OKLAHOMA
Office of Management
& Enterprise Services

Solicitation Cover Page

DUE DATES AND TIME (CENTRAL STANDARD TIME):

Bid Response:

3:00 p.m. on February 8, 2023

Actuarial Bidder's Conference:

3:00 p.m. on January 17, 2023

Request for administrative review:

3:00 p.m. on November 16, 2022

Last Day to Submit Questions:

3:00 p.m. on December 6, 2022

CONTRACT TYPE:

Agency: [X] **Statewide:** [ ]

Agency Name/Number: **Oklahoma Health Care Authority/807**

RETURN SEALED BID TO:	**CONTRACTING OFFICER:**
Office of Management and Enterprise Services Attn: Richard Williams Solicitation 8070000053 2401 N. Lincoln Blvd., ste CP Oklahoma City, OK 73105	**Name:** Richard Williams **Email:** Richard.Williams@omes.ok.gov

The Oklahoma Health Care Authority

SoonerSelect Program

Request for Proposals

Solicitation Number 8070000052

November 10, 2022

Table of Contents

1 Introduction and Solicitation Overview 4

1.1 Authority to Procure Medicaid Managed Care Services 4

2 Solicitation Guidelines 10

2.1 Overview 10

2.2 Eligibility to Submit Proposal 11

2.3 Submission of Proposal 11

2.4 Proposal Structure and Submission Requirements 15

2.5 Technical Proposal Requirements 16

2.6 Proposal Evaluation 46

1 Appendix 1 – Draft Contract 50

1.1 Basis of Contract Authority 51

1.2 General Terms and Conditions 52

1.3 Payments to Contractor 75

1.4 Administrative Requirements 78

1.5 Mandatory, Voluntary, and Excluded Populations 93

1.6 Enrollment and Disenrollment 96

1.7 Covered Benefits 103

1.8 Medical Management 128

1.9 Care Management and Population Health 135

1.10 Transition of Care (TOC) 146

1.11 Quality 152

1.12 Enrollee Services 167

1.13 Provider Network Development 198

1.14 Provider Agreement Requirements 204

1.15 Provider Services 224

1.16 Provider Payment 235

1.17 American Indian/Alaska Native Population and Indian Health Care Providers 247

1.18 Enrollee Grievance and Appeal 251

1.19 Cost Sharing 266
1.20 Program Integrity 268
1.21 Information Technology 284
1.22 Financial Standards and Third-Party Liability 303
1.23 Reporting 311
1.24 Contractor Performance Standards 322
1.25 Remedies and Disputes 325
1.26 Termination 326

Appendix 1A: Acronyms 338

Appendix 1B: Definitions 347

Appendix 1C: Quality Performance Withhold Program 369

Appendix 1D: Contract Minimum Insurance Requirements 376

Appendix 1E: Consequential and Liquidated Damages 377

Appendix 1F: List of Deliverables to OHCA 389

Appendix 1G: Covered Benefits 415

1. Medical and Related Benefits 415
2. Behavioral Health Benefits 424

Appendix 1H: Provider Types and Specialties 427

1 Introduction and Solicitation Overview

1.1 Authority to Procure Medicaid Managed Care Services

1.1.1 State Authority

Oklahoma Health Care Authority (OHCA) has general authority to enter into contracts for the delivery of State-purchased health care pursuant to 63 Oklahoma Statute (O.S.) § 5006(A)(2). The Oklahoma Legislature, through the Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, *et seq*., established and defined the scope of OHCA's authority and responsibility to procure the Medicaid managed care services that are the subject of this Request for Proposal (RFP).

1.1.2 Federal Authority

The Centers for Medicare and Medicaid Services (CMS), pursuant to 42 Code of Federal Regulations (C.F.R.) Part 438, has the authority and responsibility to review and approve or deny any contract for Medicaid managed care services. For any contract resulting from this solicitation, only those contract terms that are applicable to and permissible for managed care organizations (MCOs) as defined at 42 C.F.R. § 438.2, are enforceable.

1.1.3 Oklahoma Privatization of State Functions Actions

The Ensuring Access to Medicaid Act, 56 O.S. § 4002.3a, defined at Section 1.1.1: "State Authority" of this RFP, directs OHCA to enter public-private partnerships with Contracted Entities (CEs), through risk-based Capitated Contracts, to provide Medicaid integrated medical services to specified populations. The Oklahoma Privatization of State Functions Act (Privatization Act, 74 O.S. §§ 586, *et seq*.) establishes guidelines for the privatization of State services to ensure that such privatization is cost effective and in the best interest of the State. OHCA has submitted a cost analysis to OMES, and OMES has found that the analysis fulfills the content requirements of the Privatization Act. OHCA has also provided the notices required under Section 589 of the Privatization Act. To the extent that OHCA receives a response to those notices that requires it to modify or amend this solicitation, those updates or amendments will be posted in accordance with Section 1.1.11: "Changes in Solicitation Specifications or Contract Terms" of this RFP.

Bidders will be required to provide in their Proposal all the information and certifications required by the Privatization Act. Failure to provide this information and certifications could result in a Proposal being considered non-responsive and not considered for further evaluation. Failure to abide by the Privatization Act may also result in a Bidder's disqualification.

1.1.4 The RFP

The Ensuring Access to Medicaid Act, 56 O.S. § 4002.3b, directs OHCA to contract with at least three (3) Statewide Capitated Contracts to provide comprehensive integrated health services including, but not limited to, medical, behavioral health, and pharmacy services to the following Medicaid populations as specified at 56 O.S. § 4002.3a(B)(1) and referred to as SoonerSelect Eligibles: SoonerCare Children, Pregnant Women, Deemed Newborns as defined by 42 C.F.R. § 435.117, Parents and Caretaker

Relatives, and the Expansion Population. OHCA requests Proposals from qualified Bidders to coordinate and deliver Medicaid services to the specified Medicaid populations while demonstrating improved health outcomes, increased access to care, and increased accountability in the State's Medicaid program, referred to as SoonerCare.

The Contracts resulting from this RFP process will be for an initial term from Contract award through June 30, 2024, with five (5) one (1) year renewal options at the discretion of OHCA. Enrollment of SoonerSelect Eligibles in the SoonerSelect Program will be effective October 1, 2023, or the first Day of the first month following CMS approval.

1.1.4.1 SoonerSelect Goals

The Oklahoma Legislature and Governor Stitt have directed OHCA to design the Oklahoma Medicaid program to achieve the following goals:

a. Improve health outcomes for Medicaid members and the State as a whole;

b. Ensure budget predictability through shared risk and accountability;

c. Ensure access to care, quality measures, and member satisfaction;

d. Ensure efficient and cost-effective administrative systems and structures; and

e. Ensure a sustainable delivery system that is a Provider-led effort and that is operated and managed by Providers to the maximum extent possible.

OHCA designed the SoonerSelect Program to meaningfully achieve stated goals, as well as to advance Governor Stitt's plan to transform Oklahoma into a Top Ten (10) state in health outcomes.

1.1.4.2 SoonerCare Program Background

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

a. Dual Eligible Individuals;

b. Individuals residing in an institution or nursing home;

c. § 1915(c) Waiver enrollees;

d. Individuals infected with tuberculosis covered under §§ 1902(a)(10)(A)(ii)(XII) and 1902(z)(1) of The Act;

e. Individuals eligible as a Former Foster Care Child (FFCC) under 42 C.F.R. § 435.150;

f. Pregnant Women with incomes between one hundred thirty-four percent (134%) and one hundred eighty-five percent (185%) federal poverty level (FPL) converted to the Modified Adjusted Gross Income (MAGI) equivalent plus applicable disregards (two hundred ten percent (210%) FPL); and

g. Individuals with other creditable coverage, except Indian Health Service (IHS) coverage.

Below is a high-level summary of the current Care Coordination models available to SoonerCare Eligibles.

a. ***Patient Centered Medical Home (PCMH):*** A Statewide enhanced Primary Care Case Management (PCCM) model in which OHCA contracts directly with Primary Care Providers (PCPs) to serve as PCMHs. PCMH Providers are arrayed into three (3) tiers, depending on the number of standards they agree to meet. OHCA pays monthly Care Management payments (in addition to regular fee-for-service (FFS) payments) that increase at the higher tiers. Providers can also earn "SoonerExcel" quality incentive payments for meeting or exceeding various quality-of-care targets within an area of clinical focus selected by OHCA.

b. ***Health Access Network (HAN):*** Non-profit, administrative entities that work with affiliated Providers to coordinate and improve the quality of care provided to Eligibles. The HANs employ Care Managers to provide telephonic and in-person Care Management and Care Coordination to Eligibles with complex health care needs who are enrolled with affiliated PCMH Providers. The HANs also work to establish new initiatives to address complex medical, social, and behavioral health issues. For example, the HANs have implemented evidence-based protocols for Care Management of aged, blind, and disabled (ABD) Eligibles with, or at risk for, complex/Chronic Health Conditions, as well as Temporary Assistance for Needy Families (TANF) and related Eligibles with asthma and diabetes, among other conditions.

c. ***Health Management Program (HMP):*** The SoonerCare HMP is an initiative developed to offer Care Management to Eligibles most at-risk for chronic disease and other adverse health events. The program is administered by OHCA and is managed by a vendor selected through a competitive procurement. The SoonerCare HMP serves Eligibles ages four (4) through sixty-three (63) who are not enrolled with a HAN and have one (1) or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease specific, but prominent conditions of Eligibles in the program include asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, and hypertension.

Medicaid expansion went into effect on July 1, 2021, and expanded Medicaid eligibility to adults ages nineteen (19) through sixty-four (64) whose income is at or below one hundred thirty-eight percent (138%) FPL (Expansion Adults).

OHCA has made great strides in improving Care Coordination among SoonerCare Eligibles, especially those with Chronic Conditions through the work of its Chronic Care Unit and HMP. However, Oklahoma continues to rank near the bottom on many indicators of health outcomes. The State was ranked 44th in

the nation for health outcomes by America's Health Rankings[1] and 50th on the Commonwealth Fund's 2022 Scorecard on State Health System Performance.[2] Among the measures in which Oklahoma is in the bottom quartile of states include adult cancer screenings, child immunization rates, infant mortality, obesity, smoking, and suicide and drug overdose deaths.

In an effort to focus on improving these outcomes, OHCA is seeking Proposals from Bidders with demonstrated success in increasing access to quality care and improving health outcomes through Care Coordination, prioritization of preventive care, and encouraging Eligibles to seek care from the appropriate health care provider type.

1.1.4.3 SoonerSelect Program Enrollment

The enrollment table below is for informational purposes only. The enrollment data used in Capitation Rate setting is presented separately in the SoonerSelect Program Capitation Rate data book. Data presented below reflects average monthly enrollment from July 2021 to October 2022. This data includes enrollment increases that were attributed to the Public Health Emergency (PHE) and COVID-19, including requirements to maintain eligibility for otherwise ineligible individuals in accordance with the Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, § 6008, 134 Stat. 178, 208 (2020).

SoonerSelect Program Populations

Eligibility Group	Overall Enrollment July 2021 to October 2022* (Includes PHE)	PHE Enrollment in October 2022 (Subset of Total)
Children	608,589	99,952
Pregnant Women	26,402	17,852
Deemed Newborns	1,904	34
Parent and Caretaker Relatives	90,557	18,045
Expansion Adults (effective July 2021)	259,803	87,741
TOTAL	**987,256**	**223,624**

Notes: *Average per month

1.1.4.4 Future Reform

Per 56 O.S. § 4002.3a(A)(2), if, during the initial term or a renewal term of a Contract awarded under this procurement, the Oklahoma Legislature expressly authorizes OHCA to expand the SoonerSelect Program to additional eligibility groups, such expansion will be implemented as directed, to the extent authorized by law.

[1] America's Health Rankings Annual Report 2021: https://assets.americashealthrankings.org/app/uploads/americashealthrankings-2021annualreport.pdf.
[2] 2022 Scorecard on State Health System Performance: https://www.commonwealthfund.org/publications/scorecard/2022/jun/2022-scorecard-state-health-system-performance

1.1.4.5 Sustainability of the Transformed Medicaid Delivery System

OHCA is committed to the sustainability of the transformed Medicaid delivery system. In accordance with 56 O.S. § 4002.12b and subject to approval by CMS, OHCA will preserve and, to the maximum extent permissible under federal law, improve existing levels of funding through directed payments or other mechanisms outside the capitated rate to CEs.

1.1.5 Evaluation Criteria, Documentation and Scoring Methodology

For purposes of evaluating Proposals, OHCA has developed evaluation criteria and documentation in accordance with OAC 260:115-7-32. OHCA's evaluation criteria conforms to the best value criteria as defined at 74 O.S. § 85.2(2). As directed by 56 O.S. § 4002.3b, OHCA's scoring methodology affords preferential scoring to a Bidder that both meets the definition of Provider-Led Entity (PLE) as defined in 56 O.S. § 4002.2(17) and submits a responsive Proposal demonstrating ability to fulfill Contract requirements.

1.1.6 Definitions

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

1.1.7 Effect of the Federal Waiver or State Plan Authority

As directed at 56 O.S. § 4002.15, OHCA shall seek federal authority from CMS to operate the SoonerSelect Program. The Contractor shall comply with any modifications to this RFP and the final Contract resulting from the approval process. In the event CMS denies the request prior to Contract award or signature, OHCA shall be under no obligation to award a Contract as a result of this RFP. In the event CMS denies the request following Contract award and signature, OHCA may terminate the Contract immediately in writing to the Contractor without penalty. OHCA shall not be liable or required to compensate the Contractor for any work performed or expenses incurred prior to termination.

1.1.8 Geographic Scope, Number of Contracts, and New Solicitations

As directed at 56 O.S. § 4002.3b(C), OHCA intends to award no fewer than three (3) Statewide Capitated Contracts for the coordination and delivery of Medicaid services to SoonerSelect Program Enrollees in accordance with the scoring methodology developed by OHCA. 56 O.S. § 4002.3b(D) details OHCA's Contract award obligations related to PLEs:

1.1.8.1 Statewide PLEs

At least one (1) Contract will be awarded to a PLE that submits a responsive Proposal demonstrating ability to fulfill the Contract's requirements. If no PLE submits a responsive Proposal demonstrating Contract fulfillment capability, OHCA is not obligated to award a Contract to a PLE, in accordance with 56 O.S. § 4002.3b.

1.1.8.2 Urban PLEs

OHCA may select at least one (1) PLE for the Urban Region if:

a. The PLE submits a responsive Proposal demonstrating ability to fulfill the Contract's requirements; and

b. The PLE demonstrates the ability, and agrees continually, to expand its coverage area throughout the Contract term to develop Statewide operational readiness within a time frame set by OHCA but such timeframe will not be mandated before five (5) years following the effective date of the Contract.

1.1.9 Cost of Preparation

The Bidder is liable for all costs incurred in preparing its Proposal and participating in any related pre-award or post-award activities, including oral presentations and Readiness Reviews, as necessary to fulfill any provisions of this solicitation, an awarded Contract, or any federal or State authority, and as OHCA determines necessary for successful implementation and/or initiation of Enrollment.

1.1.10 Proposals Subject to Public Disclosure/Proprietary Information

Unless otherwise specified in the Oklahoma Open Records Act (51 O.S. §§ 24A.1, *et seq*.), the Central Purchasing Act, or other applicable law, documents, and information a Bidder submits as part of or in connection with a solicitation, including any materials provided at an in-person meeting, are public records and subject to disclosure if the Bidder is awarded a contract. Unless incorporated into an awarded contract, Proposal documents are not disclosable (OAC 260:115-3-9). This practice protects the integrity of the competitive bid process and prevents excessive disruption to the procurement process as required under 51 O.S. § 24A.5(6). After the Contract has been awarded, the Proposals for those Bidders who were awarded Contracts will be open for public inspection, with the exception of those portions of the Proposals that OHCA has reviewed and determined to be confidential prior to award (OAC 317:10-1-25.1(f)).

Bidders claiming any portion of their Proposal as proprietary or confidential must:

a. Specifically identify what documents or portions of documents they consider confidential;

b. Enumerate the specific grounds, based on applicable laws, which support treatment of the information as exempt from disclosure;

c. Explain why disclosure is not in the best interest of the public if the information is incorporated into an awarded contract;

d. Submit all information considered confidential under separate cover in an electronic redacted copy with the claimed information redacted and labeled "Redacted Copy;" and

e. Include the content considered confidential in applicable sections of the Proposal in accordance with instructions provided in Section 2.4.2: "Proprietary Information."

OHCA is the sole and final determiner of the proprietary or confidential nature of a Proposal in part or in whole.

1.1.11 Changes in Solicitation Specifications or Contract Terms

Any solicitation amendment shall be set forth at the same online link as the solicitation. If one (1) or more amendments to this solicitation are issued, the Bidder shall acknowledge receipt of any/all such amendment(s) by signing and returning the amendment cover page in accordance with instructions provided in Section 2.5.2: "Technical Proposal Contents." OHCA must receive the amendment acknowledgement(s) by the closing date/time for the Proposal to be deemed responsive. Failure to acknowledge solicitation amendment(s) may be grounds for rejection.

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

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

1.1.12 Waiver of Objections

The Bidder is responsible for reviewing all materials associated with this solicitation and submitting questions and comments in advance of the deadline specified.

1.1.13 Disability Accommodations

OHCA will make appropriate accommodations, upon proper notice from the Bidder, for any individual who represents a Bidder in the solicitation process and whose disabled status impairs full engagement in the solicitation process. It is the responsibility of any Bidder seeking accommodations for its solicitation process representative(s) to promptly notify OHCA through the sole point of contact for the solicitation.

2 Solicitation Guidelines

2.1 Overview

The submission requirements have been developed to identify organizations with the necessary experience, demonstrated outcomes, capacity, and processes to deliver high-quality, cost-effective services to SoonerSelect Program Enrollees (Enrollees).

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

a. Reject any Proposals that do not comply with the requirements and specifications of the solicitation. A Proposal may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation, require indemnification by OHCA, or limit the Bidder's liability to the State.

b. Waive minor deficiencies in Proposals that do not result in substantive changes to the Proposal as determined by OHCA to be in the best interest of the State. A minor deficiency does not affect the price, quantity, quality, delivery or conformance to specifications and is negligible in comparison to the total cost or scope of the acquisition. If granted, the waivers will in no way modify the requirements of the solicitation or the obligations of Bidder's awarded Contract.

c. Award a Contract based on this solicitation and the Proposals of selected Bidder(s);

d. Award the Contract to more than one (1) Bidder, or reject any or all Proposals received, if deemed to be in the best interest of the State of Oklahoma.

e. Request clarification or correction of Proposals.

f. Amend this solicitation, or any segment hereof.

g. Cancel this solicitation, if determined to be in the best interest of the State.

h. Discontinue the contracting process at any time.

2.2 Eligibility to Submit Proposal

An entity eligible to submit a Proposal for this solicitation will:

a. Meet the definition of CE as defined at 56 O.S. § 4002.2(8);

b. Meet the definition of MCO as defined at 42 C.F.R. § 438.2; and

c. Meet the definition of Health Maintenance Organization (HMO) as defined at 36 O.S. §§ 6901, *et seq.* and related provisions of the Oklahoma Insurance Code.

An eligible entity may, but is not required to, meet the definition of PLE as defined at 56 O.S. § 4002.2(17).

2.3 Submission of Proposal

Submitted Proposals shall be in strict conformity with the instructions to Bidders and shall be submitted with a completed "Responding Bidder Information" Bidder's Cover Page form, and any other forms required by the solicitation.

As discussed in Section 2.4.1: "Proposal Submission" all Proposals must be submitted by mail.

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

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

A Proposal shall remain firm for a minimum of one hundred eighty (180) Days from the RFP closing date. Bidders guarantee unit prices to be correct.

In accordance with 74 O.S. § 85.40, all travel expenses to be incurred by a Bidder in performance of the Contract shall be included in the total Proposal price/contract amount. Travel expenses include, but are not limited to, transportation, lodging, and meals. Examples of other miscellaneous travel expenses are referenced in Section 10.14 of the OMES Statewide Accounting Manual.

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

After review of a Bidder's submitted Proposal, OHCA may require additional terms related to consumer data that will be accessed, processed, or stored by the Contractor. If consumer data includes any Protected Health Information (PHI), as that term is defined by Health Insurance Portability and Accountability Act (HIPAA), OHCA and the Bidder awarded a Contract shall enter into a business associate agreement, as required by law.

All Proposals submitted shall be subject to the Central Purchasing Act, Central Purchasing Rules, and other statutory and regulatory requirements as applicable.

2.3.1 One Proposal

Except as requested by OHCA, a Proposal may not be changed after the closing date/time. If the Bidder needs to change a submitted Proposal prior to the closing date/time, the Bidder shall withdraw the original Proposal submission and a new Proposal shall be submitted to OHCA by the closing date/time. Bidders may withdraw and resubmit a Proposal at any time prior to the closing date/time. As part of the resubmission process, Bidders must acknowledge in writing that the resubmitted Proposal supersedes all previously submitted Proposals by including the following statement on the superseding Proposal Bidder's Cover Page "THIS PROPOSAL SUPERSEDES ANY PROPOSAL PREVIOUSLY SUBMITTED." The resubmitted Proposal should contain the solicitation number and closing date/time in the body of the submission email.

2.3.2 Strict Closing Date and Time

In accordance with OAC 260:115-1-2, closing date/time means the date and Central Time Proposals are due. Proposals received by OHCA after the closing date/time shall be deemed non-responsive and shall NOT be considered for any resultant award.

2.3.3 Property of the State

Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a Proposal that are incorporated into an awarded Contract are public records and subject to disclosure after the Contract has been awarded pursuant to OAC 260:115-3-9.

2.3.4 Withdrawal from Solicitation

Except as authorized by the State Purchasing Director after proof by the Bidder that a significant error by the Bidder exists in the Bid, a Bid may not be withdrawn after the Bid Response Due Date and Time. If the Bidder wishes to withdraw a Bid prior to the Bid Response Due Date and Time, the Bidder shall submit a written withdrawal request to the Contracting Officer in accordance with OAC 260:115-3-13 at the email address listed on the Solicitation Cover Page.

Except as requested by the State, a Bid may not be changed after the Bid Response Due Date and Time. If the Bidder needs to change a submitted Bid prior to the Bid Response Due Date and Time, the Bidder shall withdraw the originally submitted Bid and a new Bid shall be submitted to the State by the Bid Response Due Date and Time and include the following statement on the superseding Bidder's Cover Page Form: "THIS BID SUPERSEDES THE BID PREVIOUSLY SUBMITTED" AND "SUPERSEDING BID" MUST APPEAR IN THE SUBJECT LINE OF THE EMAIL.

2.3.5 Binding Proposals

All Proposals shall be firm representations that the responding Bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the Solicitation. Bidders whose Proposals are accepted for evaluation will be bound by the terms of the solicitation and the contents of the Proposals, subject to OHCA's discretionary authority to require modifications necessary to meet the terms of the Contract, State or federal law, or program objectives, for the duration of the solicitation and Contract period. Bidders awarded a Contract will be governed by the terms outlined in Appendix 1: "Draft Contract" as may be executed and amended by the parties.

2.3.6 Proposal Rejection

The Bidder's failure to submit required information may cause the Proposal to be rejected. In addition, a Proposal received after the Proposal closing date/time shall be deemed non-responsive and shall not be considered.

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

Other possible reasons for rejection are listed in OAC 260:115-7-32(f).

2.3.7 Deficiencies

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

2.3.8 Submission of Questions

For all Bids whether Information Technology or Non-Information Technology, Bidder may submit general questions concerning Contract or Bid specifications or requirements to the Contracting Officer's email address shown on the Solicitation Cover Page. Questions received via any other means will not be addressed. Questions may be submitted as soon as the solicitation is posted. You are encouraged to submit your questions as soon as possible to allow adequate time for answers and any issues that may arise.

2.3.9 Clarification Questions

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

2.3.10 Administrative Review

A Bidder that believes the Contract or Bid requirements or specifications, or Bid Response Due Date, are unnecessarily restrictive or limit competition may email a request for administrative review to the Contracting Officer. A request received via any other means will not be addressed. The State shall promptly respond in writing to each written administrative review request, and where appropriate, issue a revision, substitution, or clarification through an Amendment. Requests for administrative review shall include the reason for the request, supported by information, and any proposed changes.

If a Bidder fails to notify the Contracting Officer of an ambiguity, conflict, discrepancy, omission or other error in any of the documents provided by the State that is known to Bidder, or that reasonably should be known by Bidder, the Bidder accepts the risk of submitting a Bid and, if awarded the Contract, shall not be entitled to additional compensation, relief or time by reason of the error or its later correction.

Bidders may submit written questions by email only to the Contracting Officer. Questions must be submitted using the SoonerSelect Program Solicitation Questions form, attached hereto. The form must be submitted in the original Excel format.

OHCA will provide written answers to all technical Proposal questions received on or before the dates specified on the Solicitation Cover Page. Answers will be made publicly available in the form of one (1) or more solicitation amendments posted to the solicitation website, Oklahoma Office of Management and Enterprise Services (OMES) Central Purchasing (https://www.ok.gov/dcs/solicit/app/index.php).

Only posted answers will be considered official and valid by the State. No Bidder shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee.

2.3.11 Actuarial Bidder's Conference

OHCA will hold an actuarial Bidder's conference. Additional information about the Bidder's conference will be provided in advance of the session. OHCA may modify the place, date, or time of the Bidder's conference to accommodate public health needs that exist or that may be reasonably expected to exist on the specified date. Any public health accommodation made pursuant to this section may include but is not limited to rescheduling, limiting attendance, changing the venue from in-person to virtual, and offering a virtual option in addition to an in-person expectation.

2.3.12 Evaluation

A responsive Proposal will proceed to the evaluation process. The evaluation process will be conducted in accordance with Section 2.6: "Proposal Evaluation." Proposals will be evaluated on best value criteria in accordance with 74 O.S. § 85.2(2). Bidder's past performance may be considered when evaluating a Bid.

2.4 Proposal Structure and Submission Requirements

2.4.1 Proposal Submission

Supplier is to submit two (2) electronic copies of their complete response on two (2) separate USBs (one (1) on each USB) which includes scanned images of the required completed and signed forms. Electronic copy can be in Word, Excel, or PDF format; but, is to be an unprotected document provided on a USB drive/flash drive/thumb drive. One (1) flash/thumb drive shall be marked as the original and will be considered the official response in evaluating responses for scoring, Open Records Requests, and protest resolution. Each Bid must be submitted in a sealed envelope, package, or container. The bidder is allowed to tag the flash/thumb drive to identify the bidder and if it is the original or a copy. Faxed or emailed responses will not be accepted.

USBs are to be mailed to:

Office of Management and Enterprise Services
ATTN: Richard Williams
Solicitation 8070000052
2401 N. Lincoln Blvd., Ste CP
Oklahoma City, OK 73105

USBs are to be delivered no later than 3:00 pm Central Time on the proposal due date.

2.4.2 Proprietary Information

Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information a Bidder submits as part of or in connection with a Bid are

public records and subject to disclosure after Contract award pursuant to OAC 260:115-3-9. However, a public Bid opening does not make the Bid immediately accessible to the public. All material submitted by a Bidder becomes the property of the State. No portion of a Bid shall be considered confidential after award of the Contract except, pursuant to 74 O.S. § 85.10, information in the Bid determined to be confidential by the State Purchasing Director or delegate. Typically, a properly submitted confidentiality claim of a potential awardee is reviewed and determined prior to award; a properly submitted confidentiality claim of a non-awarded Bidder is reviewed and determined only when responding to an open records request concerning the Bid. If the Bid Packet contains information the Bidder believes to be confidential, the Bid Packet shall be conspicuously marked on the outside to indicate it contains information considered confidential.

Any portion of the Bid that the Bidder requests be held confidential shall be inserted on a separate document and the Bidder must specifically identify, on each page, the specific information considered confidential and otherwise fully comply with OAC 260:115-3-9 which additionally requires a Bidder to enumerate the specific grounds, based on applicable laws which support treatment of the information as exempt from disclosure and explain why disclosure is not in the best interest of the public.

2.5 Technical Proposal Requirements

2.5.1 Format

Technical Proposals should conform to the following formatting requirements:

Proposal header must include the solicitation number and the Bidder's legal name.

a. Proposal footer should include a page number. Pages should be numbered sequentially, beginning with the transmittal letter, and continuing to the end of the technical Proposal. Pages should run 1, 2, 3, etc., without starting over and with no section or question prefixes. It is not necessary to erase page numbers on pre-printed documents, such as solicitation amendments, as long as the sequential page numbering is visible. The original worksheet files included in Proposal Forms folder do not require page numbers that align with the consolidated Portable Document Format (PDF) version;

b. Narrative submission responses should be in twelve (12) point or greater, Calibri or Times New Roman font, with a minimum of one-inch margins, and 1.15 line spacing;

c. Wording in any figures, tables, or exhibits included or attached to Proposal narrative should be in eight (8) point or greater font;

d. Narrative submission responses should begin by restating the submission requirement number (i.e., Item Number) and bold-faced title. It is not necessary to restate the question;

e. Page limits, where applicable, are noted at the end of a submission requirement. Page limits include headers, footers, and titles. Page limits also apply to exhibits and attachments, unless otherwise specified. OHCA will not review material outside of page limits; and

f. The Proposal and each form and document submitted as part of the Proposal should have the Bidder's legal name and complete address, the solicitation number, and the closing date of the RFP.

2.5.2 Technical Proposal Contents

The Technical Proposal must contain the elements listed below, which should be in the order shown. Mandated forms/templates are included in the solicitation.

In preparing technical Proposals, Bidders are encouraged to:

a. Be as specific as possible when documenting past performance (i.e., outcomes) and when describing actions or initiatives to be undertaken on behalf of Enrollees;

b. Use flow charts and other exhibits to help illustrate processes, where applicable;

c. Address diversity within the State when describing challenges to, and strategies for, meeting program requirements, including but not limited to differences between Urban and Rural Areas;

d. Discuss innovative programs and best practices implemented in other states or for other Oklahoma populations that also will be offered to the Enrollees;

e. Avoid use of tentative language such as "may undertake" or "will explore doing," as this may result in the proposed activity or initiative being given reduced or no weight in the evaluation; and

f. Reference publicly available data and reports, including but not limited to, Dashboards, Fast Facts, and the OHCA Annual Report, online at https://oklahoma.gov/ohca/research/data-and-reports.html.

ITEM	INSTRUCTIONS
Administrative Requirements	
1.	**Bidder Proposal Submission Checklist** Complete and include a copy of the Bidder Proposal Submission Checklist form**.** Indicate whether each submission item is included by checking "Yes" or "No." If "No" is checked for an item, explain the reason**,** which is to be submitted with Bidder's Proposal. Note that failure to submit a required submission item may result in rejection of the Bidder's Proposal as non-responsive. (Page Limit: N/A)

ITEM	INSTRUCTIONS
2.	**Transmittal Letter** Include a dated Proposal Transmittal Letter signed by an individual authorized to bind the Bidder's organization to the terms of the solicitation. The contents of the letter must include: a. Solicitation number, Bidder's full legal name and mailing address and Federal Employer Identification Number (FEIN); b. Name and contact information for a point-of-contact for ongoing communication; c. A statement attesting to the accuracy and truthfulness of all information contained in the Proposal; d. A statement that a true and correct List of Authorized Signatories of the Bidder is attached to the Proposal Transmittal Letter as an exhibit; e. A statement that the Bidder is willing to enroll and serve all Eligibles for Enrollment in the SoonerSelect Program as identified in Contract Section 1.5: "Mandatory, Voluntary and Excluded Populations;" f. A statement that the entity proposing to contract with OHCA is located inside the United States; and g. A statement that the Bidder has reviewed and accepts the SoonerSelect Program Capitation Rates as calculated, the Capitation Rate methodology, and methodology for updating the rates. The letter also must include either: a. A statement that the Bidder has read, understands and is able and willing to comply with all terms of the Contract and standards and participation requirements described in the solicitation; or b. A request for exceptions to terms form is attached to specify any objections the Bidder has to one or more solicitation terms or conditions. Each objection to a solicitation term or condition shall identify (i) the document and section reference of the specific affected term or condition and (ii) either that the term is inapplicable and should be intentionally omitted or offer alternative language. OHCA has no responsibility to independently review an entire Proposal for objections and any objection embodied in a section of the Proposal but not listed in the Proposal Transmittal Letter will not be considered. Any additional terms that the Bidder requests be applicable to the Contract shall also be included in the Proposal Transmittal Letter and shall also be provided in a separate Word format document. OHCA has no responsibility to independently review an entire Proposal for additional terms and any such terms not listed in the Proposal Transmittal Letter shall not be considered. If a Proposal includes an offer of Value-Added Benefits, such offer shall be included in the Proposal Transmittal Letter and include associated pricing and any other information relevant to such value-added offer. However, OHCA is not obligated to purchase Value-Added Benefits. (Page Limit: N/A)

ITEM	INSTRUCTIONS
3.	**PLE Status** The organization must submit documentation if it is seeking to qualify as a PLE under 56 O.S. § 4002.2(17). Specifically, the Bidder should submit: a. Proof that a majority of the entity's ownership is held by Medicaid providers in the State of Oklahoma or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in Oklahoma; or b. Summary and supporting proof that a majority of the entity's Governing Body is composed of individuals who: i. Have experience serving Medicaid members; ii. Are licensed in Oklahoma as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists, or at least one (1) Governing Body member is a licensed behavioral health Provider, or are employed by a hospital or other medical facility licensed and operating in Oklahoma, or an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by Oklahoma and operating in Oklahoma; and iii. Represent the providers or facilities described above, or are non-clinical administrators of clinical practices serving Medicaid members. Include the completed PLE Ownership and Governing Body Summary form. Submit requested information for each owner and/or Governing Body member included on the form. OHCA will determine the status of each organization as to whether it qualifies as a PLE. (Page Limit: N/A)

ITEM	INSTRUCTIONS
4.	**Governance** Describe the organization's Governing Body at the time of Proposal submission. Describe how the entity will align with requirements in 56 O.S. § 4002.5 to have a shared governance structure including: a. Representatives of Local Oklahoma Provider Organizations (LOPOs) who are Medicaid providers; b. Essential community providers; and c. Representative from a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust. This description should include a breakdown of the Governing Body by the three (3) categories outlined by 56 O.S. § 4002.5. Describe how your organization will meet the requirement that no less than one-third (1/3) of the local Governing Body shall be compromised of representatives of LOPOs. Describe how your organization will meet the requirement that no less than two (2) members of your clinical and quality committees shall be representatives of LOPOs, and the committees shall be chaired or co-chaired by a representative of a LOPO. (Page Limit: Five pages)
5.	**Solicitation Amendments** RFP amendment(s), if any, will be located at the same online link as the RFP. The Bidder shall acknowledge agreement with each RFP amendment, if any, by including each RFP amendment, signed by an authorized signatory of the Bidder, in its bid. (Page Limit: N/A)
6.	**OMES- and OHCA-Mandated Representations and Certifications** Include the completed Bidder's Cover Page and Bidder Representations and Certifications forms. Note that the Bidder Representations and Certifications form consists of both a Word document and an Excel File ("companion templates"). Include an electronic copy of the Excel file content immediately behind Bidder Representations and Certifications form. If a template within the Excel file does not contain data, enter "N/A" in the first row of the template and include in the Proposal. The Bidder's Cover Page form and Bidder Representations and Certifications form include signature requirements. The forms should be signed by the same individual signing the Bidder's Transmittal Letter. (Page Limit: N/A)
7.	**Privatization Act Mandated Representations and Certifications** Include a section in the Bidder's Proposal which addresses the following items: a. A description of any past (within the past ten (10) years) or present litigation involving the Bidder;

ITEM	INSTRUCTIONS
	b. The financial stability of the Bidder, including its ability to fund its operations during the term of the Contract; c. At least three (3) references related to the Bidder's performance of a contract with a governmental entity or agency covering Medicaid Populations; and d. A detailed description of how the Bidder will perform the Contract, including anticipated staffing and equipment information. To the extent that a Bidder has addressed these items elsewhere in the Proposal, the Bidder may attest that all requested information has been provided. Any such attestation must clearly identify where the requested information is located in the Proposal. Bidders must ensure that all requests for information are answered completely. Include a certification, in accordance with 74 O.S. § 589, certifying that the Bidder: a. Will offer available employee positions pursuant to the Contract to qualified employees of OHCA who meet the hiring criteria of the Bidder (or any applicable Subcontractor) and whose State employment is terminated because of the awarding of the Contract to the Bidder; b. Agrees that the Contract shall provide that the dollar amount agreed upon in the Contract may be reduced if the agency experiences a budget shortfall, but such adjustment shall ensure Capitation Rates remain actuarially sound and are approved by CMS; and c. Is financially stable as of the date of its Proposal and shall maintain a financially stable operation in accordance with all State and federal laws, regulations, and guidance during the term of the Contract, including any extensions thereof. (Page Limit: N/A)
8.	**Contract Termination** Describe whether your organization has had a contract terminated or not renewed for any reason within the past ten (10) years. The response should include all parent organizations, Affiliates, Subsidiaries, and any proposed or contracted PLE owners/partners conducting Medicaid or other state/federal health business. Include a description of the issues and the parties involved and provide the name, title, email address, and direct telephone number of the primary contact for the party with whom the contract was held. (Page Limit: N/A)
Executive Summary	
9.	**Executive Summary** Include an Executive Summary of your Proposal to serve Enrollees. The Executive Summary should describe your approach to improve health outcomes, increase access to care, promote value-based payments (VBPs) and increase accountability in the SoonerSelect Program. Information included in the Executive Summary may be used by OHCA when preparing public announcements concerning solicitation awards. (Page Limit: Four pages)

ITEM	INSTRUCTIONS
Organizational Structure	
10.	**Oklahoma and Medicaid Experience** Describe your organization's experience serving the Medicaid populations covered under SoonerSelect in Oklahoma and/or other states, if applicable. Limit your response to 2017 or later. As part of your response, provide examples of innovative programs and initiatives implemented in Oklahoma and/or other states, results achieved, and data collected to document and measure those results. Describe their relevance to the SoonerSelect Program, potential barriers to implementation in Oklahoma, and how you intend to overcome these barriers. Include the completed Other State Medicaid Experience form. Describe your organization's experience in the State of Oklahoma serving publicly- and privately-funded populations, including examples of implemented programs and results achieved and how they will be integrated into your strategy for serving Enrollees. Limit your response to 2017 or later. Include the completed Oklahoma Experience form. Responses highlighting strong Oklahoma experience will receive preference. (Page Limit: Six (6) pages, excluding required forms)
11.	**References** References shall be completed and submitted using the References form in accordance with the instructions on the front page of the form. It is the responsibility of the Bidder to collect references from its customers. All references should be signed and clearly list the contact information of the responding customer. Bidder will submit three (3) to five (5) references where Medicaid managed care for services covered under the Contract is currently in use. At least three (3) references must relate to the Bidder's performance of a contract with a governmental entity or agency covering Medicaid populations. (Page Limit: N/A)
12.	**Organization Overview** Provide a brief company profile, including: a. Company Name; b. Ownership (e.g., sole proprietor, partnership); c. State of Incorporation; d. Date of Incorporation; e. Number of years in business; f. List of top officers; g. Location of company headquarters; h. Location(s) of the company offices; i. Location(s) of the office that will provide the services in the RFP; j. Number of employees locally with the expertise to support the requirements in the RFP; and k. Number of employees nationally with the expertise to support the requirements in the RFP. (Page Limit: One (1) page)

