AMENDMENT ONE TO THE CONTRACT
BETWEEN
OKLAHOMA HEALTH CARE AUTHORITY
AND
AETNA BETTER HEALTH OF OKLAHOMA, INC.

The Oklahoma Health Care Authority (OHCA) and Aetna Better Health of Oklahoma, Inc. (hereinafter referred to as Contractor) mutually consent to modify the Agreement associated with Purchase Order number 8079004725 as reflected below. All revisions are shown in red text; removals are indicated with strikethroughs, and additions are notated with underlines.

1.2.20.10 Performance Bond or Substitutes

The Contractor shall furnish a performance bond, cash deposit, United States (US) Treasury Bill, or an irrevocable letter of credit (together, performance bond, or substitutes). The performance bond or substitute shall be in a form acceptable to OHCA. The performance bond or substitute shall cover the full duration of the Contract period including all Contract renewal periods through twelve (12) months post Contract termination or expiration.

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 (1) dollar for each capitation dollar expected to be paid to Contractor in month one (1) of the Rating Period.

This requirement must be satisfied within ten (10) Business Days following notification by OHCA of the required amount. Thereafter, OHCA shall evaluate Enrollment and Capitation Payment data on a ~~monthly~~ quarterly basis. If there is an increase in Contractor's monthly Capitation Payment that equals or exceeds ten percent (10%) 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 (10) 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 1.26: "Termination" of this 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 and legal 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.

1.6.8 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 an Enrollee's health, it is OHCA's intent that a Disenrollment shall be effective no later than 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 Enrollee's health care needs or other matters deemed sufficient to warrant Disenrollment under Section 1.6.7.2: "Enrollee Request" of this 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 Enrollee's SoonerSelect Program eligibility status changes:

a. Loss of eligibility for Medicaid;
b. Transition to a SoonerCare eligibility group excluded from the SoonerSelect Program;
c. Enrollee becomes a foster child under the custody of the State;
d. Enrollee becomes JJ Involved under the custody of the State;

e. Enrollee becomes eligible for Medicare;
f. Death;
g. Enrollee becomes an inmate of a public institution;
h. Enrollee commits Fraud or provides fraudulent information;
i. Disenrollment is ordered by a hearing officer or court of law; or
j. Enrollee requiring long-term care.

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 1.7.6: "Nursing Facility and ICF-IID Stays" of this 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.

1.7.1.5 Tobacco Cessation Services

The Contractor shall, at a minimum:

a. Cover OHCA standard of care Tobacco Cessation Services as outlined in Appendix 1G: "Covered Benefits" of this Contract;
~~b. Enter into a cost share agreement with the administrative agency overseeing the Statewide Oklahoma Tobacco Helpline (OTH) contract. OTH services to be covered under the cost share for Enrollees will include:~~
~~i. Five (5) coaching sessions with a quit coach and eight (8) weeks of combination nicotine replacement therapy (NRT);~~
~~ii. Access to specialized pregnancy protocol offered by the current OTH vendor (including coaching and NRT) for women who are pregnant, currently breastfeeding, or who gave birth in the past year;~~
~~iii. Access to specialized behavioral health protocol offered by the current OTH vendor (including coaching and NRT); and~~
~~iv. If offered by the OTH vendor, Contractor will allow fulfillment of Enrollee's NRT prescription benefit via the OTH vendor prescription fulfillment service~~;
c. Develop and implement an OHCA approved Tobacco Cessation Outreach Plan that must be submitted for review and approval consistent with the requirements outlined in Section 1.12.3.2: "Prior Approval Process" of this Contract. To reduce tobacco use among Enrollees, the Tobacco Cessation Outreach Plan, shall at a minimum address how the Contractor will:

i. Collaborate with the TSET Health Communications team, University of Oklahoma Health Sciences Center, Stephenson Cancer Center and the OTH vendor to promote tobacco cessation;
ii. Promote tobacco free campuses with all Participating Providers and at all contracted facilities; iii. Promote OTH and Contractor services to Enrollees;
iii. Promote OTH and Contractor services to Enrollees;
iv. Ensure tobacco screenings and treatment, including NRT and pharmacotherapy, are provided to all relevant Enrollees in both inpatient, facility-based, and outpatient/community settings;
v. Ensure tobacco use and exposure needs, including e-cigarettes, are assessed and addressed in all relevant screenings (initial assessment, comprehensive assessment, Care Plan, etc.);
vi. Develop and implement strategies to increase the utilization of and expand Providers eligible to conduct tobacco cessation 5As counseling;
vii. Develop and utilize strategies for Provider training and education on best-practices and Contractor benefits; and
viii. Develop and submit an annual report on efforts and outcomes;

d. Require tobacco-free policies covering one hundred percent (100%) of medical and behavioral health campuses contracted with the Contractor; and
e. Enter into a Data Use Agreement with the University of Oklahoma Hudson College of Public Health for evaluation purposes.

1.7.5 State Plan Personal Care Services

Enrollees may qualify for Personal Care Services based on the findings of a Comprehensive Assessment. When the Contractor identifies an 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 Enrollee meets the medical eligibility standards for Personal Care Services in accordance with ~~OAC 317:35-15-4.~~ OAC 317:35-16-1 through 317:35-16-2, and OAC 317:35-16-5 through 317:35-16-12.

Eligibility for Personal Care Services, and corresponding nurse supervision, is contingent upon an individual requiring one (1) 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 Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) assessed needs.

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

a. 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:
   i. 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
   ii. 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;
b. Require a Care Plan involving the planning and administration of services delivered under the supervision of professional personnel;
c. 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;
d. 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;1.2.20.10 Performance Bond or Substitutes
e. Lack the ability to meet personal care needs without additional supervision or assistance, or to communicate needs to others;
f. Require assistance, not of a technical nature, to prevent or minimize physical health regression and deterioration; and
g. If it is determined that the Enrollee meets criteria for Personal Care Services, based on the UCAT, the Contractor shall authorize these services.

1.7.12 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 twenty-one (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 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 OSDE's 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:

a. The credentialing requirements for school-based Providers will not change under the SoonerSelect Program. 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, including:

   i. The Contractor shall accept the licensure requirements currently outlined by OSDE;

   ii. The Contractor shall not require any additional paperwork be submitted in order for claims to be submitted by school-based Providers; and Solicitation 8070000052 November 10December 9, 2022 122

   iii. The Contractor shall not require any school-based Providers to be included in their mandatory training, professional development, or dictate the structure or language of the plan(s) of care;

b. The Contractor shall establish a separate Network structure for Providers operating within the school setting. The Contractor cannot opt to close the Network structure 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;

c. Provide services in accordance with OAC 317:30-5-1020;

d. 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 Program CEs;

e. The Contractor shall not provide an Explanation of Benefits (EOB) to Enrollees or school districts directly but rather a single 837 file to OSDE or their vendor for all school-based claims;

f. In collaboration with OSDE, the Contractor will develop and implement a strategy to assist OSDE in the submission of school-based services claims for SoonerSelect eligible Children; and

g. All school-based program components will be managed consistently across all SoonerSelect Program CEs as referenced on the OHCA website: School-Based Services Claim Tools (https://oklahoma.gov/ohca/providers/types/school-based-services).

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, Individualized Family Service Plan, other individualized health or behavioral health plan, or where Medical Necessity has been otherwise established in a school setting.

School-based program services will not be implemented into SoonerSelect for the first 15 months from the date of SoonerSelect implementation, or until July 1, 2025. Through the 15-month extension, school-based services will be processed and reimbursed through OHCA, maintaining current reimbursement practice(s). Medical and Children's Specialty Program CEs will reimburse OHCA-enrolled qualified school providers providers beginning July 1, 2025.

1.7.12.1 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 IDEA Part C and the Oklahoma Early Intervention Act.

The Contractor shall reimburse the OSDH in accordance with Section 1.14.3.8: "Department of Health" of this Contract for all SoonerCare covered benefits received through the SoonerStart program.

SoonerStart program services will not be implemented into SoonerSelect for the first 15 months from the date of SoonerSelect implementation, or until July 1, 2025. Through the 15-month extension, SoonerStart services will be processed and reimbursed through OHCA, maintaining current reimbursement practice(s). Medical and Children's Specialty Program Contractors will reimburse OHCA-enrolled SoonerStart providers beginning July 1, 2025.

1.7.22 Telehealth

OHCA encourages the appropriate utilization of Telehealth services as a mechanism to deliver Medically Necessary services to Enrollees. The Contractor shall develop and submit to OHCA for approval, policies and procedures that implement Telehealth services in accordance with OAC 317:30-3-27. The Contractor shall at a minimum provide ~~education to Providers and Enrollees about Telehealth through the Provider Manual and Enrollee Handbook, respectively~~. the same audio-only telehealth service option, as applicable, and as per the SoonerCare FFS policy at Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

1.8.6.3 Timeliness Standards

The Contractor shall decide standard PA requests within seventy-two (72) Hours of receipt of the request or as expeditiously as the Enrollee's health requires. If the Provider indicates, or the Contractor is aware, that adhering to the standard seventy-two (72) Hour timeframe could jeopardize the 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 twenty-four Hours ~~Hours after receipt of the request for service,~~ and within ~~twenty-four (24)~~ forty-eight (48) Hours if an extension request is submitted. Notwithstanding the foregoing, all inpatient behavioral health PA requests must be decided within twenty-four (24) Hours.

With either the standard or expedited Prior Authorization requests, if the Enrollee, or Provider on behalf of the Enrollee in the case of standard authorizations, requests an extension or if the Contractor can justify to OHCA the need for additional information and show that an extension is in the Enrollee's best interest, the Contractor may have an extension of up to fourteen (14) Days from the receipt of the request and at least forty-eight (48) Hours for an expedited request 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 Enrollee, the Contractor shall provide the Enrollee with a written explanation and **information on how an Appeal may be filed in response to the extension.**

1.12.8.6 Use of 988 Mental Health Lifeline

The Contractor shall utilize the Statewide 988 Mental Health Lifeline as a Behavioral Health Services hotline. The Contractor shall coordinate with the Statewide 988 Mental

Health Lifeline line and establish a bi-directional business associate agreement with the established Oklahoma 988 Mental Health Lifeline vendor(s).

The Contractor shall support TOC between the Contract and the 988 Mental Health Lifeline by:

a. Following up on all dispatched 988 calls to Enrollees within seventy-two (72) Hours to determine the need for any further services or referrals;

b. Including community treatment services for all Enrollees for no less than ninety (90) Days after discharge from Urgent Recovery Centers, Crisis Stabilization Units, and Inpatient Hospitals;

a. Including transition services, including but not limited to community service Provider outreach services, to Enrollees while in Urgent Recovery Centers, Crisis Stabilization Units, and Inpatient Hospitals to support the successful transition to the community from higher levels of care.

All SoonerSelect and SoonerSelect Children's Specialty Plan CEs will be required to review whether enrollees are aligned with a CCBHC upon notification that an enrollee made a crisis call and / or had an emergency behavioral health visit. The CE will be required to conduct outreach to the CCBHC and ensure that the enrollee has been contacted by the CCBHC and provided with follow up care. Impacted contract reference includes Section 1.12.8.6, Use of 988 Mental Health Lifeline, of the SoonerSelect and SoonerSelect Children's Specialty Plan contracts.

1.12.12 Assignment Requirements

In accordance with 42 C.F.R. § 438.3(l) and 56 O.S. § 4002.3d, each Enrollee shall be allowed to choose their PCP to the extent possible and appropriate. The Contractor shall implement procedures to assist Enrollees in selecting a PCP upon Enrollment with the Contractor. The Contractor shall educate Enrollees on factors to consider in making a PCP selection, such as travel distance, Special Health Care Needs, and Providers seen by family members. The Contractor must share the name of three (3) PCPs nearest to the Enrollee's home address that are participating with the Contractor and are accepting new Enrollees.

