s Library

The OHCA has posted documents relevant to the specialty populations to the on-line Bidder’s Library at <http://www.okhca.org/about.aspx?id=74>. New content may be added to the Bidder’s Library as appropriate throughout the solicitation. It is the Bidder’s responsibility to check the library frequently for updated information. The OHCA will not routinely notify Bidders when new material has been posted to the library.

2.4 Administrative Requirements

2.4.1 Staffing

In addition to the requirements specified in Section 1.3.6: “Staffing” of the SoonerSelect Model Contract, the following requirements must be met for the SoonerSelect Specialty Children’s Plan.

The Contractor shall have sufficient staff to meet all Contract standards. This includes, at a minimum, the following:

- Care managers dedicated to SoonerSelect Specialty Children’s Plan Health Plan Enrollees.
- Additionally, at least one member of the dedicated Care Management staff will meet the following requirements:
 - Intellectual/Developmental Disabilities (I/DD) Subject Matter Expert (SME); and
 - Licensed Registered Nurse with psychiatric experience.

SME is defined as having substantial knowledge about the I/DD population through education, personal or employment experience.

2.4.2 Key Staff

In addition to the requirements specified in Section 1.3.6.2: “Key Staff” of the SoonerSelect Model Contract, the following requirements must be met for the SoonerSelect Specialty Children’s Plan.

The following are required Key Staff positions for the SoonerSelect Specialty Children’s Plan Contract and shall be:

- Dedicated full-time to the SoonerSelect Specialty Children’s Plan Contract; and

- Based in Oklahoma as required under Section 1.3.5: “Oklahoma Presence” of the SoonerSelect Model Contract.
- *Specialty Population Strategy Officer (Strategy Officer)* who shall serve as the primary contact/liaison between the Contractor’s executive leadership and management team and the DHS and OJA project managers (or other designated agency representatives). The Strategy Officer must have a background in the Plan’s processes, procedures, and systems (e.g., care management system) and expertise with the specialty populations. The Strategy Officer shall:
 - Participate in workgroups and meetings with the DHS and OJA to develop processes and procedures specific to serving the specialty population;
 - Be responsible for implementing the communication and decision-making protocols described in Section 2.4.6: “Coordination with Other State Agencies;”
 - Have decision making authority within the Plan to develop processes, procedures, and system changes for implementation by the Plan.
- *Medical Director* who shall be board-certified and currently licensed in Oklahoma as a child psychiatrist. Preference should be given to physicians with experience with these populations.
- *Care Management Director* who shall oversee the Contractor’s care management and population health model in accordance with Section 1.8: “Care Management and Population Health” of the SoonerSelect Model Contract and Section 2.11: “Care Management and Population Health” of this Appendix 2. The Care Management Director will have expertise with the specialty populations.
- *Health Plan Enrollee Advocate* who shall be responsible for representation of Health Plan Enrollee’s interest, including input in policy development, planning and decision-making. The Health Plan Enrollee Advocate should have lived experience as a Health Plan Enrollee. The Health Plan Enrollee Advocate shall be responsible for development and oversight of the Health Plan Enrollee Advisory Board. The Health Plan Enrollee Advocate will have expertise with the specialty populations.
- *Transition Coordinator* who shall oversee all Health Plan Enrollee transitions and Contractor compliance with all policies in accordance with the requirements of Section 2.12: “Transition of Care” in this Appendix 2. The Transition Coordinator shall have expertise with the specialty populations.

The following Key Staff positions shall meet the requirements specified in Section 1.3.6.2: “Key Staff” of the SoonerSelect Model Contract and shall have expertise with the specialty populations:

- Health Plan Enrollee Services Director
- Utilization Management Director
- Behavioral Health Director
- Native American Liaison

Expertise is defined as having substantial knowledge about the complex care needs of the populations served (particularly children receiving prevention services and adjudicated deprived and in custody of the DHS or OJA) and/or Oklahoma’s child welfare or juvenile justice system through formal education, personal, or employment experience.

In addition to the requirements specified in Section 1.3.6.2: “Key Staff” of the SoonerSelect Model Contract, the Pharmacy Director shall lead the Plan’s efforts implementing the psychotropic medication

guidelines in accordance with the publication, *Oklahoma Pediatric Psychotropic Medication Resource Guide*.

2.4.3 Care Management

In addition to the requirements specified in Section 1.3.6.3: “Care Management” of the SoonerSelect Model Contract, the SoonerSelect Specialty Children’s Plan Care Management program shall have dedicated care management staff. The Contractor shall submit the proposed staffing ratios as part of the Care Management Staffing Plan for review and approval by the OHCA.

2.4.4 Health Plan Enrollee Care Support Staff

In addition to the requirements specified in Section 1.3.6.4: “Health Plan Enrollee Care Support Staff” of the SoonerSelect Model Contract, the SoonerSelect Specialty Children’s Plan shall have adequate numbers of staff with training, education, and/or backgrounds with the specialty populations to meet their needs. The Contractor shall include the approach to meet this requirement as part of the Staffing Plan as required in Section 1.3.6.6: “Staffing Plan and Implementation Plan” of the SoonerSelect Model Contract.

2.4.5 Staff Training

In addition to the requirements in Section 1.3.6.8: “Staff Training” of the SoonerSelect Model Contract, the following is required for the SoonerSelect Specialty Children’s Plan.

The Contractor shall ensure all staff and Subcontractor staff receive adequate training on the requirements, policies and procedures of the SoonerSelect Specialty Children’s Plan program. All Contractor staff shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under this Contract.

The Contractor shall conduct initial and ongoing staff training to ensure staff are educated and able to address the unique needs of the specialty populations. The training must address at a minimum:

- Detailed overview of the SoonerSelect Specialty Children’s Plan and the roles and responsibilities of the OHCA, DHS, and OJA;
- An overview of the Oklahoma child welfare and juvenile justice systems, processes and terminology;
- The unique physical health, developmental, and behavioral needs of the specialty populations;
- The Oklahoma behavioral health system of care and provider network;
- An overview of the contractual requirements of the SoonerSelect Specialty Children’s Plan and those specific to the new hire’s role within the organization;
- The SoonerSelect Specialty Children’s Plan business processes and workflows;
- The Family First Prevention Services Act and any other federally mandated services or programs impacting the specialty population;
- Trauma-informed Care, Science of HOPE, and evidence-based care;
- Rights of American Indian/Alaska Native populations;
- Initiatives identified by the OJA; and
- The aging out process and support from the SoonerSelect Specialty Children’s Plan; including but not limited to assistance with housing, employment, education, and obtaining SoonerCare benefits available to FFC.

In addition, the Contractor’s initial and ongoing training to Subcontractors, Care Managers and all Health Plan Enrollee facing staff shall include:

- Language and cultural competency training as described in Section 1.11.2: “Cultural Competency” of the SoonerSelect Model Contract;
- Oklahoma’s Child Welfare, Juvenile Justice and Permanency System of Care;
- The Child Welfare and Juvenile Justice court systems;
- Services specific to the specialty population;
- The role of Child Placing Agencies and placement types available to children in the custody of the state;
- The roles and decision-making authorities of CW Specialists, OJA TCMs, foster parents, biological parents and other caregivers; and
- Privacy laws specific to the specialty populations.