ITEM	INSTRUCTIONS
13.	**Litigation** Describe whether a contracting party found you to be in breach of any of your medical services contracts within the past ten (10) years. The response should include parent organization, Affiliates, Subsidiaries and any proposed or contracted PLE owners/partners conducting Medicaid or other state/federal health business. Provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond your control. Specifically: a. If a Corrective Action Plan (CAP) was imposed, describe the steps and timeframes in the CAP and whether the CAP was completed. b. If a sanction was imposed, describe the sanction, including the amount of any monetary sanction (e.g., penalty or consequential/liquidated damage). c. If the breach was the subject of an administrative proceeding or litigation, indicate the result of the proceeding/litigation. Responses should also include: a. A statement of whether there is any pending or recent (2017 or later) litigation against the Bidder. This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality services. Disclose the case name, court, case number, and a brief description of the case and any judgments, settlements, or decisions. The Bidder does not need to report workers' compensation cases. Describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include an opinion of counsel as to the degree of risk presented by any pending litigation and whether pending or recent litigation will impair the Bidder's performance in a contract. The Bidder shall also include any Securities and Exchange Commission (SEC) filings discussing any pending or recent litigation. The Bidder shall also address the Bidder's parent organization, Affiliates, and Subsidiaries conducting Medicaid or other state/federal health business. b. The Bidder shall specify whether there is any pending or recent (2017 or later) litigation against a major health care service Subcontractor, as defined in Contract Section 1.4.3: "Subcontracting." This shall include, but not be limited to, litigation involving failure to provide timely, adequate, or quality physical or Behavioral Health Services. Disclose the case name, court, case number, and a brief description of the case and any judgments, settlements, or decisions. The Bidder does not need to report workers' compensation cases. Describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Also, the Bidder shall include any SEC filings discussing any pending or recent Major health care service Subcontractor litigation. The Bidder shall address the Major Subcontractors' parent organization, Affiliates, and Subsidiaries. Tab B.12 Legal Actions of the Bidder Representations and Certifications form must be completed in addition to, and may not serve as a substitute for, Items 6 and 13. (Page Limit: N/A)

ITEM	INSTRUCTIONS
14.	**Financial Information** Provide a copy of the Bidder's audited or reviewed financial statements (preferably audited) prepared by an independent Certified Public Accountant for each of the last three (3) years. The submission should include at least a balance sheet, income statement, and cash flow statement for each year and the auditor's report (if applicable). This information must also be submitted with respect to the Bidder's corporate parent organization and any Major Subcontractors, as applicable. Also, describe how the Bidder can assist the State with cash flow for start-up costs such as FFS claims run out, if the need arises. In your response, provide any suggestions on how best to offset initial costs to the State and assisting with potential cash flow issues. Please use experience in other states to provide response. (Page Limit: N/A)
15.	**Reinsurance** Describe how you intend to meet the reinsurance requirements outlined in Contract Section 1.2.19.7: "Reinsurance." (Page Limit: One (1) page)
16.	**Licensure** The Contractor shall be licensed as an HMO and authorized to transact business in the State of Oklahoma in accordance with Contract Section 1.4.1: "Licensure." Include a copy of your license, or if not currently licensed in Oklahoma, your plan for obtaining licensure and the date by which this is anticipated to occur. (Page Limit: One (1) page, excluding license. If already licensed Statewide, do not submit a narrative.)
17.	**Major Subcontractors** Identify the services to be furnished by Major Subcontractors, as defined in Contract Section 1.4.3: "Subcontracting." As part of your response, discuss: a. Roles and locations of each Major Subcontractor, Subsidiary, and Affiliate; b. Relevant experience of each Subsidiary, Major Subcontractor and Affiliate; c. Metrics used to evaluate prospective Major Subcontractors,' Subsidiaries,' and Affiliates' abilities to perform delegated activities prior to delegation; d. Policies and procedures for monitoring Major Subcontractor activity; e. Enforcement policies used for Major Subcontractor non-performance, including examples; f. How you will ensure ongoing collaboration with Major Subcontractors for a streamlined and coordinated approach to serving Enrollees and Providers; and g. Quality goals and performance oversight activities for Major Subcontractors providing health services. Also include the completed Major Subcontractors form for each applicable Subcontractor. (Page Limit: Three (3) pages, excluding Major Subcontractors form)

ITEM	INSTRUCTIONS
18.	**Key Staff** Describe your staffing plan and management structure for the SoonerSelect Program that meets the requirements of Contract Section 1.4.6: "Staffing." Include the rationale and methodology utilized for determining required numbers of staff by position type. Also include a copy of the following completed forms: a. Plan Staffing form denoting the estimated number of staff, by position, along with a job description for each position denoted on the Plan Staffing form that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable. b. Key Staff and Oklahoma Presence form identifying the individuals who will serve in the Key Staff positions described in Contract Section 1.4.6.2: "Key Staff" and other staffing as described in Contract Section 1.4.5: "Oklahoma Presence," if known. Include job descriptions for each position (responsibilities, position requirements, licenses, etc.), resumes for individuals, and summary of recruitment timelines and contingency plans if positions remain open. (Page Limit: Six (6) pages, excluding required forms, job descriptions, resumes, recruitment timelines and contingency plans)
19.	**Contractor's Association with PLEs** Describe any subcontracts with PLEs that meet minimum eligibility to submit a Proposal to the RFP, regardless of whether the PLE actually submits or intends to submit a Proposal. (Page Limit: Three (3) pages)
20.	**Local Oklahoma Provider Organizations (LOPOs)** Describe the organization's contracted status with LOPOs for a model of care containing Care Coordination, Care Management, utilization management (UM), disease management, and Network management. If already contracted, list the names of each LOPO and the scope of services included within the model. If not already contracted, describe how the organization will put in place a contractual arrangement within twelve (12) months of the effective date of any Contract that may arise from this RFP. Responses highlighting current LOPO contracting will receive preference. (Page Limit: Three (3) pages)
21.	**Oklahoma Presence** Identify your existing and proposed office locations within Oklahoma and any other office locations outside of Oklahoma. Describe your rationale and methodology for selecting these locations, including a service area-level map denoting the locations. Also describe how staff located outside of Oklahoma will be structured to ensure compliance with Contract requirements and how Oklahoma-based staff will maintain a full understanding of the operations conducted out-of-State. (Page Limit: Two (2) pages, excluding map)

ITEM	INSTRUCTIONS
22.	**Economic Impact** Describe the projected economic impact that your organization will have on Oklahoma. Describe partnerships that your organization will develop with Oklahoma-based entities to improve economic outcomes and improve workforce pipeline across the State. Also include a copy of the completed Economic Impact form documenting the estimated economic impact of your proposed Oklahoma-based staff. (Page Limit: Three (3) pages, excluding Economic Impact form)
Operations Plan	
23.	**Operations Plan** Describe how your organization will begin operations in the first twelve (12) months post-award through all of the following: a. Identify key implementation activities and describe your approach for ensuring these activities will be completed prior to the on-site Readiness Review scheduled to occur approximately one-hundred twenty (120) Days prior to initial Enrollment of Eligibles; b. Required OHCA resources to ensure Contractor readiness; c. Discuss potential barriers or risks to timely implementation and your process for addressing; d. Discuss plan and timeline for Statewide operations, if applicable; e. Discuss how you will operationalize any partnership(s) with PLEs, if applicable; and f. Discuss how you will operationalize at least one (1) partnership(s) with LOPOs. Discuss your results of Readiness Reviews conducted in other Medicaid managed care programs or other government-sponsored health programs (e.g., Medicare). Limit examples to 2017 or later. Identify all examples of functions that failed at the time of the review and any CAPs issued as a result. Provide a Gantt chart showing implementation steps and responsible parties for implementation planning and the first twelve (12) months serving Enrollees. The Gantt should be in sufficient detail to serve as a management tool for tracking implementation progress in the event of Contract award. (Page Limit: Five (5) pages, excluding Gantt chart)
24.	**Mandatory, Voluntary and Excluded Populations** Identify any populations mandatorily or voluntarily enrolled in SoonerSelect Program, as identified in Contract Section 1.5: “Mandatory, Voluntary and Excluded Populations” that you do not have experience covering under a risk-based Medicaid managed care contract. (Page Limit: Two (2) pages)

ITEM	INSTRUCTIONS
Provider Network and Services	
25.	**PCP Providers** Describe your proposed approach for contracting with PCP Providers in accordance with requirements outlined in Contract Sections 1.14.1.3: “Provider Agreement Requirements for Specific Provider Types” and 1.14.1.3.1: “PCP Provider Standards.” In addition, provide an example of an innovative approach you took to supporting PCP activities and quality of care through use of health information technology, the results achieved and how you will apply this experience to SoonerSelect Program. Limit your example to 2017 or later. (Page Limit: Five (5) pages)
26.	**Adequacy** Describe your organization's approach (including methodology, timeline, etc.) to developing a comprehensive Provider Network that meets the requirements of Contract Section 1.13: "Provider Network Development." Please address plan to meet adequacy requirements, focusing on geographic areas of Oklahoma and/or specific Specialty Provider types where access may be more challenging. (Page Limit: Four (4) pages)
27.	**Onboarding** Describe your organization's process for onboarding a new Provider from contracting through credentialing including how the Bidder will meet the requirements of Contract Section 1.14.2.1: “Credentialing and Recredentialing Timeframes.” Specifically identify how this process may differ for essential community providers and LOPOs. (Page Limit: Four (4) pages)
28.	**Provider Education** Describe your proposed approach to preparing Participating Providers to serve Enrollees in accordance with Contract Section 1.15: "Provider Services." Please address the following pre-go-live activities in your response: a. Network education and training; and b. Assessment of Provider readiness. In addition, provide an example of an innovative approach you took to educating Providers without managed care experience on managed care principles and procedures, the results achieved and how you will apply this experience to SoonerSelect Program. Limit your example to 2017 or later. (Page Limit: Five (5) pages)

ITEM	INSTRUCTIONS
29.	**Monitoring** Describe your organization's approach to ongoing Provider Network monitoring to ensure quality access to Enrollees across the State, especially in Rural Areas. Include descriptions of how time and distance and appointment access standards are regularly monitored, how the impact of Provider terminations is assessed, and the process for resolving non-compliance. (Page Limit: Four (4) pages)
30.	**Statewideness and Development Challenges** Describe your organization's most significant challenges to developing a Statewide Provider Network and how your organization will address them. If not able to serve Enrollees Statewide on the Operations Start Date, describe how your organization will expand the PLE Network beyond Urban Areas. Provide detailed timelines and milestones to achieving Statewide coverage. (Page Limit: Three (3) pages, excluding timeline(s) and milestones)
31.	**Access to Services in Rural Areas** Describe how your organization will maintain and enhance access to services in rural communities including supporting rural providers in their sustainability efforts. In your response, provide specific examples of key initiatives and/or partnerships you have developed or plan to develop within Oklahoma to better serve Enrollees in the Rural Area of the State. (Page Limit: Four (4) pages)
32.	**Claims Processing** Describe your claims system and proposed processes for meeting the requirements outlined in Contract Section 1.16.4: “Claims Processing.” As part of your response, describe: a. Procedures for receipt and adjudication of electronic and paper claims; b. Process for identification and resolution of Provider- or system-level issues; c. Processes for ensuring compliance with timely payment requirements; d. Process for ensuring claims accuracy; and e. Process for ongoing education and re-education of providers regarding issues with claims processing. Additionally, include a copy of the completed Claims Processing form. (Page Limit: Five (5) pages, excluding Claims Processing form)
Covered Benefits	
33.	**Access to Covered Benefits** Describe how your organization will ensure and enhance access to the benefits outlined in Contract Section 1.7: "Covered Benefits." Describe proposed strategies to ensure Enrollees have timely access to quality care and how you will engage Enrollees in preventive care. (Page Limit: Three (3) pages)

ITEM	INSTRUCTIONS
34.	**Service Integration** Provide a detailed description of how your operational structure and practices will support the integrated delivery of physical health, behavioral health, pharmacy benefits and services to address Social Determinants of Health within Oklahoma. Describe your strategies to ensure coordination of care for Enrollees and how they may vary for different parts of the State. (Page Limit: Five (5) pages)
35.	**Behavioral Health Benefits** Describe your relevant experience and proposed approach for delivering behavioral health benefits to Enrollees in accordance with the requirements outlined in Contract Section 1.7.1: "Medical and Related Benefits." Include in your response: a. Processes for ensuring compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) as outlined in Contract Section 1.7.1.1: "Mental Health Parity;" b. Strategies to integrate behavioral and physical health services, including proposed approach for all minimum required components as outlined in Contract Sections 1.7.1.2: "Substance Use Disorder (SUD) Treatment" and 1.7.1.3: "Behavioral and Physical Health Integration;" c. Strategies to improve coordination between Emergency Rooms (ERs), primary care physicians and Medication Assisted Treatment (MAT) Providers as outlined in Contract Section 1.7.1.4: "Medication Assisted Treatment (MAT);" d. Proposed processes for crisis services in accordance with Contract Section 1.12.8.6: "Use of 988 Mental Health Lifeline;" e. Processes for complying with 42 C.F.R. Part 2 Confidentiality of Substance Use Disorder Patient Records in the context of integrated care for Enrollees; f. How you will ensure compliance with the Section 1115(a) Institutions for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI)/Substance Use Disorder (SUD) requirements and support OHCA in collecting IMD Waiver reporting requirements; and g. Proposed strategies and services for high-need and vulnerable populations, including individuals experiencing first episode psychosis, individuals receiving crisis services, individuals over age 65, and veterans. If you intend to subcontract to a third-party to deliver behavioral health benefits, identify the organization, identify the tasks to be performed by the Subcontractor, and how you ensure delegation does not compromise the integrated delivery of physical and behavioral health benefits. (Page Limit: Eight (8) pages)

ITEM	INSTRUCTIONS
36.	**Pharmacy Program** Describe your proposed structure and approach for pharmacy benefit management. Include in your response: a. Prospective and retrospective drug utilization review, including the integration of programs and implementation of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act; b. Pharmacy claims payment processing; c. Integration of pharmacy data into clinical programs; d. Process for ensuring that drugs are not subject to 340B discounts or paid at 340B rates during claims processing under the pharmacy benefit or medical benefit drug program; and e. Process and reporting that will be used to ensure that Pharmacy Benefit Managers (PBMs) do not engage in spread pricing, direct and indirect remuneration (DIR) fees, and that they employ a transparent model, if using a PBM subcontractor. If you intend to subcontract to a third-party PBM, identify the organization and discuss your existing relationship. Identify the tasks that will be performed by the PBM and how you will perform oversight of its functions. Identify how you will integrate data from the Subcontractor in your Care Management program. (Page Limit: Five (5) pages)
37.	**Value-Added Benefits** Identify any Value-Added Benefits you propose to offer to Enrollees, including the target population, the scope of the benefit (including any limitations), the desired outcome of providing the Value-Added Benefits, and how the Value-Added Benefit will be monitored and evaluated. Complete the Value-Added Benefits form specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or Medical Management requirements. (Page Limit: Four (4) pages, excluding Value-Added Benefits form)
38.	**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)** Describe your strategies for increasing EPSDT screening visit rates. Provide an example of an innovative approach you took to address EPSDT, the results achieved, and how you will apply this experience to SoonerSelect Program. Limit your examples to 2017 or later. (Page Limit: Two (2) pages)
39.	**School-Based Services** Describe your approach for reimbursing school-based services in accordance with Contract Section 1.7.12: "School-Based Services." Include in your response how you will ensure compliance with the requirements of OAC 317:30-5-1020 through 317:30-5-1027. (Page Limit: Two (2) pages)

ITEM	INSTRUCTIONS
40.	**Coordination with Other SoonerSelect Programs and Other State Agencies** Describe your procedures to coordinate services delivered under the Contract with services Enrollees receive from the Dental CE, the FFS SoonerCare program and community and social support providers in accordance with Contract Section 1.9.6: "Coordination with Other SoonerCare Programs." Also describe your procedures to coordinate services delivered under the Contract with other State agencies in accordance with Contract Section 1.4.6.10: "Coordination with Other State Agencies and Entities." Provide examples of successful collaborations with other State agencies that have been implemented in other State Medicaid programs. (Page Limit: Three (3) pages)
Enrollee Services	
41.	**New Enrollee Outreach** Describe your relevant experience and proposed approaches for conducting outreach to new Enrollees and making initial contact in accordance with requirements outlined in Contract Section 1.12.4: "New Enrollee Materials and Outreach." As part of your response discuss: a. How you will undertake and track initial contact efforts including the completion of Health Risk Screenings; b. SoonerSelect Program population segments most likely to be "hard-to-contact" and steps you will take to reach hard-to-contact Enrollees; c. How you will ensure distribution of Enrollee materials in compliance with timeliness standards; and d. Initial Enrollee education activities. In addition, provide an example of an innovative approach you took to improve contact rates among hard-to-contact Enrollees with respect to services within Medicaid managed care, the results achieved and how you will apply this experience to the SoonerSelect Program. Limit your example to 2017 or later. Additionally, include a completed copy of the New SoonerSelect Enrollee Contact Rates form. (Page Limit: Three (3) pages, excluding New SoonerSelect Enrollee Contact Rates form)

ITEM	INSTRUCTIONS
42.	**Enrollee Information** Describe your relevant experience and proposed approach to using the Enrollee website, social media, and mobile applications to enhance communications with Enrollees. As part of your response, discuss: a. The types of social media applications and platforms you will employ; b. How social media, the Enrollee website and mobile applications will be tailored to the different SoonerSelect Program populations; c. How you will monitor Enrollee use and responsiveness to social media, mobile applications, and the Enrollee website; and d. How you will ensure compliance with all State and federal privacy requirements, including but not limited to HIPAA, 42 United States Code (U.S.C.) § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109. In addition, provide an example of an innovative approach you took to improve Enrollee health outcomes through social media, mobile applications or website, the results achieved and how you will apply this experience to the SoonerSelect Program. Limit your example to 2017 or later. (Page Limit: Three (3) pages)
43.	**Call Center** Describe your relevant experience and proposed approach to operating a call center, in accordance with the requirements outlined in Contract Section 1.12.8: "Enrollee Services Call Center." As part of your response, discuss: a. Call center location(s) and Hours of operation; b. How you will train call center staff, especially with respect to Enrollees who will be referred to the 988 Mental Health Lifeline; c. How you will monitor compliance with performance standards and address staffing needs during unanticipated spikes in volume; d. How you will handle calls received from non-English speakers; and e. Whether you will operate a combined call center for Enrollee and Provider services. If not, describe your proposed Provider Service call center structure in accordance with the requirements of Contract Section 1.15.2: "Provider Services Call Center." Additionally, include a completed copy of the Call Center Performance form. (Page Limit: Three (3) pages, excluding Call Center Performance form)

ITEM	INSTRUCTIONS
44.	**Enrollee Grievance and Appeal** Describe your proposed structure and process for meeting the requirements outlined in Contract Section 1.18: "Enrollee Grievance and Appeal." As part of your response discuss: a. How you will provide assistance to Enrollees in filing Grievance or Appeal; b. How you determine if a Grievance or Appeal will undergo an expedited review; c. Who in your organization will serve as decision makers when reviewing Grievances and Appeals; d. How you will ensure compliance with timeliness requirements; e. Processes for continuing or reinstating benefits; f. How you will incorporate Grievance and Appeal data into your quality improvement process; and g. Your process for remediation as required by certain Grievance and Appeal outcomes. In addition, provide an example of a trend you identified through analysis of Grievances data, the steps you took to address, and the results achieved. Provide a separate example for a trend identified through analysis of Appeals data. Limit your examples to 2017 or later. Also include a completed copy of the Enrollee Grievance and Appeal Resolution form. (Page Limit: Five (5) pages, excluding Enrollee Grievance and Appeal Resolution form)
45.	**Cost Sharing** Describe your methodology, in accordance with the requirements of Contract Section 1.19: "Cost Sharing," for the following: a. Systematically identifying Cost Sharing exempt Enrollees; b. Ensuring Cost Sharing is not imposed on Cost Sharing exempt services; c. Reducing claims payment to Providers by the amount of an Enrollee's Cost Sharing obligation; d. Notifying Providers when an Enrollee is exempt from Cost Sharing; and e. Tracking and responding to the five percent (5%) Cost Sharing limit. (Page Limit: Four (4) pages)
American Indian/Alaska Native Health (AI/AN)	
46.	**Tribal Government Liaison** Describe your relevant experience and proposed approach for undertaking an outreach strategy for AI/AN Enrollees and how you will use the Tribal Government Liaison position to support AI/AN Enrollees and Indian Health Care Providers (IHCPs) in accordance with the requirements outlined in Contract Section 1.17.1: "Tribal Government Liaison." Also include the process for identification and resolution of barriers that are unique to service delivery on and off Tribal lands. (Page Limit: Three (3) pages)

ITEM	INSTRUCTIONS
Quality Improvement	
47.	**Quality Assessment and Performance Improvement (QAPI)** Describe your organizations approach to implementing and administering QAPI: a. The QAPI governance and committee structure, responsibilities, and functions, and how any PLE functions are integrated into the structure; b. Provider representation on the Quality Improvement Committee (QIC) and other quality committees, including the total number and types of specialties represented; c. How the larger organization, including Plan leadership, is committed to quality improvement; d. How you will ensure that Providers actively participate in the QAPI program; e. How you will make information about the QAPI program available to Providers and Enrollees; f. How the proposed QAPI will expand the quality improvement services beyond what the Bidder is currently providing in other markets and should explain the difference between the Bidder's current programs and the proposed programs that are being proposed for the SoonerSelect Program; g. How the proposed QAPI will improve the health care status of the Managed Care Program population; and h. How you will collaborate with OHCA and other SoonerSelect Program CEs to accomplish SoonerSelect Program quality goals. (Page Limit: Eight (8) pages)
48.	**Quality Performance Measures** Select three (3) measures from Contract Appendix 1C: "Quality Performance Withhold Program" and describe strategies you employed in one or more Medicaid managed care programs to improve performance on the measure(s). As part of your response, discuss: a. Why the measure(s) were selected for improvement; b. Populations targeted; c. Specific interventions undertaken; d. Intervention time period; and e. Results achieved. If your organization has not previously operated a Medicaid managed care program, select measures, as outlined above, and describe how your organization would implement strategies to improve performance. (Page Limit: Six (6) pages)

ITEM	INSTRUCTIONS
49.	**Performance Improvement Projects (PIPs)** Describe your proposed approach to ensure PIPs, as required under Contract Section 1.11.6: "Performance Improvement Projects (PIPs)," are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees. Include the following in your response: a. Lessons learned, challenges and successes you have experienced while conducting PIPs, and how you will consider those experiences in implementing SoonerSelect Program PIPs; b. Proposed PIP focus areas for the first two (2) Contract Years; c. Rationale for proposed PIPs; and d. Methods for monitoring and ongoing evaluation of PIP progress and effectiveness. (Page Limit: Four (4) pages)
50.	**Enrollee Satisfaction** Provide the two (2) most recent years of Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data available for up to three (3) Medicaid managed care programs. If you do not have CAHPS® data but have other Enrollee satisfaction data, provide the substitute data along with a description of the methodology employed in its collection and analysis. (Page Limit: N/A)
51.	**Provider Satisfaction** Provide the two (2) most recent years of Provider satisfaction data available for up to three (3) Medicaid managed care programs. If you do not have Medicaid managed care Provider satisfaction data but have other Provider satisfaction data, provide the substitute data along with a description of the methodology employed in its collection and analysis. (Page Limit: N/A)
52.	**Accreditation** Indicate whether you are currently accredited in accordance with Contract Section 1.4.2: "Accreditation." If not currently accredited, describe your plan to achieve accreditation within the required timeframe. Identify the entity from which you will be seeking accreditation. (Page Limit: Two (2) pages)
Population Health	
53.	**Risk Stratification Level Framework** Describe your proposed approach to Risk Stratification Level Framework that meets the requirements of the Contract Section 1.9: "Care Management and Population Health." Include in your description: a. How you utilize the following minimum strategies to determine the appropriate level of Care Management and population health intervention for each Enrollee: i. Initial Health Risk Screening; ii. Comprehensive Assessment; iii. Predictive modeling; iv. Claims review; v. Enrollee and caregiver requests; vi. Information received from OHCA; and vii. Physician referrals.

ITEM	INSTRUCTIONS
	b. Your levels of Care Management and population health interventions, including: i. The criteria that qualify an Enrollee for each level; ii. The condition(s) targeted at each stratification level and why each condition was selected; iii. Which risk stratification levels are assigned a Care Manager and associated caseload levels; and iv. The intensity and frequency of interventions received by Enrollees in each level; c. How you leverage, coordinate, or engage with other entities delivering Care Coordination or case management to Enrollees, such as community-based organizations; d. Methods you utilize to evaluate an Enrollee's need for changes in intensity and frequency of Care Management and population health interventions, and conditions which trigger a change; and e. How the effectiveness of Care Management and population health interventions will be monitored over time. In addition, provide a draft of the Health Risk Screening instrument and Comprehensive Assessment tool or a representative tool utilized in another program. Also include a completed copy of the Health Risk Screening Activity Rates form, documenting Health Risk Screening activity and the Comprehensive Assessment Activity Rates form**,** documenting Comprehensive Assessment activity. (Page Limit: Twelve (12) pages excluding Health Risk Screening instrument, Health Risk Screening Activity Rates form and Comprehensive Assessment Activity Rates form; there is no page limit for the Health Risk Screening instrument, Comprehensive Assessment Tool, and any related instructions)
54.	**Care Planning** Describe your relevant experience and proposed approach for developing and implementing Care Plans in accordance with requirements outlined in Contract Section 1.9.4: "Care Plans." As part of your response, discuss: a. How Providers are engaged in the Care Planning process and supported by Care Managers; b. Procedures and timeframes for development, review, and approval of the Care Plan; and c. Procedures for review of existing Care Plans. In addition, provide a draft of the proposed Care Plan template or a representative example. (Page Limit: Five (5) pages, excluding Care Plan; there is no page limit for the Care Plan.)

ITEM	INSTRUCTIONS
55.	**Transition of Care (TOC)** Describe your relevant experience and proposed approach for completing TOC activities in accordance with requirements outlined in Contract Section 1.10: "Transition of Care (TOC)." As part of your response, discuss how you will: a. Capture existing Prior Authorizations (PAs) in your medical management system and ensure they are honored during the Continuity of Care Period; b. Identify Enrollees with continuity of care needs beyond the ninety (90) Day Continuity of Care Period as described in Contract Section 1.10.3: "Transition of Prior Authorizations;" c. Ensure Enrollee services are not interrupted during the Transition Period; d. Outreach proactively to Enrollees with continuity of care needs to educate them on this process; and e. Share data and coordinate with other CEs, OHCA, and Non-Participating Providers. (Page Limit: Four (4) pages)
56.	**Transitions from Inpatient/Residential Settings** Describe your proposed approach for coordinating services to Enrollees between settings of care in accordance with requirements outlined in Contract Section 1.10.11: "Transitions from Inpatient/Residential Settings." As part of your response, discuss how you will: a. Identify Enrollees in an inpatient/residential setting; b. Coordinate with Enrollees and relevant Providers to facilitate timely and appropriate discharge planning; c. Evaluate risk of hospital readmission; d. Identify, refer to, and assist with engagement with appropriate community-based providers; e. Identify strategies to support the Enrollees in their family home and/or community; f. Develop a discharge plan; g. Conduct post-discharge outreach to Enrollees; and h. Monitor Enrollee health status for a period of time to confirm Enrollee needs are fully met. (Page Limit: Four (4) pages)
57.	**Medical Management** Describe your organization's approach to UM that will result in high quality, cost efficient, timely, and effective care; consistent and informed decisions; and the reduction of unnecessary administrative Provider burden, in alignment with the requirements defined in Contract Section 1.9: "Care Management and Population Health." (Page Limit: Four (4) pages)

ITEM	INSTRUCTIONS
58.	**Prior Authorization (PA)** Describe your relevant experience and proposed approach for performing PAs in accordance with the requirements outlined in Contract Section 1.8: "Medical Management." Include a flow chart depicting the proposed workflow for processing PA requests from initial request to final disposition, including the process for expedited authorizations. As part of your response, discuss: a. External guidelines to be used, if applicable; b. How you will identify services that should require PA, beyond those currently required by OHCA; c. Methods of PA submission available to Providers; d. Processes to ensure timely processing; e. Qualifications of PA personnel; f. Who will have authority to deny services; g. Your peer-to-peer review process; and h. How you will ensure consistent application of review criteria. (Page Limit: Five (5) pages)
59.	**Hospital Utilization** Provide your assessment of hospital utilization rates within the SoonerSelect Program population and their potential for being lowered. Describe your strategy for reducing inpatient hospital admissions, readmission, and potentially preventable Hospitalization rates within the SoonerSelect Program population. In addition, provide an example of an initiative undertaken to reduce hospital utilization. Discuss the identified problem, intervention and results achieved. Limit your examples to 2017 or later. Also include a completed copy of the Hospital Utilization form. (Page Limit: Four (4) pages, excluding Hospital Utilization form)
60.	**Emergency Room Utilization** Provide your assessment of ER utilization rates within the SoonerSelect Program population and their potential for being lowered. Describe your strategy for reducing ER visit rates within the SoonerSelect Program population. In addition, provide an example of an initiative undertaken to reduce ER utilization. Discuss the identified problem, intervention and results achieved. Limit your examples to 2017 or later. Also include a completed copy of the Emergency Room Utilization form. (Page Limit: Four (4) pages, excluding Emergency Room Utilization form)
61.	**High Utilizers** Describe your organization's approach for improving the quality of care and outcomes for high utilization populations and how you will apply that experience to SoonerSelect Program. (Page Limit: Two (2) pages)

ITEM	INSTRUCTIONS
62.	**Evidence-Based Guidelines** Describe your relevant experience and approach to developing an evidence-based medical management strategy. As part of your response, describe: a. How evidence-based guidelines are developed and employed in medical management decision making; b. How Providers are educated about guidelines, including updates; c. How service utilization and other operational data are used to evaluate the effectiveness of guidelines; and d. How guidelines are updated based on outcomes and how they remain current with national trends. In addition, provide two (2) examples of medical management guidelines that were updated in response to evaluation of utilization/operational data or national trends and the impact of the changes. Limit your examples to 2017 or later. (Page Limit: Three (3) pages)
63.	**Health Outcomes** Describe how your organization uses rural/urban and other available data to improve health outcomes and address disparities in health outcomes for Enrollees in rural communities. (Page Limit: Two (2) pages)
64.	**Provider Profiling** Describe your relevant experience and proposed approach to conducting Provider profiling, in accordance with the requirements outlined in Contract Section 1.11.8: "Provider Profiling." Include the following in your response: a. Methodology for determining which and how many Providers will be profiled; b. Proposed performance measures; c. Rationale for selecting proposed measures; d. Process for providing feedback to Providers; and e. Expectations of Providers following receiving the feedback. Also include a sample profile report or a representative sample used in another program. (Page Limit: Three (3) pages; there is no page limit for the sample profile)
65.	**Health Equity** Describe your organization's plan to improve health equity across the State of Oklahoma. In your response, include specific racial and ethnic minority populations and health disparities that present the biggest potential areas of improvement. (Page Limit: Two (2) pages)

ITEM	INSTRUCTIONS
66.	**Primary Care Spending** Describe your organization's approach for spending not less than eleven percent (11%) of total health care expenses on primary care services by the fourth year of the Contract. Include your approach for working directly with Providers to achieve this goal, and any challenges and lessons learned from managing spending on primary care from other government-sponsored programs, Commercial programs, or other states. (Page Limit: Two (2) pages)
Value-Based Payment	
67.	**Approach** Describe your relevant experience and proposed approach for meeting the VBP targets outlined in Contract Section 1.16.1.12: "Value-Based Payments." As part of your response: a. Separately discuss PCP and Specialists; b. Outline the specific reimbursement methodology, or methodologies, to be implemented, including payment structure, performance incentives and metrics; c. Describe how your organization will support Providers participating in VBP arrangements to achieve VBP goals, including how data sharing and reporting will be used to promote transparency, collaboration, and accountability with Provider partners of all types; and d. Explain how your organization will identify targeted health conditions and establish outcome goals for its VBPs. (Page Limit: Five (5) pages)
68.	**Design and Experience** Describe how your organization's knowledge of the SoonerSelect Program population and provider delivery system will allow your organization to design the most successful value-based payment program possible given local dynamics in Oklahoma. Describe your organization's plan and related timelines for engaging Providers in VBP programs. (Page Limit: Three (3) pages)
69.	**Innovation** Provide an example of an innovative approach your organization took to successfully implement a VBP program. Include outcomes and demonstrate success. Limit your examples to 2017 or later. (Page Limit: Two (2) pages)
Case Studies	
70.	**Onboarding Case Study (Linda)** Linda is a 33-year-old single mother of two (2) Children under the age of five (5). All three (3) of them are new members of your organization. Linda calls into the call center to find out where she can get treatment for significant pain she is having due to her sickle cell. Describe the steps your organization will take to evaluate Linda and her family's needs related to medical and potential Social Determinant of Health needs. (Page Limit: One (1) page)

ITEM	INSTRUCTIONS
71.	**Care Management Case Study (Jim)** Jim is a 46-year-old diabetic who has struggled with homelessness for a number of years. Over the past three (3) months, he has gone to the emergency room five (5) times due to complications from his disease. Describe the steps your organization will take to locate and assist Jim. (Page Limit: One (1) page)
72.	**Care Management Case Study** Describe your organization's approach to the following scenario: A Tribal Enrollee who had been stratified as low risk was admitted to a rural hospital following a cardiac event. (Page Limit: One (1) page)
73.	**Discharge Planning Case Study** Describe your organization's approach to the following scenario: An Enrollee was recently admitted to a hospital with COVID-19 for six (6) Days. He is ready for discharge from the hospital; however, the hospital staff are not responsive to outreach efforts to coordinate his discharge. (Page Limit: One (1) page)
74.	**Care Management Case Study** Describe your organization's approach to the following scenario: An Enrollee with COPD and has been identified as high risk, but the Care Manager has been unable to reach the Enrollee by phone or in-person and mail has been returned as undeliverable. (Page Limit: One (1) page)
75.	**Care Management Case Study** A 19-year-old Enrollee was recently admitted to a psychiatric crisis stabilization unit after experiencing a first episode of psychosis. His symptoms at admission included delusions of persecution and auditory hallucinations. There is no history of psychotic symptoms and no history of or recent substance use. Describe your organization's approach to supporting his discharge and ongoing care. (Page Limit: One (1) page)
Compliance	
76.	**Reporting** Describe your relevant experience and proposed approach for meeting the requirements outlined in Contract Section 1.23: "Reporting." As part of your response, discuss: a. Your monitoring and evaluation procedures for ensuring reports are accurate and submitted timely; b. Your ability to generate ad hoc reports if requested by OHCA; c. How changes to reporting requirements will be addressed, including testing and quality assurance procedures; d. How reports are continually analyzed and incorporated into quality improvement initiatives;

ITEM	INSTRUCTIONS
	e. Your process for monitoring, tracking, and validating data from Subcontractors; and f. Your capability to produce system-generated reports versus manual. (Page Limit: Three (3) pages)
77.	**Contractor Performance Standards** Describe your relevant experience and proposed approach for monitoring performance against program standards and identifying and correcting deficiencies proactively. As part of your response, discuss: a. The role individual departments will play in monitoring performance; b. Whether there will be a centralized function within the plan responsible for monitoring performance; and c. Process for identifying, reporting, and remediating performance issues. Also include a completed copy of the Contractor Performance History form. (Page Limit: Four (4) pages, excluding Contractor Performance History form)
78.	**Program Integrity** Describe your structure and proposed processes for meeting the requirements outlined in Contract Section 1.20.2: "Compliance Program." As part of your response, provide an overview of your Compliance Program and discuss: a. Your procedures for educating and training both employees and Subcontractors in accordance with Contract Section 1.20.2.2: "Compliance Education and Training;" b. Your internal and external focused Fraud and Abuse detection methodologies, including but not limited to, analytics, referral processes, audit techniques (or practices), and reporting; c. Your procedures for reporting changes in Enrollee or Provider circumstances; d. Your procedures for suspending payments for credible allegations of Fraud; and e. Your procedures for verifying delivery of services to Enrollees. (Page Limit: Five (5) pages)
79.	**Third-Party Liability (TPL)** Describe your relevant experience and proposed approach for identification and management of TPL in accordance with the requirements outlined in Contract Section 1.22: "Financial Standards and Third-Party Liability." (Page Limit: Three (3) pages)
Information Technology (IT)	
80.	**IT General Requirements** Describe your capacity and proposed approach for meeting the requirements outlined in Contract Section 1.21.1: "General Requirements." Include in your response the following: a. A description and system diagram of the proposed Management Information System (MIS) solution that will support the SoonerSelect Program. Ensure at a minimum the response covers all systems that support the required functional areas that you will provide as a part of your solution.

ITEM	INSTRUCTIONS
	b. Provide a narrative and diagram that demonstrates an understanding of all required interfaces. c. Describe and discuss your data analytics and reporting tools capabilities. How do your tools and processes provide you with the capability to prepare timely and accurate reports for submission to OHCA as required? Describe internal reports you can create to monitor internal operations and system performance. d. Describe and discuss your current state of readiness for implementation of the features and functions required in the 21st Century Cures Act – specifically the support application programming interface (API), easy access to Eligibles' data in real time, Interoperability and application authentication and Anti-blocking provisions. If not currently operational, indicate when the compliance systems will be in place. e. Describe your standard (out of the box) reporting as well as your ability to provide ad hoc reporting based on the changing CMS environment. f. Describe your IT infrastructure regarding the MIS platform; explain your IT Roadmap for continued development and improvements in the Care Management enterprise. g. Discuss your System Development Lifecycle (SDLC) for new development and correcting defects and how you will notify and keep OHCA, Enrollees and Providers informed of any updates or releases to your systems. h. Confirm your ability to utilize all batch and online HIPAA transactions listed in Contract Section 1.21.1: "General Requirements." i. Confirm your ability and experience in providing Transformed Medicaid Statistical Information System (T-MSIS) data to State Medicaid agencies for submission to CMS. (Page Limit: Ten (10) pages; page limit does not include IT Roadmap or MIS Diagram)
81.	**Communications with OHCA** Describe your approach to meeting the requirements of Contract Section 1.21.6: "Communications with OHCA." Include in your response an explanation of how you will communicate with OHCA, including how you will meet OHCA security standards for encryption of Confidential Information. (Page Limit: Three (3) pages)
82.	**System Security** Describe your approach to meeting the requirements of Contract Sections 1.21.12: "System Security." Include responses to the following questions: a. Description of your overall cybersecurity methodology, with an emphasis on which best practices your organization follows to manage its cybersecurity risks. Clarify whether your methodology adheres to any cybersecurity frameworks, including but not limited to, National Institute of Standards and Technology (NIST), or HiTrust Common Security Framework (CSF). If so, provide documentation on how your practices align. b. Description of what auditing capabilities exist in the system. What are your processes around security audits to include frequency, results reporting, and corrective actions? c. How you will manage security authorizations to the system. At a minimum, include content regarding processes for role-based security, fine-grained controls for authorization, and your processes for identification and authentication.