In accordance with 42 C.F.R. § 438.52(b), for Enrollees who qualify under the rural resident exception (under which a state may limit a Rural Area resident to a single CE), the limitation on the Enrollee's freedom to change between PCPs can only be as

restrictive as the limitations on Disenrollment from the Contracted Entity as requested by the Enrollee in accordance with 42 C.F.R. § 438.56(c).

If an Enrollee does not select a PCP ~~within thirty (30) Days of their Enrollment effective date,~~ upon enrollment of the SoonerSelect program, the Contractor shall assign one. All Contractor-initiated PCP assignments shall:

a. Be within the time and distance standards of the Enrollee's residence as specified in Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract;
b. Be made to an age, gender, and culturally appropriate Provider;
c. Consider the following factors:
    i. Previous or current relationship the Enrollee has with a Provider;
    ii. Previous or current relationship the Enrollee's family members have with a Provider;
    iii. Any special medical needs of the Enrollee, including pregnancy; and
    iv. Any Enrollee language needs made known to the Contractor.

Pursuant to 42 C.F.R. § 438.208(b)(1), within three (3) Days of the Enrollee's selection or Contractor's assignment to a PCP, the Contractor shall notify the Enrollee, in writing, of the name and contact information of the PCP.

OHCA intends to provide the Contractor with Enrollees' historical PCP assignments from the SoonerCare FFS delivery system to facilitate the Contractor's assignment of Enrollees to a PCP during Initial Program Implementation.

1.12.13.2 Contractor-initiated PCP Changes

The Contractor may initiate a change in PCP only under the following circumstances:

a. Enrollee requires specialized care for an acute of Chronic Condition and the Enrollee and the Contractor agree that reassignment to a different Participating Provider is in the Enrollee's interest;
b. Enrollee's place of residence has changed such that they have moved beyond the PCP travel time and distance standard;
c. Enrollee's PCP ceases to participate in the Contractor's Network;
d. Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the PCP has made all reasonable efforts to accommodate the Enrollee; ~~or~~
e. Enrollee has taken legal action against the Provider~~.~~; or

f. Enrollee's claims history indicates they are actively receiving care from another PCP Provider. The Contractor may utilize this claims-based attribution to reassign the Enrollee to the PCP Provider actively providing care.

Whenever initiating a change, the Contractor must offer affected Enrollees the opportunity to select a new PCP. The Contractor shall notify the Enrollee within three (3) Days of the name and contact information of the new Contactor-assigned or Enrollee-selected PCP.

1.12.14.2 Content

Pursuant to 42 C.F.R. §§ 438.10(h)(1)(i)-(viii) and 438.10(h)(2), and § 5123 of the Consolidated Appropriations Act (2023), Requiring Accurate, Updated and Searchable Provider Directories, the Provider directory shall contain the following information about the Contractor's Participating Providers:

a. Provider's name as well as any group affiliation, including the following Provider types:
   i. Physicians, Physician Assistants, and Advanced Practice Registered Nurses, including Specialists;
   ii. Hospitals;
   iii. Pharmacies;
   iv. Behavioral Health Providers; ~~and~~
   v. SUD providers; and
   ~~v.~~ vi. Other Providers required under this Contract;
b. Street address(es);
c. Telephone number(s);
d. Website URL, as appropriate;
e. Specialty, if appropriate;
f. Certification in evidence-based treatment modalities;
g. Gender;
h. Whether the Provider will accept new Enrollees (necessary only in the online version);
i. Mapping capabilities (necessary only in the online version);
j. Provider's cultural and linguistic capabilities, including languages (ASL included) offered by the Provider or by skilled medical interpreter at the Provider's office and whether the Provider has completed cultural competence training; ~~and~~

k. Whether the Provider's office/facility has accommodations for persons with disabilities, including offices, exam room(s) and equipment~~.~~; and

l. Whether the Provider's office/facility has capabilities for telehealth services.

1.14.1.3.2 Behavioral Health Providers

In addition to the minimum Provider Agreement requirements in Sections 1.14.1.1: "Minimum Content Requirements" and 1.14.1.2: "Network Provider Agreement Limitations/Restrictions and Assurances" of this Contract, the Contractor shall require that all Provider Agreements with behavioral health Providers identified in Section 1.14.3.4: "Behavioral Health Provider Standards" of this Contract include the following requirements:

a. Requirement that Participating Providers providing inpatient psychiatric services to Enrollees schedule the Enrollee for outpatient follow-up care prior to discharge from the inpatient setting with the outpatient treatment occurring within seven (7) Calendar Days from the date of discharge.

b. ~~Requirement that Participating Providers complete ODMHSAS Customer Data Core form located at~~ http://www.odmhsas.org/picis/CDCPAT_Forms.htm ~~as a condition of payment for services provided under this Contract.~~

c. Requirement that Participating Providers provide treatment to pregnant Enrollees who are intravenous drug users and all other pregnant substance users within twenty-four (24) Hours of assessment.

d. Agreement that the Contractor will obtain the appropriate Enrollee releases to share clinical information and 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.

1.14.2 Credentialing

All Contractor's must align and utilize the same single Credential Verification Organization (CVO) that is certified by a CMS-approved accrediting organization and approved by OHCA as part of its Provider credentialing and recredentialing process. The CVO shall facilitate the Provider enrollment process including the collection and verification of Provider education, training, experience, and competency. The CVO will be responsible for receiving completed applications, attestations, and primary source verification documents. The Contractor's credentialing and re-credentialing processes

shall be consistent with recognized managed care industry standards and comply with relevant State and federal regulations including 63 O.S. § 1-106.2, 42 C.F.R. § § 438.12, 438.206(b)(6), and 438.214, relating to Provider credentialing and notice.

OHCA is requiring the following interim solution from the date of this memo until July 1, 2025, or until such time as a CVO is implemented, whichever is earlier.

1. All SoonerSelect Medical and Children's Specialty Program (CSP) Contractor's will approve providers actively enrolled with OHCA. The Contractors will only consider OHCA's provider enrollment status when making determinations for network participation for the SoonerSelect and SoonerSelect Children's Specialty Plan provider populations.
2. Upon implementation of the CVO, all providers will submit applications and documentation to the single CVO and each Contractors will access the documentation to complete Primary Source Verification (PSV) necessary to make a credentialing determination and acceptance for network participation.
3. Contractor's will monitor provider sanctions, exclusions, and debarments at the time OHCA enrollment status is validated and monthly thereafter. The Contractor's will ensure corrective actions are taken to address occurrences of adverse actions. Ongoing monitoring and appropriate interventions will be taken, up to and including removal from the network, upon discovery by collecting and reviewing the following information at least every 30 calendar days of its release:
    a. OIG/LEIE/SAM/GSA;
    b. CMS preclusion list;
    c. Ad-hoc notifications from OHCA;
    d. Sanctions or limitations on license;
    e. Medicare and Medicaid sanctions and exclusions;
    f. Complaints;
    g. Voluntary terminations; and
    h. Identified adverse actions.
4. When a provider has already been credentialed by a Contractors for an existing product, the Contractors will leverage their existing credentialing for the Oklahoma Medicaid network rather than requiring the provider to complete the full credentialing process again. If a provider has already been credentialed to NCQA's standard for an existing product line, Contractors will confirm that these providers are actively enrolled with OHCA, have an active Oklahoma SoonerCare ID, and are in good standing with Federal and State entities.

1.14.3 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, which must consider, at a minimum:

a. Anticipated Enrollment;

b. Expected utilization of services; Solicitation 8070000052 November 10December 9, 2022 213

c. Characteristics and health care needs of populations covered;

d. Minimum Provider-to-Enrollee ratios;

e. Maximum travel time or distance to Providers;

f. Minimum percentage of contracted Providers that are accepting new patients;

g. Ability to communicate with LEP Enrollees;

h. Ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Enrollees with physical or mental disabilities;

i. Maximum wait times for an appointment; and

j. Hours of operation requirements. These standards are required, pursuant to pursuant to 42 C.F.R. § 438.68(b)(3), for the following types of Participating Providers:

a. Adult PCPs;

b. Pediatric PCPs;

c. Obstetrics and Gynecology (OB/GYN) Providers;

d. Adult mental health Providers;

e. Adult SUD Providers;

f. Pediatric mental health Providers;

g. Pediatric SUD Providers;

h. Adult Specialist Providers;

i. Pediatric Specialist Providers;

j. Hospitals; and

k. Pharmacies.

PCPs, as indicated in federal regulations, are known as PCPs throughout this Contract. The standards in Section 1.14.3.1: "PCP Provider Standards" of this 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 1.14.3.7.2: "Essential Community Providers" of this Contract. OHCA reserves the right to set time and distance standards for additional Provider types that it determines necessary to improve Enrollee access and further the goals of the SoonerSelect Program.

The Contractors' submitted provider network will be evaluated against the RFP's Network Adequacy requirements using the following guidelines:

1. OHCA will evaluate each Contractor's network by each identified provider type listed in the RFP. The Agency will additionally compare the Contractor's network to the current Medicaid Fee for Service (FFS) provider network.
2. To assist with this evaluation, OHCA has provided each Contractor a copy of the current provider file, including addresses for each office and NPI numbers, along with a deidentified recipient file that provides the address of recipients. OHCA will also provide a historical claims file to Contractors to allow them to evaluate current utilization of services as they develop their provider network.
3. OHCA will only utilize executed provider contracts to evaluate the Contractor network with wait times specified by provider in each individual contract. Each Contractor's provider network must be sufficient to provide a robust network that reduces appointment and wait times for recipients while also providing culturally competent care. The Agency will evaluate wait times and cultural competency six months after go-live. OHCA has created the reporting template for the requirements that it will evaluate standards for provider networks. The report, SEL_110X_Network_Adequacy_Report_20230801, requires Contractor's to provide the number of providers and locations in their network by urban vs. rural and by provider type. They must also report the number and percentage of enrollees who meet the distance and time standards. Contractor's must additionally report those enrollees that do not meet the standards and the average distance to at least one provider.

1) Appointment Wait Times
   a. Contractor's must include requirements in provider contract templates by provider type as well as in Policies and Procedures related to contracting and network development.
   b. This includes availability to get an appointment or seek sick care and the period to wait to be seen at the scheduled appointment.
   c. Review of Contractor-specific analyses of appointment wait times will not be available or assessed until after go-live as Contractors are still building provider networks during the readiness review assessment.
2) Distance Requirements
   a. OHCA will provide files on provider ratio determination for Contractors to use to understand compliance with sufficiency. One file will be a complete copy of the current FFS provider file and the other will be a delimited recipient file that include their address.
      i. OHCA will determine whether there is enough of a provider type in a zip code area (or county) to adequately serve the population of SoonerSelect members. The Agency will additionally assess member choice of providers based on a comparison to the current Medicaid provider network.
   b. Distance to provider adequacy will be determined by number of contracted provider types in a zip code area:
      i. Contractors will create Geo-Access maps by provider type indicating distance to nearest provider against location of the current Medicaid population. Appendix A lists the specialties that each GeoAccess submission should contain.
      ii. Where distance does not meet distance requirement within defined geographic area, OHCA will consider the Contractor noncompliant.
      iii. Contractor's must have 90% or greater compliance with all distance requirements. Anything less results in a Corrective Action Plan (CAP).
3) Provider Ratios
   a. OHCA to confirm sufficient number of providers in a zip code / county.
   b. Contractor's will provide OHCA with the following information by provider type and zip code/county or other OHCA defined geographic area:
      i. Ratio comparison of Medicaid population compared to Contractor contracted provider.
      ii. Indication of percent Contractor contracted providers

compared to current FFS ratio.
iii. Indication of number of contracted provider types not currently a Medicaid provider.
iv. Indication that the contracted provider is accepting new Medicaid patients.
v. Indication of network adequacy concerns.