The Contractor shall track and document completion of all staff training and provide evidence of training completion to the OHCA upon request.

2.4.6 Coordination with Other State Agencies

In addition to the requirements specified in Section 1.3.8: “Coordination with Other State Agencies” in the SoonerSelect Model Contract, the following requirements must be met for the SoonerSelect Specialty Children’s Plan.

The Contractor shall work in a collaboration with DHS and OJA at times and places designated by the OHCA, to develop protocols and procedures in preparation of implementation of the SoonerSelect Specialty Children’s Plan. The Contractor in coordination with the DHS and OJA shall delineate roles and responsibilities, develop communication, decision making protocols and tracking tools as part of this process.

Personnel collaborating and interacting with DHS and OJA personnel shall have experience or detailed knowledge of the Oklahoma child welfare and juvenile justice systems, the delivery of Behavioral Health Services, Trauma-informed Care, Science of HOPE, and evidence based practices applicable to the populations served through this Contract.

The Contractor shall participate in Provider and stakeholder meetings as requested by OHCA, DHS or OJA including, but not limited to:

- Monthly TFC Provider meeting hosted by OHCA and DHS-CWS;
- Provider meetings with OK Care;
- Provider meetings with Oklahoma Association of Youth Services congregate/residential providers and group home providers;
- Quarterly OHCA and DHS leadership team meeting;
- Department of Mental Health and Substance Abuse Services (DMHSAS) and DHS leadership team meetings;
- DHS and Health Department Office (HDO) of Child Abuse and Neglect meetings; and
- HDO Infant Health Advisory Committee meetings.

The Contractor shall develop relationships with advocacy organizations. The Contractor shall have a mechanism to incorporate feedback obtained through these relationships into the Contractors’ Quality Improvement activities. Advocacy organizations include, but are not limited to:

- Foster Care and Adoption Association of Oklahoma (FCAO); and
- Youth Advocacy Board.

2.4.7 Policies and Procedures

The OHCA will coordinate the review and approval of submitted policies and procedures with other state agencies as appropriate. The Contractor shall ensure that all communications related to submissions, revisions, amendments and/or Contract interpretation are directed to the OHCA.

2.4.8 Readiness Review

The OHCA anticipates the DHS and OJA will participate in Readiness Review activities and deemed readiness must be to the satisfaction of the DHS and OJA as well as the OHCA and CMS before being eligible to receive enrollment of Health Plan Enrollees.

2.5 Mandatory, Voluntary and Excluded Populations

2.5.1 Mandatory Enrollment Populations

The following Eligibles will be mandatorily enrolled in the SoonerSelect Specialty Children’s Plan upon entering custody of the state:

- Foster Care Children (FC); and
- Certain children in the custody of OJA (OJA).

The following Eligibles will be mandatorily enrolled in the SoonerSelect Specialty Children’s Plan if they do not make another Plan selection during the choice period during the implementation phase of the SoonerSelect program or fail to make an election on the SoonerCare application after program implementation:

- Former Foster Care (FFC);
- Children with an open prevention service case (PSC) through CWS; and
- Children receiving adoption assistance (AA).

The OHCA reserves the right to disenroll Health Plan Enrollees that are deemed to be on a “runaway” status.

2.5.2 Voluntary Enrollment Populations

Children in Tribal Custody and Children receiving prevention services may voluntarily enroll in the SoonerSelect Specialty Children’s Plan at any time.

2.5.3 Eligibles Opting out of the SoonerSelect Specialty Children’s Plan

Former Foster Children, Children Receiving Adoption Assistance, and Children receiving prevention services shall be enrolled in the SoonerSelect Specialty Children’s Plan if they do not make another choice. These Eligibles may opt-out of enrollment in the SoonerSelect Specialty Children’s Plan and enroll with a SoonerSelect MCO.

2.6 Enrollment and Disenrollment

2.6.1 Enrollment Process

2.6.1.1 Enrollment Choice Counseling

In addition to the requirements specified in Section 1.5.2.1: “Enrollment Choice Counseling” in the SoonerSelect Model Contract, the following applies to the SoonerSelect Specialty Children’s Plan.

The OHCA, or its designee, will be responsible for educating FFC, AA, and PSC Eligibles about the SoonerSelect and SoonerSelect Specialty Children’s Plan providing unbiased Choice Counseling concerning enrollment options.

2.6.1.2 Materials for Enrollment Choice Counseling

In addition to the requirements specified in Section 1.5.2.2: “Materials for Enrollment Choice Counseling” in the SoonerSelect Model Contract, the following is required for the SoonerSelect Specialty Children’s Plan.

The Contractor shall conduct Marketing and outreach efforts to raise awareness of the SoonerSelect Specialty Children’s Plan and their product, subject to the requirements of Section 1.11.15: “Marketing and Outreach” in the SoonerSelect Model Contract.

2.6.1.3 Auto Assignment

Both FC and OJA Eligibles will be auto enrolled in the SoonerSelect Specialty Children’s Plan upon program implementation. After implementation, FC and OJA Eligibles will be auto enrolled in the SoonerSelect Specialty Children’s Plan upon entering custody of the state.

FFC, AA, and PSC Eligibles will be auto enrolled in the SoonerSelect Specialty Children’s Plan if they do not make another Plan selection during the choice period during the implementation phase of the SoonerSelect program or fail to make an election on the SoonerCare application after program implementation. The OHCA reserves the right to modify the auto-assignment algorithm at any time.

Notwithstanding the above language, the OHCA will not make auto-assignments to the Contractor if any of the following conditions exist:

- The Contractor has been excluded from receiving new enrollment due to the imposition of Non-Compliance Remedies, as outlined in Section 1.23: “Non-Compliance Remedies” of the SoonerSelect Model Contract; or
- The Contractor has failed to meet Readiness Review requirements.

2.6.2 **Enrollment Effective Date**

It is the OHCA’s intent that FFC and AA Eligibles, with the exception of Deemed Newborns, who select or are assigned to the SoonerSelect Specialty Children’s Plan before the fifteenth day of the month shall be enrolled effective on the first day of the following month. FFC and AA Eligibles who select or are assigned to an MCO on the fifteenth day of the month or later will be enrolled effective on the first day of the second following month. Prior to these enrollment dates, most FFC and AA Eligibles will be covered by a fee-for-service payment structure administered by the OHCA.

FC and JJ Eligibles shall be enrolled effective the date they are deemed eligible for the Medicaid program and enter custody of the state. PSC Eligibles shall be enrolled effective the date the authorized representative chooses the SoonerSelect Specialty Children’s Plan and deemed eligible for enrollment into the Plan. The OHCA will pro-rate the capitation payment based on the effective date.

Deemed Newborns shall be enrolled in the SoonerSelect Specialty Children’s Plan Health Plan effective as of the date of birth, if the newborn’s mother also is enrolled in the SoonerSelect Specialty Children’s Plan.

Notwithstanding the foregoing, the effective date of enrollment with the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by the OHCA.