ITEM	INSTRUCTIONS
	d. What encryption level does your system support and what type of encryption do you recommend and upon what bases? e. What type of security controls and measures will you implement? Include both system and physical security controls at national offices and any proposed local Oklahoma offices. f. What is your process for handling security incidents? "Security Incident" refers to attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with the hosted environment used to perform the services. g. Describe your process for corrective action should a system error or penetration test reveal that Protected Health Information (PHI)/Personally Identifiable Information (PII) could have been or was compromised. h. Describe how you perform data masking in test environments and/or production. i. Describe data management techniques and processes as they relate to security. j. Describe your security monitoring and evaluation activities. Include both system monitoring and operational monitoring and evaluation activities. k. What type of security and privacy training do you provide? How often and to whom? l. Describe the extent of your latest HiTrust CSF/R2, or equivalent audit and did you have any findings? If so, what corrective actions were done or will be done to address the findings? m. If you are utilizing a cloud hosting service, describe a breakdown of security shared responsibility model, with supportive roles, processes, policies, and procedures defining how those security responsibilities are being maintained. n. Describe any third-party security assessments performed on your cloud providers. o. Do you classify assets by risk and criticality and if so, describe your methodology and approach to classifying your IT assets? p. If you upgrade your system(s), what kind of security testing is done prior to implementing the new solution or fix? q. Provide a list of all HIPAA breaches reported to the Secretary of Health and Human Services from the date of the RFP release with details regarding each breach to include: the number of patients impacted, a description of the breach, and steps taken to mitigate breaches in the future. Include a completed copy of the State of Oklahoma Security and Accreditation Assessment form. Please note that in the State of Oklahoma Security and Accreditation Assessment form, the maturity levels for each control are based on NIST 800-53 Rev 5 guidance. See the Security Specifications and the CMS Minimum Acceptable Risk Safeguards for Exchanges (MARS-E) Document Suite 2.2 forms for reference. These forms are to be completed only upon Notice of Award. Note that the CMS Minimum Acceptable Risk Safeguards for Exchanges (MARS-E) Document Suite 2.2 form is based on Rev 4 controls until CMS releases the new MARS-E version expected in mid-2023. If State data is to be stored or hosted by the vendor, the Contractor shall complete, execute, and submit the OMES Hosting Agreement form upon Notice of Award and meet or exceed terms therein.

ITEM	INSTRUCTIONS
	(Page Limit: Ten pages, excluding the State of Oklahoma Security and Accreditation Assessment form)

SoonerSelect Program Solicitation Forms – Summary Listing

Form Title
SoonerSelect Program Solicitation Questions
Bidder Proposal Submission Checklist
PLE Ownership and Governing Body Summary
Bidder's Cover Page
Bidder Representations and Certifications
Other State Medicaid Experience
Oklahoma Experience
References
Major Subcontractors
Plan Staffing
Key Staff and Oklahoma Presence
Economic Impact
Claims Processing
Value-Added Benefit
New SoonerSelect Program Enrollee Contact Rates
Call Center Performance
SoonerSelect Program Enrollee Grievance and Appeal Resolution
Health Risk Screening Activity Rates
Comprehensive Assessment Activity Rates
Hospital Utilization
Emergency Room Utilization
Contractor Performance History
State of Oklahoma Security and Accreditation Assessment

SoonerSelect Solicitation Forms to be Completed Upon Notice of Award – Summary Listing

Form Title
Security Specifications
CMS Minimum Acceptable Risk Safeguards for Exchanges (MARS-E) Document Suite 2.2
OMES Hosting Agreement
OMES-Form-CP-004 -Certification for Competitive Bid and/or Contract

2.5.3 Written Clarification and Oral Presentations

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

If a Bidder fails to notify OHCA of an error, ambiguity, conflict, discrepancy, omission, or other error in the Solicitation that is actually or constructively known by the Bidder or that reasonably should have been known by the Bidder, the Bidder shall submit a Proposal at its own risk; and if awarded the Contract, the Bidder shall not be entitled to additional compensation, relief, or time, by reason of the error or its later correction. If a Bidder takes exception to any requirement or specification contained in the Solicitation, these exceptions must be clearly and prominently stated in the Proposal. OHCA does not exempt a requirement or specification by Contract award, and exceptions must be agreed upon in writing through a Contract amendment.

OHCA may schedule oral presentations as part of Proposal evaluation activities. Further information on any oral presentation schedule and content requirements will be provided, if at all, after the closing date/time.

2.6 Proposal Evaluation

2.6.1 Step One – Administrative Review (Pass/Fail)

OHCA will review the Bidder's Proposal for timely submission, completeness, and compliance with general submission guidelines outlined in this RFP.

2.6.2 Step Two – Technical Proposal Evaluation

OHCA will review each Proposal passing the Administrative Review and use the Evaluation Areas to determine a Technical Proposal score for each Bidder. For each Technical Proposal, OHCA evaluators will provide independent raw scores, which will be extrapolated through an internally defined process to produce the overall score described in this section.

In compliance with 56 O.S. § 4002.3b, OHCA has developed a preferential scoring methodology for PLEs, as long as the PLE otherwise demonstrates ability to fulfill Contract requirements. As such, OHCA will establish two (2) separate evaluation pools to assess Bidders: (1) PLEs who meet the criteria outlined in 56 O.S. § 4002.2(17) and (2) all other care entities.

PLEs must meet a minimum threshold to confirm the Bidder's Proposal is responsive and determined able to demonstrate ability to fulfill Contract requirements (56 O.S. § 4002.3b). OHCA will award PLEs qualifying for the PLE pool up to fifty (50) additional points, in compliance with 56 O.S. § 4002.3b. These fifty (50) points will be added to the Technical Proposal score.

Technical Proposal Evaluation Areas

Evaluation Area	Points Possible
Executive Summary	25
Organizational Structure	250
Operations Plan	180
Provider Network and Services	210
Covered Benefits	100
Enrollee Services	120
American Indian/Alaska Native Health	50
Quality Improvement	100
Population Health	120
Value-Based Payment	80
Case Studies	120
Compliance	75
Information Technology	120
Total Technical Proposal Points Available	***1550***
PLE Bonus (if organization meets criteria outlined in 56 O.S. § 4002.2(17))	***50***
Total Technical Proposal Points Available to PLEs	***1600***

2.6.3 Step Three – Oral Presentation Evaluation

As stated in Section 2.5.3: "Written Clarification and Oral Presentations," OHCA may invite some or all Bidders to participate in Oral Presentations. In-person presentations shall be conducted in Oklahoma City, Oklahoma at a site chosen by OHCA or may be held virtually by video conference. The presentations will address specific topics provided in advance to the Bidder.

OHCA may "short-list" some Bidders as a result of their Administrative Review and Technical Proposal scores from Steps 1 and 2 and invite only those Bidders "short-listed" to participate in Oral Presentations. OHCA may limit any presentations only to those Bidders which are deemed competitive. Additional details regarding the scheduling of the in-person, oral, or virtual presentations will be provided to selected Bidders by OHCA upon determination that such presentation is needed. The Bidders are solely responsible for any costs associated with making oral presentations, including but not limited to travel and the preparation of additional materials.

If Bidders are invited to provide Oral Presentations, the Oral Presentations will be evaluated and eligible to be awarded points based on the possible point values below.

Oral Presentation: Points Possible

Evaluation Area	Points Possible
Oral Presentation	50

The final Proposal score will be comprised of both the Oral Presentation score and Technical Proposal score.

Bidders may have little notice as to whether they will be invited or not invited to provide Oral Presentations. All Bidders should be prepared to provide Oral Presentations that follow the instructions for oral presentations that will be distributed after the Proposal submission deadline.

2.6.4 Step Four – Scoring Review

OHCA will review the final Proposal scores across both pools and select Bidders based on the following order of priority:

a. Final Proposal scores; and

b. Guarantee Enrollee choice, in accordance with 42 C.F.R. § 438.52, to Enrollees Statewide.

OHCA reserves the right, but is not obligated, to contract with more than one (1) PLE should multiple PLEs be among the highest Bidders responding to this RFP.

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

2.6.5 Step Five – Final Negotiations

In accordance with the Oklahoma Central Purchasing Act and OAC 260:115, OHCA reserves the right to negotiate with one, selected, all, or none of the Bidders responding to this RFP to obtain the best value for OHCA. OHCA reserves the right to limit negotiations to those Proposals that received the highest rankings during the initial evaluation phase. Negotiations will be conducted in accordance with OAC 260:115-7-32, and may be conducted in person, in writing, or by electronic means. Negotiations could entail discussions on products, services, pricing, contract terminology, or any other issue that mitigate OHCA's risks. OHCA will consider all issues negotiable and not artificially constrained by internal corporate policies. Negotiation may be with one (1) or more Bidders, for any and all items in the Bidder's Proposal. Bidders that contend a lack of flexibility because of corporate policy on a particular negotiation item shall face a significant disadvantage and may not be considered.

2.6.6 Step Six – Award of Contract

Contract awards shall be made in accordance with OAC 260:115-7-32. OHCA may award the Contract to more than one Bidder by awarding the Contract(s) by item or groups of items or may award the Contract on an all or none basis, whichever is deemed to be in the best interest of OHCA.

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

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

2.6.7 Step Seven – Notice of Award

The successful Bidder(s) shall be notified they have been selected for award, and before the official award, the items within this subsection shall be requested to be completed.

In order to receive an award or payments from the State of Oklahoma, Bidder must be a registered vendor. The Bidder registration process can be completed electronically through the website at the following link: https://www.ok.gov/dcs/vendors/index.php.

The successful Bidder shall register with the Oklahoma Secretary of State or shall attach a signed statement that provides specific details supporting the exemption the supplier is claiming. The Oklahoma Secretary of State Office's contact information is as follows: www.sos.ok.gov or 405-521-3911. The Bidder is required to provide a certificate of liability insurance showing proof of compliance with Section 1.2.19: "Insurance" of this Contract.

The successful Bidder shall submit the following forms upon notice of award:

a. Security Specifications form;
b. CMS Minimum Acceptable Risk Safeguards for Exchanges (MARS-E) Document Suite 2.2 form;
c. OMES Hosting Agreement form; and
d. OMES-Form-CP-004 -Certification for Competitive Bid and/or Contract (Non-Collusion Certification). This form must be made out in the name of the Bidder and must be properly executed by an authorized person representing the Bidder with full knowledge and acceptance of all of its provisions.

A notice of award in the form of a purchase order or other Contract documents resulting from this RFP shall be furnished to the successful Bidder(s) and shall result in a binding Contract.

Notification of award shall also be posted on OHCA website.

1 Appendix 1 – Draft Contract

OKLAHOMA HEALTH CARE AUTHORITY

AND

[CONTRACTOR NAME]

The purpose of this Contract is to establish standard terms for a risk-based Capitated Contract between the Oklahoma Health Care Authority (OHCA) and [CONTRACTOR NAME] (Contractor) for the delivery of Medicaid services to certain Eligibles through managed care in the Oklahoma Medicaid program known as SoonerCare.

1.1 Basis of Contract Authority

1.1.1 General State Authority

Office of Management and Enterprise Services (OMES) has general procurement authority under 74 Oklahoma Statute (O.S.) §§ 85.1, *et seq*. The Central Purchasing Division of OMES has delegated the right to procure needed products and services for OHCA to the OHCA Chief Executive Officer (CEO) and other OHCA officers and personnel, subject to certain prior approval requirements from the Oklahoma Health Care Authority Board. As such, OHCA has general authority to enter into contracts for the delivery of State-purchased health care pursuant to 63 O.S. § 5006(A)(2). Pursuant to 63 O.S. § 5008(B), OHCA CEO has authority to act for the Authority in all matters except as may be otherwise provided by law or Contract.

1.1.2 Specific State Authority

The Oklahoma Legislature, through the Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, *et seq*. (Ensuring Access Act), established and defined the scope of OHCA's authority and responsibility to contract for the delivery of Medicaid medical services that are the subject of this Contract.

1.1.3 Federal Authority

The Centers for Medicare and Medicaid Services (CMS), pursuant to 42 Code of Federal Regulations (C.F.R.) Part 438, has the authority and responsibility to review and approve or deny Oklahoma's Medicaid delivery system, as set forth at 56 O.S. §§ 4002.1, *et seq.* Only those Contract terms that are applicable to and permissible for managed care organizations (MCOs), as defined at 42 C.F.R. § 438.2, are enforceable.

1.2 General Terms and Conditions

1.2.1 Parties

Oklahoma Health Care Authority

OHCA is the single State agency designated by the Oklahoma Legislature through 63 O.S. § 5009(B) to administer Oklahoma's Medicaid program, known as SoonerCare.

Contractor

Contractor's Full Legal Name:

Point of Contact:

Address:

Phone Number:

Fax Number:

Email Address:

Web Address:

FEI/SSN:

PeopleSoft Vendor Number:

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

1.2.1.1 Oklahoma Health Care Authority

OHCA has appointed a contracts designee responsible for all matters related to the Contract. The designee shall be the Contractor's primary liaison in working with other OHCA staff. The Contract designee is Susan Nichols. If a new Contract designee is appointed, OHCA will provide written notice of the change to the Contractor.

Upon the effective date of this Contract, the Contractor shall not refer any matter to OHCA CEO, the Oklahoma Health Care Authority Board, or any other official in Oklahoma unless initial contact regarding the matter has been presented to the Contract designee both orally and in writing. Notwithstanding the foregoing, a Contractor may contact or communicate with a member of the Legislature to the extent permitted by 74 O.S. § 464.1.

1.2.1.2 Contractor

The Contractor shall designate a Contract Officer. Such designation may be changed during the period of the Contract only by written notice. The Contract Officer shall be listed on the Contractor's List of Authorized Signatories attached to this Contract, which List of Signatures may be amended from time to time and shall be authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of the Contract.

1.2.2 Legal Contract

Submitted bids are rendered as a legal offer and any bid, upon acceptance by OHCA, shall constitute a Contract. The Contract consists of the following documents in order of preference:

a. Contract award documents, including but not limited to the Contract, purchase orders, any addendum to the Contract, Contract modifications or amendments, negotiated statements of work, required certifications, affidavits, and change orders;

b. Approved Corrective Action Plans (CAPs) submitted by the Contractor in response to deficiencies documented by OHCA through Readiness Reviews, operational/financial audits, routine reporting and/or other oversight activities as described in Section 1.24: "Contractor Performance Standards" of this Contract;

c. The Proposal (Solicitation Number 8070000052) in its entirety, including any amendments or attachments such as drawings, attachments, schedules, diagrams, illustrations, OHCA answers to Bidder's questions that lead to a change in the project scope, and the like; and

d. The Contractor's accepted Proposal, including Contractor's responses to OHCA questions.

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

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

a. Betterments: Any portions of the Contractor's response to the Proposal (including, but not limited to, Contractor's answers to OHCA questions asked in response to a Proposal) which both conform to and exceed the requirements of the Proposal;

b. Contract award documents, including but not limited to this Contract, the Purchase Order, Contract modifications, negotiated statements of work, required certifications, affidavits, and change orders;

c. The Proposal in its entirety, including any amendments or attachments; and

d. All other provisions of the Contractor's response to the Proposal to the extent that the Contractor's response does not conflict with the requirements of any Contract award documents, this Request for Proposal (RFP), or applicable law.

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

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

1.2.3 Contract Effective Date, Approval, and Implementation

This Contract becomes effective upon Notice of Award. A notice of award in the form of a purchase order or other Contract documents resulting from this RFP shall be furnished to the successful Bidder(s) and shall result in a binding Contract. The validity of such effectiveness is contingent upon both full execution of the final proposed Contract and, pursuant to Oklahoma Administrative Code (OAC) 317:10-1-16, OHCA Board approval.

Implementation of the contracted delivery of services is contingent upon CMS approval of the fully executed Contract, rates, and readiness, in accordance with 42 C.F.R. §§ 438.3(a), 438.7, and 438.66(d)(1) and (d)(2)(iii). OHCA may, in its sole discretion, set a go/no-go date occurring before implementation. If CMS has not completed its review by any set go/no-go date, or, if none, by the Implementation Date, OHCA may delay implementation in the manner described at 56 O.S. § 4002.3b(H). If CMS disapproves any required pre-implementation document or activity, OHCA may seek to remediate the CMS-identified defects or may terminate this Contract without penalty.

1.2.4 Notices

Whenever a notice is required to be given to the other party, the notice shall be made in writing and delivered to that party personally, by reputable courier service such as Federal Express (signature required), or by registered or certified mail, return receipt requested, to the addresses below or to such other address as designated by a party. Delivery shall be deemed to have occurred if a signed receipt is obtained, either when delivered by hand, by courier or return receipt requested. Notices shall be effective upon receipt if delivered personally, one (1) Business Day after sent if delivered by courier service, three (3) Business Days if the addressee is outside the United States, three (3) Business Days after sent by registered or certified mail, and five (5) Business Days if the addressee is outside the United States. All notices must be in English.

1.2.4.1 Notices to OHCA

Susan Nichols
Contracting Officer
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

1.2.4.2 Notices to the Contractor

[Name and Address]

1.2.5 Notification of Material Change and Authorized Signatories

The Contractor shall promptly notify OHCA of any material change. Pursuant to 56 O.S. § 4002.2(11), the term material change includes, but is not limited to, any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of SoonerSelect Program Enrollees (Enrollees) or Participating Providers.

The Contractor shall notify OHCA within three (3) Business Days of any change to the Contractor's assigned Contract Officer and shall provide an updated List of Authorized Signatories reflecting the same.

1.2.6 Contract Term

In accordance with Article X of the Oklahoma State Constitution, this initial Contract shall begin upon Notice of Award and terminate on June 30, 2024. OHCA may renew this Contract for five (5) additional one (1) year periods. OHCA's renewal shall be contingent upon the needs of OHCA and funding availability, as more fully discussed below, and is at the sole discretion of OHCA.

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

OHCA may choose to exercise an extension for up to one hundred eighty (180) Days beyond the final renewal option period at the Contract pricing rate; if so elected by OHCA, Contractor and OHCA shall execute a document reflecting such extension. If this option is exercised, OHCA shall notify the Contractor in writing prior to the Contract end date.

OHCA may choose to exercise subsequent extensions, up to one hundred eighty (180) Days each, by mutual agreement and at the Contract pricing rate, to facilitate the finalization of related terms and conditions of a new Contract or as needed for transition to a new Contractor. Payment terms for any renewal period shall be administered in accordance with Section 1.3: "Payments to Contractor" of this Contract.

The Contractor shall have certain obligations that will survive Contract expiration. These obligations are described in the relevant sections of the Contract, including but not limited to Section 1.26: "Termination" of this Contract.

The initial Rating Period shall be nine (9) months (October 1, 2023 through June 30, 2024). Each subsequent Rating Period shall be twelve (12) months (July 1-June 30).

1.2.7 Free to Contract

Notwithstanding any other language in this Contract and as authorized at law, OHCA retains full freedom throughout the Contract period to solicit and/or award one (1) or more Contracts for the delivery of Medicaid services. In future solicitations and/or awards, OHCA is under no obligation to replicate any part of the solicitation released or any contract term adopted in relation to this Contract. OHCA is under no obligation to provide prior notice of any such solicitation or award to the Contractor. As appropriate, OHCA shall provide reasonable subsequent notice of any such contract awarded to a party unrelated to the Contractor. Any such contract has no impact on OHCA's or the Contractor's rights and obligations under the terms of this Contract.

Notwithstanding any other language in this Contract, the Contractor retains full freedom throughout the Contract period to engage with any other state Medicaid agency in procurement activities up to and including the delivery of managed care Medicaid services. The Contractor shall provide notice of material change, if any. Engagement with any other state Medicaid agency has no impact on OHCA's or the Contractor's rights and obligations under the terms of this Contract.

1.2.8 Amendments or Modifications

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

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

1.2.9 Assignment

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

1.2.10 Waivers

No covenant, condition, duty, obligation or undertaking in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS. Forbearance or indulgence in any form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation or undertaking to be kept, performed, or discharged by the party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other party shall have the right to invoke any remedy available under law or equity until complete performance or satisfaction of all such covenants, duties, obligations, and undertakings is achieved.

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

1.2.11 Policy Determinations

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

Such determinations shall only be valid if issued by OHCA's Contract designee.

1.2.12 Disputes

Pursuant to OAC 260:115-9-1 and 317:10-1-3 and prior to the institution of arbitration or litigation concerning any Contract Dispute, OHCA's Contracting Officer, as that term is used in OAC 317:10-1-3 and/or OHCA CEO are authorized to seek Contract Dispute resolution if Contractor (1) fails to timely retrieve and replace an acquisition that does not meet or exceed contract specifications; (2) does not refund payment for an acquisition that does not meet or exceed contract specifications; or (3) fails to resolve any other problem that conflicts with the contract specifications or terms and conditions in a timely manner.

This authority to resolve Disputes, as well as the process for such resolution, is subject to limitations or conditions imposed by federal and State law. Such Disputes may include a cause for Contract modification such as in the case of a mistake, misinterpretation or other cause for Contract modification or rescission. This excludes any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official, other than OHCA's Contracting Officer and/or OHCA CEO, are specifically authorized to resolve or determine such controversy.

OHCA's Contracting Officer and/or OHCA CEO shall be authorized to resolve Contract Disputes between the Contractor and OHCA upon submission of a request in writing from either party. Such a request shall provide:

a. A description of the problem, including all appropriate citations and references from the Contract;

b. A clear statement by the party requesting the decision or interpretation of the Contract; and

c. A proposed course of action to resolve the dispute.

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

If OHCA's Contracting Officer and/or OHCA CEO does not issue a written decision within forty-five (45) Days after written request for a final decision, or within such longer period as might be established in writing by the parties to the Contract, then the Contractor may proceed as if an adverse decision had been received.

1.2.13 Record Retention

Unless specified, the term "record" means all documents including, but not limited to, any book, paper, photograph, microfilm, data files created by or used with computer software, computer tape, disk, record, sound recording, film recording, video record, or other material regardless of physical form or characteristic, created by, received by, under the authority of, or coming into the custody, control or possession of Contractor in connection with or related to fulfilling the terms and conditions of this Contract.

For purposes of this Contract, a record shall be considered a public record only if the record meets a definition provided in the Oklahoma Public Records Laws, including the Oklahoma Open Records Act, 51 O.S. §§ 24A.1—29, the Oklahoma Open Meetings Act, 25 O.S. §§ 301—314, and the Records Management Act, 67 O.S. §§ 201—217.

The Contractor and Subcontractors, as well as Subsidiaries, Affiliates and Employees thereof, shall retain records in compliance with both the provisions and spirit of relevant State and federal law.

For a period of no less than ten (10) years immediately following the completion and/or termination of the Contract, the Contractor and Subcontractors shall retain in retrievable form all records that exist at any time and that relate to or arise from the Contract, including but not limited to the fulfillment of any Contract term and the solicitation resulting in the Contract.

If an action to review, audit, investigate, litigate, or otherwise assess any matter related to or arising from the Contract begins before the end of the ten (10) year period, the Contractor and Subcontractors shall retain in retrievable form records for two (2) years after the date that the last of all issues arising out of the action are resolved, or until the end of the ten (10) year retention period, whichever is later. Regarding an action initiated by a State or federal agency, the "date that the last of all issues arising out of the action are resolved" means the effective date of the relevant agency's written notification that the action is complete.

For records that are under State or federal agency audit, review, or investigation on the Day that the ten (10) year period expires, the Contractor or Subcontractor shall retain in retrievable form any such records until the effective date of the relevant agency's written notification that the action is complete. In accordance with 42 C.F.R. § 438.3(u) and for a period of no less than ten (10) years, the Contractor and Subcontractors shall retain, as applicable:

a. Enrollee Grievance and Appeal records in accordance with 42 C.F.R. § 438.416;

b. Base data in accordance with 42 C.F.R. § 438.5(c);

c. Medical loss ratio (MLR) reports in accordance with 42 C.F.R. § 438.8(k); and

d. Data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, and 438.610.

1.2.14 Inspection and Audit Rights

In accordance with 42 C.F.R. § 438.3(h) and 74 O.S. § 85.41, the State, including, but not limited to, OHCA, the State Auditor and Inspector (SA&I), the Office of State Finance—Central Purchasing Division

(CPD), and the Oklahoma Attorney General's Medicaid Fraud Control Unit (MFCU), and CMS, the Office of Inspector General (OIG), and the Comptroller General, and their designees shall have, at any time, the right to:

a. Inspect and audit any records or documents of the Contractor or Subcontractors; and

b. Inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted.

The aforementioned right to audit exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

1.2.14.1 Subcontractor Inspection and Audit

In accordance with and 42 C.F.R. § 438.230(c)(3)(ii), the Secretary and the State, or any person or organization designated by either, shall also have the right to audit and inspect any books or records of the Contractor and of any Subcontractors, Subsidiaries, or Affiliates that pertain to:

a. The ability of the Contractor to bear the risk of financial losses; and

b. Services performed or payable amounts under the Contract.

1.2.15 Oklahoma Public Records Laws

OHCA is a public body defined by and subject to the Oklahoma Open Records Act, 51 O.S. §§ 24A.1—29, and the Oklahoma Open Meetings Act, 25 O.S. §§ 301—314. OHCA is an agency defined by and subject to the Records Management Act, 67 O.S. §§ 201—217. Together, these laws are referenced in this Contract as Oklahoma Public Records Laws.

OHCA is not required to maintain the confidentiality of non-public information that is furnished by the Contractor to OHCA to the extent that OHCA believes, after due inquiry, that it is required to disclose such information pursuant to the Public Records Laws. OHCA in its sole discretion shall determine whether OHCA is legally required to disclose non-public information pursuant to the Public Records Laws. OHCA shall allow for retention and public inspection of public records as required by one or more of the Oklahoma Public Records Laws.

The Contractor shall cooperate with OHCA as necessary to comply with Oklahoma Public Records Laws.

1.2.16 Confidentiality; Health Insurance Portability and Accountability Act (HIPAA) and Business Associate Requirements

1.2.16.1 Definitions

HIPAA Rules shall mean the Health Insurance Portability and Accountability Act of 1996, as amended, 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 United States Code (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, all as amended thereto.

The Contractor constitutes a "Business Associate" of OHCA for purposes of this Contract. Therefore, the term, "Contractor" as used in this section shall mean "Business Associate."

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

"Discovery" or "discovered" shall generally mean the first Day a Security Incident or Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor. Contractor shall be deemed to have knowledge of a Security Incident or Breach if known, or if, by exercising reasonable diligence, the Security Incident or Breach would have been known, to any person other than the person committing the Breach, who is an employee or Agent of Contractor (determined in accordance with the federal common law of agency).

1.2.16.2 Permitted Uses and Disclosures by Contractor

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

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

b. Use PHI to de-identify the information in accordance with 45 C.F.R. § 164.514(a)-(c), with OHCA's prior written consent.

c. Disclose PHI to report violations of law to appropriate federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1). OHCA shall be furnished with a copy of all correspondence sent by Contractor to a federal or State authority.

d. If directed to do so in writing by OHCA, create a limited data set as defined at 45 C.F.R. § 164.514(e)(2), for use in public health, research, or health care operations. Any such limited data sets shall omit all of the identifying information listed in 45 C.F.R. § 164.514(e)(2). Contractor will enter into a valid HIPAA-compliant Data Use Agreement, as described in 45 C.F.R. § 164.514(e)(4), with the limited data set recipient. Contractor will report any material breach or violation of the data use agreement to OHCA immediately after it becomes aware of any such material breach or violation.

e. If authorized to do so in writing by OHCA, use or disclose PHI for public health activities in accordance with 45 C.F.R. § 164.512(b)(1)(i)-(iv) and State public health reporting requirements established by the Oklahoma State Department of Health (OSDH).

f. Use or disclose PHI within limitation(s) of OHCA's notice of privacy practices, in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Contractor's use or disclosure of PHI.

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

a. Use PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor.

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

c. Provide data aggregation services relating to the health care operations of OHCA.

1.2.16.3 Obligations of the Contractor

Contractor is OHCA's Business Associate and agrees to comply with the HIPAA Rules and all other terms as required in this Contract upon execution of this Contract through any Contract termination procedures.

Contractor agrees not to use or further disclose PHI (including but not limited to electronic PHI) in whole or in part, other than as permitted by this Contract or as Required by Law. Contractor agrees not to use or disclose information in a manner that would violate the provisions of 42 C.F.R. Part 2 (regarding substance abuse information), 43A O.S. § 1-109 (regarding mental health records), or any other applicable privacy law.

Contractor acknowledges that Enrollee information is confidential and not to be released pursuant to 42 U.S.C. § 1396a(a)(7), 42 C.F.R. §§ 431.300 - 431.307, 42 C.F.R. § 438.224 and 63 O.S. § 5018. The Contractor agrees not to release the information governed by these laws and regulations to any other person or entity without the approval of OHCA, or as required by law or court order.

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

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

Contractor will implement, maintain, and document appropriate technical, physical, and administrative safeguards and comply with 45 C.F.R. Part 164 with respect to electronic PHI (ePHI) to prevent use or disclosureof PHI other than as provided for by this Contract, and will protect the confidentiality,

integrity, and availability of PHI that it creates, receives, maintains, or transmits for or on behalf of OHCA in accordance with the HIPAA Rules, including but not limited to training all employees, Agents, and Subcontractors in HIPAA to protect OHCA's PHI and prevent, detect, contain, and correct security violations in accordance with the HIPAA Rules.

The Contractor agrees to report the following:

a. Potential known violations of 21 O.S. § 1953 to the OHCA Privacy Officer within one (1) Hour of discovery of an unauthorized act. In general, this criminal statute makes it a crime to willfully and without authorization gain access to, alter, modify, disrupt, or threaten a computer system.

b. Any Use or Disclosure of PHI not provided for by this Contract of which it becomes aware, including Breaches of Unsecured PHI, as provided herein and in accordance with the HIPAA Rules, including but not limited to 45 C.F.R. § 164.410. Where this Contract requires a shorter notification period than the HIPAA Rules, the Contract provisions control. Contractor shall notify the OHCA Privacy Officer of such Breach in writing within one (1) Hour from discovery as prescribed in the Reporting Manual. Contractor shall be diligent in monitoring systems and taking appropriate measures to become aware of Security Incidents and Breaches.

c. Any Security Incident of which it becomes aware within one (1) Hour of discovery of the incident that may constitute a reasonable concern to the privacy and security posture affecting OHCA, including its Enrollees, data, networks, or reputation. For purposes of this Contract, "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system. Examples of Security Incidents include, but are not limited to, unauthorized use of a system for processing, accessing, or storing ePHI; changes to system hardware, firmware, or software without Contractor's consent; or suspicious patterns of Distributed Denial of Service (DDoS) attacks, pings, port scans, and similar exploratory contacts or access attempts. Security Incidents will be reported to the OHCA Privacy Officer and the OHCA Compliance Risk Management Analyst via email (securitygovernance@okhca.org) within forty-eight (48) Hours of awareness of event, but immediately within one (1) Hour from discovery. Mark these emails as a High Priority and include "Partner Incident Breach Submission" in the subject. Notwithstanding anything herein, Contractor may report innocuous Security Incidents consisting of unsuccessful attempts that, in Contractor's reasonable determination, do not present a legitimate risk of unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations (such as random pings, DDoS attempts, port scans, similar exploratory contacts, and unsuccessful log-on attempts) in the form of a brief general summary statement provided via email not more than every sixty (60) Days upon OHCA's request.

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

1.2.16.3.1 Breach

In the event that OHCA informs Contractor that (i) OHCA has determined that the affected Individuals must be notified because a Breach of unsecured PHI has occurred and (ii) Contractor is in the best position

to notify the affected Individuals of such Breach, Contractor shall, within ten (10) Days from receipt of such notice, provide a draft letter for OHCA to approve for use in notifying the Individuals, and upon OHCA's approval, Contractor shall give the required notice (1) within the time frame defined by 45 C.F.R. § 164.404(b); (2) in a form and containing such information reasonably requested by OHCA; (3) containing the content specified in 45 C.F.R. § 164.404(c), and (4) using the method(s) prescribed by 45 C.F.R. § 164.404(d). In addition, in the event that OHCA indicates to Contractor that OHCA will make the required notification, Contractor shall promptly take all other actions reasonably requested by Covered Entity related to the obligation to provide a notification of a Breach of unsecured PHI under 45 C.F.R. §§ 164.400, *et seq.*

In addition, the Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor in connection with all suspected or known security incidents or disclosure of PHI by the Contractor in violation of the requirements of this Contract. If OHCA requests, Contractor shall promptly submit a proposed remediation plan to address the Breach and prevent further Breaches for OHCA's approval. Once approved by OHCA, Contractor will remediate the Breach in accordance with the approved plan. OHCA incident response contacts shall be kept aware of the progress of the incident through timely completion of a final remediation report that is satisfactory to both parties.

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

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

1.2.16.3.2 Additional Requirements

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

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

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

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

Contractor will indemnify and hold OHCA harmless from all liability, costs, expenses, claims, or other damages that OHCA or any if its directors, officers, Agents, or employees may sustain as a result of Contractor's breach or Contractor's Subcontractor's, Affiliate's, Agent's, Employee's, or Independent Contractor's breach of its obligations under this entire section. The Contractor shall reimburse OHCA for any and all actual and direct costs and/or losses, including those incurred under civil penalties implemented by legal requirements, including but not limited to the HIPAA Rules, and including reasonable attorney's fees, which may be imposed on OHCA under legal requirements, arising from or in connection with the Contractor's negligent or wrongful actions or inactions or violations of this Agreement.

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

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

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

Except as otherwise provided for in this Contract, any disclosure of OHCA data shall be approved in advance and in writing by OHCA and then only to persons expressly authorized to review such information under applicable federal or State laws. If Contractor, employees, or Subcontractors disclose(s) or attempt(s) to disclose OHCA data, an injunction may be sought to prevent that disclosure as well as any other remedies of law that may be available. Contractor shall provide written notice to OHCA of any use or disclosure of OHCA data not provided for by this Contract of which Contractor becomes aware within five (5) Calendar Days of its discovery.

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

1.2.16.4 Obligations of the Contractor Upon Termination

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

a. Retain only that PHI which is necessary for the Contractor to continue its proper management and administration or to carry out its legal responsibilities;

b. Return to OHCA or, if agreed to by OHCA, and if feasible, destroy the remaining PHI that the Contractor still maintains in any form. If return or destruction is not feasible, Contractor will limit further uses and disclosures to those purposes that make the return or destruction infeasible;

c. Extend the protections of this Contract and continue to use appropriate safeguards to protect PHI it maintains in any form and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as the Contractor retains the PHI; and

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

The Contractor will transmit the PHI to another Business Associate or designee of OHCA at termination and the Contractor is obligated to obtain or ensure the destruction of PHI created, received, or maintained by Subcontractors. Contractor shall send OHCA written certification on oath of such destruction within twenty (20) Days from the date of destruction. Where data is to be destroyed per this section, sanitization shall be in alignment with the current National Institute of Standards and Technology (NIST) 800-88 Guidelines for Media Sanitization.

The obligations of the Contractor under Section 1.2.16: "Confidentiality; Health Insurance Portability and Accountability Act (HIPAA) and Business Associate Requirements" of this Contract shall survive the termination of this Contract.

1.2.16.5 Obligations of OHCA

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

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

OHCA shall notify the Contractor of any restriction to the use or disclosure of PHI that OHCA has agreed to or is required to abide by in accordance with 45 C.F.R. § 164.522, or as mandated pursuant to Section 13405(c) of the HITECH Act, to the extent that such restriction may affect the Contractor's use or disclosure of PHI.

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

1.2.16.6 Miscellaneous

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

1.2.16.7 Confidentiality: Substance Use Disorder (SUD) Diagnosis and Treatment in Compliance with 42 C.F.R Part 2

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

1.2.17 Conflict of Interest

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

If Contractor acquires such a conflict, it shall notify OHCA in writing within five (5) Business Days.

1.2.18 Hold Harmless

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

a. Any claims for damages or losses arising from any breach of this Contract by Contractor, or by officers or employees of, the Contractor, Agents, Subcontractors, Providers, or Affiliates;

b. Any claims for damages or losses arising from services rendered by any Subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the Contract by Contractor;

c. Any claims for damages or losses arising from erroneous or negligent acts occurring in performance of the Contract, including but not limited to, the disregard of federal or State Medicaid laws or regulations, when such erroneous or negligent act is performed by, or by an officer or employee of, the Contractor, Agents, Subcontractors, Providers, or Affiliates, in performance of the Contract;

d. Any claims for damages or losses arising from the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or State regulations or statutes, when such act is performed by Contractor, or by officers or employees of, the Contractor, Agents, Subcontractors, Providers, or Affiliates;

e. Any damages or losses arising from any failure to comply with any federal or State laws, regulations, rules, policies, or guidance, including but not limited to labor laws and minimum wage laws, when such failure is due to any act or failure to act by, or by officers or employees of, the Contractor, Agents, Subcontractors, Providers, or Affiliates; and

f. Any claims for damages, losses or costs associated with legal expenses, including but not limited to those incurred by or on behalf of OHCA in connection with the defense of claims for such injuries, losses, claims, or damages specified above.

Before delivering services under the Contract, the Contractor shall provide adequate demonstration to OHCA that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in Section 1.2.19: "Insurance" of this Contract.

1.2.19 Insurance

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

a. Automobile insurance;

b. Comprehensive liability insurance;

c. Errors and omissions insurance;

d. Commercial general liability insurance;

e. Medical malpractice insurance;

f. Professional liability insurance;

g. Directors' and officers' liability insurance;

h. Cyber liability insurance;

i. Property damage insurance; and

j. Worker's compensation and employer's liability insurance.

A table outlining the required, minimum insurance coverages and applicable limits is included in Appendix 1D: "Contract Minimum Insurance Requirements" of this Contract.

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

The required insurance policies shall be provided by carriers authorized to do business within Oklahoma and rated as "A+" or higher by the A.M. Best Rating Service. Certificates of Insurance, original and any renewal or revision, shall be incorporated as an attachment into this Contract. Upon request by OHCA or the State, the Contractor shall promptly provide proof to the State of any renewals, additions, or changes to such insurance coverage. Each required insurance policy and any renewed or revised policy shall contain the following endorsement:

"The State of Oklahoma and the Oklahoma Health Care Authority are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary, and any insurance carried by the State or any of its agencies, boards, departments, or commissions shall be secondary to this policy. This policy shall not expire, be cancelled, or materially change without thirty (30) Days' written notice to the

State of Oklahoma and the Oklahoma Health Care Authority. The insurer and the insured party obtaining this Policy shall each be independently obligated to provide timely written notice. This policy is invalid unless countersigned by an Authorized Representative of the insurance company."

The Contractor shall ensure that Certificates of Insurance:

a. State the policy number, the insured parties, including the State of Oklahoma and OHCA, and the insurance period;

b. Are supported by a policy that obligates the insurer and the insured Contractor, independently, to provide written notice to the State and OHCA at least thirty (30) Days prior to cancellation, expiration, or material change;

c. Are submitted to OHCA within thirty (30) Days of official notice of Contract award and prior to commencement of service delivery to Medicaid beneficiaries; and

d. Are renewed and resubmitted to OHCA annually on or before the anniversary of the originally submitted Certificate of Insurance.

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

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

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

1.2.19.1 Professional Liability Insurance

The Contractor shall obtain and maintain, for the duration of the Contract, professional liability insurance in the amount of at least $1,000,000 for each occurrence.