4) Exceptions to Network Adequacy Requirements (i.e., waivers)
a. Through the readiness review process, OHCA will review the elements under Distance Requirements. Should a Contractor wish to request an exception to network adequacy requirements, they must do so by November 5, 2023.
b. Contractors must include justification and analysis to support the need for a waiver by completing the SEL1102_Network_Adequacy_Exception_Report_20230801.The Contractor's will be required to provide the following data elements including for OHCA to review:
i. County
ii. Provider type for which an exception is needed
iii. Description of exception
iv. Strategy for assuring access to medically necessary services
v. Description of efforts to contract with additional providers to meet the network adequacy standard.
c. If Contractor's do not resolve and reflect resolution of distance and provider ratio CAPs by finalized contracts, and OHCA has not approved an exception by November 24, 2023, OHCA will consider the Contractor network to be inadequate, which may impact the Contractor's approval for SoonerSelect participation.

5) Cultural Competency
a. Within program agreements and policies, Contractor's must include:
i. Language of the provider or the availability of translation services, closed captioning, speech to text, and any other accommodations for telemedicine services.
ii. ADA compliance of the provider's office.
iii. A review of whether provider offices are accessible via public transportation.
iv. Access to Tribal Health providers and policies and/procedures to ensure members have access to providers who understand and respect their cultural norms and beliefs.

1.16.1.12.1 Directed Payments to Certain Qualified Providers

The Contractor shall fully participate in and faithfully execute all directed payment programs (DPPs) established by OHCA in accordance with 42 C.F.R. § 438.6(c) and 56 O.S. § 4002.12b. These DPPs will be defined by OHCA. OHCA will establish criteria for each DPP, including but not limited to the time frame for the directed payment; Providers who will participate in the directed payment; and the mechanism for the calculation and delivery of the amount(s) to be paid to the selected Providers. The CE will collect and provide to OHCA such information as is required to support all directed payment programs. Directed payment programs will be in accordance with CMS requirements, including 42 C.F.R. § 438.6(c).

~~Annually,~~ ~~t~~The State will estimate the allocation to be assigned to each Contractor ~~rate cell using rate development based historical utilization~~ for the estimated payment distribution depending on the approved DPP by CMS. Directed payments are required to be made via EFT unless requested in another form by the qualifying Provider.

1.16.1.12.2 Directed Payments Reporting

OHCA will send each Contractor a report along with its quarterly payment that indicates the amount of the total payment for each Qualified Provider.

~~OHCA will send each Qualified Provider a quarterly report summarizing utilization per category of service by the Contractor used to determine the Directed Payments.~~

Contractors shall pay as directed by OHCA within five (5) business days of receiving payment and report from OHCA. Contractors are prohibited from withholding or delaying a directed payment for any reason.

Within thirty (30) Calendar Days of receipt of payment of the Directed Payments from OHCA, the Contractor must submit a ~~quarterly~~ report indicating the following:

a. Qualified Providers that received Directed Payments;
b. Total amount paid to each Qualified Provider;
c. The date such Directed Payments were made to the Qualified Providers; and
d. The amount of total payment made to all Qualified Providers.

1.16.1.12.4 DPP Description

As noted in 1.16.1.12.1, The Contractor shall fully participate in and faithfully execute all DPPs established by OHCA in accordance with 42 C.F.R. § 438.6(c) and 56 O.S. § 4002.12b. These special payment arrangements will be defined by OHCA and OHCA will establish criteria for each arrangement.

1.16.1.12.4.1 Supplemental Hospital Offset Payment Program (SHOPP)

OHCA will require each Contractor to make directed payments to qualified SHOPP-eligible hospitals. For each class of SHOPP-eligible hospitals, OHCA calculates a uniform dollar increase per managed care plan discharge for inpatient services and a uniform percentage increase to base managed care plan payments for outpatient services such that total modeled managed care plan payments (including base and directed payments) for the class are equal to 90% of the commercial payment equivalent.

To ensure OHCA's anticipated transition to managed care is not delayed or disrupted and to preserve the existing SHOPP payment timing, quarterly interim payments will initially be made to each SHOPP-eligible hospital based on modeled managed care plan discharges and base payments for the hospital. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan discharges and payments for the contract period. Under this reconciliation, OHCA will calculate an updated uniform dollar increase per discharge (for inpatient services) and an updated uniform percentage increase (for outpatient services) for each class based on actual in-network managed care plan discharges and payments for the contract period such that total SHOPP directed payments by class remain unchanged relative to the initial modeled amounts and continue to sum to the amounts previously approved by CMS. If, based on the updated uniform dollar and percentage increase amounts and actual in-network managed care plan discharges and payments for the contract period, the average absolute percentage change in directed payments would be greater than 5% relative to the interim payments across all hospitals within a given class, a settlement adjustment will be made for hospitals in the class based on the contract period experience. Relevant information for this payment arrangement:

a. Control name of Section 438.6(c) pre-print is OK_Fee_IPH.OPH1_Renewal_20240401-20250630

b. The DPP is effective from April 1, 2024 – June 30, 2025
c. Hospitals eligible to receive payments under this arrangement are consistent with the SHOPP Act and Oklahoma's State Plan. Qualifying SHOPP-eligible hospitals are separated into the following two provider classes for the purposes of calculating uniform dollar (for inpatient services) and percentage (for outpatient services) increases: Critical access hospitals (CAHs) and all other (non-CAH) hospitals
d. Uniform increase for inpatient and outpatient hospital services at private, non-state government, and critical access hospitals for the rating period incorporated in the capitation rates through a separate payment term of up to $1,262,703,035
e. Interim quarterly payments will be made by the managed care plans to qualifying SHOPP-eligible hospitals based on modeled managed care plan discharges and payments for the hospitals. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan discharges and payments for the contract period.

1.16.1.12.4.2 Level 1 Trauma Hospital

OHCA will require each Contractor to make directed payments to qualified Level I Trauma hospitals. OHCA calculates a uniform dollar increase per managed care plan discharge for inpatient services and a uniform percentage increase to base managed care plan payments for outpatient services such that total modeled managed care plan payments (including base and directed payments) for qualifying hospitals are equal to 100% of the commercial payment equivalent. The portion of payments from 90% to 100% of commercial payment equivalent under this arrangement are contingent on the qualifying hospitals improving or maintaining performance on specific quality metrics related to healthcare–associated infections (HAIs) and patient mortality.

To ensure the OHCA's anticipated transition to managed care is not delayed or disrupted and to preserve the existing timing for Level I Trauma inpatient and outpatient supplemental payment programs, quarterly interim payments will initially be made to the qualifying hospitals based on modeled managed care plan discharges and base payments for the hospitals. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan inpatient discharges and outpatient base payments for the contract period. Under this reconciliation, if actual in-network managed care plan inpatient discharges or outpatient base payments for the qualifying hospitals are less than 95% of modeled managed care plan inpatient discharges or outpatient base payments, a

settlement adjustment will be made for inpatient discharges or outpatient base payments below 95% of modeled levels. Relevant information for this payment arrangement:

a. Control name of Section 438.6(c) pre-print is OK_Fee_IPH.OPH_Renewal_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. Hospitals eligible to receive payments under this arrangement are consistent with existing Supplemental Payments for Hospitals with Level 1 Trauma Centers as defined in Oklahoma's State Plan. Oklahoma hospitals that have Level 1 Trauma Centers providing inpatient or outpatient services and are owned or operated by the public trust established pursuant to section 63-3224 of the Oklahoma Statutes or affiliates or locations of those hospitals designated by said trust as part of the hospital Trauma system.
d. Uniform increase for inpatient and outpatient hospital services at level 1 trauma hospitals for the rating period incorporated in the capitation rates through a separate payment term of up to $520,040,434. A portion of this amount is contingent on the qualifying hospitals improving or maintaining performance on specific quality metrics.
e. Interim quarterly payments will be made by the managed care plans to the qualifying hospitals based on modeled managed care plan discharges and payments for the hospitals. At the conclusion of the contract period and after the contract period encounter data is sufficiently complete, OHCA will perform a reconciliation based on actual in-network managed care plan discharges and payments for the contract period.

1.16.1.12.4.3 Academic Medical Center Affiliated Physicians

OHCA will require each Contractor to make directed payments to qualified professionals practicing as part of an academic medical center for the purpose of improving access to quality healthcare for all Medicaid members.

Each quarter OHCA will calculate directed payments for all encounters incurred from the start of the managed care rating period through the end of the prior quarter, less any directed payments previously calculated for prior quarters in the managed care rating period. Directed payments will be calculated as the difference between base managed care plan payments and 175% of the Medicare fee schedule amount, excluding vaccines, laboratory, and technical component of radiology services. A final calculation of directed payments under this arrangement including all encounters incurred in the managed care rating period will be made after there is sufficient runout following the end of the

managed care contract period, less any directed payments previously calculated for the managed care rating period. Relevant information for this payment arrangement:

a. Control name of Section 438.6(c) pre-print is OK_Fee_AMC_New_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. The class of Qualified Providers is consistent with the OHCA's CMS-approved FFS supplemental payments to Oklahoma Universities Affiliated Physicians, as defined in Oklahoma's State Plan. Designated professionals who are enrolled SoonerSelect network providers, and employed by or contracted with, or otherwise a member of the faculty practice plan of, (1) a public, accredited Oklahoma medical school or (2) a hospital or healthcare entity directly or indirectly owned or operated by the entities created pursuant to Section 63-3224 or 63-3290 of the Oklahoma Statutes.
d. OHCA will provide directed payments such that total payments (including base and directed payments) to Qualified Providers is equal to 175% of the Medicare fee schedule amount for the rating period incorporated in the capitation rates through a separate payment term of up to $127,410,566.
e. OHCA will calculate the difference between base managed care plan payments and 175% of Medicare for encounters incurred from April 1, 2024 (the start of the contract period) through the end of the prior quarter, less the amount previously calculated for prior quarters. A final calculation of directed payments under this arrangement including all encounters incurred in the managed care rating period will be made after there is sufficient runout following the end of the managed care contract period, less any directed payments previously calculated for the managed care rating period. After the provider-level calculations have been completed for a given period, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

1.16.1.12.4.4 Ground Emergency Medical Transport (GEMT)

OHCA will require each Contractor to make directed payments to qualified governmental ground ambulance transportation providers for the purpose of improving access to quality healthcare for all Medicaid members.

OHCA will calculate directed payments for all encounters incurred during the managed care rating period. The directed payments will be calculated as the difference between base managed care plan payments and cost for each provider for services incurred during the rating period. To align with the data collection and payment calculation process already in use for the OHCA's FFS supplemental payments for the same set of Qualified

Providers, payment calculations will be done for each state fiscal year (July through June). After the conclusion of a given state fiscal year, OHCA will calculate the directed payment amounts attributable to managed care program utilization for each provider. As a result, for the first contract period of the SoonerSelect program, separate calculations will occur for April 1, 2024 through June 30, 2024 managed care program utilization and for July 1, 2024 through June 30, 2025 managed care program utilization. Relevant information for this payment information:

a. Control name of Section 438.6(c) pre-print is OK_Fee_Oth_New_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. The class of Qualified Providers is consistent with the OHCA's CMS-approved FFS supplemental payment program for governmental ground ambulance transportation providers, as defined in Oklahoma's State Plan. A single class of Qualified Providers will be used for this DPP. To be eligible for this directed payment, Qualified Providers must meet all the following requirements:

a. Be enrolled as an Oklahoma Medicaid provider for the period claimed on their annual cost report;
b. Provide ground ambulance transportation services to Medicaid recipients; and
c. Be an organization that either:
    i. Is publicly owned or operated, defined as a unit of government which is a State, a city, a county, a special purpose district or authority, or other government unit in the State that has taxing authority or has direct access to tax revenues; or
    ii. Contracts with a local government, defined as an interlocal agreement with a city, county, or local service district, including but not limited to, a rural fire protection district, and all administrative subdivisions of such city, county, or local service district, pursuant to a plan for emergency medical services.