2.6.2.1 Medicaid Beneficiaries Entering State Custody

Post implementation of the SoonerSelect Specialty Children’s Plan, Eligibles entering state custody and enrolled in a SoonerSelect managed care plan will be transitioned to the SoonerSelect Specialty Children’s Plan. The OHCA will pro-rate the capitation payment based on the effective date.

Notwithstanding the foregoing, the effective date of enrollment with the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by the OHCA.

2.6.2.2 Medicaid Beneficiaries Exiting State Custody

Eligibles who have been mandatorily enrolled in the SoonerSelect Specialty Children’s Plan will maintain enrollment in the Plan through the trial reunification period. Upon Final Reunification (court relinquishes state custody) the OHCA will inform the Health Plan Enrollee or authorized representative how to select a Plan available through the SoonerSelect program.

2.6.3 **Enrollment Lock-In Period**

In addition to the requirements in Section 1.5.4: “Enrollment Lock-In Period” in the SoonerSelect Model Contract, FFC, AA and PSC Health Plan Enrollees enrolled in a SoonerSelect managed care plan will be able to enroll into the SoonerSelect Specialty Children’s Plan at any time.

2.6.4 **Reenrollment Following Loss of Eligibility**

Health Plan Enrollees who lose and regain eligibility for the SoonerSelect Specialty Children’s Plan for a period of two months or less will be re-enrolled automatically with the Contractor if they meet enrollment criteria for the SoonerSelect Specialty Children’s Plan. Re-enrolled AA and FFC Eligibles will have the right to change MCOs in accordance with Section 1.5.4: “Enrollment Lock-In Period” of the SoonerSelect Model Contract.

2.7 **Covered Benefits**

In addition to the requirements in Section 1.6: “Covered Benefits” in the SoonerSelect Model Contract, the following is required of the SoonerSelect Specialty Children’s Plan.

The Contractor shall be responsible for furnishing the physical health, behavioral health and pharmacy benefits described in this section.

The Contractor shall also coordinate with:

- Providers of benefits outside of the SoonerSelect Specialty Children’s Plan capitation to promote service integration and the delivery of holistic, person- and family-centered care;
- Oklahoma agencies that provide and/or coordinate services due to a Health Plan Enrollee’s involvement in the child welfare and/or juvenile justice system;
- The OHCA Dental PAHP; and
- SoonerSelect MCOs during Health Plan Enrollee transitions.

This includes:

- SoonerSelect Specialty Children’s Plan covered non-capitated benefits, as outlined in Section 1.6.4: “Excluded Benefits” of the Model Contract;
- Services provided by or through the DHS and OJA;

- Services and/or supports provided by the school system;
- Services and/or supports provided by the Oklahoma Department of Mental Health and Substance Abuse Services; and
- Other benefits a Health Plan Enrollee receives, regardless of payer, including volunteered services.

2.7.1 Medical and Related Benefits

In addition to the requirements and benefits in Section 1.6.1: “Medical and Related Benefits” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

It is the OHCA’s expectation that the SoonerSelect Specialty Children’s Plan shall utilize the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to furnish the most holistic and advantageous combination of interventions necessary to reverse trauma, build resilience, and prepare for successful adulthood.

2.7.2 Behavioral Health Benefits

In addition to the requirements and benefits in Section 1.6.2: “Behavioral Health Benefits” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

Service	Children	Adults
Therapeutic Foster Care (317:30-5 Part 83)	Covered when prior authorized	No Coverage
Intensive Treatment Family Care (317:30-5 Part 84)	Covered when prior authorized	No Coverage
Case Management Services for at risk or children in temporary custody of the Office of Juvenile Affairs (317:30-5 Part 97)	Covered	No Coverage
Case Management Services for at risk or children in temporary custody of the Department of Human Services (317:30-5 Part 99)	Covered	No Coverage
Residential Behavior Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Centers (317:30-5 Part 105)	Covered when prior authorized	No Coverage
Multi Systemic Therapy (MST) (317:30-5-241.2(d))	Covered when prior authorized	No Coverage

2.7.2.1 Behavioral Health Crisis Services

In addition to the requirements specified in Section 1.6.2.6: “Behavioral Health Crisis Services” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall develop and maintain policies and procedures to ensure:

- Mobile behavioral health crisis services provided to children in the care and custody of DHS or OJA do not duplicate crisis services provided through another service (e.g., TFC); and
- DHS and OJA are notified of all behavioral health crisis services provided through any modality (face-to-face, telehealth, or the hotline) to children in the care and custody of the respective agency, within one business day in a manner established between the Contractor and OHCA.

2.7.3 **Non-Emergency Medical Transportation**

In addition to the Contract requirements specified Section 1.6.7: “Non-Emergency Medical Transportation” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor will develop policies and procedures for review and approval by the OHCA, specific to FC and OJA Health Plan Enrollees that:

- Consider the social/emotional needs of the Health Plan Enrollee; and
- Support the transportation services provided by the Health Plan Enrollees’ placement as appropriate to the Health Plan Enrollees’ needs.

2.7.4 **Value-Added Benefits**

In addition to the requirements specified Section 1.6.11: “Value-Added Benefits” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The OHCA encourages the Contractor to consider the complex needs of the populations served through this program in developing value added services. For example, value added services that support:

- Adoptive, kinship, and foster home/placements;
- Independence and or independent living and related supports for transition of Eligibles aging out of care;
- Services to support diversion or transition from psychiatric residential services or any other services to fill gaps in the care continuum;
- Respite for foster parents;
- Exceptional transportation supports to accommodate behavioral needs of Health Plan Enrollee;
- Transportation services that support reunification efforts (e.g., transportation for biological parents attend medical and behavioral health appointments); and
- The social needs of Health Plan Enrollees (extracurricular activities, camps, etc.).

2.7.5 **Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)**

In addition to the requirements specified in Section 1.6.12: “Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT)” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor will provide screening and assessment services that align with the standards specified by the American Academy of Pediatrics (AAP) and Child Welfare League of America (CWLA) for children and teens in foster care.

2.7.6 Telehealth

The OHCA encourages the appropriate utilization of Telehealth services as a mechanism to deliver medically necessary services to Health Plan Enrollees. The Contractor shall develop and submit to OHCA for approval, policies and procedures that implement Telehealth services in accordance with OCA 317:30-3-27 specific to the populations served through SoonerSelect Specialty Children's Plan. The Contractor shall at a minimum provide education to Providers and Health Plan Enrollees about Telehealth through the Provider and Health Plan Enrollee manuals.

2.7.7 Pharmacy Program

In addition to the Pharmacy Program requirements specified in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

The Contractor shall incorporate the Oklahoma Pediatric Psychotropic Medication Guidelines (Guidelines) and any updated guidelines released by the state, into the Pharmacy Program. The Pharmacy Director, in conjunction with the Contractor's Chief Medical Officer shall develop and oversee the program, including education provided to Providers. A current version of the Guidelines is available through the Bidder's Library located at: <http://www.okhca.org/about.aspx?id=74>. The Contractor shall monitor utilization of psychotropic medications and report to the OHCA in a manner and frequency specified by the OHCA.