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

Failure to advise OHCA that it is the Contractor's intention for covered Subcontractors, independent contractors, Agents, employees, or Affiliates thereof, to utilize Oklahoma Governmental Torts Claim Act protection in lieu of professional liability insurance in amount of at least $1,000,000 for each occurrence during the Contract term shall result in the Contractor being obligated to substitute professional liability insurance in an amount of at least $1,000,000 per occurrence for said Subcontractors, independent contractors, Agents or employees.

1.2.19.2 Minimum Liability and Property Damage Insurance

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

a. Commercial general liability insurance covering the risks of personal injury, bodily injury (including death) and property damage, including coverage for contractual liability, with a limit of liability of not less than $25,000,000 per occurrence;

b. Automobile liability insurance with limits of liability of not less than $5,000,000 combined single limit each accident; and

c. Insurance against liability for property damages, as well as first party fire insurance, including contents coverage for all records maintained pursuant to the Contract, in the amount of $500,000 for each occurrence.

1.2.19.3 Directors and Officers Liability Insurance

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

1.2.19.4 Cyber Liability Insurance

The Contractor shall obtain, pay for, and keep in force cyber liability insurance, including coverage for failure to protect Confidential Information and PHI, and failure of the security of the Contractor's computer systems that results in unauthorized access to OHCA data with limits no less than $50,000,000 per occurrence.

1.2.19.5 Errors and Omissions Insurance

The Contractor shall obtain, pay for, and keep in force for the duration of the Contract errors and omissions insurance in the amount of $50,000,000.

1.2.19.6 Workers' Compensation and Employer's Liability Insurance

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

1.2.19.7 Reinsurance

The Contractor shall have the option of purchasing reinsurance from a commercial reinsurer. The Contractor may elect to self-insure based upon the Contractor's ability to survive a series of adverse financial events.

1.2.20 Ownership of Data and Reports

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

1.2.20.1 Intellectual Property Infringement, Hold Harmless, and Specific Performance

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

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

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

1.2.20.2 Publicity

Any publicity given to the program or services provided therein, including but not limited to notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for the Contractor or its Subcontractors, shall identify the State of Oklahoma as the sponsor and shall not be released without prior written approval from OHCA pursuant to Section 1.12.16.4: "OHCA Review and Approval Process" of this Contract. In circumstances where time is of the essence, OHCA will make a good faith effort to review and respond within one (1) Business Day.

1.2.20.3 Employment Relationship

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

1.2.20.4 Force Majeure

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

The Contractor shall have in place a disaster recovery plan that has been reviewed and approved by OHCA and that meets the specifications of Section 1.21.13: "Disaster Preparation and Data Recovery" of this Contract.

1.2.20.5 Compliance with Law

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

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

a. Federal requirements within 42 C.F.R. §§ 438.1, *et seq*., as applicable to MCOs;

b. Title VI of the Civil Rights Act of 1964;

c. The Age Discrimination Act of 1975;

d. The Rehabilitation Act of 1973;

e. Title IX of the Education Amendments of 1972 (regarding education programs and activities);

f. The Americans with Disabilities Act of 1990 as amended;

g. Section 1557 of the Patient Protection and Affordable Care Act (ACA);

h. Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. § 290dd-2;

i. Mental Health Parity and Addiction Equity Act (MHPAEA), 42 C.F.R. Part 2;

j. Oklahoma Electronic and Information Technology Accessibility (EITA) Act (Oklahoma 2004 House Bill (HB) 2197) regarding information technology (IT) accessibility standards for persons with disabilities;

k. Ensuring Access to Medicaid Act, 56 O.S. §§ 4002.1, *et seq*.;

l. Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5054;

m. Oklahoma Worker's Compensation Act, 85A O.S. §§ 1, *et seq*.;

n. 74 O.S. §§ 85.44(B) and (C) and 45 C.F.R. § 75.320 with regard to equipment (as defined by 2 C.F.R. Parts 220, 225, or 230 as applicable to the Contractor's entity) purchased with monies received from OHCA pursuant to this Contract;

o. Title 317 of the Oklahoma Administrative Code (OAC);

p. Oklahoma Taxpayer and Citizen Protection Act of 2007, 25 O.S. § 1313 and participates in the Status Verification System. The Status Verification System is defined at 25 O.S. § 1312; and

q. Deceptive Trade Practices; Unfair Business Practices:

    i. Contractor represents and warrants that neither Contractor nor any of its Subcontractors:

        a) Have been found liable in any administrative hearing, litigation or other proceeding of Deceptive Trade Practices violations as defined under the Oklahoma Consumer Protection Act, 15 O.S. §§ 751, *et seq*.;

        b) Have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation, or other proceeding;

        c) Have officers who have served as officers of other entities who have been found liable in any administrative hearing, litigation, or other proceeding of Deceptive Trade Practices violation; or

        d) Have officers who have outstanding allegations of any Deceptive Trade Practice pending in any administrative hearing, litigation, or other proceeding.

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

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

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

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

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

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

1.2.20.6 Titles Not Controlling

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

1.2.20.7 Counterparts

The Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one (1) and the same instrument.

1.2.20.8 Administrative Procedures Not Covered

Administrative procedures not covered in the Contract or other applicable statutory or regulatory provisions will be set forth where necessary in separate memoranda from time to time.

1.2.20.9 Days Terminology

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

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.

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 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.

1.3 Payments to Contractor

OHCA shall pay the Contractor a monthly Capitation Payment for each Enrollee through the Medicaid Management Information System (MMIS), in accordance with the final certified rates approved by CMS. OHCA will pay the monthly Capitation Payments no later than the tenth Business Day of each month, in accordance with the final rate schedule following rate certification. The Contractor and OHCA agree that Capitation Payments must be in accordance with 42 C.F.R. § 438.3(c) and approved as actuarially sound by the CMS in accordance with 42 C.F.R. § 438.4. Capitation Rates shall be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles.

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

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

1.3.1 Payment Schedule

The Contractor shall be notified of Enrollment and Disenrollment updates through receipt of outbound American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X 12 834 electronic transactions. The Contractor shall receive notification of Capitation Payment through receipt of an ASC X12N 820 electronic transaction. Capitation Payment will be made through EFT in accordance with a schedule to be published by OHCA for Enrollees after the Operational Implementation Date.

1.3.2 Capitation Reconciliation

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

1.3.3 Report of Capitation Overpayment

In accordance with 42 C.F.R. § 438.608(c)(3), the Contractor shall report to OHCA within sixty (60) Days when it has identified Capitation Payments or other payments in excess of amounts specified in the Contract as specified in the Reporting Manual.

1.3.4 Capitation Payment Recoupment

OHCA shall be the sole determiner of an Enrollee's Enrollment and Disenrollment effective dates for purposes of capitation and recoupment, as described in Section 1.6: "Enrollment and Disenrollment" of this Contract.

For Enrollees whose Enrollment lapses for any portion of a month in which a Capitation Payment was made, as described in Section 1.6.8: "Disenrollment Effective Date" of this Contract, OHCA shall adjust the Capitation Payment through a reconciliation process to be defined by OHCA.

1.3.5 Capitation Rate Changes

OHCA and the Contractor understand and agree that the agreed upon Capitation Rates are subject to modification in accordance with Section 1.2.8: "Amendments or Modifications" of this Contract if changes in State or federal laws, rules, regulations, guidelines, policies, or court orders affect the rates or the actuarial soundness of rates. Material programmatic changes requiring an increase or decrease of more than one and a half percent (1.5%) per rate cell of the rates previously certified for the applicable rating shall be included in the Contract amendment issued to the Contractor in accordance with the provisions outlined in Section 1.2.8: "Amendments or Modifications" of this Contract.

1.3.6 Capitation Withhold

OHCA shall withhold amounts specified in Section 1.16.1.12: "Value-Based Payments" of this Contract and Appendix 1C: "Quality Performance Withhold Program" of the Contractor's Capitation Payments beginning July 1, 2024. The amounts include:

Contract Year	Value-Based Payment (VBP) Withhold		Quality Withhold	
	Performance Period	Withhold Amount	Performance Period	Withhold Amount
1. Oct 2023 -Jun 2024*	*Oct 2023 -Jun 2024	Not Applicable	Jan – Dec 2024	Not Applicable
2. Jul 2024 - Jun 2025	Jul 2024 - Jun 2025	Up to 1%	Jan – Dec 2025	1%
3. Jul 2025 - Jun 2026	Jul 2025 - Jun 2026	Up to 1%	Jan – Dec 2026	1.5%
4. Jul 2026 - Jun 2027	Jul 2026 - Jun 2027	Up to 1%	Jan – Dec 2027	1.5%
5. Jul 2027 – Jun 2028	Jul 2027 – Jun 2028	Up to 1%	Jan – Dec 2028	1.5%

*Date of award through June 30, 2024

The Contractor shall be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in Section 1.16.1.12: "Value-Based Payments" of this Contract and Appendix 1C: "Quality Performance Withhold Program." OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment.

In accordance with 42 C.F.R § 438.6(b), the withhold arrangement will be:

a. For a fixed period of time (i.e., annually beginning on July 1, 2024);

b. Not to be renewed automatically;

c. Made available to both public and private contractors under the same terms of performance;

d. Does not condition the Contractor's participation in the withhold arrangement on entering into or adhering to intergovernmental transfer agreements; and

e. Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support initiatives as specified in Oklahoma's quality strategy (e.g., Section 1.16.1.12: "Value-Based Payments" of this Contract and Performance Withhold Program in Appendix 1C: "Quality Performance Withhold Program" of this Contract).

1.4 Administrative Requirements

1.4.1 Licensure

The Contractor shall be licensed as a Health Maintenance Organization (HMO) pursuant to 36 O.S. §§ 6901, *et seq*. and related provisions of the Oklahoma Insurance Code. A Certificate of Authority must be furnished to OHCA upon Contract award and must include all Oklahoma counties, unless the Contractor is only operating within the Urban Region pursuant to 56 O.S. § 4002.3b. If at any time during the term of the Contract, the Contractor incurs any change in status, including impairment, censure, or loss of clinical licensure(s), State approval and/or qualifications as an HMO in any geographic area covered under the Contract, such loss shall immediately be reported to OHCA. Such loss may be grounds for termination of the Contract under the provisions of Section 1.26.1: "Early Termination" of this Contract.

1.4.2 Accreditation

In accordance with 56 O.S. § 4002.4, the Contractor shall be accredited by an Accrediting Entity identified by 45 C.F.R. § 156.275 within eighteen (18) months of Operations Start Date. If the Contractor is undergoing accreditation, the Contractor shall submit reports documenting the status of the accreditation process as required by OHCA. In accordance with 42 C.F.R. § 438.332(a), the Contractor shall inform OHCA when it has been accredited.

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

a. Accreditation status, survey type, and level (as applicable);

b. Accreditation results, including recommended actions or improvements, CAPs, and summaries of findings; and

c. Expiration date of the accreditation.

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

The Contractor shall undergo reaccreditation in accordance with the timeframes required by the Accrediting Entity and federal regulations. Failure to achieve or maintain accreditation in accordance with the provisions of this Contract shall be considered a breach of this Contract and may result in penalties or termination. The Contractor must earn National Committee for Quality Assurance's (NCQA's) Health Equity Accreditation in the State of Oklahoma within two (2) years from the Operations Start Date and maintain Health Equity Accreditation throughout the term of the Contract. The Contractor shall provide the State with evidence of the Contractor's Health Equity Accreditation, including the results of the Contractor's most recent NCQA review. The Contractor shall authorize NCQA to provide the State a copy of the most recent Health Equity Accreditation review for the Contractor.

1.4.3 Subcontracting

The Contractor may enter into written subcontract(s) for performance of certain responsibilities listed in the Contract. All subcontracts must be in writing and fulfill the requirements of 42 C.F.R. §§ 438.230 and 438.3(k) that are appropriate to the service or activity being delegated. The Contractor shall make available all subcontracts in electronic format, in the manner and format required in the Reporting Manual, for review and comment by OHCA and all Subcontractors, including Major Subcontractors, within thirty (30) Days of award. OHCA reserves the right to review and approve any future subcontracts.

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

a. Administrative – Entity anticipated being paid $2,000,000 or more annually for Enrollee- or Provider-facing administrative activities, including but not limited to operation of call centers, claims processing, and Enrollee/Provider education.

b. Health Service – Entity, not including Participating Providers, that has an executed agreement to deliver or arrange for the delivery of any physical health, behavioral health, or pharmacy benefit covered under the Contract in accordance with Section 1.7: "Covered Benefits" of this Contract.

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

The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with OHCA, notwithstanding any relationship(s) with any Subcontractors. The Contractor shall actively monitor Subcontractors to ensure their compliance with the Contract and verify the quality of their services.

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

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

a. Provide for revocation of the delegation of activities or obligations, or must specify other remedies in instances where OHCA or the Contractor determines that the Subcontractor has not performed satisfactorily;

b. Require Subcontractor compliance with all applicable Medicaid laws, regulations, and applicable sub-regulatory guidance and Contract provisions;

c. Specify that the Subcontractor agrees that the State, CMS, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), the Comptroller General, or their

designees have the right to audit, evaluate, and inspect any books, records, Contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contract for ten (10) years from the later of final date of the Contract period or from the date of completion of any audit; and specify that the Subcontractor will make available its premises, physical facilities, equipment, books, records, Contracts, computer, or other electronic systems relating to its Medicaid Enrollees; and

d. Specify that if the State, CMS, or the HHS OIG determine that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the HHS OIG may inspect, evaluate, and audit the Subcontractor at any time.

The Contractor shall provide OHCA written notice at least thirty (30) Days in advance of any contractual changes in subcontracted services. Notice of these changes shall include a written Transition Plan describing how the Contractor will notify Enrollees and Providers, as applicable, of the change and how the Contractor will maintain continuity of care for those affected Enrollees. At its discretion, OHCA may elect to conduct a Readiness Review of the Contractor and/or Subcontractor(s) pursuant to a change in subcontracted services, to ensure continued compliance with Contract terms.

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

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

1.4.4 Business Relationship Disclosure

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

1.4.5 Oklahoma Presence

To ensure models of care are developed to meet the needs of Medicaid members, each Contractor must Contract with at least one (1) Local Oklahoma Provider Organization (LOPO) for a model of care containing Care Coordination, Care Management, utilization management (UM), disease management, Network management, or another model of care as approved by OHCA. Such contractual arrangements must be in place within twelve (12) months of the effective date of this Contract authorized by 56 O.S. § 4002.4(C).

The Contractor shall have an office in Oklahoma, from which, at a minimum, Key Staff members in accordance with Section 1.4.6.2: "Key Staff" of this Contract physically perform their daily duties and responsibilities. OHCA reserves the right to grant any exceptions to Key Staff its sole discretion. At a minimum, the Contractor shall maintain the following roles and positions at the Oklahoma Office:

a. Chief Executive Officer (CEO);

b. Chief Financial Officer (CFO);

c. Chief Medical Officer;

d. Chief Operating Officer (COO);

e. Behavioral Health Director;

f. Care Management Director;

g. Compliance Officer;

h. Data Compliance Manager;

i. Grievance and Appeal Manager;

j. Information Systems Manager;

k. Pharmacy Director;

l. Program Integrity Lead Investigator;

m. Provider Services Director;

n. Quality Director;

o. Security and Privacy Officer;

p. SoonerSelect Enrollee Advocate;

q. SoonerSelect Enrollee Services Director;

r. Transition Coordinator;

s. Tribal Government Liaison; and

t. UM Director.

The Contractor may maintain the following Key Staff positions within or outside of Oklahoma, as appropriate:

a. Claims Manager; and

b. Internal Audit Director.

The Contractor may maintain the following positions throughout Oklahoma in order to best serve the needs of the Enrollees:

a. Behavioral Health support staff;

b. Care Managers;

c. Grievance and Appeal staff;

d. Internal Audit staff;

e. Pharmacy support staff;

f. Provider services staff;

g. Quality management staff;

h. SoonerSelect Enrollee care support staff;

i. SoonerSelect Enrollee services staff;

j. Transition coordination staff; and

k. UM staff.

Additionally, the following staff must be located and operate within Oklahoma:

a. Program Integrity staff as required under Section 1.20.2: "Compliance Program" of this Contract;

b. Enrollee services call center as required under Section 1.12.8: "Enrollee Services Call Center" of this Contract; and

c. Provider services call center as required under Section 1.15.2: "Provider Services Call Center" of this Contract.

The Contractor shall ensure the location of any staff or operational functions outside of Oklahoma does not compromise the delivery of integrated services to Enrollees and Providers. The Contractor shall be responsible for ensuring all staff functions conducted outside of Oklahoma are readily available to OHCA to ensure such location does not hinder OHCA's ability to monitor the Contractor's performance and compliance with Contract requirements.

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

1.4.5.1 Prohibition on Off-Shoring

In accordance with 42 C.F.R. § 438.602(i), the Contractor shall not enter into any subcontract for the performance of any duty under this Contract in which such services are to be transmitted or performed outside of the United States and that nor shall any claims be paid by the Contractor to a Network Provider, out-of-Network Provider, Subcontractor, or financial institution located outside of the U.S. that is considered in the development of actuarially sound Capitation Rates. In accordance with this section,

the purchase of offshore services is expressly prohibited and upon the request of OHCA, the Contractor shall:

a. Disclose the location(s) where all services will be performed by the Contractor and Subcontractor(s);

b. Disclose the location(s) where any State data associated with any of the services are provided, or seek to be provided, will be accessed, tested, maintained, backed-up, or stored;

c. Disclose any shift in the location of services being provided by the Contractor or Subcontractor(s); and

d. Disclose the principal location of business for the Contractor and all Subcontractor(s) who are supplying services to the State of Oklahoma under this Contract(s).

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

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

1.4.6 Staffing

The Contractor shall have sufficient staff to meet all Contract standards. Pursuant to the Oklahoma Privatization Act, 74 O.S. §§ 588, *et seq*., and because of this Contract, the Contractor shall be required to offer available employee positions pursuant to the Contract to qualified regular employees of OHCA who satisfy the hiring criteria of the Contractor. This includes, at a minimum, the following:

a. Key Staff in accordance with Section 1.4.6.2: "Key Staff" of this Contract;

b. Utilization and medical management staff dedicated to performing UM and review activities in accordance with Section 1.8: "Medical Management" of this Contract;

c. Care Managers to staff the Contractor's Care Management and population health programming required under Section 1.9: "Care Management and Population Health" of this Contract;

d. Enrollee care support staff as described under Section 1.4.6.4: "Enrollee Support Staff" of this Contract;

e. Enrollee services staff, including Marketing and outreach staff to conduct all Enrollee activities required under Section 1.12: "Enrollee Services" of this Contract;

f. Quality management staff dedicated to quality management and improvement activities in accordance with Section 1.11: "Quality" of this Contract;

g. Grievance and Appeal staff to ensure the timely and accurate processing of all Grievances and Appeals in accordance with Section 1.18: "Enrollee Grievance and Appeal" of this Contract;

h. Provider reconsiderations and appeals staff to ensure timely and accurate processing of all reconsiderations and Appeals in accordance with Section 1.15.6: "Provider Complaint System" of this Contract;

i. Technical support staff to ensure the timely and efficient maintenance of all health information management system functionality, including Encounter Data reporting, required under Section 1.21: "Information Technology" of this Contract;

j. Compliance and reporting staff to complete all reporting required under Section 1.23: "Reporting" of this Contract;

k. Program integrity staff to comply with the requirements of Section 1.20: "Program Integrity" of this Contract;

l. Provider services staff to develop the Contractor's Network and coordinate communications with Participating and Non-Participating Providers as required under Section 1.15: "Provider Services" of this Contract;

m. Claims processing staff sufficient to meet the timely claims processing standards in Section 1.16.5: "Timely Claims Filing and Processing" of this Contract;

n. Accounting and finance staff; and

o. Website staff to maintain and update the Contractor's Enrollee and Provider websites.

The Contractor may combine functions as long as it is able to demonstrate that all tasks are being performed. A request to combine functions shall be submitted to OHCA for approval within thirty (30) Days of award. The Contractor may also use administrative service organizations to perform some or all of the above functions, subject to the conditions specified in Section 1.4.3: "Subcontracting" of this Contract.

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

1.4.6.1 Governing Body

The Contractor shall have a Governing Body specifically constituted for purposes of this Contract, and any subsequent Contracts, with OHCA. OHCA does not require a minimum number of Governing Body members.

In accordance with 56 O.S. § 4002.5, to ensure Providers have a voice in the direction of Contractor operations, the Contractor shall have a shared governance structure that includes:

a. Representatives of LOPOs who are Medicaid providers;

b. Essential community providers; and

c. A representative from a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust.

No less than one third (1/3) of the Contractor's local Governing Body shall be comprised of representatives of LOPOs.

1.4.6.2 Key Staff

The Key Staff positions required under the Contract include:

a. Chief Executive Officer (CEO) who shall have ultimate responsibility for the administration and implementation of all Contract provisions.

b. Chief Financial Officer (CFO) who shall oversee the budget and accounting systems under the Contract and ensure compliance with Contract requirements for financial performance and reporting.

c. Chief Medical Officer who shall be board-certified and currently licensed in Oklahoma as a medical doctor (MD) or doctor of osteopathy (DO).

d. Chief Operating Officer (COO) who shall oversee processes and operations related to claims, as well as oversight of all aspects of Enrollee and Provider services.

e. Behavioral Health Director who shall be licensed in Oklahoma as a behavioral health professional and responsible for oversight of all behavioral health initiatives and services delivered under the Contract. If the Contractor subcontracts for the provision of Behavioral Health Services, the Behavioral Health Director shall be responsible for oversight of all behavioral health initiatives and services delivered under the subcontract and Contract compliance of the Subcontractor.

f. Care Management Director who shall be a registered nurse licensed in Oklahoma, hold a nationally recognized case management certification, and shall oversee the Contractor's Care Management and population health model in accordance with Section 1.9: "Care Management and Population Health" of this Contract.

g. Claims Manager who shall be responsible for ensuring prompt and accurate claims processing in accordance with the requirements of Section 1.16.4: "Claims Processing" of this Contract. The Claims Manager shall also be responsible for managing a staff of claims representatives who monitor billing activities, provide technical assistance, and ensure encounter claims submitted are for actual rendered services performed and meet Medical Necessity.

h. Compliance Officer who shall, in accordance with 42 C.F.R. § 438.608, be responsible for developing and implementing policies, procedures and practices designed to ensure Contract compliance and shall report directly to the CEO and Governing Body. The Compliance Officer shall be responsible for oversight and evaluation of any Contractor corrective actions required to correct non-compliance in accordance with the requirements of Section 1.25: "Remedies and Disputes" of this Contract. The Compliance Officer shall be responsible for development and oversight of the Regulatory Compliance Committee.

i. Data Compliance Manager who shall provide oversight to ensure all Contract data conforms to OHCA data standards and policies. The Data Compliance Manager shall have extensive experience in managing data quality and exchange processes, including data integration and verification.

j. Enrollee Advocate who shall be responsible for representation of Enrollee's interest, including input in policy development, planning and decision-making. The Enrollee Advocate should have lived experience as an Enrollee. The Enrollee Advocate shall be responsible for development and oversight of the Enrollee Advisory Board.

k. Enrollee Services Director who shall oversee all Enrollee services functionality in accordance with Section 1.12: "Enrollee Services" of this Contract.

l. Grievance and Appeal Manager who shall manage the Contractor's Grievance and Appeal System in accordance with the requirements of Section 1.18: "Enrollee Grievance and Appeal" of this Contract.

m. Information Systems Manager who shall oversee, manage, and maintain the Contractor's management information system (MIS) in accordance with the requirements of Section 1.21: "Information Technology" of this Contract. The Information Systems Manager will serve as a liaison between the Contractor and the State regarding encounter claims submissions, Capitation Payment, Enrollee eligibility, Enrollment and other data transmission interface and management issues. The Information Systems Manager, in close coordination with other Key Staff, is responsible for ensuring all program data transactions are in compliance with the terms of the Contract. The Information Systems Manager is responsible for attending all technical meetings called by the State. If the Information Systems Manager is unable to attend a technical meeting, the Information Systems Manager shall designate a representative to take their place.

n. Internal Audit Director who shall serve as an independent party, responsible for oversight of the Contractor's risk management process. The Internal Audit Director shall analyze operations and critically assess compliance with all requirements as outlined in this Contract.

o. Pharmacy Director who shall be an Oklahoma licensed pharmacist. The Pharmacy Director shall represent the Contractor at all meetings of the State's Drug Utilization Review (DUR) Board. If the Contractor subcontracts with a Pharmacy Benefit Manager (PBM), the Pharmacy Director shall be responsible for oversight and Contract compliance of the PBM. The Pharmacy Director may not be an employee of the PBM/Pharmacy Benefit Administrator (PBA).

p. Program Integrity Lead Investigator who shall be responsible for oversight of all Provider or Enrollee investigations related to possible Fraud, Waste, or Abuse and coordinating all referrals, investigations, and audits with OHCA in accordance with the requirements of Section 1.20: "Program Integrity" of this Contract.

q. Provider Services Director who shall oversee all Provider services and Network development functionality in accordance with Section 1.15: "Provider Services" of this Contract. The Provider Services Director is responsible for managing a staff of Provider representatives who assist SoonerSelect Program providers. The Provider Services Director is also responsible for the growth and retention of SoonerSelect Program providers, creating a qualified and comprehensive Provider Network.

r. Quality Director who shall be responsible for the operation of the Contractor's Quality Assessment and Performance Improvement (QAPI) program in accordance with the requirements of Section 1.11: "Quality" of this Contract. The Quality will be responsible for developing and managing the Contractor's portfolio of improvement projects and will work collaboratively with all Contractor's and OHCA to improve population health outcomes, including addressing health equity and Social Determinants of Health.

s. Security and Privacy Officer who shall be responsible for the operation of the Contractor's programs to ensure the security and privacy of all applicable data and information systems to comply with the requirements of Section 1.21: "Information Technology" and Section 1.2.16: "Confidentiality; Health Insurance Portability and Accountability Act (HIPAA) and Business Associate Requirements" of this Contract.

t. Transition Coordinator who shall oversee all Enrollee transitions and Contractor compliance with all policies in accordance with the requirements of Section 1.10: "Transition of Care (TOC)" of this Contract.

u. Tribal Government Liaison who shall be responsible for outreach to Enrollees, Indian Health Care Providers (IHCPs), the Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us), and Indian Tribe representatives. The Tribal Government Liaison shall serve as a resource to and advocate for American Indian/Alaska Native (AI/AN) Enrollees and IHCPs in their interactions with the Contractor.

v. UM Director who shall be responsible for the operation of the Contractor's UM functionality in accordance with the requirements of Section 1.8: "Medical Management" of this Contract. The UM Director will serve as a liaison between the Contractor and the State regarding Prior Authorization (PA) reviews, prepayment retrospective reviews, and any additional UM functions. The UM Director, in close coordination with other Key Staff, is responsible for ensuring all utilization reviews are in compliance with the terms of the Contract.

All Key Staff shall be dedicated full time to the SoonerSelect Program Contract and based in Oklahoma under Section 1.4.5: "Oklahoma Presence" of this Contract. OHCA reserves the right at its sole discretion to review any Key Staff, approve or deny the individuals filling Key Staff positions, and request reassignment of Key Staff.

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

1.4.6.3 Care Management

The Contractor's Care Management function shall include a Care Management Director located in Oklahoma, sufficient management, supervisory level, direct care, and support staff to support timely Health Risk Screenings, Comprehensive Assessments, Care Plan development and Enrollee interventions in accordance with the Contractor's Risk Stratification Level Framework and the standards described in Section 1.9: "Care Management and Population Health" of this Contract.

1.4.6.4 Enrollee Support Staff

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

a. Advocating on behalf of an Enrollee and their preferences with respect to receiving Enrollee- and family-centered care;

b. Assisting the Enrollee to access community-based resources to address non-medical needs and to support the Enrollee's Care Plan objectives and independence;

c. Obtaining information about available SoonerSelect Program services;

d. Helping them with the filing of Grievances and Appeals; and

e. Outreach and engagement including, but not limited to re-Enrollment and Primary Care Physician or Provider (PCP) assignment.

1.4.6.5 Pharmacy Benefit Manager Liaison

The Contractor, or to the extent the Contractor subcontracts with a PBM, shall employ a State liaison with whom OHCA may communicate directly. The State liaison also must be available for direct communication with pharmacy Providers to resolve issues and to work directly with OHCA to resolve drug rebate disputes or other issues that arise from Contractor's pharmacy and medical claims files. If employed by the Contractor, this role shall not be filled by the Pharmacy Director. The State liaison may be an employee of the PBM as long as they are dedicated to the SoonerSelect Program.

1.4.6.6 Staffing Plan and Implementation Plan

The Contractor shall provide the following for OHCA review and approval no later than thirty (30) Days after Contract award:

a. Identification of the Contractor's implementation team;

b. Names of the Governing Body and their current resumes;

c. Implementation Plan;

d. Hiring and Staffing Plan; and

e. Diversity and Inclusion Plan.

The Contractor shall provide regular status updates to OHCA on Implementation Plan and Hiring and Staffing Plan activities during the Readiness Review, and as specified in the Reporting Manual.

1.4.6.7 Changes in Governing Body and Key Staff

The Contractor shall notify OHCA of all changes in composition of the Governing Body and Key Staff. The Contractor shall notify OHCA at least five (5) Days in advance of the change, whenever practical. The

Contractor shall submit a current resume and job description for the new Governing Body member(s) or Key Staff position for OHCA's review as specified in the Reporting Manual.

1.4.6.8 Staff Training

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

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

a. Enrollee Services Call Center that meets the minimum requirements of Section 1.12.8.3: "Call Center Training" of this Contract;

b. Provider Services Call Center that meets the minimum requirements of Section 1.15.2: "Provider Services Call Center" of this Contract;

c. Care Managers that meet the minimum requirements of Section 1.9.5.4: "Training" of this Contract;

d. Language and Cultural Competency Training as described in Section 1.12.2: "Cultural Competency" of this Contract to Subcontractors and all Enrollee facing staff; and

e. Marketing staff in accordance with Section 1.12.16.2: "Training Curriculum" of this Contract.

All Contractor staff and Subcontractors shall receive training on security and compliance in accordance with Section 1.20.2.2: "Compliance Education and Training" of this Contract. The Contractor shall track and document completion of all staff training and provide evidence of training completion to OHCA upon request.

1.4.6.9 Coordination with OHCA

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

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

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

1.4.6.10 Coordination with Other State Agencies and Entities

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

a. SoonerSelect Children's Specialty Program and SoonerSelect Dental Contracted Entities (CEs);

b. Oklahoma State Immunization Information System (OSIIS);

c. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS);

d. The Oklahoma Office of Juvenile Affairs (OJA);

e. The Oklahoma Department of Corrections (ODOC);

f. The Oklahoma State Department of Education (OSDE);

g. The Oklahoma State Department of Health (OSDH);

h. Oklahoma Human Services (OHS);

i. Tobacco Settlement Endowment Trust (TSET); and

j. Other entities as identified by OHCA.

1.4.7 Policies and Procedures

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

The Contractor and any Subcontractor(s) must submit all policies and procedures for OHCA's review and approval prior to their adoption and implementation. The Contractor and any Subcontractor(s) shall furnish policies and procedures to OHCA upon request. OHCA will examine policies and procedures as part of Readiness Review activities described in Section 1.4.8: "Readiness Review" of this Contract and may require modifications or additions as part of Readiness Review findings. OHCA may also review the Contractor and any Subcontractor(s) policies and procedures and related matters associated with meeting the requirements of this Contract as part of ongoing oversight activities. This provision applies to all sections of the Contract regardless of whether a section contains separate language concerning review of policies and policies pertaining to that section.

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

As outlined in the Reporting Manual, OHCA shall require an annual certification from the Contractor attesting to updated policies and procedures and the operational execution of such.

1.4.8 Readiness Review

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

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

a. Administrative staffing and resources;

b. Subcontracted functionality;

c. Enrollee and Provider communications;

d. Grievances and Appeals;

e. Enrollee services and outreach;

f. Participating Provider management;

g. Program integrity and compliance;

h. Care Coordination and Care Planning;

i. Quality improvement;

j. UM;

k. Financial reporting and monitoring;

l. Financial solvency; and

m. Information technology including claims management, Encounter Data, and Enrollment information management.

Failure of the Contractor to meet Readiness Review requirements shall subject the Contractor to the remedies in Section 1.25: "Remedies and Disputes" of this Contract.

1.4.9 Response to State Inquiries and Request for Information

The Contractor shall prioritize requests from OHCA to respond to inquiries from any Departments under the State of Oklahoma, the Oklahoma Legislature, or other government agencies or bodies. The

Contractor shall respond to urgent requests from OHCA within twenty-four (24) Hours and according to the guidance and timelines provided by OHCA. The Contractor may be required to participate with and respond to inquiries from a consultant contracted with OHCA.

1.5 Mandatory, Voluntary, and Excluded Populations

1.5.1 Eligibility Determinations

OHCA has sole authority for determining eligibility for SoonerCare and for determining whether an Eligible is able to be enrolled in the SoonerSelect Program. The eligibility and Enrollment process is described in Section 1.6: "Enrollment and Disenrollment" of this Contract.

1.5.2 Mandatory Enrollment Populations

The following Eligibles will be mandatorily enrolled with a CE under the SoonerSelect Program:

a. Expansion Adults;

b. Parents and Caretaker Relatives;

c. Pregnant Women;

d. Deemed Newborns, as per 42 C.F.R. § 435.117;

e. Children; and

f. All other populations requiring mandatory coverage pursuant to 42 C.F.R. Subpart B (§§ 435.100 – 435.172) unless otherwise covered by SoonerCare.

The following Eligibles will be mandatorily enrolled in the SoonerSelect Children's Specialty Program upon entering custody of the State:

a. Foster Care Children (FCC); and

b. Certain children in the custody of OJA.

The following Eligibles will be mandatorily enrolled in the SoonerSelect Children's Specialty Program if they do not make another selection during the initial selection process described in Section 1.6.2.3: "Initial Contractor Selection Process" of this Contract or fail to make an election on the SoonerCare application after initial SoonerSelect Program implementation:

a. Former Foster Care Children (FFCC); and

b. Children Receiving Adoption Assistance (AA).

1.5.3 Voluntary Enrollment Populations

Notwithstanding the requirements outlined in Section 1.5.2: "Mandatory Enrollment Populations" of this Contract, AI/AN Eligibles, except those who are eligible under the aged, blind, and disabled (ABD) population, who are determined eligible for a SoonerCare population will have the option to voluntarily enroll in the SoonerSelect Program through an opt-in process in accordance with 42 C.F.R. § 438.3(d)(2).

1.5.4 Eligibles Opting Out of SoonerSelect Children's Specialty Program

FFCC and Children Receiving assistance shall be enrolled in the SoonerSelect Children's Specialty Program. These Eligibles may opt-out of Enrollment in the SoonerSelect Children's Specialty Program and enroll with a SoonerSelect CE.

1.5.5 Excluded Populations

The following Eligibles will be excluded from Enrollment in SoonerSelect:

a. Dual Eligible Individuals;

b. Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), Qualified Disabled Workers (QDWs) and Qualified Individuals (QIs);

c. Persons with a nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) level of care (LOC), with the exception of Enrollees with a pending level of care determination as described in Section 1.7.6: "Nursing Facility and ICF-IID Stays" of this Contract;

d. Individuals during a period of Presumptive Eligibility;

e. Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;

f. Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;

g. Individuals enrolled in a § 1915(c) Waiver;

h. Undocumented persons eligible for Emergency Services only in accordance with 42 C.F.R. § 435.139;

i. Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI State Plan;

j. Coverage under Title XXI for the benefit of unborn Children ('Soon-to-be-Sooners'), as allowed by 42 C.F.R. § 457.10;

k. Individuals determined eligible for Medicaid on the basis of age, blindness, or disability; and

l. Populations other than those described above that remain enrolled due to the continuous Enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA).

1.5.6 Enrollment Phase-In

OHCA does not anticipate phasing-in Enrollment of the populations in Section 1.5.2: "Mandatory Enrollment Populations" of this Contract. However, OHCA reserves the right to phase-in Enrollment by eligibility category, geographic area or other means if deemed necessary for the successful implementation of the SoonerSelect Program. The Contractor shall cooperate in the implementation of a phase-in schedule, if it is implemented.

1.5.7 Changes in Covered Populations

OHCA reserves the right to enroll Eligibles in a SoonerCare eligibility group outlined in Section 1.5.5: "Excluded Populations" of this Contract into the SoonerSelect Program in future years upon legislative authority. Expansion of enrolled populations would be implemented through the procurement or Contract amendment process and the Contractor would be required to go through the Readiness Review process.

1.6 Enrollment and Disenrollment

1.6.1 Non-Discrimination

Consistent with 42 C.F.R. § 438.3(d), the Contractor may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for Health Care Services or due to an adverse change in the Enrollee's health in Enrollment, Disenrollment, or re-Enrollment.

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

The Contractor shall not request Disenrollment because of a change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued Enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees. The Contractor may only request Disenrollment of the Enrollee in accordance with the provisions outlined in Section 1.6.7.1: "Contractor Request" of this Contract.

1.6.2 Enrollment Process

1.6.2.1 Enrollment Choice Counseling

OHCA, or its designee, will be responsible for educating Eligibles about the SoonerSelect Program and providing unbiased Choice Counseling concerning Enrollment options. Choice Counseling will be available at the time of initial Enrollment, during the annual Open Enrollment Period described in Section 1.6.5: "Annual and Special Enrollment Periods" of this Contract and under the provisions described in Section 1.6.7: "Disenrollment Request Process" of this Contract.

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

1.6.2.2 Materials for Enrollment Choice Counseling

The Contractor shall furnish materials regarding its CE and up-to-date Participating Provider rosters in a manner and on a schedule to be defined by OHCA. Materials must comply with OHCA review and approval process described in Section 1.12.16.4: "OHCA Review and Approval Process" of this Contract, including adherence to allowable and prohibited Marketing and Material requirements. The rosters shall include up-to-date information on whether each Participating Provider has an open or closed panel with respect to accepting new patients. Inaccurate Participating Provider information shall be grounds for consequential or liquidated damages, as described in Section 1.25: "Remedies and Disputes" of this Contract.

The Contractor shall also conduct Marketing and outreach efforts to raise awareness of the SoonerSelect Program and their product, subject to the requirements of Section 1.12.16: "Marketing and Outreach" of this Contract.

1.6.2.3 Initial Contractor Selection Process

OHCA, at its discretion, may allow up to sixty (60) Days for Eligibles to select a CE prior to the Enrollee's start of coverage under the SoonerSelect Program. Subsequent to program implementation, SoonerCare Applicants eligible for the SoonerSelect Program will have an opportunity to select a CE on their application. Eligibles who do not make an election within the allowed timeframe will be assigned to a CE in accordance with the rules outlined in Section 1.6.2.4: "Auto Assignment" of this Contract.

1.6.2.4 Auto Assignment

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

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

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

a. The Contractor's maximum Enrollment has been capped under the terms outlined in Section 1.6.6: "Enrollment Caps" of this Contract and actual Enrollment has reached ninety-five percent (95%) of the cap;

b. The Contractor has been excluded from receiving new Enrollment due to the application of Non-Compliance Remedies, as outlined in Section 1.26.3.4: "Non-Compliance Remedies" of this Contract; or

c. The Contractor has failed to meet Readiness Review requirements.

It is OHCA's intent to modify the assignment algorithm in future Contract Years of the SoonerSelect Program to take into consideration the Contractor's performance on improving health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.2.8: "Amendments or Modifications" of this Contract.