Qualified Providers must certify their uncompensated cost for providing ambulance transportation services for Medicaid recipients through an annual submission of the Centers for Medicare and Medicaid Services (CMS)-approved cost report in order to receive payments under the arrangement.

a. OHCA will provide directed payments such that total payments (including base and directed payments) for each eligible provider is equal to cost for the state fiscal year incorporated in the capitation rates through a separate payment term of up to $17,013,980 for the rating period.

b. OHCA will calculate directed payments for all encounters incurred during the managed care rating period. The directed payments will be calculated as the difference between base managed care plan payments and cost for each provider for services incurred during the rating period. To align with the data collection and payment calculation process already in use for the OHCA's FFS supplemental payments for the same set of Qualified Providers, payment calculations will be done for each state fiscal year (July through June). After the conclusion of a given state fiscal year, OHCA will calculate the directed payment amounts attributable to managed care program utilization for each provider. As a result, for the first contract period of the SoonerSelect program, separate calculations will occur for April 1, 2024 through June 30, 2024 managed care program utilization and for July 1, 2024 through June 30, 2025 managed care program utilization. After calculations have been performed for a given state fiscal year, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

1.16.1.12.4.5 Ambulance Service Provider Access Payment Program (ASPAPP)

OHCA will require each Contractor to make directed payments to Qualified private ambulance service providers for the purpose of improving access to quality healthcare for all Medicaid members.

OHCA will set the total amount of the uniform increase payments for each calendar quarter during the managed care rating period. Payments attributable to a given calendar quarter will be distributed to Qualified Providers based on utilization incurred during the given quarter as reported in the encounter data submitted by managed care plans. Each provider's directed payment for a given quarter will be determined as a flat percentage of the gap between actual incurred Medicaid base managed care plan payments and the calculated commercial payment equivalent. Relevant information for this payment information:

a. Control name of Section 438.6(c) pre-print is OK_Fee_Oth1_New_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. The class of Qualified Providers is consistent with the providers eligible for the OHCA's CMS-approved Access Payment Program Fee for Emergency Ambulance Service Providers. This supplemental payment is defined in Oklahoma's State Plan. A single class of Qualified Providers will be used for this DPP. Ambulance service providers of emergency services, who are

eligible for the OHCA's FFS supplemental payments under the Access Payment Program Fee for Emergency Ambulance Service Providers, are eligible to participate. The following types of ambulance service providers are not eligible:

i. An ambulance service that is owned or operated by the state or a state agency, the federal government, a federally recognized Indian tribe, or the Indian Health Service;
ii. An ambulance service that is eligible for Supplemental Hospital Offset Payment Program (SHOPP);
iii. An ambulance service that provides air ambulance services only; or
iv. An ambulance service that provides non-emergency transports only.

d. Within each quarter, payments will be determined for each provider as a flat percentage of the gap between Medicaid base managed care plan payments and the calculated commercial payment equivalent incorporated in the capitation rates through a separate payment term of up to $12,258,457 for the rating period.
e. To allow sufficient time for claim payment runout and encounter submission, OHCA anticipates the distribution of directed payments will lag two quarters after the quarter in which the utilization occurred. For example, the provider-level payments attributable to utilization incurred during the second quarter of 2024 (April 2024 through June 2024) will be calculated during the fourth quarter of 2024 (October 2024 through December 2024). After the provider-level calculations have been completed for a given period, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

1.16.1.12.4.6 Enhanced Tier Payment System (ETPS)

Oklahoma's Enhanced Tier Payment System (ETPS) promotes health improvement and aligns financial incentives to pay for outcomes. OHCA will require each Contractor to make directed payments to Qualified Community Mental Health Centers (CMHCs) for the purpose of improving access to quality healthcare for all Medicaid members.

Consistent with 42 CFR 438.6(c)(1)(i), Oklahoma Medicaid health plans will implement a value-based payment (VBP) program for Oklahoma Community Mental Health Centers. These payments will encourage Community Mental Health Centers to contract with Contractors which will sustain access to vital mental health services for SoonerSelect enrollees. The payments will increase quality of care for Medicaid members.

Two Community Mental Health Center (CMHC) provider types are allowed to participate in this

payment system, Qualified governmental providers, and Qualified private providers. The state will use Managed Care encounter data quarterly to calculate each provider's performance based on twelve required measures. Qualified Providers must meet the benchmarks established in order to receive payment. The dollars are distributed to Qualified Providers based on the volume of unique clients served; Qualified Providers that serve 10% of the total number of clients receive 10% of the pool. Counted clients must be an open client in an outpatient or crisis unit level of care during the measured quarter and have at least one claim billed under contract source 01, 30, 53, 55 or Medicaid. PACT clients are excluded, as well as individuals with '99' on their first or last CAR score. Payments are also calculated on Qualified Providers who exceed a benchmark by one standard deviation, referred to as a "bonus" payment. The bonus payment dollars come from any remaining money in the pool that is not distributed if a Qualified Provider (or providers) does not meet benchmark requirements. In this way, Qualified Providers are incentivized to exceed benchmarks. Additionally, OHCA will use a "safety valve" approach which allows Qualified Providers who are within one standard deviation below the benchmark to receive a 50% partial payment. This ensures that Qualified Providers receive payment for partially meeting benchmarks. However, if a Qualified Provider performs more than one standard deviation below the benchmark, that Qualified Provider does not receive payment for that measure. Qualified Providers that receive only a 50% partial payment or 0% of their available funds for a measure leave money "on the table" to be distributed as a bonus to Qualified Providers exceeding the benchmarks by at least one standard deviation.

Oklahoma Medicaid health plan encounter data will be used to directly link payments to utilization of mental health services by CMHC for plan enrollees. CEs are required to submit encounter data to the OHCA in accordance with formatting and timeliness standards set forth in their contracts with OHCA. Upon completion of the quarter, the state will calculate each CMHC's payment by CE using valid encounters during the previous quarter. OHCA will then issue a supplemental payment to each Medicaid health plan based on the calculated amount earned for services provided to the health plan's enrollees. Due to the VBP being calculated after the encounter has been paid, the directed payment will occur retroactively to each health plan based on actual encounters paid during the previous quarter. Relevant information for this payment information:

a. Control name of Section 438.6(c) pre-print is OK_VBP_BHO_New_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. The classes of Qualified Providers are consistent with the CMS-approved FFS supplemental payments to public and private Community Mental Health Centers (CMHCs), as defined in Oklahoma's State Plan Attachment including State-operated and private organizations contracted as Community Mental Health Centers (CMHCs).
d. The state calculates each Qualified Provider's performance on twelve measures. Qualified Providers must meet the benchmarks established in order to receive payment. The payments are incorporated in the capitation rates through a separate payment term of up to $46,316,476 for the rating period.
e. To allow sufficient time for claim payment runout and encounter submission, OHCA anticipates the distribution of directed payments will lag one quarter after the quarter

in which the utilization occurred. For example, the provider-level payments attributable to utilization incurred during the second quarter of 2024 (April 2024 through June 2024) will be calculated toward the end of the third quarter of 2024 (July 2024 through September 2024). After the provider-level calculations have been completed for a given period, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

f. Value-based models elements that condition payment based upon performance:
   i. For approved performance measures, see Addendum XX upon which payment will be conditioned;
   ii. For approved measurement period for those measures, see Addendum XX;
   iii. For approved baseline statistics for all measures against which performance will be measured, see Addendum XX;
   iv. For performance targets that must be achieved on each measure for the provider to obtain the performance based payment, see Addendum XX;
   v. Methodology to determine if the provider qualifies for the performance-based payment as well as the amount of the payment
   § For 10 of the 12 outcome measures, the benchmarks were determined by the distribution of data from all Community Mental Health Centers for a period of six months. From these data points, the average and standard deviations were calculated. These statistics were then used to establish the benchmark. For two of the 12 outcome measures (access to treatment for adults and access to treatment for children), outcomes are based on monthly "Secret Shopper" calls. Scores are averaged over three months to determine result. Scoring: See a clinician for screening 0-3 days = 3 (bonus); See a clinician within 4-5 days = 2 (meets); come in for paperwork in 1-5 days, but won't see a clinician = 1 (partially meets); anything else = 0 (does not meet).The benchmarks are utilized to assess monthly performance. The State updates the benchmarks periodically. The last update was effective in SFY 2018. The State does not currently have plans to revise the benchmarks but will evaluate when they should be updated next based on the number of Qualified Providers who meet or exceed the benchmarks to ensure the benchmarks remain incentives for improving care. Qualified Providers may receive a portion of the payment if they meet the performance target on some but not all measures. Each measure is calculated as an individual pool.

1.16.1.12.4.7 Provider Incentive Pool

OHCA will require each Contractor to make directed payments to Qualified Providers practicing for the purpose of improving access to quality healthcare for all Medicaid members.

Each quarter OHCA will calculate directed payments for all encounters incurred from the start of the managed care rating period through the end of the prior quarter, less any

directed payments previously calculated for prior quarters in the managed care rating period. For each class of eligible professionals, OHCA will calculate a uniform $25 dollar increase for targeted services including Well Visits, After Hours Care, and Screening, Brief Intervention and Referral to Treatment (SBIRT). OHCA will also calculate a uniform percentage increase to base managed care plan payments for professional services. Relevant information for this payment arrangement:

a. Control name of Section 438.6(c) pre-print is OK_Fee_OTH2_New_20240401-20250630
b. The DPP is effective from April 1, 2024 – June 30, 2025
c. The class of Qualified Providers includes designated professionals (as defined by OHCA) who are enrolled SoonerSelect network providers, and are not employed by or contracted with, or otherwise a member of the faculty practice plan of, (1) a public, accredited Oklahoma medical school or (2) a hospital or healthcare entity directly or indirectly owned or operated by the entities created pursuant to Section 63-3224 or 63-3290 of the Oklahoma Statutes.
d. OHCA will pay Qualified Providers of $25 per qualifying well visit, after hours visit, or SBIRT screen and a uniform percent increase to base managed care plan payments for professional services (primary and specialty care) for the rating period incorporated in the capitation rates through a separate payment term of up to $134,330,110.
e. Each quarter OHCA will calculate the enhanced payments for encounters incurred. After the provider-level calculations have been completed for a given period, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

1.16.5.4 Interest Payment for Delayed Adjudication of Clean Claims

The Contractor shall pay a monthly interest rate of one and a half percent (1.5%) on all Clean Claims that are not adjudicated within forty-five (45) Days of receipt by the Contractor, in accordance with Section 1219 of Title 36 of the Oklahoma Statutes ~~62 O.S. § 34.72~~. This interest rate shall be prorated on a daily basis.

1.17.4.3 IHCP Payments

~~All Contractor payments to IHCPs shall be made in accordance with 42 C.F.R. § 438.14.~~ OHCA will reimburse IHCPs for services ~~that are eligible for one hundred percent (100%) federal reimbursement and are~~ provided by IHCPs ~~an IHS or 638 Tribal facility.~~

to all SoonerSelect Enrollees. ~~AI/AN Enrollees who are eligible to receive services through an IHS or 638 Tribal facility.~~ Encounters for SoonerCare services billed by IHCPs ~~IHS or 638 Tribal facilities and eligible for one hundred percent (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 one hundred percent (100%) federal reimbursement and provided to Enrollees who are eligible to receive services through the IHCP, regardless of whether the IHCP is a Participating Provider, contracted at the applicable encounter rate published annually in the Federal Register (FR) by the 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 FFS methodology.~~

~~In the event the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the FR 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 FFS or the applicable encounter rate.~~

~~In accordance with 42 C.F.R. § 438.14(c)(1), IHCPs enrolled in Medicaid as a FQHC but are not a Participating Provider must be paid an amount equal to the amount the Contractor would pay a FQHC that is a Network Provider but is not an IHCP, 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 FFS.~~

~~The Contractor shall timely pay all I/T/U Participating Providers in accordance with the requirements of Section 1.16.5: "Timely Claims Filing and Processing" of this 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 Enrollees and such services are eligible for one hundred percent (100%) federal funding. The Contractor shall provide reporting in the manner and format required in the Reporting Manual to facilitate the State's collection of one hundred percent (100%) federal funding for the services furnished by the non-IHS/Tribal Providers acting with a Care Coordination agreement with IHCPs. 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 Enrollees.