2.8 Provider Payment

In addition to the requirements in Section 1.14.1: "Provider Payment Rates" in the SoonerSelect Model Contract, the following is required for the SoonerSelect Children's Specialty Plan.

The Contractor shall reimburse the following services as follows:

- TCM services shall be reimbursed at the current Medicaid rate;
- RMBS shall be reimbursed at the current Medicaid rate; and
- TFC, ITFC, and Multi Systemic Therapy shall not be reimbursed at rate lower than the current Medicaid rate.

2.9 Medical Management

In addition to the requirements specified Section 1.7: "Medical Management" in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

For the purpose of this Contract, Medically Necessary covered services must be furnished in a manner that:

- Considers the role of non-medical factors (ex. placement, placement changes, involvement with the child welfare and/or the juvenile justice system).

2.9.1 Medically Necessary Services

In addition to the requirements specified in Section 1.7.1: "Medically Necessary Services" in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

In addition to the requirements in Appendix 1B: “Model Contract Definitions,” OAC 317:30-3-1(f) and federal requirements described in 42 C.F.R. § 438.210(a)(5), services are considered medically necessary when they meet the applicable service specific medical necessity criteria established in Oklahoma Administrative Code (OAC). For example, OAC 317:30-5-741 (c) specifies medical necessity criteria for Therapeutic Foster Care and OAC 317:30-5-751 (c) specifies medical necessity criteria for Intensive Family Therapeutic Care. The Contractor shall include service specific medical necessity criteria set forth in OAC as a component of the applicable service authorization process unless alternative criteria is proposed by the Contractor and approved in writing by the OHCA.

2.9.2 Medical Management Program Components

In addition to the requirements specified Section 1.7.2: “Medical Management Program Components” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Medical Management Program must include:

- Restrictions against requiring pre-admission certification for TFC and ITFC placements.

The Contractor shall propose medical management review criteria, standards, and protocol which address the unique needs of the target populations and must be approved by OHCA prior to implementation.

2.9.3 Qualified Staff

In addition to the specifications described in Section 1.7.3: “Qualified Staff” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall monitor staff (e.g., inter-rater reliability activities) reviewing Providers’ requests for intensive behavioral health and placement-based services to ensure the consistent application of utilization management criteria and practice guidelines. The Contractor shall provide the OHCA the monitoring protocols, monitoring results, staff remediation training, and monitoring results upon request.

2.9.4 Authorization Process

In addition to the requirements described in Section 1.7.6: “Authorization Process” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall identify services that will utilize an open access prior authorization (PA) approach. An open access approach means that the PA is not limited to a specific Provider but may be limited to a specific Provider type, facilitating timely access to care when:

- A FC or OJA Health Plan Enrollee has changed placements and a change in Provider is necessary; and
- The Provider is unable to meet the needs of a FC or JJ Health Plan Enrollees and a change in Provider is necessary.

The Contractor’s open access approach may be limited to FC and JJ Health Plan Enrollees and shall be limited to network Providers eligible to provide the authorized services. The Contractor shall:

- Submit policies and procedures specific to this requirement for review and approval by the OHCA as part of the Readiness Review process; and
- Educate Providers and stakeholders about the parameters of this requirement.

2.10 Special Program Requirements

2.10.1 Education and Training of the OHCA, DHS, OJA, Judicial system, and Stakeholders

The Contractor shall be responsible for developing training in coordination with OHCA, DHS, and/or OJA for multiple stakeholder groups. The purpose of the training is to ensure that all stakeholders involved in the system of care (e.g., CW Specialists, foster parents, JJ TCMs) are educated about the processes and procedures of accessing services through the SoonerSelect Specialty Children's Plan. Education and training for state personnel and stakeholders must be provided at times and location(s) approved by the OHCA.

The educational and training approach must address at a minimum the following:

- The initial and ongoing education of state personnel;
- An understanding of the SoonerSelect Specialty Children's Plan and the roles and responsibilities of the OHCA, DHS, and OJA.;
- The contractual requirements of the SoonerSelect Specialty Children's Plan;
- The organization, staffing, and infrastructure of the SoonerSelect Specialty Children's Plan; and
- The SoonerSelect Specialty Children's Plan business processes and workflows.

2.11 Care Management and Population Health

In addition to the requirements specified in Section 1.8: "Care Management and Population Health" in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

The Contractor shall develop a care management and population health model that avoids duplication of the TCM activities completed by DHS and OJA for children in the custody of the state.

The Contractor shall develop policies and procedures specific to FC and OJA Health Plan Enrollees that:

- Facilitates the exchange of screening and assessment information between DHS, OJA and the Contractor that minimizes duplication of efforts;
- Delineates which parties will be responsible for which screening and assessments for FC and OJA Health Plan Enrollees;
- Aligns with the requirements of the Family First Prevention Act (as applicable and implemented by Oklahoma);
- Includes how the administration of assessments takes into consideration the priority to limit trauma from making the child subject to excessive assessments;
- Establishes any expectation about how the comprehensive assessment should tie into any intake assessment requirements (i.e., CW or OJA) including opportunities to streamline and avoid duplication, including coordinating with the Health Plan Enrollees authorized representatives, in a manner and timeframe agreed upon and approved by DHS and OHCA.
- Reduces the unnecessary duplicative assessment of Health Plan Enrollees (particularly for those that cycle in and out of care) by coordinating with the DHS and OJA to develop policies permitting a Comprehensive Assessment to remain current based on specified criteria (e.g., it has been less than a year, a screening substantiates there have been no changes in condition, circumstances, or exposure to trauma that would indicate the need to reconduct a comprehensive assessment);
- Delineates the roles and responsibilities related to developing Care Plans and Care Management assignments; and

- Communicates with the utilization management staff to ensure Health Plan Enrollees access to care.

The Contractor shall include the following in its Risk Stratification Level Framework:

- Additional data/factors to be considered in the stratification assignment; and
- Screening and assessments completed by DHS and OJA when assigning FC and OJA Health Plan Enrollees to a risk level.

The Contractor's Care Management model shall provide for case management and intensive case management for children, youth, and young adults with special health care needs including those with chronic conditions and who are medically-complex. The description of the approach shall include how case managers will engage the Health Plan Enrollee, caregivers, and other community members involved in the Health Plan Enrollee's care and what best-practices will guide that engagement.

2.11.1 Screening and Assessment Tools

In addition to the requirements specified in Section 1.8.1: "Health Risk Screening" and Section 1.8.2: "Comprehensive Assessment" in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

The Contractor shall incorporate screening tools and/or assessments (e.g., Child and Adolescent Needs and Strengths (CANS)) utilized and/or recommended by the state into their Care Management processes as directed by the OHCA.

The Contractor shall propose modifications to assessment domains to adequately capture the unique needs of targeted populations

2.11.1.1 Timeline for Completion

The Contractor shall partner with the DHS and OJA to develop a process and timeline to complete the Comprehensive Assessment prior to Initial Program Implementation. The Contractor shall submit the proposed process and timeline for review and approval by the OHCA. During Steady State operations, the Contractor shall align the timeframes for completing medical and behavioral health assessments for Health Plan Enrollees in the custody of the state with the timelines required by DHS/OJA as applicable.