1.6.3 Enrollment Effective Date

Eligibles, with the exception of Deemed Newborns, who select or are assigned to a CE from the first Day of the month through the fifteenth Day of the month shall be enrolled effective on the first Day of the following month. Eligibles who select or are assigned to a CE on the sixteenth Day of the month through the last Day of the month will be enrolled effective on the first Day of the second following month. Prior to these Enrollment Dates, most Eligibles will be covered by a fee-for-service (FFS) payment structure administered by OHCA. Deemed Newborns eligible for the SoonerSelect Program shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect Program.

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

1.6.4 Enrollment Lock-In Period

Enrollees will be permitted to change CEs, without showing cause, during their first ninety (90) Days of Enrollment with the Contractor, or during the ninety (90) Days following the date OHCA sends the Enrollee notice of that Enrollment, whichever is later. Enrollees will also be permitted to change CEs, without cause, at least once every twelve (12) months during the Open Enrollment Period. After the Enrollee's period for Disenrollment from the Contractor has lapsed, Enrollees will remain enrolled with the Contractor until the next annual Open Enrollment Period, unless:

a. The Enrollee is disenrolled due to loss of SoonerCare eligibility;

b. The Enrollee becomes a foster child under custody of the State;

c. The Enrollee becomes Juvenile Justice (JJ) Involved under the custody of the State;

d. The Enrollee is a FFC or Child Receiving AA and opts to enroll in the SoonerSelect Children's Specialty Program;

e. The Enrollee demonstrates cause in accordance with Section 1.6.7.2: "Enrollee Request" of this Contract;

f. A temporary loss of eligibility or Enrollment has caused the Enrollee to miss the annual Disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

g. OHCA imposes Intermediate Sanctions on the Contractor and allows Enrollees to disenroll without cause.

1.6.5 Annual and Special Enrollment Periods

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

Enrollees will be informed that if they do not request a new CE, they will remain in their current CE. All Enrollees, including those who do not make a change, will be permitted to change CE during the first ninety (90) Days of the new Enrollment period in accordance with the process outlined in Section 1.6.4: "Enrollment Lock-In Period" of this Contract.

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

a. In the event of the early termination of a CE under the process described in Section 1.26.1: "Early Termination" of this Contract; or

b. The loss of a major Participating Provider places the Contractor at risk of failing to meet service accessibility standards and the Contractor does not have an acceptable plan for mitigating the loss or finding of non-compliance.

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

1.6.6 Enrollment Caps

OHCA, at its sole discretion, may impose a cap on the Contractor's Enrollment, in response to a request by the Contractor or as part of a corrective action occurring under Section 1.26.3.4: "Non-Compliance Remedies" of this Contract.

1.6.7 Disenrollment Request Process

1.6.7.1 Contractor Request

The Contractor must comply with Section 1.6.1: "Non-Discrimination" of this Contract and seek to disenroll an Enrollee only for good cause in accordance with 42 C.F.R. § 438.56(b)(3). The following actions, if found by OHCA, comprise good cause:

a. Enrollee requires specialized care for a Chronic Condition and the Enrollee or Enrollee's representative, the Contractor, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

b. Enrollee has been enrolled in error, as determined by OHCA;

c. Enrollee has exhibited disruptive behaviors to the extent that the Contractor cannot effectively manage their care, and the Contractor has made all reasonable efforts to accommodate the Enrollee; or

d. Enrollee has committed Fraud, including but not limited to, loaning an identification (ID) card for use by another person.

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

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

1.6.7.2 Enrollee Request

Enrollees shall be permitted to disenroll from the Contractor without cause, in accordance with the provisions of Section 1.6.4: "Enrollment Lock-In Period" of this Contract.

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

a. The Enrollee moves out of the Contractor's service area;

b. The Enrollee requires specialized care for a Chronic Condition and the Enrollee or Enrollee's representative, the Contractor, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

c. Enrollee seeks covered benefits that the Contractor does not cover for moral or religious reasons;

d. Enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the Contractor's Network; and the Enrollee's PCP or another Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

e. Enrollee has filed and prevailed in a Grievance regarding poor quality of care, lack of access to services covered under the Contract, or lack of access to Providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant Disenrollment; or

f. Enrollee has been enrolled in error, as determined by OHCA.

Enrollees shall seek redress through the Contractor's Grievance process before OHCA will make a determination on an Enrollee's request for Disenrollment. The Contractor shall accept Enrollee requests for Disenrollment orally or in writing. The Contractor shall complete a review of the request within ten (10) Days of the Enrollee filing the Grievance. If the Enrollee remains dissatisfied with the result of the Grievance process, the Contractor shall refer the Disenrollment request to OHCA. The Contractor shall send records gathered during the Grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA consistent with Section 1.6.8: "Disenrollment Effective Date" of this Contract.

1.6.7.3 At OHCA's Initiation

OHCA will initiate Disenrollment of Enrollees under the following circumstances:

a. Loss of eligibility for Medicaid;

b. Transition to a SoonerCare eligibility group excluded from the SoonerSelect Program;

c. Enrollee becomes enrolled in Medicare;

d. Death;

e. Enrollee becomes a foster child under the custody of the State;

f. Enrollee becomes JJ Involved under the custody of the State;

g. Enrollee becomes an inmate of a public institution;

h. Enrollee commits Fraud or provides fraudulent information; or

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

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 on the first Day of the second following month. Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to Providers experienced in dealing with the 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.

1.6.9 Enrollee Status Changes

The Contractor shall notify OHCA, in the manner required by OHCA, within five (5) Business Days of learning of any change in an Enrollee's status or circumstances that could affect the Enrollee's eligibility for the SoonerSelect Program.

1.6.10 Retroactive Dual Eligibility

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

1.6.11 Re-enrollment Following Loss of Eligibility

Enrollees who lose and regain eligibility for SoonerSelect Program within a period of sixty (60) Days or less will be re-enrolled automatically with their prior Contractor unless the Contractor is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE in accordance with Section 1.6.4: "Enrollment Lock-In Period" of this Contract.

1.7 Covered Benefits

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

a. SoonerCare-covered benefits which are not covered services through this Contract, as outlined in Section 1.7.4: "Excluded Benefits" of this Contract; and

b. Other benefits an Enrollee receives, regardless of payer, including volunteered services.

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

a. Each service is provided to Enrollees in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services provided under the SoonerCare FFS program;

b. Services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished; and

c. It does not arbitrarily deny or reduce the amount, duration, or scope of a required service on the basis of the diagnosis, type of illness, or condition of the Enrollee. Notwithstanding the foregoing, in accordance with Section 1.8: "Medical Management" of this Contract, the Contractor may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, such as Medical Necessity, or for utilization control, provided the services furnished can reasonably achieve their purpose and services supporting Enrollees with ongoing or Chronic Conditions are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports.

The Contractor shall furnish all Medically Necessary capitated benefits in accordance with applicable OHCA policies and rules in effect at the time of Contract execution, or as updated in accordance with the amendment process outlined in Section 1.2.8: "Amendments or Modifications" of this Contract.

The Contractor may require PA to the extent these are required under OHCA's policies and rules. The Contractor may propose to impose alternative PA requirements, subject to OHCA's review and approval, except for those benefits identified as exempt from PA, as delineated in this section. Contractor may be less restrictive on the requirements of a PA than OHCA but may not impose greater restrictions.

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

1.7.1 Medical and Related Benefits

The Contractor shall ensure that all Medically Necessary covered services are available to Enrollees on a timely basis and that services are consistent with appropriate guidelines, generally accepted practice parameters and Contract requirements.

The Contractor shall furnish the medical and related benefits outlined in the table in Appendix 1G: "Covered Benefits" of this Contract. Annual benefit limits are tracked on a Contract Year basis.

1.7.1.1 Mental Health Parity

In accordance with 42 C.F.R. § 438, Subpart K, the Contractor shall ensure all behavioral health benefits are delivered in compliance with the MHPAEA. This includes, but is not limited to:

a. Ensuring medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits;

b. Ensuring compliance with MHPAEA for any benefits offered by the Contractor to Enrollees beyond those otherwise specified in the Contract;

c. Making the criteria for Medical Necessity determinations for mental health or SUD benefits available to any Eligible, Enrollee or Participating Provider upon request;

d. Providing notice of Adverse Benefit Determinations including the reason for any denial of reimbursement or payment with respect to mental health or SUD benefits to Enrollees;

e. Providing out-of-Network coverage for mental health or SUD benefits when made available for medical and surgical benefits;

f. The Contractor shall not impose an aggregate lifetime or annual dollar limit on mental health or SUD benefits in accordance with 42 C.F.R. § 438.905;

g. Ensuring that any financial requirement or treatment limitation to mental health or SUD benefits in any classification (inpatient, outpatient, emergency care, or Prescription Drugs) is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification in accordance with 42 C.F.R. § 438.910(b)(1);

h. Ensuring any cumulative financial requirements for mental health or SUD benefits in a classification are not accumulating separately from any established medical/surgical benefits in the same classification, in accordance with 42 C.F.R. § 438.910(c)(3);

i. Ensuring that mental health or SUD benefits are provided to the Contractor in every classification of benefits in which medical/surgical benefits are provided, in accordance with 42 C.F.R. § 438.910(b)(2); and

j. Ensuring no non-quantitative treatment limits (NQTLs) are imposed for mental health or SUD benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification, in accordance with 42 C.F.R. § 438.910(d).

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

1.7.1.2 Substance Use Disorder (SUD) Treatment

The Contractor shall work with Providers, facilities, and Enrollees to coordinate care for Enrollees with a SUD and to ensure Enrollees have access to the full continuum of covered services as per the State Plan and the 1115 Institutions for Mental Disease (IMD) Waiver including but not limited to assessment, detoxification, residential treatment, outpatient services, Partial Hospitalization Program (PHP), and medication assisted treatment, as Medically Necessary and appropriate.

1.7.1.3 Behavioral and Physical Health Integration

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

a. Implement validated behavioral health screening tools for PCPs to utilize to determine if further Enrollee assessment for Behavioral Health Services is necessary, including but not limited to, Screening Brief Intervention and Referral to Treatment (SBIRT);

b. Implement a streamlined mechanism for PCPs to refer Enrollees who are screened at risk for a behavioral health need to the appropriate behavioral health Provider for further assessment;

c. Work with PCPs and behavioral health Providers to facilitate a high degree of coordination and communication across disciplines for the benefit of Enrollees;

d. Implement best practices to engage Enrollees and their physical and behavioral health Providers and address barriers to integration;

e. Offer clinical support, such as practice guidelines, consultation with a psychiatrist, or training to Providers treating behavioral health conditions in the primary care setting;

f. Support primary care-based behavioral health for Pediatric populations;

g. Coordinate with OHCA's efforts to integrate behavioral and physical health services, including policies, processes, and initiatives around co-locating Behavioral Health Services in a primary care setting and vice versa;

h. Coordinate management of utilization of Behavioral Health Services with services for physical health, including coordination and notification with inpatient and outpatient service Providers following an emergency department and/or inpatient behavioral health care stay;

i. Promote care that addresses the needs of Enrollees in an integrated manner, with attention to the physical health and chronic disease contributions to behavioral health; and

j. Promote and support efforts of behavioral health Providers to integrate primary care services within specialty behavioral health settings.

1.7.1.4 Medication Assisted Treatment (MAT)

The Contractor shall implement strategies that improve or expand the infrastructure of MAT Providers for opioid use, alcohol dependence, and other SUDs to improve Enrollee access to MAT, particularly in the Rural Areas of the State. Such strategies shall include efforts to improve referral rates of Enrollees to Behavioral Health Services by MAT Providers.

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;

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. Use financial and/or non-financial incentives for Enrollees and Providers;

viii. Develop and utilize strategies for Provider training and education on best-practices and Contractor benefits; and

ix. 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.

1.7.1.6 Behavioral Health Crisis Services

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

a. Crisis responsiveness which includes twenty-four (24 Hours) a day, seven (7) Days a week, three hundred sixty-five (365) Days a year emergency treatment and first response, including, when appropriate, mobile, and community-based response;

b. Provision of or referral to psychiatric, addiction, and other community services, including but not limited to same day outpatient appointments;

c. Crisis care shall be coordinated with the Oklahoma Comprehensive Crisis Response system, a Statewide continuum of crisis response services developed by the ODMHSAS;

d. Services necessary to stabilize in the community any Enrollee experiencing a behavioral health crisis, as defined by the Enrollee, including but not limited to screening, assessment, case management, and peer services. If the Enrollee is unable to safely be stabilized in the community, as determined by screening and assessment, transportation to and services within higher levels of care including Urgent Recovery Centers, Crisis Intervention and Crisis Stabilization Facilities, Inpatient Psychiatric Hospitals, Freestanding Psychiatric Hospitals, and General Hospitals with Psychiatric Units shall be included;

e. Transition and community treatment services for all Enrollees for no less than ninety (90) Days after discharge from Urgent Recovery Centers, Crisis Intervention and Crisis Stabilization

Facilities, and Inpatient Psychiatric Hospitals, Freestanding Psychiatric Hospitals, and General Hospitals with Psychiatric Units;

f. Follow up with any Enrollee seen for or provided with any Emergency Service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) Hours of crisis resolution; and

g. Access to a Behavioral Health Services hotline twenty-four (24) Hours a day, seven (7) Days a week, three hundred sixty-five (365) Days a year in accordance with the requirements of Section 1.12.8.6: "Use of 988 Mental Health Lifeline" of this Contract. The Contractor shall use the established Oklahoma 988 call center vendor network as the solution for meeting the requirement of the Contractor's Behavioral Health Services hotline.

1.7.1.7 1115 IMD Waiver

The Section 1115(a) Institutions for Mental Disease (IMD) Waiver for Serious Mental Illness (SMI)/Substance Use Disorder (SUD) demonstration provides authority to reimburse Medically Necessary residential SUD treatment, facility-based crisis stabilization, and inpatient treatment services within settings that qualify as IMDs.

The Contractor shall comply with all the 1115 IMD SMI/SUD demonstration waiver's special terms and conditions. This includes, but is not limited to:

a. Complying with the requirements of the SMI and SUD Implementation Plan Protocols;

b. Coordinating with OHCA in implementing all required components of the waiver health information technology (HIT) plans;

c. Submitting to OHCA all data and reports necessary to fulfill OHCA's waiver reporting obligations to CMS;

d. Complying with OHCA directives regarding implementation of a value-based payment (VBP) structure for Medicaid-enrolled residential SUD Providers;

e. Developing methods, in accordance with the requirements to be issued by OHCA, to track if Participating Providers are accepting new SoonerCare patients for purposes of OHCA completion of the CMS-required mental health availability assessment;

f. Developing methods, in accordance with the requirements to be issued by OHCA, to track Enrollees' visits to the emergency department related to SMI/SUD/Serious Emotional Disturbance (SED) and follow up efforts made with the Enrollee within seven (7) Days and thirty (30) Days post discharge from the emergency department;

g. Authorizing and reimbursing for acute inpatient psychiatric stays in an IMD for no more than sixty (60) consecutive Days per episode of care;

h. Authorizing and reimbursing for residential SUD stays and ensuring that the Statewide aggregate average length of stay remains at or below thirty (30) consecutive Days per episode of care; and

i. Reimbursing qualified residential treatment programs (QRTPs) upon implementation of such programs.

1.7.2 Pharmacy Program

1.7.2.1 Pharmacy Services

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

All SoonerSelect Program CEs, including the Contractor, shall be required to use a uniform Preferred Drug List (PDL) and open drug formulary, which shall be developed by OHCA. This common list of covered drugs includes preferred brands as indicated by their placement in lower tiers of tiered therapeutic categories. The CEs, including the Contractor, shall not put in place or implement any product coverage criteria outside of what OHCA has developed, including products that are covered without criteria. Notwithstanding the foregoing sentence, the Contractor may seek OHCA approval for a Value-Added Benefit that extends, eliminates, or otherwise modifies the six (6) prescription OHCA limit.

The Contractor must post the list of covered drugs, noting covered generic and name brand medications and what tier each medication is on, on its website and post coverage information with a formulary listing service or electronic prescribing service.

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

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

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

If a drug product can either reasonably be dispensed by a pharmacy or administered by a health care practitioner, the Contractor shall follow the SoonerCare pharmacy program policy by making the drug product available through both settings. The Contractor must follow OHCA's processing procedure for physician-administered drugs either through the medical claims process or through the pharmacy claims process.

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

1.7.2.2 Physician Administered Drugs

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

1.7.2.3 Participation in DUR Board and Clinical Meetings

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

1.7.2.4 Pharmacy Benefit Management Services

1.7.2.4.1 General

If the Contractor utilizes a PBM or PBA, the Contractor shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with any affiliated pharmacy Providers, monitor PBM or PBA performance and ensure the confidentiality of Enrollee information and State information that is not public. These policies shall be submitted to OHCA for review and approval during the Readiness Review.

1.7.2.4.2 Data Sharing

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

1.7.2.4.3 Pharmacy Benefit Financial Disclosures

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

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

1.7.2.4.4 Rebates and Financial Reports

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

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

As required in 42 C.F.R. § 438.3(s)(3) and as defined in Section 1927 of The Act, the Contractor or their Subcontractor shall establish procedures, to be approved by OHCA, to ensure that covered outpatient drugs dispensed to Enrollees will not be subject to discounts under the 340B drug pricing program, which would exclude rebate submission from federal and State supplemental rebate programs. OHCA is excluding the Contractor or their Subcontractor from reimbursing Providers at the 340B ceiling price when dispensing covered outpatient drugs purchased under the 340B drug pricing program to their Enrollees. OHCA retains all rights to rebates and discounts for covered outpatient drugs, including but not limited to, federal and supplemental rebates.

1.7.2.4.5 Drug Utilization Review

The Contractor shall have policies and procedures that subject the utilization of Prescription Drugs to prospective and retrospective review. The Contractor shall operate a drug utilization program that complies with 42 C.F.R. § 438.3(s)(4) requirements described in Section 1927(g) of The Act, Subpart K of

42 C.F.R. Part 456, Omnibus Budget Reconciliation Act (OBRA) 1990 and OBRA 1993, and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act or the SUPPORT for Patients and Communities Act if such requirement applies to the Contractor. The program policies and all program materials shall be submitted to OHCA for review and approval prior to implementation by the Contractor or its PBM.

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

a. Drug-disease contraindications;

b. Drug-drug interactions;

c. Dosage appropriateness;

d. Inappropriate duration of treatment;

e. Drug-to-drug interactions;

f. Clinical Abuse indicators;

g. Drug-pregnancy precautions;

h. Over or underutilization;

i. Drug-age precautions;

j. Duplicative prescriptions or therapies;

k. Excessive or low dosages;

l. Maximum daily morphine milligram equivalents (MME) on opioids, currently set at ninety (90) MMEs, or as otherwise defined by OHCA; and

m. Safety edits for opioid prescriptions as defined by OHCA.

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

Retrospective review shall review for, at a minimum Fraud, Abuse, gross overuse, including potential Fraud or Abuse of opiates and controlled substances, inappropriate utilization, inappropriate or medically unnecessary care, duplicative therapies, or prescribing or billing practices that indicate Abuse or excessive utilization. As required by the SUPPORT for Patients and Communities Act, retrospective DUR program shall also include review of concurrent use of opiates and benzodiazepines, opiates and antipsychotics, and a review of the appropriateness of antipsychotic Agents for all Children under eighteen (18), including FCC based on approved indications and guidelines. Pharmacies and prescribing Providers shall be contacted about aberrant drug use patterns, and the Contractor or their Subcontractor will report on program outcomes on a quarterly basis as specified in the Reporting Manual. The Contractor or their Subcontractor will be responsible for coordinating with the State to

identify retroDUR initiatives, perform data-mining and analysis, producing and mailing letters or otherwise delivering correspondence, and measuring and reporting on results.

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

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

1.7.3 Lock-In Program

In accordance with 42 C.F.R. § 431.54(e), the Contractor shall have a pharmacy lock-in program that promotes appropriate utilization of health care resources by monitoring potential abuse or inappropriate utilization of prescription medications. The Contractor shall have a pharmacist on staff to oversee the lock-in program. The Contractor shall develop lock-in criteria as well as policies and procedures for lock-in program referrals, interventions, monitoring, reporting and exceptions for Emergency Services; these shall be reviewed and approved by OHCA prior to adoption and implementation. Enrollees may be enrolled in the lock-in program for a minimum of two (2) years and re-evaluated regularly (at least annually). Enrollees may change their lock-in pharmacy or prescriber no more than once per year except in extenuating circumstances.

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

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

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

The Contractor shall place in its lock-in program any Enrollees who were in a lock-in program within FFS Medicaid or another CE at the time of Enrollment with the Contractor.

1.7.4 Excluded Benefits

Dental services, except for Dental Related Emergency Services in the inpatient, outpatient, and ambulatory surgery center settings, will be reimbursed by OHCA outside of the Contractor's capitation and delivered through the SoonerSelect Dental program. Additionally, in accordance with Section 1.17.4.3: "IHCP Payments" of this Contract, the Contractor shall not be financially responsible for services rendered by IHCPs that are eligible for one hundred percent (100%) federal funding.

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.

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;

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.

1.7.6 Nursing Facility and ICF-IID Stays

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

1.7.7 Non-Emergency Medical Transportation (NEMT)

1.7.7.1 Handling Enrollee Requests for NEMT

The Contractor shall operate a reservation system for Enrollees to schedule NEMT services via the following modes, at minimum:

a. Toll-free telephone line;

b. Email; and

c. Website.

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

1.7.7.2 NEMT Covered Services

The Contractor shall provide NEMT to Enrollees to access all SoonerCare covered services in accordance with 42 C.F.R. § 440.170. The Contractor is also required to ensure necessary transportation and to use the most appropriate form of transportation for the Enrollee and provide assistance with transportation to Children and their families as part of Medicaid's EPSDT benefit. This includes all benefits for which the Contractor is responsible, as well as benefits which are covered by SoonerCare but not the responsibility of the Contractor as outlined in Section 1.7.4: "Excluded Benefits" of this Contract. The Contractor, at its sole discretion, may offer additional NEMT services as a Value-Added Benefit.

1.7.7.3 NEMT Scheduling Timeframes

The Contractor shall require an Enrollee to request NEMT for routine non-emergency appointment no more than seventy-two (72) Hours prior to the appointment, excluding weekends and State Holidays.

The Contractor shall develop policies and procedures to make exceptions to the seventy-two (72) Hour advance notice requirement under the minimum following circumstances:

a. Urgent Care – Medical or behavioral health care provided for illnesses, injuries, or conditions which are not life-threatening but require prompt treatment that cannot wait for routine care by a regularly scheduled clinical appointment because of the prospect of the condition worsening without timely medical or behavioral health intervention;

b. Recently-scheduled Appointments – The appointment was scheduled within seventy-two (72) Hours of the visit;

c. Follow-up Appointments – The Enrollee must be seen that day or the following day;

d. Hospital and Inpatient Mental Health Discharges;

e. Standing Appointment Orders – The Contractor shall establish procedures to handle trip requests so that Enrollees are not required to continually make arrangements for standing appointments;

f. Residential SUD Treatment – Within twenty-four (24) Hours of identifying a receiving facility;

g. Psychiatric Residential Treatment Facility (PRTF) admissions; and

h. Inpatient Psychiatric Mental Health Acute Level II admissions.

1.7.7.4 NEMT Modes of Transportation

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

a. Stretcher Van - A van or similar vehicle that has been modified, converted, and equipped to safely transport Enrollees on one (1) of two (2) types of certified stretchers. Enrollees who must travel in a prone position and who do not need any type of medical care or monitoring are transported on a stretcher to Medicaid covered services. Ambulances may be used to provide this level of service.

b. Wheelchair Van - A motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs, or other mobility devices. Wheelchair van services are used for Enrollees who can sit upright and have no acute medical problems that require the Enrollee to remain in a lying position, and by Enrollees who use a mobility device. The vehicle is configured with side or rear entry and has a ramp or certified motorized lift to load Enrollees

c. Ambulatory - A vehicle used for transportation of Enrollees whose medical condition does not require use of a wheelchair, hydraulic lift, or stretcher. Ride sharing may be used to provide this level of service.

d. Volunteer Driver - Community organizations that provide transportation services for which mileage reimbursement is available.

e. Personal Vehicle and Mileage Reimbursement - Mileage reimbursement is available for Enrollees to travel roundtrip from their residence to their medical appointments(s) using a personal vehicle.

f. Mass Transit - Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule and does not deviate from the route or the schedule. Passengers are picked up at designated stops. The Contractor shall only schedule mass transit (bus passes) for Enrollees who meet the following criteria:

   i. Reside within one quarter (1/4) of a mile distance from a public transportation stop;

   ii. Plan to use a bus line that is operational on the day and/or time of appointment;

   iii. Are going to a facility or Provider within three-fourths of a mile from the transportation stop;

   iv. Are not requesting transport for surgical/sedation procedures;

   v. Are not going to dialysis; or

   vi. Mass transit is also not suitable for any Enrollee under care for a high-risk pregnancy, is in the third trimester of pregnancy, is within six (6) weeks post-partum, or has mobility issues precluding use of mass transit.

1.7.7.5 NEMT Pick-Up and Drop-Off Times

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

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

If a return pick-up was not scheduled, the Contractor must ensure that the driver arrives within one (1) Hour from notification. If a delay prevents the driver from picking up the Enrollee within the one (1) Hour time frame, the Contractor or transportation Provider must contact riders at their pick-up points to inform them of the delay in arrival of vehicle and related schedule. The Contractor or transportation Provider must advise scheduled riders of alternate pickup arrangements when appropriate.

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

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

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

1.7.8 Referrals

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

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

If the Contractor has exhausted all in-State options and demonstrated that a Medically Necessary service is unavailable within the State, the Contractor shall provide for these services through out-of-State Providers in accordance with OAC 317:30-3-89 – OAC 317:30-3-92 and as per Section 1.7.20: “Out-of-State Services” of this Contract. The Contractor shall facilitate such referrals as appropriate.

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

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

a. Behavioral Health Services, including SUD treatment;

b. Vision services;

c. Emergency Services;

d. Family Planning Services and Supplies;

e. Prenatal care;

f. Department of Health Providers, including mobile clinics; and

g. Services provided by IHCPs to AI/AN Enrollees.

1.7.9 In Lieu of Services

In accordance with 42 C.F.R. § 438.3(e)(2), the Contractor may provide, at its option, services or settings that are in lieu of services or settings covered under the State Plan if:

a. The Contractor has proposed any in lieu of services or settings in its response to the Solicitation and OHCA determines that the proposal is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan; and

b. The Enrollee is not required by the Contractor to use the alternative service or setting.

In lieu of services, if approved by OHCA, may be included in determining the Contractor's Capitation Rates. The Contractor must report Encounter Data related to approved in lieu of services, and such Encounter Data may be used in rate-setting activities. The approved in lieu of services shall be identified and incorporated into the Contract.

1.7.10 Value-Added Benefits

The Contractor may offer Value-Added Benefits in addition to the capitated benefit package to support the health, wellness, and independence of Enrollees and to advance the State's objectives for the SoonerSelect Program. The Contractor shall report information on Value-Added Benefits to OHCA as specified in the Reporting Manual. This may include, but is not limited to vision, DME, transportation, pharmacy, and Physician Services for Enrollees in excess of FFS program limits. Value-Added Benefits may include more lenient utilization standards than OHCA uses (such as allowance to exceed the prescription per month limit) so long as any such lenience is documented, provided to all eligible Enrollees, and included in the Contractor's mental health parity analysis.

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

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

For each Value-Added Benefit proposed or revised, the Contractor must:

a. Define and describe the Value-Added Benefit, including the rationale for adding or revising;

b. Specify the applicable service areas for the proposed Value-Added Benefit;

c. Identify the category, group, or Enrollees eligible to receive the proposed Value-Added Benefit if it is a type of service that is not appropriate for all Enrollees;

d. Note any limitations or restrictions that apply to the Value-Added Benefit; and

e. Describe if, and how, the Contractor will identify the Value-Added Benefit in the Encounter Data.

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

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

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

a. Educating Enrollees and their caregivers on the value of preventive health care, benefits provided as part of EPSDT, and how to access EPSDT services;

b. Providing notification to Enrollees under age twenty-one (21) when appropriate periodic assessments or needed services are due and coordinating appointments for care;

c. Tracking Enrollee compliance with the EPSDT periodicity and screening schedule and providing outreach when missed appointments are identified; and

d. Providing PCPs, on a quarterly basis, a list of Enrollees who have not complied with the EPSDT periodicity requirements, for the purpose of outreach by PCPs to Enrollees. PCPs are expected to use the list provided to increase Enrollees visits and compliance with EPSDT screenings/compliance.

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

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.

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.

1.7.13 Advance Directives

The Contractor shall develop and maintain written policies and procedures for Advance Directives, such as a living will or durable power of attorney for health care as recognized under Oklahoma law. These policies and procedures shall comply with all State and federal requirements, including but not limited to 42 C.F.R. §§ 422.128, 438.3(j)(1) - (j)(4), Subpart I of 42 C.F.R. Part 489, and 63 O.S. §§ 3101.1 through 3101.16, 3102.1 through 3102.5, 3102A, and 3111.1 through 3111.13. Any and all changes in State law

as they pertain to Advance Directives must be incorporated into the written policies and procedures within thirty (30) Days of the change and must then subsequently be submitted to OHCA for approval.

Pursuant to 42 C.F.R. §§ 438.3(j)(3)-(4) and 63 O.S. 63 §§ 3101, *et seq*., the Contractor shall provide adult Enrollees with written information on Advance Directives policies at the time of initial Enrollment, as required under OAC 317:30-3-13(a)(2) and including a description of applicable State law. The format of the Advance Directive will follow State requirements in 63 O.S. § 3101.4 and the format of the Health Care Power of Attorney will follow 63 O.S. § 3111.5.

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

a. Clarifying any differences between institution-wide conscience objections and those that may be raised by individual physicians;

b. Identifying the State legal authority permitting such objection; and

c. Describing the range of medical conditions or procedures affected by the conscience objection.

In accordance with OAC 317:30-3-13(a)(3)), Advance Directives shall be incorporated into the Enrollee's Case File within the Care Management system as well as the Enrollee's medical records, as applicable. The Advance Directive becomes operative when it is communicated to the attending physician and the Enrollee is no longer able to make decisions regarding administrative of life sustaining treatment, in accordance with 63 O.S. § 3101.5. The Health Care Power of Attorney becomes effective when the attending physician determines that the Enrollee is no longer able to make their own health care decisions, unless the Enrollee elected to have the Agent's authority take effect upon execution of the Health Care Power of Attorney, in accordance with 60 O.S. § 3111.5. Revocation of an Advance Directive may happen at any time by the Enrollee, without regard to their medical or mental health, in accordance with 63 O.S. § 3101.6, and the following:

a. If the Enrollee is pregnant and the physician is aware, the pregnant patient is to be provided with life-sustaining treatment unless the patient has specifically authorized to withhold treatment during the course of pregnancy, pursuant to 63 O.S. § 3101.8.

b. If a physician is unable or unwilling to provide care as per the Advance Directive (63 O.S. § 3101.9), the Contractor will process the information. The physician will transfer care of patient to another physician to comply with medical decisions of the patient. The original physician must comply with the Enrollee's Advance Directives during the transfer process, if the Enrollee may die, unless the Provider is physically or legally unable to provide without thereby denying the same treatment to another patient.

c. An Advance Directive from another state is valid to the extent that it does not exceed authorizations allowed under Oklahoma laws. It must have been executed by the individual the directive applies to and it must specifically authorize withholding/withdrawal of artificial nutrition/hydration and be signed, pursuant to 63 O.S. § 3101.14.

An Enrollee may revoke a Health Care Power of Attorney at any time by a signed writing or by personally informing the health care provider at any time and in any manner that communicates an intent to revoke. 63 O.S. § 3111.4.

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

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

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

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

1.7.14 Organ Transplants

The Contractor shall have written standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Enrollees in accordance with Section 1903(i) of The Act (Refer to the Oklahoma State Plan at Attachment 3.1-E, Page 1).

1.7.15 Prohibited Payments

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

a. Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) of The Act;

b. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Title V, XVIII, or XX or under this Title pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) or The Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

c. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of Fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

d. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997; and

e. With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

1.7.16 Emergency and Post-Stabilization Services

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

1.7.16.1 Emergency Services

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

a. Pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid program;

b. Cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Contractor;

c. Not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

d. Not deny payment for treatment obtained when a representative of the Contractor instructs the Enrollee to seek Emergency Services; and

e. Provide coverage and payment for services until the attending emergency physician, or the Provider actually treating the Enrollee, determines that the Enrollee is sufficiently stabilized for transfer or discharge.

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

a. Limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms;

b. Refuse to cover Emergency Services based on the emergency room Provider, hospital, or fiscal Agent not notifying the Enrollee's PCP or the Contractor, or applicable State entity of the Enrollee's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services; and

c. Hold an Enrollee who has had an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition.

With regard to emergent Behavioral Health Services, the Contractor shall:

a. Pay Non-Participating Providers for emergent Behavioral Health Services no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid program;

b. Not deny payment for treatment obtained when an Enrollee is experiencing a Behavioral Health Emergency or seeks crisis services or services necessary to stabilize in the community any Enrollee experiencing a behavioral health crisis, as defined by the Enrollee, including but not limited to screening, assessment, case management, and peer services;

c. Hold an Enrollee who has had a behavioral health crisis liable for payment of subsequent screening and treatment needed to diagnose or stabilize the condition;

d. Not deny payment for treatment obtained when a representative of the Contractor instructs the Enrollee to seek emergent Behavioral Health Services; and

e. Provide coverage and payment for services until the attending emergency physician, or the Provider actually treating the Enrollee, determines that the Enrollee is sufficiently stabilized for transfer or discharge.

1.7.16.2 Post-Stabilization Services

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

a. Obtained within or outside the Contractor Network that are:

   i. Pre-approved by a Contractor Provider or representative; or

   ii. Not pre-approved by a Contractor Provider or representative but administered to maintain the Enrollee's stabilized condition within one (1) Hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services;

b. Administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within the Contractor Network when the Contractor:

   i. Did not respond to a request for pre-approval within one (1) Hour;

   ii. Could not be contacted; or

   iii. Representative and the treating physician could not reach agreement concerning the Enrollee's care and a Contractor physician was not available for consultation.

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

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

a. A Contractor physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

b. A Contractor physician assumes responsibility for the Enrollee's care through transfer;

c. A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or

d. The Enrollee is discharged.

1.7.17 Family Planning

In accordance with Section 1902(a)(23) of The Act and 42 C.F.R. § 431.51(b)(2), the Contractor shall not restrict the Enrollee's free choice of Family Planning Services and Supplies Providers and shall provide all family planning benefits in accordance with OHCA's policies and rules and 42 C.F.R. § 438.210(A)(4)(ii)(C).

1.7.18 Abortions

In accordance with 42 C.F.R. §§ 441.202, 441.203, and 441.206, the Consolidated Appropriations Act of 2008, and Oklahoma law, to include 63 O.S. §§ 1-730, 1-731.4, 1-745.13, 1-745.35, and 1-745.51, the Contractor shall only cover Enrollee abortion services to save the life of a pregnant woman in a medical emergency.

1.7.19 Delivery Network

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

a. If a female Enrollee's designated PCP is not a women's health Specialist, the Contractor shall provide the Enrollee with direct access to a women's health Specialist within the Provider Network for covered routine and preventive women's Health Care Services, in accordance with 42 C.F.R. § 438.206(b)(2);

b. The Contractor shall provide for a second opinion from a Participating Provider or arrange for the Enrollee to obtain a second opinion outside the Network, at no cost to the Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3); or

c. If the Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover the services

out of Network, for as long as the Contractor's Provider Network is unable to provide them, in accordance with 42 C.F.R. § 438.206(b)(4).

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

1.7.20 Out-of-State Services

Consistent with 42 C.F.R. § 431.52 and OAC 317:30-3-90, the Enrollee may travel to a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma State border to receive services covered under this Contract. Reimbursement for covered services furnished in another state is available to the extent reimbursement for covered services are furnished within Oklahoma boundaries. The services being rendered must be provided by a Provider who is contracted with OHCA and must be appropriately licensed and in good standing with the state in which they practice.

1.7.21 Moral Objections

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

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.

1.8 Medical Management

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

a. Is no more restrictive than that used in the Oklahoma Medicaid program, including quantitative and NQTLs, as indicated in State statutes and regulations, the Oklahoma Medicaid State Plan, and other State policies and procedures;

b. Addresses the prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;

c. Allows Enrollees to achieve age-appropriate growth and development; and

d. Allows Enrollees the ability to attain, maintain or regain functional capacity.

1.8.1 Medically Necessary Services

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

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

1.8.2 Medical Necessity Criteria

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

1.8.3 Medical Management Program Components

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

The Medical Management Program must include:

a. PA (pursuant to 56 O.S. § 4002.6);

b. Concurrent review;

c. Pre-admission criteria for non-emergency admissions;

d. Admission review for urgent/emergent admissions on a retroactive basis where necessary;

e. Restrictions against requiring pre-admission certification for admissions for the routine delivery of Children;

f. Prospective review of same day surgery procedures; and

g. Identification and management of emergency department utilization data.

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

1.8.4 Qualified Staff

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

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

The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to Providers' requests for health care or PAs for the Contractor's Enrollees. UM staff shall receive ongoing training regarding interpretation and application of the UM guidelines. The Contractor shall prepare a written training plan with a prospective training calendar. Contractor shall maintain a contemporaneous training log with dates, subject matter, materials, trainers, and attendees. The Contractor shall be prepared to provide upon OHCA request:

a. A written training plan inclusive of dates and subject matter;

b. Training materials; and

c. Oversight and monitoring materials including an Inter-Rater Reliability Report.

The Inter-Rater Reliability Report requires the following documentation on a semi-annual basis:

a. Inter-rater reliability activities;

b. Staff monitoring protocols;

c. Monitoring results; and

d. Staff remediation and training.

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

1.8.5 Clinical Practice Guidelines

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

a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

b. Consider the needs of Enrollees in each of the eligibility groups enrolled with the Contractor;

c. Are adopted in consultation with Participating Providers; and

d. Are reviewed and updated as needed, or at least every two (2) years.

The Contractor shall ensure decisions regarding UM, Enrollee education, coverage of services, and other areas to which practice guidelines apply, are consistent with the practice guidelines. The Contractor shall coordinate the development of Clinical Practice Guidelines with other CEs to avoid the possibility that Providers receive conflicting Clinical Practice Guidelines from different CEs. The Contractor shall disseminate Clinical Practice Guidelines to all affected Participating Providers and, upon request, to Enrollees or Eligibles. The Contractor shall include the Clinical Practice Guidelines within Provider Agreements and measure Provider Compliance with the Clinical Practice Guidelines.

1.8.6 Authorization Process

The Contractor shall develop a PA process pursuant to 56 O.S. § 4002.6 as part of the Medical Management Program that comports with all State and federal requirements, including requirements for parity in mental health and SUD benefits in 42 C.F.R. § 438.910(d). In accordance with 42 C.F.R. § 438.210(b), the Contractor and any applicable Subcontractors shall have in place and follow written policies and procedures for processing requests for initial and continuing authorizations of services. The Contractor's PA process shall also put in place mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the Provider that requested the services when appropriate.

The Contractor shall provide information sufficient for OHCA to comply with its statutory responsibilities under 63 O.S. §§ 2560 – 2565, in the manner and format required in the Reporting Manual.