1.18.1 Enrollee Grievance and Appeal Overall Requirements

As provided under 56 O.S. § 4002.8 and 42 C.F.R. § 438.402(c)(2)(ii), the Contractor and OHCA shall allow an Enrollee, a Provider or an Authorized Representative to request an Appeal, file a Grievance, or request a State Fair ~~Hearing, Only Enrollees are allowed to request continuation of benefits as specified in 42 C.F.R. § 438.420(b)(5) and Section 1.18.9: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Contract.~~on behalf of an Enrollee with the written consent of the Enrollee. When the term "Enrollee" is used throughout Section 1.8: Enrollee Grievance and Appeal of this Contract, it includes Authorized Representatives.

1.18.6.6 Prior Authorization Denial or Limitation

In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d), when the action for which the notice of Adverse Benefit Determination is being provided is (a) a "Standard authorization decision[]" under 42 C.F.R. § 438.210(d)(1) to deny or limit services, the Contractor shall provide the notice as expeditiously as the enrollee's condition requires and no later than fourteen (14) Calendar Days, and (b) an "Expedited authorization decision[]" under 42 C.F.R. § 438.210(d)(2), as expeditiously as the Enrollee's condition requires and not to exceed seventy-two (72) Hours following receipt of the request for service. The Contractor may extend either notice timeframe up to an additional fourteen (14) Calendar Days when requested by the Enrollee or Provider as Authorized Representative or if the Contractor justifies (to the satisfaction of OHCA and upon OHCA request) a need for additional information and how the extension is in the enrollee's interest.

If the Contractor justifies to OHCA, upon request, the timeframe be extended for additional information and that the extension is in the Enrollee's interest, the Contractor shall, in accordance with 42 C.F.R. § 438.404(c)(4), provide the Enrollee written notice of the reason for the decision to extend the timeframe for up to fourteen (14) Days, inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision and issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

1.18.7.2 Timeframe for Requesting Appeal

In accordance with 42 C.F.R. § 438.402(c)(2)(ii), the Contractor shall allow the Enrollee, Provider or Authorized Representative to file an Appeal to the Contractor within sixty (60) Calendar Days from the date on the Adverse Benefit Determination notice.

1.19.5 Five Percent (5%) Cost Sharing Limit

In accordance with 42 C.F.R. § 447.56, Enrollee's total Cost Sharing shall not exceed five percent (5%) of the Enrollee's household income applied on a monthly basis. The Contractor shall report 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 Enrollee Cost Sharing incurred for any Excluded Benefits and will notify the Contractor via the ANSI ASC X 12 834 electronic transaction when an Enrollee has met the five percent (5%) aggregate limit.

Upon receipt of the ANSI ASC X 12 834 electronic transaction, the Contractor shall ensure that Co- payments are not deducted from Provider claims reimbursement through the end of the month. ~~The Contractor OHCA shall notify the Enrollee and Providers when the aggregate limit has been met and are no longer subject to Cost Sharing for the remainder of the Enrollee's current monthly or quarterly cap period.~~ The Contractor shall reinstate Enrollee Cost Sharing effective the first of the following month for any Enrollee who exceeded the aggregate limit in the previous month. Enrollees may request a reassessment of their household aggregate limit if they have a change in circumstances or if they are being terminated for a failure to pay a Premium.

1.20.11.4 Overpayments Resulting from Provider Disclosure

OHCA will implement policies in accordance with 42 U.S.C. § 1320a-7k(d)(l), codifying Section 6402(a) of the Patient Protection and ACA. All Overpayments resulting from situations other than Fraud, including self-reported Overpayments to the Contractor, will be considered the Contractor's property unless:

a. OHCA, OIG, CMS or its contractors, Office of Attorney General, MFCU notified the Provider that an Overpayment existed;

b. The Contractor fails to initiate recovery within twelve (12) months from the date the Contractor first paid the claim;
c. The Contractor fails to complete the recovery within fifteen (15) months from the date the Contractor first paid the claim~~;~~ or by the designated date set forth by a repayment plan approved by the OHCA; or
d. The Contractor fails to complete the recovery within sixty (60) Days from the date the Provider notified the Contractor of the Overpayment.

1.21.2 Electronic Visit Verification Requirements

OHCA contracts with an EVV vendor to monitor services under this Contract including home health Services and State Plan Personal Care Services as detailed at Section 1.7.5: "State Plan Personal Care Services" of this Contract in accordance with § 12006(a) of the 21st Century Cures Act. The Contractor shall contract with OHCA's specified EVV vendor(s) to continue the Statewide EVV system to monitor Enrollee receipt and utilization of home health services and State Plan Personal Care Services. In the event OHCA has not yet awarded an EVV vendor, Contractor must maintain an EVV vendor of their choice until OHCA has completed the award process and the EVV system is implemented, upon which Contractor will transition EVV services to the OHCA specified vendor. 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:

a. Log the arrival and departure of the Provider delivering the service;
b. Verify, in accordance with business rules, that services are being delivered in the correct location (e.g., Enrollee's home);
c. Verify the identity of the individual Provider providing the service to the Enrollee
d. Match services provided to an Enrollee with services authorized in the Enrollee's Care Plan;
e. Ensure that the Provider delivering the service is authorized to deliver such services; and

f. Reconcile paid claims with PAs, as applicable.

The Contractor shall monitor and use information from the EVV system to verify that services are provided as specified in the Enrollee's Care Plan; in accordance with the established schedule, including the amount, frequency, duration, and scope of each service; that the 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 an Enrollee is receiving services, including after the Contractor's regular Business Hours.

1.21.5 Operation

Once OHCA's care management system is fully operational and has the capability to send/receive bi-directional data, ~~.~~The Contractor's MIS 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 MIS 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):

a. Enrollee information, including:
i. Disenrollment for reasons other than the loss of Medicaid eligibility; and
ii. Grievance and Appeal;
b. Third-Party Liability;
c. Provider;
d. Reference;
e. Encounter processing;
f. Claims processing;
g. Financial;
h. Care Management, specifically addressing data related to:
    i. Health Risk Screenings;
    ii. Comprehensive assessments;
    iii. Medical history;
    iv. Past and current Care Plans and PAs;
    v. Care Management contacts and interventions; and
    vi. Reporting and analysis systems for medical management purposes;
i. UM;
j. Quality Improvement;
k. Reporting; and

l. 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 Enrollees or specific SoonerSelect Program populations.

In accordance with 42 C.F.R. 438.242(b) and Section 1.21.1: "General Requirements" of this 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.

1.22.6.1 MLR Corridor and MLR Remittance

The Contractor's total annual Capitation Payments shall be evaluated against a minimum eighty-five percent (85%) MLR, calculated in accordance with 42 C.F.R. § 438.8.~~; however, directed payments under 42 C.F.R. § 438.6(c) for MLR Remittance are excluded from both the numerator and denominator for the calculation of MLR Remittance.~~ 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 ninety percent (90%). As the Capitation Rates have not yet been developed, this illustrated ninety percent (90%) is subject to change. The corridor will be symmetric. The eighty-five percent (85%) minimum MLR will not change, and neither will the share factors. However, given the change in the priced for MLR, the eighty-eight percent (88%), ninety-two percent (92%), and ninety-five percent (95%) will be adjusted to provide a symmetrical corridor.~~ The MLR calculation will be performed across all population groups except a separate calculation will be performed for the Medicaid Expansion population for Federal match claiming purposes. The following table has been provided for illustrative purposes only:

Medical Loss Ratio Corridor	MCO Share of Gain/Loss in the Corridor	State/Federal Government Share of Gain/Loss in the Corridor
MLR of less than 85%	0%	100%
MLR ~~equal to or greater than~~ between 85% and ~~less than 88%~~ 87.86%	50%	50%
MLR ~~equal to or greater than 88%~~ between 87.86% ~~and less than 92%~~ 91.86%	100%	0%
MLR ~~equal to or greater than 92%~~ between 91.86% ~~and less than 95%~~ 94.72%	50%	50%
MLR equal to or greater than ~~95%~~ 94.72%	0%	100%

Additional details related to the risk corridor, including the target MLR, are included in the applicable rate certification, and are available to the managed care entities upon request.

OHCA reserves the right to modify the target MLR and associated corridor in future Contract Years, in accordance with Section 1.2.8: "Amendments or Modifications" of this Contract.
If the Contractor's MLR does not meet or exceed the MLR target making the MLR Non-Credible, then the Contractor shall reimburse OHCA within thirty (30) Days of OHCA identifying and finalizing the MLR Validation. OHCA shall designate the MLR rebate and initiate the recovery of funds process by providing notice to the Contractor of the amount due. This provision shall survive expiration of the Contractor's other duties under the SoonerSelect Medical Program, in the event the Contractor is terminated or not renewed.

If the Contracted Entity determines that payment of the remittance will cause the CE's risk-based capital to fall below levels required by 36 O.S. § 6~~937~~6146, et seq., the Contracted Entity's responsible official must notify OHCA in writing as soon as administratively possible and prior to making any MLR rebate payments to OHCA.

1.22.7 Risk Adjustment

The Contractor's Capitation Rates will be risk adjusted based on health status as determined by the risk adjustment model. ~~MedicaidRx~~ CDPS+RX will be used for the initial Rating Period and model selection will be re-evaluated for later Rating Periods. In accordance with 42 C.F.R. § 438.5, 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. Transition limits will be developed and applied as to how much capitation revenue can change due to risk adjustment.

1.22.8 Third-Party Liability

The Contractor will be notified of known SoonerSelect Dental Enrollee third party resources via the ANSI ASC X 12 834 electronic transactions. SoonerSelect Dental 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's 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 not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources in accordance with 42 C.F.R. § 1201(p). The Contractor shall make every reasonable effort to:

a. Determine the liability of third parties to pay for services rendered to SoonerSelect Dental Enrollees;
b. Avoid costs which may be the responsibility of third-parties;
c. Reduce payments based on payments by a third-party for any part of a service; and
d. 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 Contract and shall report all Third-Party Liability collections in the manner and timeframe required by OHCA as prescribed in the Reporting Manual. OHCA will monitor to confirm that the Contractor is upholding contractual requirements for Third-Party Liability activities.

Appendix 1B Definitions:

2. Oklahoma SoonerSelect Program Contract Definitions

1. § 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 (6) § 1915(c) Waivers: ADvantage, Medically Fragile, Community Waiver, Homeward Bound Waiver, In-Home Supports for Adults Waiver, and In-Home Supports for Children Waiver.

2. 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 Enrollee practices that result in unnecessary cost to the Medicaid program.

3. Accrediting Entity – An entity recognized by CMS under 45 C.F.R. § 156.275. Current CMSrecognized Accrediting Entities include AAAHC, NCQA, and Utilization Review Accreditation Commission. 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 1.4.2: "Accreditation" of the Contract.

4. Act/The Act – Refers to the Social Security Act.

5. Activities of Daily Living – Activities that reflect the 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 ADLs help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter, and protection.

6. Adult Protective Services – A program within the Oklahoma Human Services that provides vulnerable adults protection from abuse, neglect, or Exploitation.

7. Adverse Benefit Determination – Pursuant to 42 C.F.R. § 438.400(b), means:

a. 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;

b. The reduction, suspension, or termination of a previously authorized service;

c. The denial, in whole or in part, of payment for a service;

d. The failure to provide services in a timely manner, as defined by OHCA;

e. 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 Enrollee Grievance and Appeal;

f. For a resident of a Rural Area with only one (1) SoonerSelect Program Contractor, the denial of a SoonerSelect Program Eligible's request to exercise their right, under 42 C.F.R. § 438.52(b)(2)(ii), to obtain services outside the Network; or

g. The denial of an Enrollee's request to dispute a financial liability, including Cost Sharing, Co-payments, Premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

8. Adverse Determination – A determination by the Contractor or its designee that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Contractor's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated in accordance with 36 O.S. § 6475.3.