2.11.2 Reassessments

The Contractor shall coordinate reassessments for Health Plan Enrollees with the CW Specialist and OJA TCMs for all children in the custody of the state.

2.11.3 Care Plans

In addition to the requirements in Section 1.8.3: "Care Plans" in the Model Contract, the following requirements apply to the SoonerSelect Specialty Children's Plan.

The Contractor shall ensure the development of Care Plans for Health Plan Enrollees support strengths-based goals and health and functional outcome improvements. The Contractor shall implement a mechanism to enable multiple stakeholders and Providers to access the Care Plan through a platform maintained by the Contractor. The Contractor shall also have mechanisms to update the Care Plan as needed, while retaining a master version that consolidates updates and is accessible in real-time to authorized users.

2.11.4 Care Management and Population Health Staffing

2.11.4.1 Staffing Levels

The Contractor shall ensure an adequate number of Care Managers to address the needs of SoonerSelect Specialty Children’s Health Plan Enrollees in accordance with Contract requirements and the level of services to be delivered under the Contractor’s Risk Stratification Level Framework.

The Contractor shall submit an annual Care Management Staffing Plan specific to Specialty Children’s Health Plan Enrollees to the OHCA for review and approval. The plan shall be submitted on a schedule and in a format defined by the OHCA and shall, at a minimum, address:

- Number of Care Managers, supervisors/managers and support staff;
- Number of care management staff assigned to each area of the Contractor’s Risk Stratification Level Framework;
- Methodology by which the Contractor determined care management staffing levels were sufficient; and
- Process by which the Contractor will ensure the care management staffing levels are sufficient to meet Contract requirements.

2.11.4.2 Care Manager Assignment

In addition to the requirements in Section 1.8.4.2: “Care Manager Assignment” in the Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

All Health Plan Enrollees will, even at the lowest risk stratification tier, be assigned a Care Manager who is responsible for making contact with the Health Plan Enrollee or his authorized representative at least once following Plan assignment and at a minimum of once every six months thereafter. The Contractor’s proposed Care Management Plan should take into consideration the state’s expectation for Care Management under the Specialty Children’s Health Plan to include non-traditional staffing and assignments and approaches which are significantly more rigorous than traditional managed care approaches.

The Contractor’s Care Manager Assignment policies and procedures shall describe the unique factors and concerns to be considered in the care management assignment approach and how the proposed assignment protocol will address those factors/concerns.

2.11.4.3 Qualifications

The Contractor’s Care Managers shall, at a minimum, have the following qualifications:

- Licensed behavioral health professional in the State of Oklahoma; or
- Registered or licensed practical nurse, licensed to practice in the State of Oklahoma, with at least one year of professional experience.

Team members may also include those with a bachelor’s degree in social work, psychology or a related social services field and at least one year of related professional experience with a similar population as those in the SoonerSelect Specialty Children’s Plan. Related professional experience includes acting as a care manager, rehabilitation specialist, health specialist, or social services coordinator.

The Contractor shall complete a criminal history and background investigation on all Care Managers prior to their employment or use on a contracted basis.

2.11.4.4 Training

In addition to the requirements specified in Section 1.8.4.4: “Training” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall provide Care Managers with initial and ongoing training on the following:

- Trauma Informed Care, Science of HOPE, and evidence-based treatment approaches;
- Education about the SoonerSelect Specialty Children’s Plan and the roles and responsibilities of the OHCA, DHS, and OJA and how these agencies will coordinate and collaborate with the Contractor;
- Placement types and the role and responsibilities of Child Placing Agencies; and
- Oklahoma’s Child Welfare and Juvenile Justice systems of care (SOC) including the associated court systems.

The Contractor’s Care Managers shall successfully complete the Behavioral Health Care Manager certification training provided through the Department of Mental Health and Substance Abuse Services. Care Managers will have six months from the date of hire to successfully complete the training unless otherwise specified in writing by the OHCA.

2.11.5 **Pharmacy Lock-In Program**

In addition to the requirements described in Section 1.8.6: “Lock-in Program” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall not place FC or OJA Health Plan Enrollees in the pharmacy lock-in-program without the written consent of the OHCA.

2.12 **Transition of Care Policies and Procedures**

In addition to the requirements described in Section 1.9.2: “Transition of Care Policies and Procedures” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall develop and maintain transition of care policies and procedures for Health Plan Enrollees who are transitioning out the child welfare and/or juvenile justice system. Transition planning shall begin one year prior to the expected date upon which a Health Plan Enrollee will age-out of the child welfare system. Transition activities shall include:

- Convening a comprehensive treatment team meeting to discuss the services and supports the Health Plan Enrollee will need post-separation;
- Education about how to access services through the Medicaid program (if applicable), and other resources including community programs; and
- Referring Health Plan Enrollees to services prior to release from state custody.

The Contractor shall have additional transition of care policies and procedures that include:

- A process for transitioning services for FC and OJA Health Plan Enrollees when changing placements;
- A process for transitioning between levels of care (i.e. group home, residential treatment programs, etc.); and
- A process for educating FFC Health Plan Enrollees when they are aging out of the program.

2.12.1 Age Transitions

In addition to the requirements described in Section 1.9.8: “Age Transitions” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall monitor the age status of Health Plan Enrollees approaching an age that will affect SoonerCare coverage or eligibility. This includes, FFC Health Plan Enrollees as they approach 26 years of age. The Contractor shall propose what assistance it will offer to Health Plan Enrollees affected by age limits and the approaches to be employed for easing age-related transitions in a manner that best prepares the Health Plan Enrollees for ongoing access to healthcare and successful adulthood.

2.13 Quality

In addition to the requirements described in Section 1.10: “Quality” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall be able to track, collect, monitor and report on internal and external quality metrics for the SoonerSelect Specialty Children’s Health Plan Enrollees separately from the SoonerSelect Health Plan Enrollees.

2.13.1 Quality Assessment and Performance Improvement (QAPI) Program

In addition to the requirements described in Section 1.10.3: “Quality Assessment and Performance Improvement (QAPI) Program” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor’s QAPI Program shall encompass all Health Plan Enrollees and activities performed through the SoonerSelect Plan and the SoonerSelect Specialty Children’s Plan. The Contractor structure and activities shall be structured to enable the Contractor to assess compliance and effectiveness with each Plan population (i.e., SoonerSelect vs. SoonerSelect Specialty Children).

The QAPI program shall include all of the following, at a minimum specific to the SoonerSelect Specialty Children’s Health Plan Enrollees:

- Performance improvement projects (PIPs) that evaluate clinical and nonclinical areas, in accordance with 42 C.F.R. § 438.330(b)(1) and (d)(1), including all SoonerSelect Program population groups, care settings and types of services.
- In accordance with 42 C.F.R. § 438.330(b)(2), collection of and submission of performance measurement data, including the performance measures determined by the OHCA as required pursuant to 42 C.F.R. § 438.330(c)(1)(i), or as determined by CMS in the event CMS identifies standard required measures pursuant to 42 C.F.R. § 438(a)(2).
- Mechanisms to detect both underutilization and overutilization of services, in accordance with 42 C.F.R. § 438.330(b)(3).
- Mechanisms to assess the quality and appropriateness of care furnished to Health Plan Enrollees with Special Health Care Needs, in accordance with 42 C.F.R. § 438.330(b)(4). Health Plan Enrollees with Special Health Care Needs will be defined by the OHCA in the quality strategy developed pursuant to 42 C.F.R. § 438.340.