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

The Contractor shall implement plans and processes to monitor PA requests and denials. The Contractor shall use this information to identify strategies in the annual Medical Management workplan, policies and evaluation and available to OHCA upon request to address over- and under-utilization of services and sharing monitoring and strategies.

1.8.6.1 Services Requiring PA

The Contractor may require PA to the extent required under OHCA's policies and rules, CE operational manual, and/or Readiness Review requirements and may propose additional PA requirements, subject to OHCA review and approval. In accordance with 42 C.F.R. § 438.208(c)(4), for Enrollees with Special Health Care Needs, the Contractor shall have a mechanism in place to allow Enrollees to directly access a Specialist as appropriate for the Enrollee's condition and identified needs.

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

a. Crisis services;

b. Medication assisted treatment (MAT);

c. Programs for Assertive Community Treatment (PACTs); or

d. Urgent services.

1.8.6.2 Methods of PA Submission

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

For any Prescription Drugs, including drugs newly added to OHCA's covered drugs list, that OHCA requires to be prior authorized, the Contractor may, with OHCA prior approval, use or accept non-OHCA-standardized PA request forms or electronic processes in the operation of the Contractor's Medical Management Program so long as the forms or processes establish the exact same criteria and requirements as the OHCA-standardized form.

If phone requests are allowed, those requests shall be handled by the Contractor's toll-free Provider services call center, as described in Section 1.15.2: "Provider Services Call Center" of this Contract, or a dedicated toll-free authorization line. The line shall be equipped to respond to Urgent Care PA requests on a twenty-four (24) Hour, seven (7) Days per week basis. If an Urgent Care PA request must be recorded by a voice mail system due to capacity issues, that phone call must be returned within thirty (30) minutes and a decision rendered within one (1) Hour.

The authorization line or Provider services call center shall be equipped after regular Business Hours to field calls from Providers treating Enrollees with Urgent Care needs. Should a Provider determine that an Enrollee needs a prompt referral to a Specialist, call center policies and procedures shall be able to allow that prompt referral if necessary. All calls regarding Urgent Care situations shall be returned within thirty (30) minutes.

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 (24) Hours after receipt of the request for service. Notwithstanding the foregoing, all inpatient behavioral health PA requests must be decided within twenty-four (24) Hours.

If the Enrollee, or Provider on behalf of the Enrollee in the case of standard authorizations, requests the extension or if the Contractor can justify to OHCA the need for additional information and show that the extension is in the Enrollee's best interest, the Contractor may have an extension of up to fourteen (14) Days and at least forty-eight (48) Hours 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.

1.8.6.4 Prior Authorization Approval Notices

When the Contractor denies a PA request or authorizes services in an amount, duration or scope less than requested, the Contractor shall send a notice in accordance with Section 1.18.6: "Adverse Benefit Determinations" of this Contract. The Contractor shall also provide written notification to Enrollees and Providers when a service request is authorized.

1.8.6.5 Concurrent Review

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

1.8.6.6 Retrospective Review

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

The Contractor shall ensure the retrospective review process evaluates suspended claims within fourteen (14) Days or sooner, if feasible, and shall deliver the decision on coverage to the Provider no later than the next Business Day after a decision is reached.

1.8.6.7 Authorization Denials and Peer-to-Peer Review

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

The Contractor shall permit Providers to request a peer-to-peer review process for all PA denials or authorizations in an amount, duration, or scope less than requested. The Contractor shall provide a prompt opportunity for peer-to-peer conversations with licensed clinical staff of the same or similar specialty which shall include, but not be limited to, Oklahoma-licensed clinical staff upon Adverse Determination; and establish uniform rules for Medicaid Provider or Enrollee Appeals across all CEs in accordance with 56 O.S. § 4002.6(J)(2) as per the methodology described in Section 1.18.6: "Adverse Benefit Determinations."

1.8.6.8 Emergency Room (ER) Utilization

The Contractor shall continuously review ER utilization data of all Enrollees with the goal of identifying unnecessary or extraneous usage. The Contractor shall report to OHCA, every six (6) months, or as otherwise required in the Reporting Manual, on its ER UM activities and evaluation in a format to be specified by OHCA. For Enrollees whose utilization exceeds the threshold of ER visits defined by OHCA, the Contractor shall have procedures in place to conduct the appropriate follow-up. Appropriate follow up includes:

a. Enrollee outreach (telephonic or mail);

b. Appointment assistance with PCP or Specialist;

c. Enrollee education; and

d. Referral to Care Management.

The Contractor shall work with an Enrollee in concert with their Care Manager and Provider to reduce ER utilization. The Contractor shall ensure that appropriate and timely updates are made to the Enrollee's Care Plan, as applicable, as part of the ER utilization process.

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

1.8.6.9 Outpatient Drug Authorization Decisions

The Contractor shall develop medical management policies for the pharmacy benefit. These policies shall adhere to the requirements and regulations outlined below and in Section 1.7.2: "Pharmacy Program" of this Contract. Any PA program will adhere to the requirements of Section 1927(d)(5) of The Act and in accordance with 42 C.F.R § 438.210(d)(3) and 42 C.F.R. § 438.3(s)(6), including requirements related to provision of notices.

The Contractor shall only require PA for prescription drugs that are required to be prior authorized by OHCA, including new drugs added to OHCA list of covered drugs in accordance with the provisions in

Section 1.7.2: “Pharmacy Program.” The Contractor or their Subcontractor shall utilize the criteria established by the OHCA Drug Utilization Review Board for medication PA determinations. Any step therapy limitations or requirements shall adhere to the requirements of 63 O.S. § 7310. Quantity limits shall not exceed those established by OHCA.

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

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

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

1.9 Care Management and Population Health

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

a. Opioid and other SUDs;

b. Tobacco cessation;

c. Childhood obesity;

d. Behavioral health;

e. Diabetes;

f. Cardiovascular disease;

g. Prenatal care and post-partum outcomes;

h. Children receiving private duty nursing services;

i. Children in out of home placements;

j. Access to preventive health services;

k. Enrollee health literacy; and

l. Other emerging health trends among the SoonerCare population at the direction of OHCA or identification by the Contractor.

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

a. Initial Health Risk Screening as described in Section 1.9.2: "Health Risk Screening" of this Contract;

b. Comprehensive Assessment as described in Section 1.9.3: "Comprehensive Assessment" of this Contract;

c. Predictive modeling;

d. Claims review;

e. Enrollee and caregiver requests; and

f. Physician referrals.

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

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

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

a. Acuity of any diagnosed health conditions;

b. Behavioral health diagnoses;

c. SUD diagnoses;

d. Pregnancy status and maternal risk factors;

e. Inpatient or emergency department utilization; and

f. Social Determinants of Health.

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

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

1.9.1 Social Determinants of Health

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

a. Incorporating relevant questions in the Health Risk Screening tool and Comprehensive Assessment as described in Section 1.9: "Care Management and Population Health" of this Contract;

b. Providing Enrollees with referrals to social services based on assessed need;

c. Tracking and reporting the outcomes of referrals to social services;

d. Partnering with community-based organizations or social service Providers; and

e. Employing or partnering with community health workers or other non-traditional health workers to further address Enrollee Social Determinants of Health.

1.9.2 Health Risk Screening

In accordance with 42 C.F.R. § 438.208(b)(3) and the requirements of this section, the Contractor shall demonstrate a good faith effort to perform a Health Risk Screening on all new Enrollees in accordance with the timeline requirements in Section 1.9.2.3: "Timeline for Completion" of this Contract and make subsequent attempts to conduct the Health Risk Screening if the initial attempt to contact the Enrollee is unsuccessful, in accordance with Section 1.9.2.2: "Methods of Completion" of this Contract. The purpose of the Health Risk Screening is to obtain basic health and demographic information, identify any immediate Enrollee needs and to assist the Contractor in assigning the Enrollee to services in accordance with the Contractor's Risk Stratification Level Framework.

1.9.2.1 Screening Tool

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

a. Demographic information for verification purposes;

b. Current and past physical health and behavioral health conditions;

c. Identifying Enrollees with Special Health Care Needs and specialized treatment or equipment;

d. Services or treatment the Enrollee is currently receiving, including from out-of-State Providers;

e. Pending physical health and behavioral health procedures, including services that may have been authorized by OHCA or another CE;

f. Most recent ER visit, Hospitalization, physical exam, and medical appointments;

g. Current medications; and

h. Questions to address Social Determinants of Health, including food, shelter, transportation, utilities, and personal safety.

The Contractor must submit for OHCA review and approval any proposed changes to its Health Risk Screening tool at least forty-five (45) Days prior to its intended use.

1.9.2.2 Methods of Completion

The Contractor shall propose, for OHCA review and approval, its methodology for contacting Enrollees to complete the Health Risk Screening. At minimum, the Contractor's methodology shall include three outreach attempts and other methods to maximize contact with Enrollees in order to complete the Health Risk Screening. The Contractor may permit Enrollees to complete the Health Risk Screening in person, by phone, electronically through the secure portal described in Section 1.12.7.3: "Enrollee Website Portal" of this Contract, or by mail. The Contractor shall document all outreach attempts and make the documentation available to OHCA upon request.

1.9.2.3 Timeline for Completion

During Initial Program Implementation, the Contractor shall perform the Health Risk Screening within ninety (90) Days of a new Enrollee's Enrollment effective date. During Steady State Operations, the Contractor shall perform the Health Risk Screening within thirty (30) Days following the new Enrollee's Enrollment effective date. For purposes of this requirement, a new Enrollee is one that has not been enrolled with the Contractor during the prior twelve (12) months.

1.9.2.4 Screening Updates

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

1.9.2.5 Submission of Screening Results to OHCA

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

1.9.3 Comprehensive Assessment

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

In accordance with 42 C.F.R. § 438.208(c)(1) and 438.208(c)(2), the Comprehensive Assessment will serve as a mechanism to comprehensively assess each Enrollee identified as having a need for Long-Term Services and Supports (LTSS) or Special Health Care Needs to identify any ongoing special condition(s) of the Enrollee that require a course of treatment or regular care monitoring. The Contractor shall notify OHCA of the Enrollees who have been identified as having a need for LTSS.

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

a. Demographic intake;

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

c. Functional or adaptive deficits/needs (e.g., ADLs, IADLs);

d. Behavioral health, including previous psychiatric, addictions and/or substance abuse history, and a behavioral health, depression, and substance abuse screen;

e. Medical conditions, complications, and disease management needs;

f. Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;

g. Disability history;

h. Educational attainment, skills training, certificates, difficulties, and history;

i. Family/caregiver and social history;

j. Medication history and current medications, including name, strength, dosage, and length of time on medication;

k. Social profile, community, and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;

l. Advance directives;

m. Present living arrangements;

n. Enrollee strengths, needs and abilities;

o. Home environment; and

p. Enrollee cultural and religious preferences.

Any changes to the Contractor's Comprehensive Assessment instrument must be submitted to OHCA for review and approval at least forty-five (45) Days prior to its intended use.

1.9.3.1 Methods of Completion

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

1.9.3.2 Timeline for Completion

During Initial Program Implementation, the Contractor shall complete the Comprehensive Assessment within forty-five (45) Days of the Health Risk Screening. During Steady State Operations, the Contractor shall perform the Comprehensive Assessment within thirty (30) Days of the Health Risk Screening.

1.9.3.3 Reassessments

The Contractor shall conduct an annual Comprehensive Assessment on all Enrollees identified as having a Special Health Care Needs in accordance with the Contractor's Risk Stratification Level Framework. The annual reassessment shall be completed within one (1) year of the Enrollee's last assessment date.

The Contractor shall also conduct an updated Comprehensive Assessment when an Enrollee experiences a significant change in health status prior to the annual reassessment. As part of its Risk Stratification Level Framework, the Contractor shall propose what constitutes a significant change triggering a reassessment, such as acute illness or deterioration in the Enrollee's health, change in ability to perform ADLs, change in the status of a caregiver (e.g., death or illness), transition from one (1) setting to another (e.g., hospital to home) and change in living arrangements (e.g., new Foster Care setting placement).

1.9.3.4 Direct Access to Specialists

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

1.9.4 Care Plans

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

a. Approved by the Contractor in a timely manner, if this approval is required by the Contractor;

b. Developed in accordance with OHCA quality assurance and utilization review standards; and

c. Reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee.

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

1.9.5 Care Management and Population Health Staffing

1.9.5.1 Staffing Levels

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

The Contractor shall submit an annual Care Management Staffing Plan to OHCA, in the manner and format required in the Reporting Manual and shall, at a minimum, address:

a. Number of Care Managers, supervisors/managers, and support staff;

b. Number of Care Management staff assigned to each of area of the Contractor's Risk Stratification Level Framework;

c. Methodology by which the Contractor determined Care Management staffing levels were sufficient; and

d. Process by which the Contractor will ensure the Care Management staffing levels are adequate to meet Contract requirements.

1.9.5.2 Care Manager Assignment

The Contractor shall describe in its Risk Stratification Level Framework its proposed methodology for assigning Enrollees to a Care Manager, including which levels of Care Management and population health interventions are assigned a Care Manager. All Care Manager assignments shall be made based on the Enrollee's primary need(s) as identified in the Health Risk Screening, Comprehensive Assessment, or other Contractor assessment findings. Within ten (10) Days of Enrollee designation to a Risk Stratification Level that includes assignment to a Care Manager, the Contractor shall notify the Enrollee of the following:

a. The assigned Care Manager's name and contact information;

b. Procedures to contact the assigned Care Manager if any issues or needs arise; and

c. When the Enrollee can expect to be contacted by the Care Manager based on the Risk Stratification Level Framework assigned to the Enrollee. This communication shall be in writing to the Enrollee.

1.9.5.3 Qualifications

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

a. Bachelor's degree in social work, psychology, or a related social services field and at least one (1) year of related professional experience with a similar population as those in the SoonerSelect Program. Related professional experience includes acting as a Care Manager, rehabilitation Specialist, health Specialist, social services coordinator, or licensed behavioral health professional in the State of Oklahoma; or

b. Registered nurse or licensed clinical social worker with a license to practice in the State of Oklahoma, with at least one (1) year of professional experience.

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

1.9.5.4 Training

The Contractor shall provide Care Managers with initial and ongoing training on topics related to the populations served in the SoonerSelect Program. The Contractor shall develop a curriculum and training plan to ensure all Care Managers attend initial and ongoing training sessions. The Contractor shall retain a sufficient level of qualified staff dedicated to performing the training. Attendance at each and every training session shall be documented and stored. Contractor shall prepare a written training plan with a prospective training calendar. The Contractor shall maintain a contemporaneous training log with dates, subject matter, materials, trainers, and attendees. The Contractor shall be prepared to provide upon OHCA request:

a. A written training plan inclusive of dates and subject matter;

b. Training materials; and

c. Oversight and monitoring materials including:

    i. Staff monitoring protocols;

    ii. Monitoring results; and

    iii. Staff remediation and training.

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

a. Orientation to SoonerCare programs;

b. Overview of SoonerSelect Program population categories;

c. SoonerSelect Program benefits and services;

d. The Contractor's Risk Stratification Level Framework;

e. Behavioral health, including, but not limited to, evidence-based practices for individuals with mental illness and/or SUD, assessment tools, and Crisis Intervention;

f. Clinical conditions prevalent among the Contractor's Enrollees;

g. Instruction on conducting a home visit, as applicable to the Contractor's Risk Stratification Level Framework;

h. Enrollee outreach and interviewing techniques;

i. Completion of a Health Risk Screening and Comprehensive Assessment;

j. Reassessment procedures;

k. Care planning;

l. Identification of risk and risk mitigation techniques;

m. How to recognize and report abuse, neglect, and Exploitation;

n. Electronic Visit Verification (EVV) system and procedures;

o. Critical incident reporting;

p. PA;

q. Service delivery monitoring;

r. Care Management functions;

s. Instruction on locating and arranging community-based services;

t. Management of care transitions (e.g., hospital discharge planning);

u. Cultural competency;

v. Advance directives;

w. HIPAA and other federal and State privacy laws;

x. Disaster planning;

y. Care Management information system; and

z. Documentation of findings in an Enrollee's case record.

The Contractor's Care Managers shall successfully complete the Behavioral Health Case Manager certification training provided through the Department of Mental Health and Substance Abuse Services.

Care Managers will have six (6) months from the date of hire to successfully complete all training unless otherwise specified in writing by OHCA.

All Care Managers shall receive ongoing training at least annually. Topics to be covered shall be determined by the Contractor based on the populations served and programmatic priority areas identified by OHCA or the Contractor. OHCA may require certain trainings/topics as deemed necessary.

1.9.5.5 Care Manager Changes

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

1.9.5.6 Contractor-Initiated Care Manager Changes

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

a. The Care Manager is no longer employed by the Contractor;

b. The Care Manager is on temporary leave from employment;

c. The Care Manager has a conflict of interest and cannot serve the Enrollee; or

d. Care Manager caseloads must be adjusted due to the size or acuity of the individual Care Manager's caseload.

The Contractor shall provide advance notice to an Enrollee of the change to the extent practicable and shall minimize disruption through adherence to the process described in Section 1.10.9: "Care Manager to New Care Manager" of this Contract.

1.9.5.7 Enrollee Access to Care Managers

The Contractor shall ensure that Enrollees have access to a telephone number to either directly contact their assigned Care Managers or a member of the Care Management team during normal Business Hours. A back-up system shall be in place for Enrollees when their Care Manager is unavailable, including after Hours and holidays. Enrollees shall be given an emergency telephone number to call twenty-four (24) Hours per day, seven (7) Days per week that is answered by a live voice. Calls that require immediate attention by a Care Manager shall be warm-transferred to an on-call Care Manager so the Enrollee's need(s) are addressed as soon as possible. Procedures shall be in place to ensure Enrollees, representatives and Providers receive timely communication for calls placed on this line.

1.9.6 Coordination with Other SoonerCare Programs

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

a. The SoonerSelect Dental CE;

b. The FFS SoonerCare program; and

c. Community, LOPOs, and social support Providers.

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

1.9.7 Monitoring Service Delivery

The Contractor shall develop a comprehensive program to monitor the effectiveness of its Care Management and population health activities on an ongoing basis. The findings and strategies shall be shared and discussed during the Contractor's QIC meetings.

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

a. Care Management tools and procedures are consistently and objectively applied and outcomes are continuously measured;

b. Health Risk Screenings and Comprehensive Assessments occur within the required timeframes and are submitted to OHCA;

c. Care Plans are developed and updated on schedule and in compliance with this Contract;

d. Services are delivered in a timely manner and are provided as authorized by the Contractor;

e. Care Plans address needs identified in the Comprehensive Assessment and are appropriate and adequate to address an Enrollee's needs;

f. Service utilization is appropriate;

g. Service Gaps are identified and addressed in a timely manner;

h. Minimum Care Management contacts are performed in accordance with the Contractor's Risk Stratification Level Framework;

i. Care Manager staffing levels are in compliance with the approved Annual Care Management Staffing Plan submitted to OHCA;

j. Enrollees assigned risk levels are accurate and conducted in accordance with the Contractor's Risk Stratification Level Framework; and

k. Care Manager assignments are performed in a timely and accurate manner.

1.10 Transition of Care (TOC)

1.10.1 TOC General Provisions

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

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

The Contractor shall make TOC policies available to Enrollees and provide instructions to Enrollees on how to access continued services during the Continuity of Care Period. This information shall be available, at minimum, in the Enrollee Handbook, new Enrollee materials and via Enrollee call center representatives. Language used in all forms of communication shall conform with requirements specified in Section 1.12: "Enrollee Services" of this Contract and 42 C.F.R. § 438.10.

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

1.10.2 TOC Policies and Procedures

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

a. A schedule that ensures that the transition does not create a lapse in a service;

b. A process for timely information exchange (including transfer of an Enrollee record, including the Enrollee's Care Plan as applicable based on the Contractor's assignment in accordance with its Risk Stratification Level Framework);

c. A process for assuring confidentiality;

d. A process for allowing Enrollees to request and be granted a change of Provider;

e. An appropriate schedule for transitioning Enrollees from one (1) Provider to another when it is Medically Necessary for ongoing care, including a process for ensuring the Enrollee's new Provider(s) are able to obtain copies of the Enrollee's medical records, as appropriate and consistent with federal and State law;

f. A process for transitioning Enrollees from one (1) care setting to another; and

g. A process for transitioning Enrollees from or to another CE.

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

1.10.3 Transition of Prior Authorizations

The Contractor shall ensure all PAs for covered benefits in place on the Day prior to the Enrollee's Enrollment with the Contractor remain in place for ninety (90) Days following an Enrollee's Enrollment. This requirement applies during both Initial Program Implementation and Steady State Operations. During the ninety (90) Day Continuity of Care Period, PAs may not be denied on the basis that the authorizing Provider is not a Participating Provider. Payment to Non-Participating Providers shall be made at the current Medicaid fee schedule rate, and in accordance with OHCA's payment timeliness standards, as outlined in Section 1.16.5.1: "Timely Claims Filing Requirements" of this Contract, during the Continuity of Care Period.

Notwithstanding the foregoing requirement to honor existing PAs for ninety (90) Days, the Contractor shall have additional procedures in place that address the continuity of care needs of at least the following populations:

The Contractor shall be responsible for the costs of Pregnant Women for continuation of Medically Necessary prenatal care services, delivery, and post-natal care, through follow-up checkup within six (6) weeks of delivery, without any form of prior approval and without regard to whether such services are being provided by a Participating or Non-Participating Provider;

The Contractor shall honor the existing treatment plan until such plan has been completed for Enrollees receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for Hepatitis C treatment or who are terminally ill;

Children receiving private duty nursing services will continue to receive these services during the Continuity of Care Period. The Enrollee will continue to receive private duty nursing services after the end of the Continuity of Care Period and indefinitely until or unless the Contractor performs a comprehensive assessment and determines the appropriate level of private duty nursing services as a component of the Enrollee's overall Care Plan. The comprehensive assessment that is utilized to redetermine the private duty nursing benefit should be conducted no greater than thirty (30) Days prior to the current private duty nursing authorization redetermination date. OHCA recognizes the servicing private duty nursing agency must continue to obtain and provide valid private duty nursing prescriber orders/treatment plan in order for the authorization to be maintained in sixty (60) Day increments until transition is achieved. Children receiving private duty nursing services also will receive specific transition notification and assistance in accordance with Section 1.10.10: "Age Transitions" of this Contract.

a. The Contractor shall honor OHCA's negotiated payment rate for Enrollees who are receiving out-of-State services and/or meals and lodging assistance;

b. Enrollees who are receiving services for hemophilia shall continue to receive services by their current hemophilia Providers for up to ninety (90) Days;

c. Enrollees with a treatment plan that contains Behavioral Health Services shall be allowed to remain with the current behavioral health treatment Provider(s) for up to ninety (90) Days;

d. If DME or supplies were authorized and ordered prior to Enrollment but not received by the time of Enrollment, the Contractor shall coordinate and follow through to ensure that Enrollees receive the necessary supportive equipment and supplies without undue delay; and

e. Enrollees with an approved medication step therapy protocol shall be allowed on their current medication for up to ninety (90) Days.

1.10.4 Continuity of Provider Assignment

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

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

a. The only Participating Provider available to the Enrollee does not, because of moral or religious objections, provide the service the Enrollee seeks;

b. The Enrollee's PCP or other Provider determines that the Enrollee needs related services that would subject the Enrollee to unnecessary risk if received separately and not all of these services are available within the Network; or

c. OHCA determines that other circumstances warrant out-of-Network treatment.

1.10.5 Transitions Between Managed Care Entities and between OHCA and CEs

When an Enrollee transitions from another CE to the Contractor, the Contractor shall be responsible for making a request to the surrendering CE for any data that will facilitate a seamless transition, including but not limited to, Health Risk Screening results, comprehensive assessments, Care Plans, utilization data and Provider information. When the Contractor receives requests from an CE for transition information on a former Enrollee, the Contractor shall transmit the information within five (5) Days for data which is available electronically, and within thirty (30) Days for data which is not stored electronically.

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

When the Enrollee transitions from OHCA to an CE, from one (1) CE to another, or from the Contractor to OHCA and the Enrollee is hospitalized on the effective date of Enrollment for the receiving entity, the surrendering entity shall be responsible until the date of discharge for payment of all covered inpatient facility and professional services provided within a licensed facility for which billing is based on a diagnosis-related group (DRG), with the receiving entity responsible for all other covered services beginning on the effective date of Enrollment. Upon discharge, the Enrollee fully becomes the financial responsibility of the receiving entity. When the billing for a covered inpatient facility is based on a per diem rate, the receiving CE becomes responsible for payment of all services on the effective date of Enrollment.

The following table describes payment responsibility for Medicaid Enrollment changes that occur during an inpatient stay, as of the Enrollee's Effective Date of Coverage with the receiving CE or OHCA's other Contracted Entity.

Scenario (Enrollment on Effective Date)	Inpatient Facility and Professional Charges Provided Within Licensed Facility *(based on DRG or Per Diem)*	All Other Covered Services on Effective Date of Enrollment
Member moves from FFS to SoonerSelect CE	FFS	SoonerSelect Program CE
Member moves from former SoonerSelect Dental or Children's Specialty Contracted Entity to SoonerSelect Program CE	Former SoonerSelect Dental or Children's Specialty Contracted Entity	SoonerSelect Program CE
Member moves from SoonerSelect CE to FFS	Former SoonerSelect Program CE	FFS
Member moves from another SoonerSelect CE	Former SoonerSelect Program CE	New SoonerSelect Program CE

1.10.6 TOC Between SoonerSelect Program and SoonerSelect Children's Specialty Program Contracted Entities and SoonerSelect Dental Contractor

The Contractor shall work with SoonerSelect Program and SoonerSelect Dental CEs to transition and coordinate care after a Dental Related Emergency Service. This may include:

a. Communicating with the SoonerSelect Dental CE and Enrollees to locate Participating Providers;

b. Providing information on dental related emergencies and need for follow up appointments; and

c. Providing appointment assistance.

1.10.7 Terminated Provider to New Provider

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

a. Mail notification of Provider termination with a contact number for the Enrollee to call for reassignment;

b. Auto assigning Enrollees who do not call within thirty (30) Days of notice;

c. Sending notice of Provider reassignment; and

d. Instructions on how to call to get reassigned to a different Provider.

1.10.8 TOC to Out of Home Placement and to a New Home Placement

The Contractor shall develop policies and procedures to facilitate TOC and information between home settings. This may include:

a. Notification upon new home placement to guardian of Enrollee's benefits;

b. Assisting with Provider assignment;

c. Ensuring Enrollees have a Provider visit within thirty (30) Days of new home placement; and

d. Ensure Enrollees are up to date with recommended health screenings and immunizations.

1.10.9 Care Manager to New Care Manager

The Contractor shall have strategies in place to minimize the number of situations in which an Enrollee must be assigned a new Care Manager. However, when the Contractor must assign a new Care Manager to the Enrollee, the incoming Care Manager shall have a case conference with the outgoing Care Manager to review the Enrollee's Care Plan and transition the Enrollee to the new Care Manager. The new Care Manager shall contact the Enrollee within five (5) Business Days of assignment to the new Care Manager and shall include the prior Care Manager in the outreach, if possible.

1.10.10 Age Transitions

The Contractor shall monitor the age status of Enrollees and offer assistance to Enrollees approaching age thresholds that will affect SoonerCare coverage or eligibility, as well as Enrollee transitions of care including, but not limited to, transition aged youth, transitioning from the child/adolescent health care system to the adult system. The Contractor shall educate these Enrollees or their parents/guardians concerning the upcoming changes in their coverage and shall update Care Plans in advance of the age threshold being reached, to minimize any disruption in care.

1.10.11 Transitions from Inpatient/Residential Settings

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

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

a. Methods for identifying Enrollees who are in an inpatient/residential setting;

b. Designation of a single point of contact at the Contractor for the Enrollee's transition activities;

c. Timelines and methods for coordinating with the Enrollee, the Enrollee's PCP and other outpatient Providers, hospital discharge planner(s), caregivers, and the attending physician to facilitate timely and appropriate discharge planning;

d. Procedures for conducting a comprehensive evaluation of the Enrollee's health needs and identification of services and supplies required to facilitate transition out of the inpatient setting;

e. Processes for ensuring the Enrollee is placed in the least restrictive setting post-discharge that will meet the Enrollee's needs;

f. Methods for evaluating risk of readmission in order to determine the intensity and urgency of follow up required for the Enrollee after the date of discharge;

g. Areas to be addressed by the discharge plan such as necessary in-home supports, language or cultural needs, medications, Home Health Care needs, DME needs, outpatient service needs, transportation needs, housing needs, income support and follow-up appointments; and

h. Timeframes for post-discharge outreach to the Enrollee.

1.10.12 Transitions Between Other Settings

The Contractor shall follow OHCA identified policies and procedures to facilitate the sharing of information between settings such as jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service Providers, and the Enrollee's PCP and behavioral health Providers.

1.11 Quality

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

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

a. Adequate capacity and service to ensure Enrollee choice and timely access to appropriate services and care;

b. Effective coordination and continuity of care;

c. Protection of Enrollee rights and the provision of services in a manner that is sensitive to the cultural needs of Enrollees;

d. Encouragement and assistance to Enrollees in participating in decisions regarding their care;

e. Emphasis on health promotion and prevention, as well as early diagnosis, treatment, and health maintenance;

f. Appropriate utilization of Medically Necessary services; and

g. A continuous quality improvement approach.

1.11.1 Quality Rating System

OHCA shall develop and implement a Medicaid Managed Care Quality Rating System, in accordance with 42 C.F.R. § 438.334, to evaluate the annual performance of all Contractors participating in the SoonerSelect Program. The Contractor shall comply with all necessary OHCA reporting requirements for the quality rating system adopted by OHCA.

As part of the Quality Rating System, OHCA will develop a scorecard that compares each Contractor and will include the elements required by 56 O.S. § 4002.11. The scorecard will be compiled quarterly and will consist of the information obtained during the prior quarter. The scorecard will, at a minimum, consist of:

a. Average speed of authorization of services;

b. Rates of denials of Medicaid reimbursable services when a complete authorization request is submitted in a timely manner;

c. Enrollee satisfaction survey results; and

d. Provider satisfaction survey results.

OHCA reserves the right to include other criteria. In accordance with 42 C.F.R. § 438.334(d), OHCA shall issue an annual quality rating to the Contractor based on the performance measures collected. OHCA shall prominently display the quality rating given to the Contractor by OHCA on OHCA's website in

accordance with 42 C.F.R. § 438.334(e) and in a manner that complies with the standards at 42 C.F.R. § 438.10(d). OHCA will utilize its preferred vendor tools for assessing the quality of care and services delivered for the entire population and attribute performance to the Contractor for its enrolled population. The Contractor may be given access to the tool for near real time monitoring of selected measures for their population.

1.11.2 External Quality Review

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

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

a. Validation of the Contractor's Performance Improvement Projects (PIPs) required in accordance with 42 C.F.R. § 438.330(b)(1) that were underway during the preceding twelve (12) months;

b. Validation of the Contractor's performance measures required in accordance with 42 C.F.R. § 438.330(b)(2) or Contractor performance measures calculated by the State during the preceding twelve (12) months;

c. A review, conducted within the previous three (3) year period, to determine the Contractor's compliance with the standards set forth in 42 C.F.R. Subpart D and the QAPI requirements described at 42 C.F.R. § 438.330; and

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

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

a. Validation of the Contractor's Encounter Data;

b. Administration or Validation of Contractor or Provider surveys of quality of care;

c. Calculation of performance measures in addition to those reported by the Contractor;

d. PIPs in addition to those conducted by the Contractor;

e. Studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and

f. Assisting with the quality rating of the Contractor.

The SoonerSelect Program EQRO will produce an annual EQR Technical Report on quality outcomes, including timeliness of services and access to services covered by the SoonerSelect Program. The Technical Report will detail, analyze, and aggregate the data from all activities conducted in accordance with 42 C.F.R. § 438.358. The Technical Report must include:

a. The results of the EQR-related activities;

b. The EQRO's assessment of each managed Care Plan's strengths and weaknesses related to quality, timeliness, and access;

c. Recommendations for improving the quality of Health Care Services furnished by each managed Care Plan and recommendations for how the State can target goals and objectives in the State quality strategy;

d. Methodologically appropriate, comparative information about all managed Care Plans; and

e. An assessment of the degree to which each managed Care Plan has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

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

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

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

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

1.11.3 Quality Assessment and Performance Improvement (QAPI) Program

1.11.3.1 QAPI Program

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

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

a. PIPs that evaluate clinical and nonclinical areas, in accordance with 42 C.F.R. §§ 438.330(b)(1) and (d)(1), including all SoonerSelect Program population groups, care settings, and types of services;

b. In accordance with 42 C.F.R. § 438.330(b)(2), collection of and submission of performance measurement data, including the performance measures determined by OHCA as required pursuant to 42 C.F.R. § 438.330(c)(1)(i), or as determined by CMS in the event CMS identifies standard required measures pursuant to 42 C.F.R. § 438.330(a)(2);

c. Mechanisms to detect both underutilization and overutilization of services, in accordance with 42 C.F.R. § 438.330(b)(3); and

d. Assess the quality and appropriateness of care furnished to Enrollees with Special Health Care Needs, in accordance with 42 C.F.R. § 438.330(b)(4). Enrollees with Special Health Care Needs will be defined by OHCA in the quality strategy developed pursuant to 42 C.F.R. § 438.340.

OHCA or its designee shall perform oversight and monitoring functions, evaluate the impact and effectiveness of the Contractor's QAPI program, review performance and all reporting, and monitor the SoonerSelect Program contractual obligations. The Contractor shall be responsible for the day-to-day performance and operational requirements. The Contractor shall report to OHCA Quality Advisory Committee in accordance with 56 O.S. § 4002.13. Any changes to the QAPI program structure shall require prior written approval from OHCA, ninety (90) Days prior to implementation.

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

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

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

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

1.11.3.2 Oversight of QAPI Program

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

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

a. Quality Improvement;

b. Grievances and Appeals;

c. Care Management;

d. Medical Management;

e. Credentialing;

f. Compliance;

g. Enrollee Care Support Staff (at least one (1) staff member); and

h. Providers, including both physical health and behavioral health Providers.

Individual staff members may serve in multiple roles on the QIC if they also serve in multiple positions within the Contractor's organization. OHCA reserves the right to require the Contractor to include specific types of Providers and/or stakeholders to participate in the QIC.

The QIC shall meet no less than quarterly. Its responsibilities shall include the development and implementation of a written QAPI plan, which incorporates the strategic direction provided by the Governing Body and executive management team.

The QIC shall:

a. Direct and review QAPI activities;

b. Analyze and evaluate the results of QAPI activities and suggest new or improved activities;

c. Ensure that Participating Providers and other stakeholders are involved in the QAPI program;

d. Direct task forces or committees in specific improvement areas;

e. Review quality of care complaints;

f. Publicize findings to appropriate staff and departments within the Contractor's organization;

g. Report findings and recommendations to the Contractor's executive management team;

h. Direct and analyze periodic reviews of Enrollees' service utilization patterns, institute needed action, and ensure that appropriate follow-up occurs; and

i. Review and approve the QAPI work plan and annual evaluation.

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

1.11.3.3 QAPI Documentation

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

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

a. Guiding philosophy and strategic direction for the QAPI program;

b. Communication mechanism between the Contractor's executive management team and the QIC;

c. QAPI program committee structure, including specific committees, committee representatives and why the representatives were chosen;

d. Roles of Enrollee and Provider representatives on the QIC;

e. Process for selecting and directing task forces or subcommittees;

f. Types of training, including any quality protocols developed by the CMS, provided to quality staff and QIC members;

g. Specific components of the QAPI plan;

h. Process the QAPI program will use to review and suggest new or improved quality activities;

i. Process to report findings to appropriate executive leadership, staff, and departments within the Contractor's organization, as well as relevant stakeholders, such as Participating Providers;

j. Methodology for which and how many Participating Providers to profile and how measures for profiling will be selected;

k. Process for selecting evaluation and study design procedures;

l. How data will be collected and used;

m. How the Contractor will ensure that QAPI program activities take place throughout the Contractor's organization and the procedures to document results;

n. The Health Management Information Systems that will support the QAPI program;

o. Process for reporting findings to OHCA, Participating Providers, and Enrollees; and

p. Process for annual program evaluation.

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

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

a. A description of ongoing and completed QAPI activities;

b. Measures that are trended to assess performance;

c. Year-over-year findings that contain an analysis of demonstrable improvements in the quality of clinical care and service;

d. Development of future QAPI work plans based on previous year findings;

e. Results of QAPI projects and reviews;

f. Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey, OHCA scorecards, and other performance measure results;

g. Monitoring and evaluation of non-clinical aspects of service with timely resolution of problems and improvement in processes; and

h. Monitoring and evaluation of Network quality, including, at minimum:

    i. Credentialing and recredentialing processes;

    ii. PIPs;

    iii. Performance measurement;

    iv. Problem resolution and improvement approach and strategy;

    v. Annual program evaluation; and

    vi. Metrics for monitoring the quality and performance of Participating Providers related to their continued participation in the Contractor's Network.

In accordance with 42 C.F.R. § 438.330(e)(1), OHCA or its designees shall annually review the impact and effectiveness of the Contractor's QAPI program. This review shall utilize a variety of methods, including, but not limited to:

a. Reviewing, evaluating, and reporting all QAPI Program documents, the Contractor's performance measures, and Contractor reports regularly required by OHCA or its designees;

b. Reviewing outcomes and trended results of the Contractor's PIPs;

c. Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as Enrollee choice, rights and protections, services provided to Enrollees with Special Health Care Needs, UM, Network access standards, measurement and improvement standards, Clinical Practice Guidelines, and continuity and coordination of care;

d. Performing medical records reviews; and

e. Conducting on-site reviews to interview the Contractor's staff for clarification, to review records, or to validate implementation of processes and procedures.

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

1.11.4 Surveys

1.11.4.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys

The Contractor shall conduct annual CAHPS® surveys. Annual CAHPS® survey reports will be due to OHCA no later than June 15th of each year. OHCA, based on the recommendations of the Oklahoma Medicaid Quality Advisory Committee, will identify a single survey vendor to administer the surveys. The Contractor shall enter into an agreement with the chosen vendor to perform annual CAHPS® surveys. The vendor shall perform the CAHPS® Health Plan Survey 5.1H Children's Health Insurance Program (CHIP), non-CHIP Child, and Adult surveys. The CHIP and non-CHIP child surveys should also include the Children with Chronic Conditions (CCC) item set.

The Contractor shall submit to OHCA by November 1st of each year a proposal for survey administration and reporting that includes the sampling methodology, administration protocol, analysis plan, and reporting description.

Survey results shall be reported to OHCA separately for each required CAHPS® survey listed above. Survey results shall be submitted to OHCA, NCQA, Agency for Healthcare Research and Quality (AHRQ), and OHCA's SoonerSelect Program EQRO annually as required in Section 1.23: "Reporting" of this Contract.

The Contractor shall:

a. Use the annual CAHPS® results in the Contractor's internal QAPI plan by using areas of decreased satisfaction as areas for targeted improvement;

b. Include additional survey questions that are specified by OHCA in addition to the CAHPS®;

c. Make available results of the surveys to Participating Providers, OHCA, Enrollees and families/caregivers;

d. Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall survey results; and

e. Have mechanisms in place to incorporate survey results in the QAPI plan for program improvements and systems improvements.