9. Adverse Resolution – The final [adverse] decision notice of the CE after an Appeal (at the CE level); this notice triggers the ability for an Enrollee to file a request for a State Fair Hearing (Appeal at the State level) and file for continuation of benefits within 30 Days of receipt of the "Adverse Resolution" notice.

10. 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.

11. Agent – Any person or entity who has been delegated the authority to obligate or act on behalf of another.

12. 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.

13. 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:

a. Is a member of a federally recognized Indian Tribe;

b. Resides in an urban center and meets one (1) or more of the four (4) criteria;

i. Is a member of a 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;

ii. Is an Eskimo or Aleut or other Alaska Native;

iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

iv. Is determined to be an Indian under regulations issued by the Secretary of HHS;

c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

d. 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.

14. Appeal – A review of an Adverse Benefit Determination by the Contractor.

15. Applicant – An individual who seeks SoonerCare coverage.

16. Authorized Representative – A competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the Grievance, Appeal, and State Fair Hearing process. The written authority to act shall specify any limits of the representation.

17. Behavioral Health Emergency – A situation in which an Enrollee presents as being at imminent risk of behaving in a way that could result in serious harm or death to self or others.

18. 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.

19. Bidder – As defined in 74 O.S. § 85.2(4), an individual or business entity that submits a Proposal in response to an invitation to bid or a request for Proposal.

20. Business Days – Defined as Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

21. Business Hours – Defined as 8:30 AM – 5:30 PM Central Time, Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

22. Calendar Days – Defined as all seven (7) Days of the week, including State of Oklahoma holidays.

23. Capitated Contract – A Contract between OHCA and a Contracted Entity for the delivery of services to Medicaid members in which OHCA pays a fixed, per-member per-month rate based on actuarial calculations.

24. Capitation Payment – A payment OHCA will make periodically to the Contractor on behalf of each 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 Enrollee receives services during the period covered by the payment.

25. Capitation Rate – The per-Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the Contractor for each Enrollee enrolled in the SoonerSelect Program for the provision of services during the payment period.

26. Care Coordination/Care Management – A process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Enrollee's needs using advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the Enrollee, the Care Manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

27. Care Manager – The Contractor's staff primarily responsible for delivering Care Coordination/Care Management services to Enrollees in accordance with its OHCA-approved Risk Stratification Level Framework, and meets the qualifications specified in Section 1.9.5.3: "Qualifications" of the Contract.

28. Care Plan – A comprehensive set of actions and goals for the Enrollee developed by the Care Manager based on an Enrollee's unique needs. The Contractor shall develop and implement Care Plans for all Enrollees with a Special Health Care Needs determined through the Comprehensive Assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.9.4: "Care Plans" of the Contract.

29. Case File – An electronic record that includes Enrollee information regarding the management of Health Care Services including but not limited to: Enrollee demographics; comprehensive assessment (if applicable); Care Plan; reassessments; referrals and authorizations, and Enrollee case notes.

30. Certain Children in the Custody of Office of Juvenile Affairs – All persons in OJA custody for whom OJA is required to provide services by law or court order.

31. Certified Community Behavioral Health Clinic – Entities designed to provide a comprehensive range of mental health and SUD services as defined under the Excellence

in Mental Health Act and certified by the Oklahoma Department of Mental Health and Substance Abuse Services.

32. Child Welfare Services – The OHS division responsible for administering the State's Child Welfare Services.

33. Children – A child under age 19 determined eligible for SoonerCare under 42 C.F.R. § 435.118 or the State's Medicaid expansion CHIP.

34. Children Receiving Adoption Assistance – Individuals receiving adoption assistance benefits administered via the OHS. 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.

35. 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 SoonerSelect Program Contractors and PCP. Choice Counseling does not include making recommendations for or against Enrollment into a specific SoonerSelect Program Contractor.

36. Chronic Condition or Chronic Health Condition – A condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits Activities of Daily Living (ADL).

37. 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.

38. Clean Claim – A properly completed billing form with Current Procedural Terminology, 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases coding or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS) coding where applicable that contains information specifically required in the Provider Billing and Procedure Manual of the Oklahoma Health Care Authority, as defined in 42 C.F.R. § 447.45(b).

39. 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 Enrollees; are adopted in consultation with Participating Providers; and are reviewed and updated periodically as appropriate.

40. Cold-call Marketing – Any unsolicited personal contact by the Contractor with an Eligible for the purpose of Marketing.

41. Commercial Plan – An organization or entity that undertakes to provide or arrange for the delivery of Health Care Services to Medicaid members on a prepaid basis and is subject to all applicable federal and State laws and regulations.

42. Confidential Information – Information in any medium (e.g., visual, written, electronic, numeric, verbal) that is in some capacity restricted in disclosure or distribution. This includes medical information of individuals or 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.

43. Consumer Assessment of Healthcare Providers and Systems Survey – A survey administered to health care recipients to report on and evaluate their experiences with a particular health care system.

44. Continuity of Care Period – The ninety (90) Day period immediately following an Enrollee's Enrollment with the Contractor whereby established Enrollee and Provider relationships, current services, and existing PAs and Care Plans shall remain in place in accordance with the requirements of Section 1.10: "Transition of Care (TOC)" of the Contract.

45. 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 Program 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.

46. 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.

47. 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.

48. Contract Year – The period during which the Contract is in effect. The initial Contract Year shall be from date of award through June 30, 20242025. Each subsequent Contract Year shall be based on State Fiscal Year.

49. Contracted Entity – An organization or entity that enters into or will enter into a Capitated Contract with OHCA for the delivery of medical, pharmacy, and Behavioral Health Services not covered in this Contract that will assume financial risk, operational accountability, and Statewide or regional functionality as defined in this act in managing comprehensive health outcomes of Medicaid members. For purposes of this Contract, the term Contracted Entity includes an accountable care organization, a PLE, a Commercial Plan, or any other entity as determined by OHCA.

50. Contractor – A Contracted Entity with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect Program 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, manager, employees, independent contractors, and related parties working for or on behalf of the Contractor and other parties required to be disclosed at Section 1.20.9: "Written Disclosures" of this Contract.

51. Co-payment – A fixed amount that an Enrollee pays for a covered Health Care Service when the Enrollee receives the service.

52. Corrective Action Plan – The detailed written plan that may be required by OHCA to correct or resolve a deficiency, event, or breach causing the assessment of a remedy or damage against the Contractor.

53. Cost Sharing – When the State requires the Enrollee bear some of the cost of their care through mechanisms such as Co-payments, deductibles, and other similar charges.

54. 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.

55. 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.

56. 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.

57. 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 an Enrollee.

58. Days – Calendar Days unless otherwise specified.

59. Deemed Newborn – Children born to SoonerSelect Program enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

60. Deliverable – A written or recorded work product or data prepared, developed, or procured by the Contractor as part of the services under the Contract for the use or benefit of OHCA or the State of Oklahoma.

61. Dental Contracted Entity – An entity that serves the Enrollee under the SoonerSelect Dental Contract and who handles claims payment and PAs and coordinates dental care with Participating Providers and Medicaid members. Also known as a "Dental Benefits Manager" per defined at 56 O.S. § 4002.2(9).

62. Dental Related Emergency Service – Services provided outside of standard Business Hours to the Enrollee by the Contractor that are necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

63. 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.

64. 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.

65. Disenrollment – The removal of an Enrollee from participation in the SoonerSelect Program Contracted Entity.

66. Dual Eligible Individuals – Individuals Eligible for both Medicaid and Medicare.

67. Durable Medical Equipment, prosthetics/orthotics, and supplies; – Equipment and supplies ordered by a health care Provider for everyday or extended use. Coverage

may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

68. Early and Periodic Screening, Diagnostic, and Treatment – Screening and diagnostic services to determine physical or mental defects in Eligibles or Enrollees under age 21 and health care, treatment, and other measures to correct or ameliorate any existing defects and/or Chronic Conditions discovered.

69. Electronic Visit Verification System – An electronic system that documents the time that Providers begin and end the delivery of services to Enrollees and the location of services. The EVV System shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

70. Eligible – An individual who qualifies for SoonerSelect Program coverage.

71. 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.

72. Emergency Medical Transportation – means an ambulance transport that is required because no other effective and less costly mode of transportation can be used due to the Enrollee's medical condition. The transport is required to transfer the Enrollee to and/or from a Medically Necessary service not available at the primary location.

73. 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 in the emergency room, hospital, or other inpatient setting.

74. Encounter Data – Information relating to the receipt of any item(s) or service(s) by an Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

75. Enrollee – A SoonerCare Eligible who has been enrolled in a SoonerSelect Program CE.

76. Enrollee Handbook – A guidebook that explains the SoonerSelect Program that the Contactor shall distribute to every Enrollee. It shall be designed to help the Enrollee understand the CE, the SoonerSelect Program and the rights and responsibilities that come with membership in the program.

77. Enrollment – The process by which an Eligible becomes an Enrollee with the Contractor.

78. Enrollment Date – The date in which an Eligible becomes an Enrollee with the Contractor.

79. 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.

80. Excluded Populations – Populations that are excluded from participation in the SoonerSelect Program as specified in Section 1.5.5: "Excluded Populations" of the Contract.

81. Expansion Adult – Refers to an Eligible or Enrollee ages nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) Federal Poverty Level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119.

82. Explanation of Benefits – A written statement sent by the Contractor to the Enrollee providing an overview of the total charges from an Enrollee visit and how much the Contractor and the Enrollee are required to pay for medical treatments and/or services.

83. Exploitation – An unjust or improper use of the resources of an Enrollee for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable Enrollee through the use of undue influence, coercion, harassment, duress, deception, false representation, or false pretense.

84. External Quality Review – 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 Enrollees.

85. External Quality Review Organization – 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.

86. 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.

87. Federally Qualified Health Center – 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.

88. Former Foster Care Children – 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 and enrolled in SoonerCare on the date of attaining age 18 or aging out of Foster Care.

89. Foster Care – Planned, goal-directed service that provides 24-Hours-a-day substitute temporary care and supportive services in a home environment for Children birth to 18 years of age in OHS custody.

90. 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.

91. Grievance – An 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 Enrollee's rights regardless of whether remedial action is requested. A Grievance includes an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

92. Grievance and Appeal System – The processes the Contractor implements to handle Enrollee Grievance and Appeal of Adverse Benefit Determinations, as well as the processes to collect and track information about them.

93. Governing Body – A group of individuals appointed by the Contracted Entity who approve policies, operations, profit/loss ratios, executive employment decisions, and who have overall responsibility for the operations of the Contracted Entity of which they are appointed.

94. 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.

95. Health Insurance – A contract that requires a Contracted Entity or health insurer to pay some or all health care costs in exchange for a Premium.

96. 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 an Enrollee may have and assist the Contractor to assign a risk level for the Enrollee in order to determine the level of Care Management needed.

97. 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.

98. HIPAA Rules – HIPAA Rules shall mean the 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 (HITECH) Act of 2009 and its associated rules, including but not limited to those at 45 C.F.R. Parts 160 and 164, and all related amendments thereto.

99. Home Health Care – Wide range of Health Care Services that can be given in your home for an illness or injury. These services are furnished by a professional caregiver in the individual home where the patient or client is living as an opposed to group setting like clinics or nursing homes.

100.Hospice Services – Is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness.

101.Hospital Outpatient Care – Any health care consultation, procedure, treatment, or other service that is administered without an overnight stay in a hospital or medical facility.

102.Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

103.Hour – Shall refer to clock Hours unless otherwise noted.

104.Implementation Date– Effective date the Contractor and OHCA launch the Oklahoma SoonerSelect Program and begin offering benefits to Enrollees.

105.Indian Health Care Provider – 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).

106.Indian Health Programs – As defined in 25 U.S.C. § 1603(12): (a) any health program administered directly by the Indian Health Service (IHS); (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.