The Contractor shall be able to collect, track, collect, monitor and report on internal and external quality metrics for the SoonerSelect Specialty Children’s Health Plan Enrollees separately from the SoonerSelect Health Plan Enrollees.

2.13.1.1 Oversight of QAPI Program

In addition to the requirements described in Section 1.10.3.2: “Oversight of QAPI Program” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall have a Quality Improvement Committee (QIC), chaired by the SoonerSelect Specialty Children’s Plan Medical Director, that oversees all QAPI functions related to the SoonerSelect Specialty Children’s Plan.

The OHCA reserves the right to require the Contractor to include specific types of Providers and/or Stakeholders to participate in the Quality Improvement Committee (QIC).

2.13.2 Surveys

2.13.2.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

In addition to the requirements described in the CAHPS surveys section described in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The OHCA reserves the right to modify the population the Contractor is required to survey based on plan enrollment.

2.13.2.2 Provider Satisfaction Surveys

In addition to the requirements described in the provider satisfaction surveys section described in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The OHCA reserves the right to require the Contractor to include Provider satisfaction measures unique to SoonerSelect Specialty Children’s Plan.

2.13.2.3 Stakeholder Satisfaction Surveys

The Contractor shall develop and submit a satisfaction strategy and tool for use with stakeholders (e.g. foster parents, CW Specialists) for review and approval by the OHCA. The Contractor shall develop a method to collect, analyze and review the survey results as a part of the QAPI. The OHCA reserves the right to set quality metrics based on survey results.

2.13.3 Quality Performance Measures

The OHCA reserves the right to require the Contractor to collect, track, trend, and report all or some performance measures unique to SoonerSelect Specialty Children’s Plan separately or as part of the Contractor’s total SoonerSelect membership.

2.13.3.1 Physical Health Performance Measures

The Contractor shall be responsible for reporting on the physical health performance measures that are provided in the table below. These measures are subject to change.

Physical Health Performance Measures	Frequency	Definition	Data Source
Adult CMS Core Set measures related to physical health: <ul style="list-style-type: none"> Cervical Cancer Screening Chlamydia Screening in Women Ages 21 to 24 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records

Physical Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> • Screening for Depression and Follow-Up Plan: Age 18 and Older • Breast Cancer Screening • Adult Body Mass Index Assessment • Plan All-Cause Readmissions • HIV Viral Load Suppression 			
<p>Child CMS Core Set measures related to physical health:</p> <ul style="list-style-type: none"> • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents • Chlamydia Screening in Women Ages 16 to 20 • Childhood Immunization Status • Screening for Depression and Follow-Up Plan: Ages 12 to 17 • Well-Child Visits in the First 15 Months of Life • Immunizations for Adolescents • Developmental Screening in the First Three Years of Life • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life • Adolescent Well-Care Visits • Asthma Medication Ratio: Ages 5 to 18 • Ambulatory Care: Emergency Department (ED) Visits 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records
<p>Prevention Quality Indicators (PQI):</p> <ul style="list-style-type: none"> • Asthma in Younger Adults Admission Rate • Perforated appendix admission rate • Urinary tract infections admission rate 	Annual	Percentage of Health Plan Enrollees who were discharged in the measurement year with a principal diagnosis for each of these conditions	MMIS, Encounters, Eligibility
<p>Maternal and Perinatal Health</p> <ul style="list-style-type: none"> • Prenatal and Postpartum Care: Postpartum Care • Cesarean Birth 	Annual	CMS Core Set definitions for each measure	MMIS, Encounters, Eligibility, Medical Records

Physical Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> • Audiological Diagnosis No Later Than 3 Months of Age • Live Births Weighing Less Than 2,500 Grams • Prenatal and Postpartum Care: Timeliness of Prenatal Care • Contraceptive Care – Postpartum Women Ages 15 to 20 • Contraceptive Care – All Women Ages 15 to 20 			
Preventive care & screening: tobacco use: screening & cessation intervention	Annual	Percentage of patients aged 18 and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	MMIS, Encounters, Eligibility, Medical Records, and Health Questionnaire Screenings
Tobacco use: screening	Annual	Percentage of patients aged 12+ who were screened for tobacco use at every primary care visit	MMIS, Encounter Data and Medical Records
Emergency room (ER) utilization: <ul style="list-style-type: none"> • ER visits per 1,000 member Months • Potentially avoidable ER visits 	Quarterly	Rate of ER visits per 1,000 Health member months and the number of ER visits that were potentially avoidable	MMIS, encounter data and medical records

2.13.3.2 Behavioral Health Performance Measures

The Contractor shall be responsible for reporting on the behavioral health performance measures that are provided in the table below. Performance measures are subject to change.

Behavioral Health Performance Measures	Frequency	Definition	Data Source
<ul style="list-style-type: none"> • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment • Medical Assistance with Smoking and Tobacco Use Cessation • Antidepressant Medication Management • Follow-Up After Hospitalization for Mental Illness: Age 18 and Older • Use of Opioids at High Dosage in Persons Without Cancer • Concurrent Use of Opioids and Benzodiazepines • Use of Pharmacotherapy for Opioid Use Disorder • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence • Follow-Up After Emergency Department Visit for Mental Illness • Adherence to Antipsychotic Medications for Individuals with Schizophrenia 	Annual	Adult CMS Core Set definitions for each measure	MMIS/Encounters, Eligibility, Medical Records
<ul style="list-style-type: none"> • Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication • Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics 	Annual	Child CMS Core Set Measure Definitions	MMIS/Encounters, Eligibility, Medical Records
Access to Behavioral Health Services	Annual	Number and percentage of Health Plan Enrollees receiving BH services	MMIS and Encounter Data

Behavioral Health Performance Measures	Frequency	Definition	Data Source
Access to substance abuse disorder (SUD) services	Annual	Number and percentage of Health Plan Enrollees receiving SUD services	MMIS and Encounter Data
Inpatient care	Annual	Number and percentage of Health Plan Enrollees using inpatient psychiatric services	MMIS and Encounter Data
Readmission to inpatient care	Annual	Number and percentage of Health Plan Enrollees readmitted to inpatient care within 30 days of discharge	MMIS and Encounter Data
Depression screening	Annual	Percentage of population aged 12+ who were screened for depression using age-appropriate standardized instruments jointly selected by a primary care provider and behavioral health specialist during the measurement year	MMIS, Encounter Data, and Medical Records
Depression remission at 12 months	Annual	Percentage of patients age 18 years and older who have reached remission at 12 months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a Patient Health Questionnaire-9	PHQ-9, MMIS, Encounter Data, and Medical Records

Behavioral Health Performance Measures	Frequency	Definition	Data Source
		(PHQ-9) score less than 5 at 12 months (+/- 30 days)	
Screening for alcohol or drug dependence	Annual	Percentage of population aged 12+ who were screened for alcohol or other drug dependence during the measurement year	MMIS, Encounter Data, and Medical Records
Treatment for alcohol or drug dependence	Annual	Percentage of patients who screened positive for alcohol or other drug dependence and who received treatment and follow-up	MMIS, Encounter Data, and Medical Records

The Contractor shall participate in the development of additional performance measures and metrics including, but not limited to:

- Treatment for Depression;
- BH and SUD Inpatient Follow Up – 30, 60, and 90 days;
- Reduction in pharmacological only therapies for children (i.e., only medications, no counseling);
- Increase in behavioral therapeutic interventions for children under age 6 prior to pharmacological therapies; and
- Increase in functional strengths scoring per CANS.