At its discretion, OHCA reserves the right to implement additional Mental Health Care Surveys, including, but not limited to, the CAHPS® Experience of Care & Health Outcomes (ECHO) Survey. The Contractor shall conduct any additional surveys under the same process, where appropriate, as outlined in this Section.

OHCA reserves the right to modify the population the Contractor is required to survey based on Enrollment.

1.11.4.2 Provider Satisfaction Surveys

The Contractor shall conduct an annual Participating Provider satisfaction survey that is inclusive of all Participating Providers. OHCA will collaborate with the Contractor and other SoonerSelect Program CEs to review and approve a uniform set of Provider satisfaction measures and a uniform survey instrument. The Contractor shall conduct the survey and compile and analyze its survey results for submission to OHCA annually.

The survey instrument shall include the following domains:

a. Provider relations and communication;

b. Clinical management processes;

c. Authorization processes, including denials and Appeals;

d. Timeliness of claims payment and assistance with claims processing;

e. Grievance resolution process; and

f. Care Management support.

The survey report results shall include a summary of the survey methods and findings for physical health and behavioral health Providers, with an analysis of opportunities for improvement.

The Contractor shall provide the survey results to OHCA with an action plan to address the results of the survey in accordance with Section 1.23: “Reporting” of this Contract.

1.11.5 Quality Performance Measures

The Contractor shall comply with all OHCA’s requirements to improve performance for OHCA-established quality performance measures. Annually, the Contractor shall submit a Quality Performance Measure Report for all quality performance measures established by OHCA pursuant to 42 C.F.R. § 438.330(c)(1)(i) and listed in this Section. Quality performance measures shall:

a. Be modified annually by OHCA or CMS and published in advance;

b. Be specific to the SoonerSelect Program population; and

c. Include target performance rates that will increase annually. Required quality performance measures will include measures for both physical health and behavioral health.

The performance measures in this Contract in Sections 1.11.5.1: "Performance Measures" have been selected to provide evidence of the overall quality of care and specific services provided to each SoonerSelect Program population group. The Contractor shall report the performance measures outlined in Appendix 1C: "Quality Performance Withhold Program" of this Contract to OHCA at a time and in a format specified by OHCA. The Contractor shall be expected to meet or exceed annual benchmarks/targets for specific performance measures as outlined in Appendix 1C: "Quality Performance Withhold Program" of this Contract.

Annually, the Contractor shall complete the specified measures designated by OHCA as relevant to the Enrollees being served in the SoonerSelect Program. The Contractor shall Contract with an NCQA-certified HEDIS® auditor to validate the processes of the Contractor in accordance with NCQA requirements. The Contractor shall submit to OHCA a copy of the signed Contract with the NCQA-approved vendor to perform the HEDIS® audit. Audited HEDIS® results shall be submitted to OHCA, NCQA and OHCA's SoonerSelect Program EQRO annually as required in Section 1.23: "Reporting" of this Contract.

In addition to OHCA-established quality performance measures, the Contractor shall report EPSDT information utilizing Encounter Data submissions in accordance with specifications for the CMS-416 report. This report includes information on EPSDT participation, percentage of Children identified for referral, percentage of Children receiving follow-up services in a timely manner, and other measures.

The Contractor shall meet OHCA-specified performance targets for all quality performance measures. The performance targets for each of the required measures shall be determined by OHCA in collaboration with the Contractor and other SoonerSelect Program CEs.

Although quality performance targets will be updated annually, OHCA, at its discretion, may change these targets and/or change the timelines associated with meeting the targets. The quality performance targets will be incorporated into the comprehensive Uniform Performance Monitoring Data Set described in Appendix 1C: "Quality Performance Withhold Program" of this Contract.

OHCA shall post information about quality measures and performance outcomes on OHCA's website. This information shall be updated at least annually, or as needed.

If OHCA determines that the Contractor's performance relative to any of the quality performance targets is not acceptable, OHCA may require the Contractor to submit a CAP in accordance with Section 1.25: "Remedies and Disputes" of this Contract. OHCA shall specify a time period for Contractor's submission of a CAP. OHCA also may apply Non-Compliance Remedies for failure to meet quality performance targets or demonstrate improvement in a measure rate in accordance with Section 1.26.3.4: "Non-Compliance Remedies" of this Contract. When considering whether to apply Non-Compliance Remedies, OHCA may consider the Contractor's cumulative performance on all quality performance measures.

A report, certification, or other information required for performance measure reporting is incomplete when it does not contain all data required by OHCA or when it contains inaccurate data. A report that is incomplete or contains inaccurate data shall be considered deficient and each instance shall be subject to Non-Compliance Remedies as described in Section 1.26.3.4: "Non-Compliance Remedies" of this Contract.

A report or certification is "false" if completed or made with the knowledge of the preparer or a superior of the preparer that it contains data or information that is not true or not accurate. The Contractor shall submit a detailed explanation for any measure marked as "not reported" (NR). A report that contains an "NR" due to bias for any or all measures by the HEDIS® auditor, or is "false," shall be considered deficient and will be subject to Non-Compliance Remedies as described in Section 1.26.3.4: "Non-Compliance Remedies" of this Contract.

1.11.5.1 Performance Measures

The Contractor shall be responsible for reporting on the performance measures that are provided in Appendix 1C: "Quality Performance Withhold Program" of this Contract and are subject to change. The Contractor will also be responsible for reporting on any OHCA identified tracking measures that are not tied to the Performance Withhold Program.

1.11.6 Performance Improvement Projects (PIPs)

Contractors are required to conduct at least three (3) PIPs annually. For Rating Period one (1), the Contractor shall propose, subject to OHCA's approval, one (1) non-clinical, and two (2) clinical PIPs: one (1) that addresses physical health and one (1) that addresses behavioral health. In subsequent years, PIP topics may be identified by CMS, the Contractor, or OHCA. All PIPs are subject to final approval by OHCA.

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction, in accordance with 42 C.F.R. § 438.330(d)(2), and must include the following elements set forth at 42 C.F.R. § 438.330(d)(2)(i)-(iv):

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 intervention based on the performance measures collected as part of the PIP; and

d. Planning and initiation of activities for increasing or sustaining improvement.

In accordance with 42 C.F.R. § 438.330(d)(3), the Contractor shall report the status and results of each PIP as requested by OHCA, which shall be no less than annually, or as needed. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes shall be evaluated for statistical significance using a ninety-five percent (95%) confidence interval. Status reports on PIPs may be requested more frequently by OHCA.

PIPs are subject to annual independent Validation by the SoonerSelect Program EQRO to ensure compliance with CMS protocols and OHCA's policy, including timeline requirements.

PIPs that have successfully achieved sustained improvement, as approved by OHCA, shall be considered complete and shall not meet the requirement for one (1) of the number of PIPs required by OHCA, although the Contractor may wish to continue to monitor the performance indicator as part of its overall QAPI program. In this event, the Contractor shall select a new PIP and submit it to OHCA for approval.

1.11.7 Addressing Health Disparities

The Contractor shall participate in, and support OHCA's efforts to reduce health disparities. According to the U.S. Department of Health and Human Services Office of Minority Health, and for the purposes of this Contract, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; or geographic location). To further advance OHCA's efforts to achieve health equity, the Contractor shall collect and use Enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify and reduce disparities in health care access, services, and outcomes. This includes, where possible, stratifying HEDIS® and CAHPS®, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities. The Contractor shall maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by obtaining input from Enrollees and from Providers of direct services which are intended to reduce adverse health outcomes among Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

1.11.8 Provider Profiling

The Contractor shall conduct PCP and other Participating Provider profiling activities at least quarterly, or as needed. As part of its QAPI Program, the Contractor shall describe the methodology it uses to identify which and how many Participating Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities shall include, without limitation:

a. Developing PCP and other Provider-specific reports that include a multi-dimensional assessment of a PCP or other Participating Provider's performance using clinical, administrative, and Enrollee satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

b. Establishing PCP, other Participating Provider, group, service area, or regional benchmarks for areas profiled, where applicable; and

c. Providing feedback to individual PCPs and other Participating Providers regarding the results of their performance and the overall performance of the Contractor's Participating Provider Network.

1.11.9 Medical Records

1.11.9.1 Medical Record Standards

As part of its QAPI Program, the Contractor shall establish medical records standards, as well as a record review system to assess and ensure conformity with the standards. The standards shall, at a minimum:

a. Require that the medical record be maintained by the Provider;

b. Ensure that OHCA's personnel or personnel contracted by OHCA have access to all records, if access to the records is needed to perform the duties under this Contract and to administer the Medicaid program;

c. Comply with any and all State and federal laws regarding confidentiality;

d. Provide OHCA or its designee(s) with prompt access to Enrollees' medical records;

e. Provide Enrollees with the right to request and receive copies of their medical records and to request they be amended; and

f. Allow for paper or electronic record keeping.

The Contractor and its Participating Providers shall retain all medical records for a minimum of ten (10) years from the last date of entry in the records. For minors, the Contractor and Participating Providers shall retain all medical records during the period of minority plus a minimum of ten (10) years after the age of majority.

1.11.9.2 Medical/Case Record Audits

The Contractor shall furnish specific data requested in order for OHCA to conduct the medical/case record audit, including audit of Enrollee Care Plans, Participating Provider credentialing records, service Provider reimbursement records, utilization reports, the Contractor's personnel records, and other documents and files as required under this Contract.

If the medical/case record audit and/or other document audits indicate that quality of care is not acceptable within the terms of this Contract, the Contractor shall correct the problem immediately and may be subject to Non-Compliance Remedies.

1.11.9.3 Critical Incident Reporting System

The Contractor shall develop and implement a Critical Incident reporting and tracking system for behavioral health adverse or Critical Incidents and shall require Participating Providers to report adverse or Critical Incidents to the Contractor, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with OAC 317:30-5-95.39(c). The Contractor shall provide appropriate training and take corrective action as needed to ensure its staff and Participating Providers, as applicable, comply with Critical Incident requirements, in the manner and format required in the Reporting Manual.

The Contractor shall ensure that any serious incident that harms or potentially harms the Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated, and corrected, in compliance with State and federal law, including, but not limited to, 42 C.F.R. §§ 482.13(e) through (g); 483.350-.376; and OAC 317:30-5-95.39. As required by State law, the Contractor shall report abuse, neglect and/or Exploitation on the appropriate form to OHCA within one (1) Business Day, as well as to OHS and/or law enforcement authorities, in accordance with OAC 317:30-5-97.

The Contractor's staff and Participating Providers shall immediately, but not to exceed twenty-four (24) Hours, take steps to prevent further harm to any and all Enrollees and respond to any emergency needs of Enrollees.

The Contractor's Participating Providers shall conduct an internal Critical Incident investigation and submit a report on the investigation as soon as possible, based on the severity of the Critical Incident, to the Contractor, the OHCA Behavioral Health Unit, OHS, and the Enrollee's parent or legal guardian, in accordance with the timeframes established by OAC 317:30-5-95.39(c). The Contractor shall review the Participating Provider's report and follow up with the Participating Provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

Critical Incidents shall include, but not be limited to the following when the Enrollee is in the care of a behavioral health inpatient, residential, or crisis stabilization unit, in accordance with OAC 317:30-5-95.39:

a. Suicide death;

b. Non-suicide death;

c. Death-cause unknown;

d. Homicide;

e. Homicide attempt with significant medical intervention;

f. Suicide attempt with significant medical intervention;

g. Allegation of physical, sexual, or verbal abuse or neglect;

h. Accidental injury with significant medical intervention;

i. Use of Restraints/Seclusion (Isolation);

j. Absence Without Official Leave (AWOL) or absence from a mental health facility without permission; or

k. Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

The Contractor shall identify and track Critical Incidents and shall review and analyze Critical Incidents to identify and address potential and actual quality of care and/or health and safety issues. The Contractor shall regularly review the number and types of incidents, including, for example, the number and type of incidents across settings, Participating Providers and Provider types and findings from investigations. The Contractor shall identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of care to Enrollees.

The Contractor shall submit reports of Critical Incidents in accordance with Reporting Manual requirements that provide the number and types of incidents that occurred during the reporting period, the timeliness of incident reporting, the results of the Contractor's investigations and the strategies the Contractor developed and implemented to improve care and reduce future incidents. The Contractor shall report Critical Incidents to proper oversight entities, including but not limited to, accrediting or licensing entities, OHS, and/or law enforcement agencies, when required by federal or State law.

1.12 Enrollee Services

The Contractor shall develop and operate an Enrollee Services department with adequate resources and qualified staff to deliver responsive, person-centered customer care to Enrollees, including those with visual, hearing, functional, or cognitive impairments.

The Contractor shall ensure that, through its written materials, Enrollee Services Call Center, and other Enrollee Services activities, it provides timely and accurate information to Enrollees and pursuant to 42 C.F.R. § 438.10(c)(7) has appropriate mechanisms for helping Enrollees and Eligibles to understand the benefits and requirements of the SoonerSelect Program and the Contractor's services.

1.12.1 Accessibility of Enrollee Information

Pursuant to 42 C.F.R. § 438.10(c)(1), the Contractor must provide all required information to Enrollees and Eligibles in a manner and format that may be understood easily and is readily accessible by such Enrollees and Eligibles. The Contractor shall at all times comply with the requirements of 42 C.F.R. § 438.10, including for the provision of all translation, interpretation, or other auxiliary aids requested by the Enrollee. All accommodations for an Enrollee's special needs or reading proficiency must be provided by Contractor free of cost.

The Contractor shall develop and submit to OHCA a plan to identify and assist Enrollees with LEP and visual and hearing-impaired Enrollees to understand all Enrollee materials. The plan shall be reviewed as part of the Readiness Review.

1.12.1.1 Prevalent Non-English Languages and Auxiliary Aids

The Contractor shall make all Enrollee materials available in English and Spanish and other prevalent non-English languages identified by OHCA. Pursuant to 42 C.F.R. § 438.10(d), the Contractor shall also make written Enrollee materials available in alternative formats and via auxiliary aids and services upon request of the Enrollee Eligible at no cost. Alternative formats include, but are not limited to, braille, large font letters, audiotape, and verbal explanations of written materials, and through interpretation services.

Written materials that are critical to obtaining services for prospective Enrollees must include taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free telephone number of the entity providing Choice Counseling services as required by 42 C.F.R. § 438.71(a). Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

Under this Contract, written materials critical to obtaining services includes, but is not limited to, the following written materials:

a. All critical materials listed at 42 C.F.R. § 438.10(d)(3);

b. The Provider directory described in Section 1.12.14: "Provider Directory" of this Contract;

c. The Enrollee Handbook described in Section 1.12.5: "Enrollee Handbook" of this Contract;

d. Grievance and Appeal notices; and

e. Denial and termination notices.

The Contractor shall also identify additional languages that are prevalent among Enrollees. For purposes of this requirement, prevalent language is defined as any language spoken by at least five percent (5%) of the general population in the Contractor's service area or regional area based on area coverage of Contractor.

OHCA will provide information about the Enrollee's spoken language on the ANSI ASC X 12 834 electronic transactions. The Contractor shall utilize this information to ensure written materials are distributed in the appropriate prevalent non-English language.

When the Contractor learns the Enrollee requires a prevalent non-English language, a note shall be made in the Enrollee record and all Contractor correspondence thereafter shall be provided in both English and the required non-English language. If a non-English language is preferred, the Contractor must notify OHCA in a manner to be specified by OHCA so it may note the preferred language in their records.

1.12.1.2 Interpretation Services

Pursuant to 42 C.F.R. § 438.10(d)(4), the Contractor shall make interpretation services available to Enrollees at no cost. This includes oral interpretation and the use of auxiliary aids such as Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD) and American Sign Language (ASL). Oral interpretation requirements apply to all non-English languages, not just those that OHCA identifies as prevalent.

Interpreters shall be made available both in-person, including at Provider's offices, and through the telephone. For telephonic assistance, the Enrollee may not be made to disconnect and call a different number. The Contractor shall provide information to its Participating Providers regarding how to access interpretation services for Enrollees and shall notify Providers they shall not suggest or require that Enrollees with LEP, or who communicate through sign language, utilize friends or family as interpreters.

1.12.1.3 Enrollee Notification of Interpretation Services and Alternative Formats

Pursuant to 42 C.F.R. § 438.10(d)(5)(i) - (iii), the Contractor shall notify Enrollees of the following:

a. That oral interpretation is available for any language;

b. Written translation is available in prevalent languages;

c. That auxiliary aids and services are available upon request and at no cost for Enrollees with disabilities; and

d. How to access those services.

1.12.1.4 Taglines

Written materials that are critical to obtaining services for prospective Enrollees must include taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free telephone number of the entity providing Choice Counseling services as required by 42 C.F.R. § 438.71(a). Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

1.12.2 Cultural Competency

As specified in CMS's *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval* (https://www.medicaid.gov/medicaid/downloads/mce-checklist-state-user-guide.pdf), the Contractor shall participate in OHCA's efforts to promote the delivery of services in a culturally competent manner to all Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

The Contractor shall develop and submit a cultural competency and sensitivity plan to OHCA during Readiness Review. The plan shall include guidelines for evaluating health equity and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:

a. Identify organizations and advocates that could work with LEP communities and individuals in a culturally competent way;

b. Incorporate cultural competence into the Contractor's medical, behavioral health, and Care Management programs, including outreach and referral methods;

c. Recruit and train culturally diverse staff that will be able to operate fluently with all Enrollee communities throughout the State;

d. Ensure Enrollee assessments inquire about language preference;

e. Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter;

f. Ensure cultural competence outcomes through internal audits and performance improvement targets;

g. Develop a set of cultural competency standards designed to help all parts of the Care Management process deliver culturally sensitive care;

h. Identify and develop intervention strategies for high-risk health conditions found in certain cultural groups; and

i. Provide annual training to Participating Providers and Enrollee-facing staff (e.g., Enrollee Services and Care Managers (if applicable) to ensure the delivery of culturally and linguistically appropriate care.

1.12.3 Written Material Guidelines

1.12.3.1 General Guidelines

In accordance with 42 C.F.R. § 438.10(d)(6), all written materials the Contractor provides to Enrollees and Eligibles shall:

a. Use easily understood language and format;

b. Use a font size no smaller than twelve (12) point;

c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of Enrollees or Eligibles with disabilities or LEP;

d. Be written at a reading level no higher than sixth grade using the Flesch-Kincaid readability test; and

e. Comply with tagline requirements outlined in Section 1.12.1.4: “Taglines.”

1.12.3.2 Prior Approval Process

The Contractor shall submit to OHCA for review and prior approval templates of all materials that will be distributed to Enrollees. The Contractor must develop and include a Contractor-designated inventory control number on all Enrollee Marketing Materials. The purpose of this inventory control number is to facilitate OHCA’s review and approval of Enrollee Marketing Materials and document its receipt and approval of original and revised documents. All submitted content must also include a clearly marked date issued or date revised and a reading level assessment, using the Flesch-Kincaid readability test. All materials translated into a non-English language shall be submitted to OHCA with a certificate of translation that shall include an official statement in which the translator confirms that they have accurately translated the document. The Contractor shall submit in English any translated materials to facilitate OHCA review.

Should the Contractor Contract with either a Subcontractor or its Participating Providers to create and/or distribute Enrollee Marketing Materials, the materials shall not be distributed to Enrollees unless the Contractor previously submitted the materials to OHCA for review and received approval.

OHCA will review the submitted materials as soon as possible but within forty-five (45) Calendar Days to ensure compliance with this Contract. Marketing Materials requiring the review of the MAC as per 42 C.F.R. § 438.104(c), must be submitted by the Contractor to OHCA for review and approval ninety (90) Days prior to intended use. OHCA will review the submitted materials as soon as possible but no later than ninety (90) Days. In the event OHCA does not approve the materials, OHCA may provide comments, and the Contractor shall resubmit the Enrollee Marketing Materials for review. OHCA will either approve or deny the resubmission. The Contractor shall not distribute materials without OHCA approval.

1.12.3.3 Modifications to Approved Enrollee Materials

The Contractor shall not make substantive changes to materials developed for use by or distribution to Enrollees without OHCA's review and prior approval.

Enrollee materials developed by a Subcontractor or Participating Provider operating on the Contractor's behalf, shall not be substantively changed without OHCA's review and prior written approval.

OHCA will review the modified Enrollee and Marketing Materials as soon as possible but within forty-five (45) Calendar Days to ensure compliance with this Contract. In the event OHCA does not approve the materials, OHCA may provide written comments, and the Contractor shall resubmit the Enrollee and Marketing Materials for review. The Contractor shall not distribute the modified materials without OHCA review and approval.

1.12.3.4 Discontinuation of Use/Modifications to Materials after Approval

OHCA reserves the right to notify the Contractor to discontinue or modify Enrollee or Marketing Materials after approval.

1.12.3.5 Distribution Guidelines

The Contractor shall distribute Enrollee materials in the preferred mode of the Enrollee, either via mail or electronically. Mailed materials shall be sent to the Enrollee's address as provided in the ANSI ASC X 12 834 electronic transactions. The name of the Contractor and its logo shall be prominently featured, once per item, on each piece of Enrollee mailed materials. It should solicit updates to any information, including address.

Pursuant to 42 C.F.R. § 438.10(c)(6), the Contractor may distribute Enrollee materials in an electronic format instead of a paper copy with an Enrollee's express prior, written consent. Enrollee materials shall not be provided electronically by the Contractor unless all the following are met:

a. The format is readily accessible;

b. The information is placed in a location on the Contractor's website that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed;

d. The information is consistent with the content and language requirements specified in Section 1.12.1: "Accessibility of Enrollee Information" of this Contract including Section 508 of the Rehabilitation Act guidance and guidelines that provide greater accessibility to individuals with disabilities; and

e. The Contractor informs the Enrollee that the information is available in paper form without charge upon request and shall be provided to the Enrollee upon request within five (5) Business Days.

1.12.3.6 Guidelines for Email

The Contractor may attempt to contact Enrollees through email unless the Enrollee does not have access to email or opts out of email. The Contractor shall not attempt to disseminate information about its program through purchased or rented email lists. The Contractor shall not email Enrollees through email addresses obtained by referrals and shall provide an opt-out process for Enrollees to no longer be contacted via email. If the email address provided for the Enrollee is non-existent, invalid, or becomes invalid or otherwise undeliverable, the Contractor shall switch back to paper correspondence and notify OHCA the email address is no longer valid in a manner to be specified by OHCA as outlined in the Reporting Manual.

1.12.3.7 Guidelines for Text

The Contractor is permitted to utilize text messaging in communicating with its Enrollees. If the Contractor elects to correspond with the Enrollee by text messaging, it shall ensure compliance with the Telephone Consumer Protection Act and all HIPAA requirements as outlined in Section 1.2.16: "Confidentiality; Health Insurance Portability and Accountability Act (HIPAA) and Business Associate Requirements" of this Contract and shall provide indemnification in Section 1.2.16.3: "Obligations of the Contractor" of this Contract. OHCA reserves the right to require prior written approval of text message content before Contractor may communicate with Enrollees via text message.

1.12.3.8 Updates to Enrollee Contact Information

The Contractor shall use and regularly update a record of the modalities used to reach the Enrollee, and shall:

a. Update the record based on changes in OHCA's registered addresses and record returned mail and re-mail attempts;

b. Call any telephone number maintained in OHCA's records or other publicly available sources; and

c. Notify OHCA, through a method to be specified by OHCA in the Reporting Manual, if the Contractor learns of a new address for the Enrollee.

1.12.3.9 Monitoring Effectiveness of Contractor Materials

The Contractor shall monitor and evaluate the effectiveness of its Enrollee and Eligible materials and distribution as directed by OHCA. The Contractor shall be responsible for tracking, at minimum, website hits and returned mail rates. The Contractor will be required to provide a tracking report, on a quarterly basis, to OHCA in a manner prescribed by OHCA in the Reporting Manual.

1.12.3.10 OHCA-Developed Enrollee Materials

Pursuant to 42 C.F.R. § 438.10(c)(4), the Contractor shall utilize OHCA-developed definitions for managed care terminology as described in Section 1.12.3.11: "Defined Terms" of this Contract, the model Enrollee Handbook as described in Section 1.12.5: "Enrollee Handbook" of this Contract and Enrollee notices. The model materials developed by OHCA may include translations of Enrollee materials into prevalent non-English languages.

The Contractor shall be responsible for producing and distributing written materials for Enrollees, in addition to OHCA-developed model materials.

1.12.3.11 Defined Terms

For consistency in the information provided to Enrollees and pursuant to 42 C.F.R. § 438.10(c)(4)(i), OHCA will develop and require the Contractor to use standardized definitions for managed care terminology, which some definitions are set forth in Appendix 1B: "Definitions" of this Contract, including:

a. Appeal;

b. Co-payment;

c. DME, prosthetics/orthotics, and supplies;

d. Emergency Medical Condition;

e. Emergency Medical Transportation;

f. Emergency Room Care;

g. Emergency Services;

h. Excluded Services;

i. Grievance;

j. Health Insurance;

k. Home Health Care;

l. Hospice Services;

m. Hospitalization;

n. Hospital Outpatient Care;

o. Medically Necessary;

p. Network;

q. Non-Participating Provider;

r. Participating Provider;

s. Physician Services;

t. Plan;

u. Preauthorization;

v. Premium;

w. Prescription Drug Coverage;

x. Prescription Drugs;

y. Primary Care Physician;

z. Primary Care Provider (i.e., PCP);

aa. Provider;

bb. Skilled Nursing Care;

cc. Specialist; and

dd. Urgent Care.

1.12.4 New Enrollee Materials and Outreach

The Contractor shall provide the following information to new Enrollees:

a. Enrollee Handbook in accordance with the timing and content requirements of Section 1.12.5: "Enrollee Handbook" of this Contract;

b. Enrollee ID card in accordance with the timing and content requirements of Section 1.12.6: "Enrollee ID Card" of this Contract; and

c. Information regarding how to access a Provider Directory as described in Section 1.12.14: "Provider Directory" of this Contract.

Additionally, the Contractor shall make all reasonable efforts during Initial Program Implementation to contact Enrollees within ninety (90) Days of initial Enrollment and within ten (10) Days of an Enrollee's Enrollment effective date during Steady State Operations. Reasonable effort is defined as at least three (3) attempts to contact the Enrollee with at least one (1) of those attempts by telephone. The three (3) attempts by the Contractor shall not be made within the same day. Telephone attempts should be staggered between different times of the day in an effort to increase the likelihood of contacting the Enrollee.

Upon contacting a new Enrollee, the Contractor shall:

a. Inquire about any urgent health needs, or previously scheduled services, or advise the Enrollee how to contact the Contractor to provide this information;

b. Conduct a Health Risk Screening, in accordance with the requirements outlined in Section 1.9.2: "Health Risk Screening" of this Contract, or inform the Enrollee that he or she will be contacted at a later time for this purpose;

c. Inform the Enrollee about their right to continue certain existing services, as applicable, in accordance with Section 1.10: "Transition of Care (TOC)" of this Contract;

d. Review with the Enrollee what to do in an emergency;

e. Inform the Enrollee about the Contractor's policies with respect to obtaining covered services;

f. Assist the Enrollee in selecting a PCP in accordance with Section 1.12.10: "PCP Selection and Assignment" of this Contract;

g. Provide the Enrollee with the Contractor's telephone numbers and website address;

h. Advise the Enrollee about opportunities available for learning about Contractor policies and benefits in greater detail; and

i. Confirm the Enrollee knows how to access the Contractor's Provider Directory.

1.12.4.1 Failure to Contact

The Contractor shall report to OHCA all Enrollees that it has failed to contact during the first ninety (90) Days of initial Enrollment and within ten (10) Days of the Enrollment effective date during Steady State Operations, the Days of Enrollment, and the nature and disposition of its contact attempts. OHCA will specify the reporting format and timelines in the Reporting Manual.

1.12.5 Enrollee Handbook

1.12.5.1 Distribution Timeframe

The Contractor shall provide each Enrollee an Enrollee Handbook within ten (10) Days after receiving notice of an Enrollee's Enrollment on the ANSI ASC X 12 834 electronic transaction and within ten (10) Days of the Enrollee's request for a new Enrollee Handbook. The Enrollee Handbook serves as a summary of benefits and coverage. Pursuant to 42 C.F.R. § 438.10(g)(4), the Contractor shall give each Enrollee notice of any change that OHCA defines as significant in the information provided in the Enrollee Handbook. The notice shall be provided at least thirty (30) Days before the intended effective date of the change.

1.12.5.2 Distribution Methods

Pursuant to 42 C.F.R. § 438.10(g)(3)(i) - (iv), the Contractor shall be considered to have provided an Enrollee Handbook to the Enrollee if one (1) of the following distribution methods is used:

a. Mailing a printed copy of the Enrollee Handbook to the Enrollee's mailing address;

b. Providing the information by email after obtaining the Enrollee's agreement to receive the Handbook by email;

c. Posting the information on the Contractor's website and advising the Enrollee in paper or electronic form that the information is available on the Contractor's website. The Contractor shall include the applicable Uniform Resource Locator (URL) address provided that Enrollees

with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

d. Providing the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

The Contractor shall develop strategies and policies to ensure that Enrollee Handbooks may be delivered to homeless Enrollees and submit these policies to OHCA for review and approval.

1.12.5.3 Number of Enrollee Handbooks

If the Enrollee Handbook is mailed and there are two (2) or more related Enrollees registered to the same address, the Contractor is permitted to mail one (1) copy to that address. The Contractor shall provide information to the Enrollee about how to request additional copies of the Enrollee Handbook.

Every Enrollee that opts to receive information via email shall receive an electronic version of the Enrollee Handbook.

1.12.5.4 Enrollee Handbook Content

Pursuant to 42 C.F.R. § 438.10(c)(4)(ii), the Contractor shall use OHCA's model Enrollee Handbook content, that includes how to exercise an Advance Directive, in developing a Contractor-specific Handbook for OHCA's review and approval. The content of the Enrollee Handbook shall include information that enables the Enrollee to understand the Contractor. This information shall include at a minimum:

a. A table of contents;

b. Information about how to update any personal information;

c. Information about what managed care is, with emphasis placed on Participating versus Non-Participating Providers;

d. The amount, duration and scope of benefits provided by the Contractor in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled, including information about the EPSDT benefit and how to access component services;

e. Procedures for obtaining benefits, including any policies, procedures, and requirements for PAs and/or referrals for specialty care and for other benefits not furnished by the Enrollee's PCP;

f. Information required AI/AN-specific policies and procedures, including:

   i. Opt-in policies; and

   ii. Rights in accessing care as described in Section 1.17: "American Indian/Alaska Native Population and Indian Health Care Providers" of this Contract;

g. Limitations or exclusions to benefits;

i. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor must inform Enrollees that the service is not covered and how the Enrollee can obtain information from OHCA about how to access those services;

h. Information on how to access all services, including but not limited to EPSDT, transportation (both emergency and non-emergency), behavioral health, and pharmacy;

i. Information on how to access services when out-of-State;

j. How and where to access any benefits provided by OHCA and the SoonerSelect Dental CE, including any Cost Sharing and how transportation is provided;

k. Cost Sharing on any benefits;

l. The toll-free telephone number and Hours of operation for the:

i. Enrollee Services Call Center;

ii. Behavioral Health Services hotline;

iii. Medical management; and

iv. Any other Contractor unit providing services directly to Enrollees;

m. Any restrictions on the Enrollee's freedom of choice among Participating Providers;

n. The process for selecting and changing the Enrollee's PCP;

o. The extent to which, and how, Enrollees may obtain benefits from, including Family Planning Services and Supplies, from Non-Participating Providers. This includes an explanation that the Contractor shall not require an Enrollee to obtain a referral before choosing a Family Planning Provider;

p. An assurance of non-discrimination of services;

q. Enrollee rights and responsibilities, including the Enrollee's right to:

i. Receive information on Enrollee and Plan information;

ii. Be treated with respect and with due consideration for dignity and privacy;

iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

iv. Participate in decisions regarding their health care, including the right to refuse treatment;

v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

vi. Request and receive a copy of their medical records and request that they be amended or corrected in accordance with HIPAA Rules and other applicable federal and State laws and regulations; and

vii. Obtain available and accessible Health Care Services covered under the Contract;

r. Grievance, Appeal, and State Fair Hearing procedures and timeframes, including:

i. The right to file Grievance and Appeal;

ii. Requirements and timeframes for filing a Grievance or Appeal;

iii. The availability of assistance in the filing process;

iv. The right to request a State Fair Hearing after the Contractor has made a determination on the Enrollee's Appeal which is adverse to the Enrollee; and

v. The fact that, when requested by the Enrollee, benefits that the Contractor seeks to reduce or terminate will continue if the Enrollee files an Appeal or requests a State Fair Hearing within the timeframes specified for filing. The Enrollee may, consistent with State policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Enrollee;

s. How to exercise an Advance Directive;

t. How to access auxiliary aids and services, including additional information in alternative formats or languages;

u. Information on how to report suspected Fraud or Abuse;

v. Explanation of the role of the PCP;

w. An explanation of how Enrollee care needs, conditions, and geographic location will factor into the assignment of a PCP;

x. TOC policies for Enrollees and Eligibles;

y. The role of the Care Manager/Care Management department and how to contact this individual or department;

z. Explanation of circumstances in which the Enrollee may be billed for services or fees;

aa. General health and wellness literacy information;

bb. In accordance with 42 C.F.R. § 438.10(g)(2)(v), Information on the extent to which, and how, after-hours and emergency care is provided, what constitutes an Emergency Medical Condition, and what constitutes an Emergency Service;

cc. Explanation about how to disenroll from the Contractor's plan; and

dd. Any other content required by OHCA.

The Enrollee Handbook shall also explicitly outline the following Enrollee responsibilities:

a. Checking OHCA/Contractor's information, correcting inaccuracies, and allowing government agencies, employers, and Providers to release records to OHCA/Contractor;

b. Notifying OHCA/Contractor within ten (10) Days if there are changes in income, the number of people living in the home, address, or mailbox changes or Health Insurance changes;

c. Transferring, assigning, and authorizing to OHCA all claims the Enrollee may have against Health Insurance, liability insurance companies, or other third-parties. This includes payments for medical services made by OHCA for the Enrollee's dependents;

d. Responding to requests from the OHS Office of Child Support Services;

e. Allowing SoonerCare to collect payments from anyone who is required to pay for medical care;

f. Sharing necessary medical information with any insurance company, person or entity who is responsible for paying the bill;

g. Inspecting any medical records to see if claims for services can be paid;

h. Obtaining permission for OHS or OHCA to make payment or Overpayment decisions;

i. Storing their identification card and knowing their Social Security Number to receive Health Care Services or prescriptions;

j. Confirming that any care received is covered;

k. Understanding Enrollee responsibility as it pertains to securing NEMT and the timeframes required to receive NEMT services;

l. Cost Sharing; and

m. Ensuring all information provided to OHCA/Contractor is complete and true upon penalty of Fraud or perjury.

1.12.6 Enrollee ID Card

The Contractor shall distribute a physical, paper Enrollee ID card to each Enrollee in a household within seven (7) Days of receiving the ANSI ASC X 12 834 electronic transactions from OHCA. Following the distribution of the initial ID card, the Contractor must provide the Enrollee the option to receive an electronic ID card, or a permanent, physical ID card that must be made out of durable material suitable for everyday use, such as durable laminated paper.

If the Enrollee loses their Enrollee ID card, or the Enrollee's information changes, the Contractor shall update and reissue the Enrollee ID card within seven (7) Days of receiving notification of the change or

loss. The Enrollee must also be able to access and print a new card through the Enrollee Portal described in Section 1.12.7.3: "Enrollee Website Portal" of this Contract.

Each Enrollee ID card must include sufficient information to identify the Enrollee's identity and Contractor information to facilitate claims filing for all Participating Providers.

The Contractor must submit a sample Enrollee ID card to OHCA during Readiness Review for review and approval.

1.12.7 Enrollee Website

1.12.7.1 General Website Requirements

The Contractor shall develop an Enrollee website. In developing the Enrollee website, the Contractor shall:

a. Maintain a separate and distinct section on its website for SoonerSelect Program information if the Contractor markets other lines of business;

b. Ensure posted information is current and accurate;

c. Review and update website content at least monthly, or as needed;

d. Include a date stamp on each webpage with the date the page was last updated;

e. Clearly label any links;

f. Notify individuals that they will leave the Contractor's SoonerSelect Program website if there is a link that will take individuals to non-SoonerSelect Program information or to a different website;

g. Comply with HIPAA when providing Enrollee eligibility or Enrollee identification on the website, including the Enrollee and Provider portal(s);

h. Ensure website content can be viewed via mobile devices;

i. Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention; and

j. Ensure accessibility for all users by following the Web Content Accessibility Guidelines (WCAG).

1.12.7.2 Website Content

The Contractor must submit all website pages and content related to the SoonerSelect Program to OHCA during Readiness Review for review and approval before making the content public. At a minimum, the Contractor shall include the following information on its website:

a. Contractor's contact information, including address, Enrollee Services Call Center toll-free number and TTY/TDD number;

b. Contractor's office Hours/Days, including availability of customer service;

c. Provider directory and information on how to find a Participating Provider near the Enrollee's residence;

d. Description of any restrictions on the Enrollee's freedom of choice among Participating Providers, as well as the extent to which Enrollees may obtain benefits from Non-Participating Providers;

e. The PDL, including:

   i. Covered generic and brand name medications;

   ii. Whether the drug requires PA; and

   iii. What tier each medication is in;

f. Link to OHCA website and/or other pages within the website, as specified by OHCA;

g. The amount, duration, and scope of benefits available by the Contractor in sufficient detail to ensure that Enrollees are informed of the services to which they are entitled, including PA requirements;

h. Procedures for obtaining benefits, including PA requirements;

i. Enrollee Handbook;

j. Accreditation information in accordance with Section 1.4.2: "Accreditation" of this Contract; and

k. Grievance, Appeal, and State Fair Hearing processes.

The Contractor may include the following information on its website:

a. Marketing Materials specific to OHCA-approved Value-Added Benefits and/or quality rating reports; and

b. Materials intended to be read by Enrollees or Eligibles, such as newspaper articles and news releases, with prior approval from OHCA.

Following SoonerSelect Program implementation, the Contractor shall request updates to website content in accordance with Section 1.12.3.2: "Prior Approval Process" of this Contract.

1.12.7.3 Enrollee Website Portal

The Contractor must provide an Enrollee portal on its website with a single sign-on process that can be accessed on a variety of electronic devices, including a computer or mobile device. The Enrollee portal must at least:

a. Allow Enrollees to access and print Enrollee ID cards; and

b. Provide EOB information.

1.12.7.4 508 Compliance

The Contractor shall ensure that all electronic information and services will be compliant with all language, formatting, and accessibility standards or guidelines that provide greater accessibility to individuals with disabilities. This includes compliance with Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-12 and the Oklahoma EITA law at 62 O.S. §§ 34.16 and 34.28 through 34.30. The Contractor shall notify Enrollees that materials are available in paper form and through auxiliary aids and services upon request and at no cost. The Contractor must provide an accessibility report to OHCA upon request.

1.12.7.5 Website Translation

The Contractor shall ensure that website content will also be available in the prevalent non-English languages, in accordance with the requirements of Section 1.12.1.1: "Prevalent Non-English Languages and Auxiliary Aids" of this Contract. The Contractor shall receive approval of the translation from OHCA before publishing it online in accordance with the requirements of Section 1.12.3.2: "Prior Approval Process" of this Contract.

1.12.7.6 Machine Readable Data

The Contractor shall post its Provider directories and formularies on its website in a machine-readable file and format specified by the Secretary of HHS.