107.Indian Managed Care Entity – An MCO, Prepaid Inpatient Health Plan (PIHP), PAHP, Primary Care Case Management (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 (1) or more I/T/Us and which also may include the Indian Health Service.

108.Indian Tribe – As defined in 25 U.S.C. § 1603.

109.Indirect Ownership Interest – Pursuant to 42 C.F.R. § 455.101 means an ownership interest in an entity that has an ownership Interest in the Disclosing Entity.

110.Initial Program Implementation – The ninety (90) Day period following OHCA initially enrolling all Eligibles who meet criteria for the SoonerSelect Program in a Contractor.

111.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.

112.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.

113.Key Staff – All staff listed in Section 1.4.6.2: "Key Staff" of this Contract.

114.Limited English Proficiency – Eligibles and 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.

115.Local Oklahoma Provider Organization – Any State Provider association, accountable care organization, Certified Community Behavioral Health Clinic, Federally Qualified Health Center, Native American tribe or Tribal association, hospital or health

system, academic medical institution, currently practicing licensed Provider, or other LOPO as approved by the Authority in accordance with 56 O.S. § 4002.2.

116.Major Subcontractor – A Major Subcontractor is defined as:

a. Major administrative Subcontractors are entities anticipated to be paid $2,000,000 or more for Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing, and Enrollee/Provider education; or

b. 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 1.7: "Covered Benefits" of the Contract.

117.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.

118.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 Program product, or either to not enroll in, or to disenroll from, another CE's SoonerSelect Program product. Marketing does not include communication to an Eligible from the issuer of a QHP about the QHP.

119.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.

120.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.

121.Medically Necessary or Medical Necessity – 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:

a. 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;

b. Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the Enrollee's need for the service;
c. Treatment of the Enrollee's condition, disease, or injury must be based on reasonable and predictable health outcomes;
d. Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the Enrollee, family, or medical Provider;
e. Services must be delivered in the most cost-effective manner and most appropriate setting; and
f. Services must be appropriate for the Enrollee's age and health status and developed for the 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 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 an Enrollee to attain, maintain, or regain functional capacity.

122.Medicare Savings Program – Provides assistance to Eligibles in paying Medicare Premium and Cost Sharing.

123.MLR Reporting Year – A period of twelve (12) months consistent with the Rating Period.

124.National Practitioner Data Bank – The National Practitioner Data Bank is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, Providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

125.National Provider Identifier – 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 10- position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care 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.

126.Network – A group of Participating Providers linked through Provider agreements or Contracts with the Contractor to supply a range of services. Also referred to as a Provider Network.

127.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.

128.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)(2)).

129.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: actual, consequential, and liquidated damages; Capitation Payment suspension; autoassignment suspension; Contract termination; and remedies under Section 1.26.3.4: "NonCompliance Remedies" of the Contract.

130.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.

131.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 seventy-two (72) Hours of Enrollee notification of a non-urgent condition, as clinically indicated.

132.Office of Juvenile Affairs – 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.

133.Oklahoma Department of Corrections – 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.

134.Oklahoma Department of Mental Health and Substance Abuse Services – 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.

135.Oklahoma Health Care Authority – The single State Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerSelect Program.

136.Oklahoma Human Services – Oklahoma Human Services is the largest State agency in Oklahoma. OHS 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 childcare assistance, licensing, and monitoring. OHS also handles applications and eligibility for SoonerCare's ABD population, and long-term care.

137.Oklahoma State Department of Education – 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.

138.Oklahoma State Department of Health – 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 sixty-eight (68) county health departments as well as guidance and consultation to the two (2) independent city-county health departments in Oklahoma City and Tulsa.

139.Open Enrollment Period – The annual period, as defined by OHCA, when Enrollees and Eligibles can enroll in a Contractor for the SoonerSelect Program.

140.Other Disclosing Entity – Pursuant to 42 C.F.R. § 455.101 means 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:

a. 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;
b. Any Medicare intermediary or carrier; and
c. 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.

141.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 OHCA to which the Contractor is not entitled to under Title XIX of The Act and under the SoonerSelect Program.

142.Parent and Caretaker Relative – An individual determined eligible under 42 C.F.R. § 435.110.

143.Participating Provider – A physician or other Provider who has a contract with or is employed by the Contractor to provide services to Enrollees under the SoonerSelect Program.

144.Pediatric – Children from birth through age 21.

145.Performance Improvement Projects – 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 Enrollee satisfaction and must include the following elements:

a. Measurement of performance using objective quality indicators;
b. Implementation of interventions to achieve improvement in the access to and quality of care; c. Evaluation of the effectiveness of the interventions; and
d. Planning and initiation of activities for increasing or sustaining improvement.

146.Person with Ownership or Control Interest – Pursuant to 42 C.F.R. § 455.101 means a person or corporation that:

a. Has a Direct Ownership Interest totaling five percent (5%) or more in a Disclosing Entity;
b. Has an Indirect Ownership Interest equal to five percent (5%) or more in a Disclosing Entity;
c. Has a combination of Direct and Indirect Ownership Interests equal to five percent (5%) or more in a Disclosing Entity;
d. Owns an interest of five percent (5%) 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 (5%) of the value of the property or assets of the Disclosing Entity;
e. Is an officer or director of a Disclosing Entity that is organized as a corporation; or
f. Is a partner in a Disclosing Entity that is organized as a partnership.

147.Personal Care Services – Assistance to an individual in carrying out ADLs, 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 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.

148.Pharmacy Benefit Manager – 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.

149.Physician Services – Services provided by an individual licensed under state law to practice medicine or osteopathy.

150.Plan – Managed care entity that manages the delivery of Health Care Services.

151.Post-Stabilization Care Services – Covered services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R. § 438.114 €, to improve or resolve the Enrollee's condition.

152.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.

153.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 an Enrollee or Eligible that is pregnant to be a Pregnancy-Related Service.

154.Pregnant Women – A women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

155.Premium – The amount paid for Health Insurance on a monthly basis.

156.Prescription Drug – A drug which can be dispensed only upon prescription by a health care professional authorized by their licensing authority and which is approved for safety and effectiveness as a prescription drug under Section 505 or 507 of the Federal Food, Drug and Cosmetic Act (52 Stat. 1040 (1938), 21 U.S.C.A., Section 301).

157.Prescription Drug Coverage – Health Insurance or entity that helps pay for prescription drugs and medications.

158.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 Modified Adjusted Gross Income (MAGI) eligibility group.

159.Primary Care Provider – 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 PAs.

160.Prior Authorization – A requirement that an Enrollee obtain the Contractor's approval before a requested medical service is provided or before services by a Non-Participating Provider are received. PA is not a guarantee of claims payment; however, failure to obtain PA 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."

161.Proposal – An offer a Bidder submits in response to an invitation to Bid or request for Proposal for the SoonerSelect Program. Also referred to as Bid.

162.Protected Health Information – Information considered to be individually identifiable health information, as described in 45 C.F.R. § 160.103.

163.Provider – Includes both Participating and Non-Participating Providers.

164.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 Enrollees.

165.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.

166.Provider-Led Entity – An organization or entity that meets the criteria of at least one (1) of following two (2) subparagraphs:

a. A majority of the entity's ownership is held by Medicaid Providers in Oklahoma or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid Providers in Oklahoma; or

b. A majority of the entity's Governing Body is composed of individuals who:

i. Have experience serving Medicaid members; and:

a) Are licensed in Oklahoma as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists,

b) At least one (1) member is a licensed behavioral health Provider, or

c) Are employed by a hospital or other medical facility licensed by and operating in Oklahoma; or an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by and operating in Oklahoma,

ii. Represent the Providers or facilities described above including, but not limited to, individuals who are employed by a Statewide Provider association, or

iii. Are nonclinical administrators of clinical practices serving Medicaid members.

167.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 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.

168.Quality Assessment and Performance Improvement – 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 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.

169.Quality Improvement Committee – A committee within the Contractor's organizational structure that oversees all QAPI functions. The Contractor's Chief Medical Officer shall chair the committee.

170.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).

171.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 Enrollee Enrollment.

172.Regulatory Compliance Committee – A committee within the Contractor's Governing Body and at the senior management level that oversees the Contractor and its Subcontractor's compliance program and its compliance with requirements under this Contract. The Compliance Officer shall be responsible for the development and oversight of the Regulatory Compliance Committee.

173. Remote patient monitoring- The use of digital technologies to collect medical and other forms of health data (e.g., vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

174.Report Period – The measurement period used for the performance withhold program described in Appendix 1C: "Quality Performance Withhold Program" of this Contract. The Report Period is a calendar year.

175.Reporting Manual – The OHCA-developed manual outlining the Contractor's performance reporting obligations, including required reporting, data definitions, frequency, and formats.

176.Risk Stratification Level Framework – OHCA-approved Contractor methodology for determining the intensity and frequency of Care Management and population health interventions received by Enrollees in accordance with the requirements of Section 1.9: "Care Management and Population Health" of the Contract.

177.Rural Area – A county with a population of less than 50,000 people.

178.Rural Health Clinic – Clinics meeting the conditions to qualify for RHC reimbursement as stipulated in Section 330 of the Public Health Services Act. RHCs

certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. RHCs 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 RHC must have a current contract on file with OHCA.

179.School-based services- Medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

180.Secretary – Refers to the Secretary of the U.S. Department of Health and Human Services.

181.Serious Emotional Disturbance – A condition experienced by persons from birth to age 18 that show evidence of points of: (a) The disability must have persisted for six (6) months and be expected to persist for a year or longer; (b) a condition or SED as defined by the most recently published version of the DSM or the International Classification of Disease 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:

a. Psychotic symptoms of a Serious Mental Illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

b. Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one (1) or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

i. Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs;

ii. 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;

iii. Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults;

iv. 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

v. 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).

182.**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 SMI as defined by the most recently published version of the DSM or the International Classification of Disease 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:

a. Psychotic symptoms of a Serious Mental Illness (e.g., schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

b. Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one (1) or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level);

i. Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs;

ii. 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;

iii. Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers;

iv. 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

v. Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

183.**Service Gap –** A delay in initiating any service and/or a disruption of a scheduled, ongoing service that was not initiated by an Enrollee, including late or missed visits.

184.**Skilled Nursing Care –** Services from licensed nurses, technicians, and/or therapists in an Enrollee's home.

185.**Social Determinants of Health –** Conditions in the places where an Enrollee lives, learns, works, and plays that affect the Enrollee's health and quality-of-life risks and outcomes.

186.**SoonerCare –** The Oklahoma Medicaid program.

187.**SoonerSelect –** Oklahoma's Medicaid service delivery model that provides comprehensive medical, pharmacy, dental, and behavioral health benefits through Contracted Entities.

188.**SoonerSelect Children's Specialty Program–** The single Statewide health care plan that covers all Medicaid services other than dental services and is designed to provide care to children in Foster Care Children, Former Foster Care Children up to twenty-five (25) years of age, Juvenile Justice Involved Children, and Children receiving adoption assistance.

189.**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.

190.Specialist – A Provider, whose practice is limited to a particular branch of medicine, including one who, by virtue of advanced training is certified by a specialty board as being qualified to so limit their practice.

191.Standing Referral – A referral from a PCP or the Contractor for an Enrollee needing access to multiple appointments with the Specialist over a set period of time, such as a year, without seeking multiple referrals.

192.State – When not otherwise specified, refers to a government entity or entities within the State of Oklahoma.

193.State Fair Hearing – The process set forth in Subpart E of 42 C.F.R. Part 431.

194.State Fiscal Year – The State of Oklahoma's fiscal year runs from July 1 to June 30.

195.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, pursuant to 25 O.S. § 82.1, Designation and dates of holidays - Executive Order - Acts to be performed on next succeeding Business Day - State employees authorized to observe certain holidays.

196.State Plan – An agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

197.State Plan Benefits – The SoonerCare benefits available to all Enrollees, with the exception of Expansion Adults.

198.State's Designated Entity for Health Information Exchange – A health information exchange organization charged with facilitating the exchange of health information to and from authorized individuals and health care organizations in this State per 63 O.S. §§ 1-133.