2.13.4 Critical Incident Reporting System

In addition to the requirements of Section 1.10.10: “Critical Incident Reporting System” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

Critical incidents shall also include:

- Maltreatments in care: any instances of “abuse” or “neglect” as defined in 10A O.S. 1-1-105.
- Runaway youth: youth who have left home without parental/caregiver permission and stay away for one or more nights.

The Contractor shall provide appropriate training and take corrective action as needed to ensure its staff and Participating Providers, as applicable, comply with Critical Incident requirements.

The OHCA reserves the right to modify the list of critical incidents the Contractor and Providers are required to report.

2.14 Health Plan Enrollee Services

2.14.1 New Health Plan Enrollee Materials and Outreach

The Contractor shall comply with the requirements set forth in Section 1.11.5: “New Health Plan Enrollee Materials and Outreach” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall develop and submit new Health Plan Enrollee materials and outreach policies and procedures (PPs) specific to the specialty populations for review and approval by the OHCA. The Contractor shall develop the PPs in coordination with DHS and OJA and ensure that:

- Materials are available to Enrollee caregivers when applicable;
- Materials are available to the CW Specialist or JJ TCM when the FC or OJA Health Plan Enrollee is placed in a group home or residential placement;
- The process for selecting and changing a PCMH Provider is delineated; and
- Designated authorities able to select/change the PCMH are clearly identified.

2.14.1.1 Health Plan Enrollee ID Card

In addition to the Section 1.11.5.3: “Health Plan Enrollees ID Card” requirements in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

Health Plan Enrollee ID Cards will identify the Contractor as the SoonerSelect Specialty Children’s Plan unless otherwise directed by the OHCA. The Contractor shall develop policies and procedures to enable Health Plan Enrollees and their authorized representatives (e.g., FC Specialist, foster parent) to access the Health Plan Enrollees’ ID Card through the Health Plan Enrollee Website Portal. The Contractor’s policies and procedures will include mechanisms to ensure that information regarding authorized representatives (e.g., FC Health Plan Enrollees changes foster homes) is updated in a timely manner to safeguard Health Plan Enrollees information.

2.14.2 Health Plan Enrollee Website

In addition to the requirements in Section 1.11.6: “Health Plan Enrollee Website” of the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall develop policies and procedures to enable CW Specialists, JJ TCMs, and authorized representatives by DHS and OJA to access FC and OJA Health Plan Enrollees’ Website Portal.

2.14.3 Health Plan Enrollee Services Call Center

2.14.3.1 Call Center Training

In addition to the call center training requirements specified in Section 1.11.7.3: “Call Center Training” of the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor’s call center training program shall include:

- Education about the SoonerSelect Specialty Children’s Plan and the roles and responsibilities of the OHCA, DHS, and OJA and how these agencies will coordinate and collaborate with the Contractor;
- Placement types and the role and responsibilities of Child Placing Agencies;
- Role and responsibilities of the Contractor;
- Needs of the SoonerSelect Specialty Children’s Plan populations;
- Trauma-informed Care; and
- Science of HOPE.

2.14.4 Behavioral Health Services Hotline

In addition to the requirements of Section 1.11.8: “Behavioral Health Services Hotline” specified in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall ensure that behavioral health professionals training includes:

- Education about the SoonerSelect Specialty Children’s Plan and the roles and responsibilities of the OHCA, DHS, and OJA and how these agencies will coordinate and collaborate with the Contractor;
- Placement types and the role and responsibilities of Child Placing Agencies;
- Role and responsibilities of the Contractor;
- Needs of the SoonerSelect Specialty Children’s Plan populations;
- Trauma-informed Care; and
- Science of Hope.

The Contractor shall implement mechanisms to ensure callers receive timely coordination of and/or follow up care through:

- Referring Health Plan Enrollees (as appropriate) to the Contractor’s care management program;
- Sharing Health Plan Enrollee call information with assigned Care Managers; and
- Sharing Health Plan Enrollee call information with CW Specialists and JJ TCMs.

2.14.5 Advisory Board

2.14.5.1 Behavioral Health Advisory Board

In addition to the requirements of Section 1.11.10.1: “Behavioral Health Advisory Board” specified in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall partner with the OHCA, DHS, and OJA to:

- Identify Provider types and stakeholders that the Contractor shall include in the Behavioral Health Advisory Board; and/or
- Develop a Specialty Children’s Advisory Board.

The Contractor shall ensure that any Advisory Board developed meets the minimum requirements in Section 1.11.10.1: “Behavioral Health Advisory Board” of the Model Contract unless otherwise directed by the OHCA.

2.14.6 **PCMH Selection and Assignment**

2.14.6.1 Assignment Requirements

In addition to the requirements in Section 1.11.11.2: “Assignment Requirements” specified in the SoonerSelect Model Contract; the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall permit the following to select the PCMH Provider for FC and JJ Health Plan Enrollees unless otherwise directed by the OHCA:

- FC Health Plan Enrollee’s assigned CW Specialist or Specialists’ supervisor;
- JJ Health Plan Enrollee’s assigned OJA TCM or TCMs’ supervisor;
- FC or JJ Health Plan Enrollee’s authorized representative per the Health Plan Enrollees CW Specialist or OJA TCM; and
- AA Health Plan Enrollee’s parent or guardian.

2.14.6.2 PCMH Changes

In addition to the requirements for Section 1.11.12: “PCMH Changes” specified in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall have a mechanism in place to inform DHS and OJA of PCMH changes made by DHS and OJA authorized representatives (i.e., foster parent) in a time and manner approved by the OHCA.

2.14.6.3 Health Plan Enrollee-initiated PCMH Changes

In addition to the requirements specified in Section 1.11.12.1: “Health Plan Enrollee-initiated PCMH Changes” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall permit FC and JJ Health Plan Enrollees to change PCMHs at any time, effective the following business day.

2.14.7 **Marketing and Outreach**

2.14.7.1 Training Curriculum

In addition to the requirement in Section 1.11.15.2: “Training Curriculum” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor’s training curriculum shall include specific education related to the SoonerSelect Specialty Children’s Plan, including but not limited to:

- Education about the SoonerSelect Specialty Children’s Plan and the roles and responsibilities of the OHCA, DHS, and OJA and how these agencies will coordinate and collaborate with the Contractor;
- Placement types and the role and responsibilities of Child Placing Agencies;
- Role and responsibilities of the Contractor; and
- Needs of the SoonerSelect Specialty Children’s Plan populations.