199.Statewide – All counties of the State of Oklahoma including the Urban Region.

200.Steady State Operations – The time period beginning ninety (90) Days after Initial Program Implementation.

201.Store and forward technologies- The transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or

treatment plan. Store and forward technologies 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.

202.**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.

203.**Subsidiary or Subsidiaries** – A company that is owned or controlled by another company or entity.

204.**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.~~ 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 healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. 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. For audio-only health service delivery, see OAC 317:30-3-27.1.

205.**Telehealth medical service-** For the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

206.**Third-Party Liability** – All or part of the expenditures for an Enrollee's medical assistance furnished under the OHCA State Plan that may be the liability of a third-party individual, entity, or program.

207.Transition of Care – The movement of a patient from one (1) setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

208.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, one hundred eighty (180) Days before the Contract termination date. The Transition Period ends upon the transition of SoonerSelect Program Enrollees to another Medical Manager or OHCAdesignated service delivery system.

209.Transition Plan – The plan developed by the Contractor and approved by OHCA documenting how the Contractor will ensure the orderly transition of Enrollees and meet the Transition Period and Post-Transition obligations upon Contract expiration or termination.

210.Urban Area – A county with a population of 50,000 people or more.

211.Urban Region – Any county within the State of Oklahoma with a county population of not less than five hundred thousand (500,000) according to the latest Federal Decennial Census; or all counties that are contiguous to the Oklahoma counties with a population of not less than five hundred thousand (500,000) according to the latest Federal Decennial Census combined into one (1) region.

212.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 twenty-four (24) Hours could result in:

a. 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;

b. Serious impairment to bodily function; or

c. A serious dysfunction of any body organ or part.

213.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.

214.Value-Added Benefit – Any product, 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.

Appendix B - SoonerSelect Medical Rates Summary

Delivery Date: November 1, 2023

Disclaimer: This deliverable was prepared by Guidehouse Inc. for the sole use and benefit of, and pursuant to a client relationship exclusively with the Oklahoma Health Care Authority ("Client").

The work presented in this deliverable represents Guidehouse's professional judgement based on the information available at the time this report was prepared. The information in this deliverable may not be relied upon by anyone other than Client. Accordingly, Guidehouse disclaims any contractual or other responsibility to others based on their access to or use of the deliverable. This deliverable must be disclosed and shared in its entirety.

Exhibit 1 - SFY2025 Manged Care Capitation Rates

Region	Population Group	Age/Gender	TPL	Voluntary	Projected Member Months	Draft Rates
EAST	TANF/CHIP Child	Newborn <1	N	N	99,203	$ 842.98
OKC	TANF/CHIP Child	Newborn <1	N	N	106,483	$ 899.26
TULSA	TANF/CHIP Child	Newborn <1	N	N	83,097	$ 768.77
WEST	TANF/CHIP Child	Newborn <1	N	N	137,897	$ 843.98
EAST	TANF/CHIP Child	Newborn <1	N	Y	5,183	$ 665.27
OKC	TANF/CHIP Child	Newborn <1	N	Y	421	$ 778.16
TULSA	TANF/CHIP Child	Newborn <1	N	Y	566	$ 554.96
WEST	TANF/CHIP Child	Newborn <1	N	Y	2,224	$ 656.88
STATEWIDE	TANF/CHIP Child	Newborn <1	Y	N	19,322	$ 305.55
STATEWIDE	TANF/CHIP Child	Newborn <1	Y	Y	335	$ 285.60
EAST	TANF/CHIP Child	1-14 Years, Male and Female	N	N	956,872	$ 215.85
OKC	TANF/CHIP Child	1-14 Years, Male and Female	N	N	1,136,981	$ 188.21
TULSA	TANF/CHIP Child	1-14 Years, Male and Female	N	N	886,713	$ 186.74
WEST	TANF/CHIP Child	1-14 Years, Male and Female	N	N	1,446,870	$ 199.88
EAST	TANF/CHIP Child	1-14 Years, Male and Female	N	Y	93,911	$ 235.33
OKC	TANF/CHIP Child	1-14 Years, Male and Female	N	Y	8,163	$ 188.32
TULSA	TANF/CHIP Child	1-14 Years, Male and Female	N	Y	11,762	$ 253.94
WEST	TANF/CHIP Child	1-14 Years, Male and Female	N	Y	41,719	$ 209.82
STATEWIDE	TANF/CHIP Child	1-14 Years, Male and Female	Y	N	500,057	$ 99.28
STATEWIDE	TANF/CHIP Child	1-14 Years, Male and Female	Y	Y	17,491	$ 124.26
EAST	TANF/CHIP Child	15+ Years, Female	N	N	112,306	$ 296.45
OKC	TANF/CHIP Child	15+ Years, Female	N	N	137,206	$ 248.76
TULSA	TANF/CHIP Child	15+ Years, Female	N	N	100,564	$ 249.88
WEST	TANF/CHIP Child	15+ Years, Female	N	N	173,806	$ 274.82
EAST	TANF/CHIP Child	15+ Years, Female	N	Y	14,920	$ 351.64
OKC	TANF/CHIP Child	15+ Years, Female	N	Y	1,564	$ 288.91
TULSA	TANF/CHIP Child	15+ Years, Female	N	Y	2,308	$ 327.59
WEST	TANF/CHIP Child	15+ Years, Female	N	Y	7,384	$ 304.94
STATEWIDE	TANF/CHIP Child	15+ Years, Female	Y	N	82,011	$ 131.66
STATEWIDE	TANF/CHIP Child	15+ Years, Female	Y	Y	3,728	$ 153.20
EAST	TANF/CHIP Child	15+ Years, Male	N	N	114,386	$ 228.02
OKC	TANF/CHIP Child	15+ Years, Male	N	N	136,607	$ 162.03
TULSA	TANF/CHIP Child	15+ Years, Male	N	N	100,918	$ 180.65
WEST	TANF/CHIP Child	15+ Years, Male	N	N	176,189	$ 199.07
EAST	TANF/CHIP Child	15+ Years, Male	N	Y	14,579	$ 228.24
OKC	TANF/CHIP Child	15+ Years, Male	N	Y	1,545	$ 211.95
TULSA	TANF/CHIP Child	15+ Years, Male	N	Y	2,241	$ 229.70
WEST	TANF/CHIP Child	15+ Years, Male	N	Y	7,316	$ 218.78
STATEWIDE	TANF/CHIP Child	15+ Years, Male	Y	N	76,254	$ 83.16
STATEWIDE	TANF/CHIP Child	15+ Years, Male	Y	Y	3,675	$ 104.69

Region	Population Group	Age/Gender	TPL	Voluntary	Projected Member Months	Draft Rates
EAST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	N	194,326	$ 480.27
OKC	TANF Parent/Caretaker	< 45 Years, Adult Female	N	N	189,472	$ 469.69
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Female	N	N	146,390	$ 463.93
WEST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	N	283,854	$ 485.96
EAST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	Y	28,252	$ 491.80
OKC	TANF Parent/Caretaker	< 45 Years, Adult Female	N	Y	4,237	$ 537.18
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Female	N	Y	6,027	$ 504.34
WEST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	Y	14,859	$ 537.41
STATEWIDE	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	N	182,190	$ 159.77
STATEWIDE	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	Y	9,242	$ 186.73
EAST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	N	57,320	$ 230.35
OKC	TANF Parent/Caretaker	< 45 Years, Adult Male	N	N	35,129	$ 238.52
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Male	N	N	29,393	$ 229.87
WEST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	N	65,899	$ 240.66
EAST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	Y	3,906	$ 307.36
OKC	TANF Parent/Caretaker	< 45 Years, Adult Male	N	Y	399	$ 369.80
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Male	N	Y	545	$ 338.58
WEST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	Y	1,930	$ 318.44
STATEWIDE	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	N	29,224	$ 80.57
STATEWIDE	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	Y	846	$ 94.55
EAST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	N	37,138	$ 597.26
OKC	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	N	26,406	$ 656.36
TULSA	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	N	23,690	$ 598.82
WEST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	N	43,941	$ 599.66
EAST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	Y	2,798	$ 912.96
OKC	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	Y	489	$ 1,233.28
TULSA	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	Y	558	$ 1,015.36
WEST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	Y	1,493	$ 853.68
STATEWIDE	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	N	16,697	$ 179.48
STATEWIDE	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	Y	529	$ 214.74

Region	Population Group	Age/Gender	TPL	Voluntary	Projected Member Months	Draft Rates
EAST	Expansion	< 45 Years, Adult Female	N	N	274,876	$ 429.20
OKC	Expansion	< 45 Years, Adult Female	N	N	268,208	$ 365.61
TULSA	Expansion	< 45 Years, Adult Female	N	N	209,771	$ 395.78
WEST	Expansion	< 45 Years, Adult Female	N	N	406,989	$ 387.69
EAST	Expansion	< 45 Years, Adult Female	N	Y	36,107	$ 496.39
OKC	Expansion	< 45 Years, Adult Female	N	Y	5,311	$ 553.34
TULSA	Expansion	< 45 Years, Adult Female	N	Y	7,439	$ 569.84
WEST	Expansion	< 45 Years, Adult Female	N	Y	18,517	$ 541.47
STATEWIDE	Expansion	< 45 Years, Adult Female	Y	N	281,150	$ 127.31
STATEWIDE	Expansion	< 45 Years, Adult Female	Y	Y	14,953	$ 185.21
EAST	Expansion	< 45 Years, Adult Male	N	N	289,399	$ 358.95
OKC	Expansion	< 45 Years, Adult Male	N	N	245,594	$ 351.25
TULSA	Expansion	< 45 Years, Adult Male	N	N	197,011	$ 433.67
WEST	Expansion	< 45 Years, Adult Male	N	N	353,512	$ 346.84
EAST	Expansion	< 45 Years, Adult Male	N	Y	20,638	$ 386.91
OKC	Expansion	< 45 Years, Adult Male	N	Y	3,145	$ 451.00
TULSA	Expansion	< 45 Years, Adult Male	N	Y	3,732	$ 513.50
WEST	Expansion	< 45 Years, Adult Male	N	Y	10,557	$ 383.47
STATEWIDE	Expansion	< 45 Years, Adult Male	Y	N	188,138	$ 136.93
STATEWIDE	Expansion	< 45 Years, Adult Male	Y	Y	6,193	$ 131.09
EAST	Expansion	45+ Years, Male and Female	N	N	347,005	$ 852.44
OKC	Expansion	45+ Years, Male and Female	N	N	234,316	$ 785.94
TULSA	Expansion	45+ Years, Male and Female	N	N	178,933	$ 843.60
WEST	Expansion	45+ Years, Male and Female	N	N	374,875	$ 801.10
EAST	Expansion	45+ Years, Male and Female	N	Y	10,396	$ 1,143.55
OKC	Expansion	45+ Years, Male and Female	N	Y	1,955	$ 1,146.69
TULSA	Expansion	45+ Years, Male and Female	N	Y	2,242	$ 1,163.41
WEST	Expansion	45+ Years, Male and Female	N	Y	5,687	$ 1,026.62
STATEWIDE	Expansion	45+ Years, Male and Female	Y	N	141,296	$ 269.87
STATEWIDE	Expansion	45+ Years, Male and Female	Y	Y	2,601	$ 444.59
ALL	**ALL**	**ALL**	**ALL**	**ALL**	**12,402,499**	**$ 335.02**

215.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.

This Amendment shall be effective beginning April 1, 2024 or by date of signature by both parties whichever occurs first. No other terms or provisions of the Contract are changed or affected.

EXECUTED:

Sonja J. Hughes, MD (Mar 29, 2024 13:02 CDT)
Sonja J. Hughes, President and CEO
Aetna Better Health of Oklahoma, Inc.

Ellen Buettner
Digitally signed by Ellen Buettner
Date: 2024.03.29 14:56:20 -05'00'
Ellen Buettner, CEO
Oklahoma Health Care Authority