2.15 **Provider Network Development**

The Contractor shall describe the methods and strategies that will be employed to address the unique needs of the target population through its Provider Network Development approach for each subsection below.

2.15.1 General Network Development and Contracting Standards

2.15.1.1 Policies and Procedures

In addition to the requirements in Section 1.12.1.1.2: “Policies and Procedures” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall not contract with any Provider that DHS or OJA has terminated or refused to re-contract.

2.15.1.2 Written Notice of Decision not to Contract

In addition to the requirements in Section 1.12.1.3.2: “Written Notice of Decision not to Contract” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall not decline to contract with Providers of TFC, ITFC or RBMS without written authorization from the OHCA. The OHCA reserves the right to include additional Provider types to this requirement.

2.15.1.3 Provider Network Development and Management Plan

In addition to the requirements in Section 1.12.1.5: “Provider Network Development and Management Plan” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor’s network development plan shall include:

- Strategies to increase the number of TFC/ITFC providers available throughout the state; and
- Strategies to increase the capacity of in-state (inpatient and outpatient) Providers to effectively treat complex behavioral health, comorbid conditions, and/or difficult to treat symptomatology such as:
 - Low IQ and behavioral health;
 - Developmentally Delayed (DD) and behavioral health;
 - Cutting and/or swallowing behaviors; and
 - Aggressive youth.

2.15.2 Time and Distance and Appointment Access Standards

2.15.2.1 PCMH Provider Standards

The Contractor shall meet the following access standards for PCMH Providers:

Provider Type	Measure	Standard
Distance		
Adult PCMH Pediatric PCMH	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence
Adult PCMH Pediatric PCMH	Rural Distance	Within 45 miles of a Health Plan Enrollee’s residence
Appointment Time		

Provider Type	Measure	Standard
Distance		
Adult PCMH Pediatric PCMH	<ul style="list-style-type: none"> Not to exceed 30 days from date of the Health Plan Enrollee’s request for routine appointment. Within 72 hours for non-urgent sick visits. Within 24 hours for urgent care. Each PCMH shall allow for at least some same-day appointments to meet acute care needs and to assess the needs of children entering custody of the state. 	

2.15.2.2 Obstetrics and Gynecology (OB/GYN) Provider Standards

The Contractor shall meet the following access standards for OB/GYN Providers:

Provider Type	Measure	Standard
Distance		
OB/GYN	Urban Distance	Within ten miles of a Health Plan Enrollee’s residence
OB/GYN	Rural Distance	Within 45 miles of a Health Plan Enrollee’s residence
Appointment Time		
OB/GYN	<ul style="list-style-type: none"> Not to exceed 30 days from date of the Health Plan Enrollee’s request for routine appointment. Within 72 hours for non-urgent sick visits. Within 24 hours for urgent care. Maternity Care: <ul style="list-style-type: none"> First Trimester – Not to exceed 14 Calendar Days Second Trimester – Not to exceed seven Calendar Days Third Trimester – Not to exceed three Business Days 	

2.15.2.3 Specialty Provider Standards

The Contractor shall meet the following access standards for Specialty Providers:

Provider Type	Measure	Standard
Distance		
Adult Specialty Pediatric Specialty	Urban Distance	Within 15 miles of a Health Plan Enrollee’s residence
Adult Specialty Pediatric Specialty	Rural Distance	Within 60 miles of a Health Plan Enrollee’s residence

Provider Type	Measure	Standard
Distance		
Appointment Time		
Adult Specialty Pediatric Specialty		<ul style="list-style-type: none"> Not to exceed 14 days from date of the Health Plan Enrollee’s request for routine appointment. Within 24 hours for urgent care.

2.15.2.4 Behavioral Health Provider Standards

In addition to the requirements in Section 1.12.4.4: “Behavioral Health Provider Standards” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor’s network shall include:

- Therapeutic Foster Care Providers;
- Intensive Treatment Family Care Providers;
- Multi Systemic Therapy; and
- Residential Behavioral Management Services Providers.

The Contractor shall meet the following access standards for Behavioral Health Providers in the SoonerSelect Specialty Children’s Plan:

Provider Type	Measure	Standard
Distance		
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use	Urban Distance	<ul style="list-style-type: none"> Within ten miles of a Health Plan Enrollee’s residence for outpatient visits Within 60 miles of a Health Plan Enrollee’s residence for all other treatment settings
Adult Mental Health Adult Substance Use Pediatric Mental Health Pediatric Substance Use	Rural Distance	<ul style="list-style-type: none"> Within 30 miles of a Health Plan Enrollee’s residence for outpatient visits Within 90 miles of a Health Plan Enrollee’s residence for all other treatment settings
Appointment Time		
Adult Mental Health Adult Substance Use		<ul style="list-style-type: none"> Not to exceed 14 days from date of the Health Plan Enrollee’s request for routine appointment.

Provider Type	Measure	Standard
Distance		
Pediatric Mental Health Pediatric Substance Use	<ul style="list-style-type: none"> • Within seven days from discharge from an inpatient setting. • Within 24 hours for urgent care. 	

2.15.3 Provider Education, Training and Technical Assistance

In addition to the Training Content described in Section 1.13.5.2 in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

- Trauma Informed Care;
- Science of HOPE and True North Goals;
- Authorization requirements regarding extraordinary medical care and treatment for children in the care and custody of the state; and
- OHCA’ s Pediatric Psychotropic Medication Guidelines and Psychiatric Consultation program <http://www.okhca.org/behavioral-health/>.

2.15.4 Reporting Changes in Circumstance

In addition to the requirements identified in reporting changes in circumstances in Section 1.18.3 in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

- Children in the state’s custody that have run away; and
- FF and AA Health Plan Enrollees that have moved out of state.

2.15.5 Communications with OHCA

The Contractor shall transmit all data directly to the OHCA in accordance with 42 C.F.R. § 438.242. If the Contractor utilizes Subcontractors for services, the Contractor shall ensure all data from the Subcontractors is provided to the Contractor and the Contractor shall transmit the Subcontractors’ data to the OHCA in a format specified by the OHCA.

2.15.6 Enrollment Data

The Contractor shall maintain an eligibility and enrollment subsystem that is continuously updated with information received from the OHCA, and received directly from a Health Plan Enrollees or authorized representative (e.g., CW Specialist). This subsystem shall have the ability to interface with the Contractor’s claims processing and care management systems and maintain information at a detail level to be specified by the OHCA.

2.16 Reporting

In addition to the requirements in Section 1.21: “Reporting” in the SoonerSelect Model Contract, the following requirements apply to the SoonerSelect Specialty Children’s Plan.

The Contractor shall submit reports for the SoonerSelect Specialty Children’s Plan separately from reports for the SoonerSelect program unless otherwise directed in writing by the OHCA.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

CONTRACTOR

By: _____

Date: _____

Title: _____

OKLAHOMA HEALTH CARE AUTHORITY

By: _____

Date: _____

Title: _____

Approved as to Form and Legal Sufficiency:

By: _____

Date: _____

Title: _____