1.12.7.7 Social Media and Mobile Applications

The Contractor or its Subcontractor shall utilize social media platforms and mobile applications to provide Enrollees with health topic information and SoonerSelect Program information. Social media shall be used to maximize Contractor communication with Enrollees.

The Contractor shall receive approval from OHCA before utilizing a new social media platform. OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

The Contractor or its Subcontractors shall comply at all times with all State and federal marketing regulations, the terms of this Contract, and with the social media and mobile applications policy within the most current OHCA Operations Manual while utilizing social media or mobile applications. OHCA must approve the use of a new social media platform prior to its use with Enrollees. OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract or regulatory standards.

A monthly social media calendar must be submitted to OHCA for prior approval of any social media posts or information targeted to SoonerSelect Program populations or using the SoonerSelect Program name or logo, as specified in the Reporting Manual.

Social media posts that boost, tag, or sponsor customer-paid insurance content must not be tailored to or directed to the SoonerSelect Program population or mention SoonerSelect Program by name or logo. Social media posts that boost, tag, or sponsor the SoonerSelect Program must not be tailored to or

directed to the SoonerSelect Program population. Social media posts that boost, tag, or sponsor free educational or healthy life content may be tailored to or directed to the SoonerSelect Program population.

Social media posts may tag or mention OHCA or any related account or channel whenever the content of the post specifically relates to the SoonerSelect Program and has been pre-approved by OHCA per the monthly social media calendar or otherwise.

During live events, OHCA will monitor social media posts in real time and will alert the Contractor's Communications Director of immediate take-down requirements. Immediate take-down means within one (1) Hour of the Contractor receiving notice of OHCA's requirement to take down a social media post.

OHCA reserves the right to require take-down of or changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

The following permissible activities are applicable to the Contractor, its Agents, Subcontractors, and Providers:

a. With OHCA's prior written approval, the Contractor may partake in forms of social media advertising (i.e., Twitter, Facebook, Instagram);

b. With OHCA's prior written approval, the Contractor may purchase advertisement banners on social media outlets. The content of such advertisements must be approved by OHCA prior to distribution;

c. The Contractor may post Medicaid events on social media sources. The content of such posts must be approved by OHCA prior to posting;

d. The Contractor may post general non-advertising information regarding the Contractor's activities. The content of such posts does not require OHCA's prior approval; and

e. Any Enrollee complaints received through the social media sources must be processed and resolved through the general complaint intake system.

The following prohibitions are applicable to the Contractor, its Agents, Subcontractors, and Providers:

a. Posting or sending any protected private information on social media sources;

b. Advertising on social media platforms that entail direct communication with prospective Enrollees. This list includes, but is not limited to: Snapchat, Skype, WhatsApp, Facebook Messenger, MeetUp, Viber, and any other personal communication services;

c. Responding to any comments on social media posts from prospective Enrollees except when to provide general response, such as the Contractor phone number, links to the Contractor web site or the Enrollment broker phone number;

d. Partaking in individual communication on social media outlets;

e. Requesting followers or adding individuals as friends (i.e., friends on Facebook, followers on Instagram or Twitter); and

f. Tagging individuals on social media source.

1.12.8 Enrollee Services Call Center

1.12.8.1 Enrollee Services Call Center Availability

The Contractor shall operate a toll-free Enrollee Services Call Center in accordance with the location requirements outlined in Section 1.4.5: “Oklahoma Presence” of this Contract and aimed at addressing questions from Enrollees and their representatives. The Contractor shall ensure that the Enrollee Services Call Center has warm transfer capabilities to 911 Emergency Services and 988 Mental Health Lifeline.

The Contractor may operate an overflow call center within the United States for the purposes of meeting the Enrollee Services Call Center performance requirements described in Section 1.12.8.2: “Enrollee Services Call Center Performance Standards” of this Contract.

The Contractor shall ensure the Enrollee Services Call Center is staffed and operational, at minimum, from 8:00 am to 5:00 pm Central Time on Monday through Friday, except for State Holidays, 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 - "Holiday" defined.

The Contractor shall operate an after-hours system for fielding calls outside of Call Center operating Hours. This system shall record any message the Enrollee leaves, their name, and telephone number. The Contractor shall ensure that all calls are returned during the next Business Day.

The Contractor shall record all calls and emails received and store them in a searchable database. The Contractor shall have the ability to retrieve these calls and emails within one (1) Business Day.

The Contractor shall also maintain a remote monitoring system that OHCA may be able to use to survey the Contractor and Enrollee interaction.

1.12.8.2 Enrollee Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Enrollee Services Call Center activities and performance. The Contractor shall ensure the Call Center meets the following minimum performance requirements:

a. Call abandonment rate shall be less than five percent (5%);

b. No incoming call shall receive a busy signal;

c. Eighty percent (80%) of calls shall be answered by a live voice within sixty (60) seconds of the first ring;

d. Average wait time shall not exceed thirty (30) seconds;

e. Blocked call rate shall not exceed one percent (1%); and

f. The overflow call center must not receive more than five percent (5%) of all incoming calls to the Call Center.

The Contractor shall have the capability to track these Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Enrollee Services Call Center reporting shall break down performance by:

a. The Contractor's main Enrollee Services Call Center;

b. Overflow call center, if applicable; and

c. Applicable Subcontractors.

The Contractor shall also have the capability to track Grievances received in the Enrollee Services Call Center by volume and type. The Contractor shall have the capability to compare and report its Oklahoma Call Center's performance to the performance of its Affiliates in other states, if it has Affiliates, and if similar performance standards are tracked.

At the end of each Contract Year, the Contractor shall issue to OHCA an annual report detailing performance of the Call Center and mapping out improvement strategies for the following year.

1.12.8.3 Call Center Training

The Contractor shall develop a program to train newly hired Enrollee Services Call Center staff and to conduct ongoing training for all Call Center staff. This training program shall address topics that include, at least:

a. The populations covered under the SoonerSelect Program;

b. Covered and non-covered services;

c. Enrollment and Disenrollment;

d. Fielding eligibility questions;

e. Accessing services in- and out-of-Network;

f. Care Management;

g. Services for AI/AN Enrollees;

h. Cultural and linguistic competency;

i. PCP selection and assignment;

j. Out-of-State services; and

k. Filing a Grievance or Appeal.

The training program shall teach Call Center staff to interact with Enrollees efficiently, patiently, and respectfully. The staff shall be trained so that they are equipped to recognize situations where an Enrollee has LEP or is hearing impaired and to direct them to the appropriate resources.

Call Center staff shall receive training quarterly, or more frequently as needed, through instructor-led training or staff meetings. The staff shall also be retrained prior to the effective date of a major change in service delivery or covered services.

The Contractor shall submit its Call Center training program to OHCA during Readiness Review and annually for review and approval as specified in the Reporting Manual.

1.12.8.4 Multilingual Representatives

The Contractor shall have multilingual Enrollee Services Call Center representatives able to field calls for every prevalent non-English language. The Contractor shall also submit a plan for identifying Enrollees with LEP and providing these Enrollees with the translation or interpretation services necessary to have their question or issue resolved in a timely manner. The Contractor's plan must comply with the minimum requirements of Section 1.12.1.2: "Interpretation Services" of this Contract.

1.12.8.5 Redetermination Assistance

The Contractor is permitted via the Enrollee Services Call Center to provide assistance to Enrollees with questions regarding the SoonerCare annual eligibility redetermination process. The Contractor is permitted to answer questions about the redetermination process and assist the Enrollee in obtaining the required documentation necessary to complete the process. In providing assistance for eligibility redeterminations, the Contractor is prohibited from the following:

a. Acting in the role of a SoonerCare eligibility Agent;

b. Discriminating against Enrollees, particularly high-cost Enrollees or Enrollees that have indicated a desire to change CEs;

c. Talking to Enrollees about changing CEs. If an Enrollee has questions or requests to change CEs, the Contractor shall refer the Enrollee to OHCA or its designee;

d. Providing any indication as to whether the Enrollee will be eligible, as this decision is at the sole discretion of OHCA;

e. Engaging in or supporting fraudulent activity in association with helping the Enrollee complete the redetermination process; or

f. Signing or sending any redetermination forms on behalf of the Enrollee.

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.

1.12.8.7 Enrollee Rights

Pursuant to 42 C.F.R. § 438.100(a)-(c), the Contractor shall have written policies guaranteeing each Enrollee's right to:

a. Receive information on the SoonerSelect Program and the Contractor;

b. Be treated with respect and with due consideration for their dignity and privacy;

c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

d. Participate in decisions regarding their health care, including the right to refuse treatment;

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

f. Request and receive a copy of their medical records, and to request that they be amended or corrected in accordance with HIPAA Rules and other applicable laws and regulations.

Pursuant to 42 C.F.R. §§ 438.100(a)(1) and 438.100(c), each Enrollee is free to exercise their rights without the Contractor or its Participating Providers treating the Enrollee adversely.

Enrollee rights will at least appear in the Enrollee Handbook, described in Section 1.12.5: "Enrollee Handbook" of this Contract.

1.12.9 Advisory Board

The Contractor shall establish a standing Advisory Board that includes Enrollees, Enrollee representatives (e.g., family members and caregivers), advocates, and Participating Providers. Enrollees and Enrollee representatives shall constitute a majority of the Advisory Board, which shall include at least ten (10) persons in total. The Advisory Board, in its composition, shall reflect the Contractor's total membership in terms of geography, aid category, race, and ethnicity and shall specifically include Enrollees who receive Behavioral Health Services, or other individuals representing the Enrollees.

The Contractor shall submit the proposed Advisory Board membership to OHCA for review and approval, prior to convening the first meeting, as specified in the Reporting Manual. The Contractor shall keep OHCA advised of changes in membership as they occur.

The Contractor shall convene meetings at least quarterly and shall consult the Advisory Board on matters affecting Enrollee and Provider experience, including but not limited to:

a. Enrollee outreach and educational activities and materials;

b. Provider outreach and educational activities and materials;

c. Quality improvement plan, including:

   i. Selection of PIP topics and sharing of results;

   ii. Identification of measures to be evaluated for the purpose of documenting the Contractor's performance in both the short- and long-term; and

   iii. Strategies for addressing operational deficiencies, as identified through Grievance and Appeal trends, Enrollee satisfaction data, Enrollee appointment wait times, and other quality data.

The Advisory Board shall meet at least quarterly, with the first meeting to be held no later than ninety (90) Days after initial Enrollee Enrollment into the SoonerSelect Program. The Contractor shall inform OHCA at least thirty (30) Days in advance of each meeting and shall permit OHCA to send representative(s) to observe the meeting, if OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the Enrollee and the family of the Enrollee, or other person assisting the Enrollee to each meeting, to facilitate attendance by board Enrollees and their representatives. The Contractor is permitted to offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Advisory Board meetings and Board activities and results. The Contractor shall submit the record in a manner and format specified by OHCA upon request.

1.12.9.1 Behavioral Health Advisory Board

In addition to the Advisory Board required under Section 1.12.9: "Advisory Board" of this Contract, the Contractor shall establish a Behavioral Health Advisory Board to enhance the delivery of Behavioral Health Services under the Contract, including SUD services. The Behavioral Health Advisory Board shall include representation by behavioral health Participating Providers, peer recovery support Specialists, Enrollees who are consumers of Behavioral Health Services, and Enrollee representatives. Enrollees and Enrollee representatives shall constitute a majority of the Behavioral Health Advisory Board.

At minimum, the Behavioral Health Advisory Board shall have input into the Contractor's policy development, planning for services, service evaluation, and Enrollee, family member and Provider education.

The Behavioral Health Advisory Board shall meet at least quarterly, with the first meeting to be held no later than ninety (90) Days after initial Enrollee Enrollment into the SoonerSelect Program. The Contractor shall inform OHCA at least thirty (30) Days in advance of each meeting and shall permit OHCA to send representative(s) to observe the meeting, if OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the Enrollee and the family member or other person assisting the Enrollee to each meeting, to facilitate attendance by Enrollees and their representatives. The Contractor may offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Behavioral Health Advisory Board meetings, activities, and results. The Contractor shall submit the record in a manner and format specified by OHCA upon OHCA request.

1.12.10 PCP Selection and Assignment

Pursuant to 42 C.F.R. § 438.208(b)(1), the Contractor shall implement procedures to ensure that each Enrollee has an ongoing source of care appropriate to their needs. The Contractor shall formally designate a PCP to all Enrollees to be primarily responsible for coordinating services accessed by the Enrollee. The Contractor shall allow each Enrollee to choose their PCP to the extent possible and appropriate and in accordance with Section 1.12.12: “Assignment Requirements” of this Contract. Any parent or guardian of a Medicaid member who is a minor child enrolled in a CE shall have the right to select the PCP for the Enrollee’s minor child and to change the PCP at any time, as long as the selected PCP is a Participating Provider. The Contractor shall have procedures for serving Enrollees and reimbursing Provider claims from the first Day of Enrollee Enrollment with the Contractor, whether or not the Enrollee has selected or been assigned a PCP.

1.12.11 Eligible Provider Types

The Contractor shall limit PCP types to those specified in Section 1.14.3.1: “PCP Provider Standards” of this Contract. An Enrollee whose PCP site is a multi-Provider clinic can be assigned either to the clinic or a specific practitioner within the clinic to serve as their PCP.

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, 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 PCP Changes

1.12.13.1 Enrollee-initiated PCP Changes

The Contractor must permit Enrollees to change PCPs, without cause. If the Contractor has made an initial assignment, the Contractor must permit the Enrollee to change during the first month, effective the following Business Day. The Contractor may limit the effective date of changes after the first month of Enrollment to the beginning of the following month.

The Contractor must ensure that Enrollees have at least two (2) age- and gender-appropriate PCPs within the travel time and distance standards specified in Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract from which to select.

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.

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.

1.12.13.3 Notification of PCP Termination

Pursuant to 42 C.F.R. § 438.10(f)(1), the Contractor shall make a good faith effort to give written notice of termination of a Participating Provider to each Enrollee who received their primary care from, or was seen on a regular basis by, the terminated Provider. The Contractor shall provide notice to an Enrollee by the later of thirty (30) Calendar Days prior to the effective date of the termination, or fifteen (15) Calendar Days after receipt or issuance of the termination notice. The Contractor may provide notice earlier, as appropriate, to ensure quality of care.

"Regular basis," at a minimum, shall be construed to mean any Provider delivering care on a routine basis defined in the Enrollee's Care Plan, as applicable. When clinically appropriate, the Contractor shall conduct immediate outreach and support for Enrollees to select alternative Providers. For Enrollees who are receiving treatment for a chronic or ongoing medical condition, the Contractor shall ensure that there is no disruption in services.

1.12.14 Provider Directory

1.12.14.1 Format and Distribution

The Contractor shall have a Provider directory available in electronic and paper formats. The directory shall be distributed to Enrollees at least annually in paper format or through a reminder notification to Enrollees of its availability on the Contractor's website. If the Contractor does not routinely distribute paper copies, the Contractor shall distribute a paper copy if requested by an Enrollee.

1.12.14.2 Content

Pursuant to 42 C.F.R. §§ 438.10(h)(1)(i)-(viii) and 438.10(h)(2), the Provider directory shall contain the following information about the Contractor's Participating Providers:

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. 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.

1.12.14.3 Submission Process and OHCA Approval

The Contractor shall submit its Provider Directory to OHCA for review and approval at least thirty (30) Days prior to distribution. The open panel status of the Provider shall be updated online as it changes. Review from OHCA is not necessary to change the open panel status.

1.12.14.4 Updates

The Contractor shall update its Provider directory at the following timeframes:

a. At least monthly for the paper directory; and

b. No later than three (3) Business Days after the Contractor receives updated Provider information for the online version of the directory.

1.12.14.5 Website Publication

In accordance with 42 C.F.R. § 438.10(h)(4), the Contractor shall make the Provider directory available on its website without a login requirement and in a machine-readable file and format as specified by the Secretary of HHS.

1.12.15 Physician Incentive Plan Notification

Pursuant to 42 C.F.R. § 438.10(f)(3), if the Contractor uses physician financial incentive plans, the Contractor must make available information about the incentive program. The Contractor shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions, and report information to OHCA as specified in the Reporting Manual. Any such incentive plans must comply with all applicable laws, including, without limitation 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R § 417.479.

1.12.16 Marketing and Outreach

Marketing is any communication from the Contractor to an Eligible who is not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Eligible to:

a. Enroll in the Contractor's Medicaid product; or

b. Either to not enroll in, or to disenroll from, another CE.

Marketing does not include:

a. Communication to an Eligible from the issuer of a Qualified Health Plan (QHP), as defined in 45 C.F.R. § 155.20, about the QHP; and

b. Communication related to educating Enrollees about Contractor operations or educating Enrollees as part of Care Management activities.

Marketing Materials are materials that are produced in any medium, by or on behalf of the Contractor, and can reasonably be interpreted by OHCA or its designee as intended to market the Contractor (or its employees, Participating Providers, Agents, or Subcontractors) to Eligibles. Marketing Materials include verbal presentation and written materials as well as advertising, public service announcements, printed publications, websites, social media, mobile device applications, broadcasts, and electronic messages.

1.12.16.1 Policies and Procedures

The Contractor shall develop and maintain written policies and procedures governing the development, implementation and distribution of Marketing activities and materials that, among other things, includes methods for quality control to ensure materials are accurate and do not mislead, confuse, or defraud Enrollees, OHCA, or the State.

1.12.16.2 Training Curriculum

The Contractor shall develop training curriculum, which should include the items at a minimum identified in Section 1.4.6.8: "Staff Training" of this Contract. The Contractor v shall provide training for Marketing representatives, including the Contractor's staff and Subcontractors. The Contractor shall maintain documentation of training efforts and provide such documentation upon request to OHCA.

1.12.16.3 Literacy/Format

The Contractor shall ensure that its Marketing activities and materials are designed to meet the informational needs, relative to Marketing, of the cultural and physical diversity of the SoonerSelect Program population. All Marketing Materials shall be in compliance with the information requirements in 42 C.F.R. § 438.10 to ensure that, before enrolling, an Eligible receives accurate oral and written information needed to make an informed decision on whether to enroll.

For further instruction on the requirements for written materials, refer to Section 1.12.3: "Written Material Guidelines" of this Contract.

1.12.16.4 OHCA Review and Approval Process

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall not distribute Marketing Materials without first obtaining OHCA written approval. As set forth in 42 C.F.R. § 438.104(c), OHCA shall consult with the Medical Care Advisory Committee established under 42 C.F.R. § 431.12 on the Marketing Material review process.

The Contractor shall submit Marketing Materials to OHCA for review and approval in accordance with the requirements of Section 1.12.3.2: "Prior Approval Process" of this Contract at least ninety (90) Days prior to expected use and distribution. The Contractor shall not change any approved materials without the consent and approval of OHCA.

1.12.16.5 Use of State Agency Logos

The Contractor shall not refer to or use OHCA, SoonerSelect, or other State agency name or logo in its Marketing Materials without prior written approval. Any approval given for the name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in its Marketing Materials upon the request of OHCA.

1.12.16.6 Service Area Distribution

In accordance with 42 C.F.R. § 438.104(b), the Contractor shall distribute Marketing Materials to its entire service area as indicated in the Contract.

1.12.16.7 Marketing Plan

The Contractor shall develop and implement a plan that details the Marketing activities the Contractor will undertake, and Marketing Materials the Contractor will create during the Contract period. The Marketing plan shall comply with the Marketing activity standards listed in 42 C.F.R. § 438.104 and include, at a minimum, the following information:

a. Marketing goals and strategies;

b. Details of proposed Marketing activities and events, including calendar of planned outreach activities and events for the first Contract Year, distribution methods, and schedules. This includes any proposed advertising campaigns, website development and launch, social media platform development and launch and printed materials development and distribution;

c. Process for removing outdated materials;

d. How the Contractor shall meet the informational needs, relative to Marketing, of the cultural and physical diversity of its membership;

e. Summary of Value-Added Benefits, if applicable;

f. List of all Subcontractors engaged in Marketing activities for the Contractor;

g. Copy of training curriculum for Marketing representatives, including employees and Subcontractors;

h. Procedures for monitoring and enforcing compliance with Marketing guidelines;

i. Methods for tracking Marketing contacts, including (but not limited to) website visits and social media interactions;

j. Process for responding to unsolicited direct contact from Enrollees or Eligibles; and

k. Details regarding the basis the Contractor uses for awarding bonuses or increasing the salary of Marketing representatives or any other employees involved in Marketing activities.

The Contractor shall submit the Marketing plan to OHCA during Readiness Review and on a schedule as specified in the Reporting Manual for review and approval. The Contractor shall submit any changes to OHCA for review and approval a minimum of thirty (30) Days before intended implementation of the Marketing activity. The plan also shall be updated as requested by OHCA for review, as outlined in the Reporting Manual.

1.12.16.8 Allowable Marketing Activities

The Contractor and its Subcontractors are allowed to perform the following Marketing activities (either written or verbal):

a. Distributing general information through mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets). General material without OHCA, SoonerSelect, or other State logo may be distributed without approval;

b. Responding to verbal or written requests for CE-specific information made by an Enrollee;

c. Organizing or attending activities/events that are designed to benefit the entire community, such as health fairs or other health education and promotion activities which have been prior approved by OHCA;

d. Attending events at the request of OHCA to disseminate or share information about the Contractor, its services, and outcomes; and

e. Offering Eligibles and Enrollees tokens or gifts of nominal value, as long as the Contractor acts in compliance with all Marketing provisions provided for in 42 C.F.R. § 438.104, which addresses

Marketing activities and other State and federal laws, regulations, and guidance regarding inducements.

1.12.16.9 Prohibited Marketing Activities

Pursuant to 42 C.F.R. § 438.104, the Contractor and its Subcontractors are prohibited from engaging in the following Marketing activities (either written or verbal):

a. Distributing Marketing Materials or attending/organizing Marketing events that have not received prior approval from OHCA;

b. Engaging in direct or indirect door-to-door, telephone, email, texting, or other Cold-call Marketing techniques or activities;

c. Influencing Enrollment in conjunction with the sale or offering of any private insurance, except as provided in 42 C.F.R. § 438.104;

d. Distributing plans and materials or making any statement that OHCA determines to be inaccurate, false, misleading, or intended to defraud Enrollees, Eligibles or OHCA. This includes, but is not limited to, statements that mislead or falsely describe covered services, membership or availability of Participating Providers or Participating Providers' qualifications or skills. The Contractor and Subcontractors must ensure this to OHCA;

e. Asserting that an Eligible must enroll in the Contractor to obtain benefits or to not lose benefits;

f. Asserting that the Contractor is endorsed by the CMS, the State, or federal government or similar entity, including any other governmental entity;

g. Assisting with Enrollment or improperly influencing CE selection;

h. Designing a Marketing plan that discourages or encourages CE selection based on health status or risk (however, this provision does not preclude the Contractor from proclaiming expertise or excellence with a specific subpopulation enrolled in the SoonerSelect Program); and

i. Conducting any other Marketing activity prohibited by OHCA during the term of the Contract. OHCA reserves the right to prohibit additional Marketing activities at its discretion.

1.12.16.10 Marketing in Provider Offices

The Contractor may distribute brochures and display posters at Provider offices and clinics that inform patients that the Provider/clinic is part of the Contractor's Network, provided that all CEs in which the Provider/clinic participates have an equal opportunity to be represented.

The Contractor is prohibited from:

a. Requiring Providers to distribute Contractor-prepared Marketing and educational communications to patients;

b. Providing incentives or giveaways to Providers to distribute them to Enrollees or Eligibles;

c. Allowing Providers to solicit Enrollment or Disenrollment with the Contractor or another CE; and

d. Conducting Marketing activities or distributing Enrollee materials in areas where patients primarily receive Health Care Services or are waiting to receive Health Care Services.

The Contractor shall instruct Providers on permissible and prohibited Marketing activities and obtain the written consent of the Provider(s) when conducting any form of Marketing in a Provider's office. The Contractor shall maintain records of the instruction and consent.

1.12.16.11 Marketing on Social Media and Mobile Applications

All Marketing activity conducted through social media or Mobile Applications is subject to the general Marketing activity standards within this Contract, as well as all State and federal regulations. For a list of social media and mobile application specific activities, please see Section 1.12.7.7: "Social Media and Mobile Applications" of this Contract.

1.12.17 Media Contacts

The Contractor shall not provide information to the media or participate in media interviews without the prior consent of OHCA. In circumstances where time is of the essence, OHCA will make a good faith effort to review the Contractor's request and respond within one (1) Business Day. The Contractor shall refer to OHCA any contacts by the media or entity/individual not directly related to the program.

1.13 Provider Network Development

1.13.1 General Network Development and Contracting Standards

1.13.1.1 Contractor Approach, Policies and Procedures for Provider Contracting

1.13.1.1.1 Approach

The Contractor shall develop and utilize a standardized approach to contracting with Providers for participation in the Contractor's Participating Provider Network. This approach shall incorporate, at a minimum, the following elements as further described in this Section:

a. Credentialing and recredentialing process; and

b. A written Provider Agreement that lists the contractual obligations between the Contractor and the Participating Provider.

1.13.1.1.2 Policies and Procedures

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(a), the Contractor shall maintain written policies and procedures on:

a. Participating Provider selection;

b. Retention and termination of a Participating Provider's participation with the Contractor;

c. Responding to changes in the Contractor's Network of Participating Providers that affect access and ability to deliver services in a timely manner; and

d. Access standards.

All policies and procedures required under Section 1.13: "Provider Network Development" of this Contract shall be submitted to OHCA during Readiness Review and upon request for review and approval as specified in the Reporting Manual.

In accordance with 42 C.F.R. §§ 438.12(a)(2) and 438.214(c), the Contractor's written policies and procedures on Participating Provider selection, retention and termination shall not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

The Contractor shall follow written policies and procedures for Provider contracting and Network development, including at minimum:

a. Provider selection, retention, and termination;

b. Network participation outreach activities;

c. Network participation application and processing;

d. Network changes impacting access standards and the Contractor's ability to deliver services under this Contract in a timely manner;

e. Credentialing and recredentialing processes;

f. Nondiscrimination of Providers;

g. Excluded Providers;

h. Provider Agreements; and

i. Provider Payment.

In accordance with 56 O.S. § 4002.5(G) the Contractor or a Subcontractor shall not enforce a policy or Contract term with a Provider that requires the Provider to Contract for all products that are currently offered or that may be offered in the future by the Contractor or Subcontractor.

1.13.1.2 Adequate Network

In accordance with 42 C.F.R. § 438.206(b)(1), the Contractor shall maintain and monitor a Network of appropriate Participating Providers, supported by a signed Provider Agreement that is sufficient to provide adequate access and availability to all services covered under this Contract for all Enrollees, including those with LEP or physical or mental disabilities. The Contractor shall provide reasonable and adequate Hours of operation, including twenty-four (24) Hour availability of information, referral, and treatment for Emergency Medical Conditions and shall make arrangements with, or referrals to, a sufficient number of physicians and other practitioners to ensure that the services under this Contract can be furnished promptly and without compromising the quality of care, in accordance with 42 C.F.R. §§ 438.3(q)(1) and (q)(3).

In developing an adequate Network of Participating Providers, the Contractor shall:

a. Meet and require its Participating Providers to meet State standards for timely access to care and services, as specified in this Contract, taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i);

b. Ensure that its Participating Providers offer Hours of operation that are no less than the Hours of operation offered to commercial Enrollees or comparable to other SoonerCare populations, if the Participating Provider serves only SoonerCare Eligibles, in accordance with 42 C.F.R. § 238.206(c)(1)(ii);

c. Make services included in this Contract available twenty-four (24) Hours a day, seven (7) Days a week, when Medically Necessary, in accordance with 42 C.F.R. § 438.206(c)(1)(iii);

d. Establish mechanisms to ensure compliance of with timely access requirements by Participating Providers, in accordance with 42 C.F.R. § 438.206(c)(1)(iv);

e. Monitor Participating Providers regularly to determine compliance with timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(v); and

f. Take corrective action if the Contractor, or its Participating Providers, fail to comply with the timely access requirements, in accordance with 42 C.F.R. § 438.206(c)(1)(vi).

The Contractor shall be able to demonstrate the Contractor's ongoing activities and efforts to comply with these standards. OHCA shall monitor and review the Contractor's compliance with these standards as part of its ongoing oversight activities.

Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract provides a listing of the minimum required components of Network access standards. This is not meant to be an all-inclusive listing of Provider types and components of the Participating Provider Network. The Contractor's Participating Provider Network for other service Providers must be adequate to ensure that care is available timely and geographically accessible. In addition, the Contractor shall add additional Participating Providers based on the needs of Enrollees or due to changes in State or federal requirements.

In accordance with 42 C.F.R. § 438.206(b)(4), if the Contractor is unable to provide necessary medical services covered under this Contract to a particular Enrollee, the Contractor shall adequately and timely cover the services provided out-of-Network by a Non-Participating Provider, for as long as the Contractor is unable to provide the services within the Contractor's Network of Participating Providers. The Contractor shall coordinate payment with Non-Participating Providers and ensure that the cost to the Enrollee is no greater than it would be if the services were furnished by a Participating Provider, in accordance with 42 C.F.R. § 438.206(b)(5).

As described in Section 1.7.19: "Delivery Network" of this Contract:

a. If a female Enrollee's designated PCP is not a women's health Specialist, the Contractor shall provide the Enrollee with direct access to a women's health Specialist within the Contractor's Participating Provider Network for covered routine and preventive women's Health Care Services, in accordance with 42 C.F.R. § 438.206(b)(2); and

b. The Contractor shall provide for a second opinion from a Participating Provider or arrange for the Enrollee to obtain a second opinion outside the Contractor's Participating Provider Network, at no cost to the Enrollee, in accordance with 42 C.F.R. § 438.206(b)(3).

1.13.1.3 Additional Network Contracting Requirements and Limitations

1.13.1.3.1 Non-Discrimination

In accordance with 42 C.F.R. § 438.12(a)(1), the Contractor may not discriminate in the participation, reimbursement, or indemnification of any Provider who is acting within the scope of their license or certification under applicable State law, solely on the basis of that license or certification.

1.13.1.3.2 Written Notice of Decision Not to Contract

If the Contractor declines to include individual or groups of Providers in its Network of Participating Providers, it must give the affected Providers written notice of the reason for its decision in accordance with 42 C.F.R. § 438.12(a)(1).

1.13.1.3.3 Limits on Network Contracting Requirements in this Contract

Notwithstanding other language in this Contract, the Contractor:

a. In accordance with 42 C.F.R. § 438.12(b)(1), shall not be required to execute a Provider Agreement beyond the number necessary to meet the needs of its Enrollees;

b. In accordance with 56 O.S. 2021 § 4002.4.B, shall not exclude essential community Providers, Providers who receive directed payments in accordance with 42 C.F.R. Part 438, and such other Providers, as directed by OHCA from execution of Providers Agreements;

c. In accordance with 42 C.F.R. § 438.12(b)(2), shall not be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

d. In accordance with 42 C.F.R. § 438.12(b)(3), shall not be precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.

1.13.1.3.4 Compliance with OHCA-Determined Provider Selection Requirements

The Contractor shall comply with any and all additional Participating Provider Network selection requirements established by OHCA or the State, in accordance with 42 C.F.R. §§ 438.12(a)(2); 42 C.F.R. 438.214(e) and 56 O.S. 2021 § 4002.4. This shall include all requirements included in this Contract and any amendments thereto, along with all other OHCA guidance on Participating Provider selection along with any applicable State law during the term of this Contract.

1.13.1.4 Screening, Enrollment and Periodic Revalidation

1.13.1.4.1 SoonerCare Participation

In accordance with the Provider disclosure, screening, and enrollment requirements at 42 C.F.R. §§ 438.608(b), 455.100-106 and 455.400-470, the Contractor shall require Providers seeking to become Participating Providers to be enrolled as a contracted Provider with SoonerCare. OHCA shall screen, enroll, and periodically revalidate all Participating Providers as a Provider with SoonerCare, in accordance with 42 C.F.R. § 438.602(b)(1).

1.13.1.4.2 Provider Agreement Execution Pending SoonerCare Enrollment

In accordance with 42 C.F.R. § 438.602(b)(2), the Contractor may execute a Provider Agreement pending the outcome of the of the screening, enrollment and periodic revalidation requirements of 42 C.F.R. § 438.602(b)(1) for up to sixty (60) Days, but must terminate a Participating Provider immediately upon notification from the State that the Participating Provider cannot be enrolled with SoonerCare, or the expiration of a sixty (60) Calendar Day period without enrollment of the Provider with SoonerCare and notify affected Enrollees.

1.13.1.5 Provider Network Development and Management Plan

In accordance with 42 C.F.R. § 438.207(a), the Contractor shall provide assurances to OHCA and provide a Provider Network Development and Management Plan, as specified in the Reporting Manual, that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with OHCA's standards for access to care and in accordance with 42 C.F.R. §§ 438.68 and 438.206(c)(1).

As part of the Provider Network Development and Management Plan, the Contractor shall demonstrate compliance with 42 C.F.R. § 438.206(b), including but not limited to:

a. It offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of Enrollees for the service area, in accordance with 42 C.F.R. § 438.207(b)(1);

b. It maintains a Network of Participating Providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area, in accordance with 42 C.F.R. § 438.207(b)(2);

c. It Contracts with at least one (1) LOPO for a model of care containing Care Coordination, Care Management, UM, disease management, Network management, or another mode of care as approved by OHCA; and

d. It requires its Participating Providers to meet requirements for access to services as set forth at Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract taking into account the urgency of the need for services, in accordance with 42 C.F.R. § 438.206(c)(1)(i).

The Provider Network Development and Management Plan shall contain, at a minimum, information on the following:

a. Summary of Participating Providers, by Provider type and geographical location in the State;

b. An attestation that the Contractor's Network of Participating Providers is sufficient to provide adequate access to all services covered under the Contract for all Enrollees, including but not limited to those with LEP or physical or mental disabilities;

c. Demonstration of monitoring activities to ensure that OHCA-defined Network access standards, including time and distance, are met;

d. Summary of capacity of the Contractor's Network of Participating Providers and Network adequacy issues by type of Provider, service and county and efforts to address those issues; and

e. Ongoing activities for Participating Provider development and expansion considerations.

At a minimum, the Plan shall be submitted to OHCA at the following timeframes in accordance with 42 C.F.R. § 438.207(b)-(c):

a. At the time the Contractor enters into a Contract with OHCA;

b. On an annual basis; and

c. At any time there has been a significant change, as defined by OHCA, in the Contractor's operations that would affect adequacy of capacity of services, including changes in the Contractor's services, benefits, geographic service area, composition of or payments to its Network of Participating Providers or Enrollment of a new population in the Contractor's CE.

OHCA shall review and approve the Contractor's Provider Network Development and Management Plan. Once approved, OHCA shall submit an assurance of compliance to CMS that the Contractor meets OHCA's requirements for availability of services, as set forth in 42 C.F.R. §§ 438.68 and 438.206. The submission to CMS shall include documentation of an analysis that supports the assurance of the adequacy of the Contractor's Network of Participating Providers. OHCA shall make available to CMS, upon request, all documentation collected by OHCA from the Contractor.

1.13.1.6 Participating Provider Network Listing

After execution of the Contract, the Contractor shall supply to OHCA, no later than five (5) Business Days before the end of each month, an up-to-date listing of all Participating Providers. The Contractor's up-to-date listing must include open capacity for PCPs. The listing shall be provided in a format specified by OHCA. OHCA reserves the right to request Participating Provider listing data on a basis more frequently than monthly.

1.13.1.7 Providers Prohibited from Participating

The Contractor shall conduct background checks and similar activities as required under State and federal law, including querying the National Practitioner Data Bank, on all Providers before entering into a Provider Agreement with the Provider.

In accordance with 42 C.F.R. § 438.610, the Contractor shall not knowingly have a relationship with and shall have a proactive method to prevent relationship(s) with entities specified in Section 1.26.9: "Termination for Debarment" of this Contract.

1.13.1.8 Use of OHCA Provider Identification

A list of all Provider types and Provider specialties enrolled by OHCA is included in Appendix 1H: "Provider Types and Specialties" of this Contract. The Contractor shall utilize the same respective identifiers, and any updates thereto, for the Contractor's Participating Providers to ensure appropriate data interfaces with OHCA.

1.14 Provider Agreement Requirements

1.14.1 General Requirements

In all Provider Agreements, the Contractor shall comply with all requirements specified in 42 C.F.R. §§ 438.12, 438.214, and 489.1 through 489.35. The Contractor shall maintain policies and procedures that reflect these requirements.

All Provider Agreements shall be executed in accordance with all applicable State and federal statutes, regulations, policies, procedures, and rules. The Contractor shall identify and incorporate the applicable terms of this Contract and any amendments by or incorporated documents from the State, including the Solicitation for this Contract. Under the terms of the Provider Agreement, the Participating Provider shall agree that all applicable terms and conditions set out in this Contract, any incorporated documents, the Solicitation for this Contract and all applicable State and federal laws, as amended, govern the duties and responsibilities of the Participating Provider with regard to the provision of services to Enrollees.

If any requirement in the Provider Agreement is determined by OHCA to conflict with this Contract, such requirement shall be null and void and all other provisions of the Provider Agreement shall remain in full force and effect.

1.14.1.1 Minimum Content Requirements

All Provider Agreements are subject to OHCA review and approval during Readiness Review and upon OHCA request, and shall contain the following provisions, at minimum:

a. *Parties to the Provider Agreement.* Identify the parties of the Provider Agreement and each party's legal basis of operation in the State of Oklahoma.

b. *Term of Provider Agreement.* Include provisions describing when the Provider Agreement shall become effective and expire.

c. *Termination of the Provider Agreement.* Include the procedures and specific criteria for:

   i. Reasons for termination;

   ii. The Contractor's ability to deny, refuse to renew or terminate any Provider Agreement in accordance with the terms of this Contract and any applicable statutes and regulations;

   iii. Written notice requirements;

   iv. In the event of termination of the Provider Agreement, the Provider shall immediately make available to OHCA or its designated representative in a usable form any or all records whether medically or financially related to the terminated Participating Provider's activities undertaken pursuant to the Provider Agreement and that the provision of such records shall be at no expense to OHCA; and

v. OHCA reserves the right to direct the Contractor to terminate any Participating Provider if OHCA determines that termination is in the best interest of the State.

d. *Independent Contractor.* Specify that the Participating Provider is not a third-party beneficiary to the Contract between the Contractor and the State and that the Participating Provider is an independent contractor performing services as outlined in this Contract between the Contractor and the State.

e. *Scope of Work.* Identify the services, activities, and reporting responsibilities to be performed by the Participating Provider.

f. *National Provider Identifier (NPI).* Require that any Provider, including Providers ordering or referring a covered service, have an NPI, to the extent such Provider is not an atypical Provider as defined by CMS.

g. *Credentialing and Recredentialing.* The Contractor shall maintain all Provider Agreements in accordance with 42 C.F.R. § 438.214.

h. *Enrollee Rights and Responsibilities.* Require all Participating Providers to abide by Enrollee rights and responsibilities denoted in this Contract.

i. *Display Notices of Enrollee Rights to Grievances, Appeals and State Fair Hearings.* Require that the Participating Provider display notices in public areas of the Participating Provider's facility/facilities in accordance with all State requirements and any subsequent amendments.

j. *Physical Accessibility.* Require Participating Providers to provide physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3).

k. *Interpreter Presence.* Require Participating Providers to accommodate the presence of interpreters.

l. *Emergency Services.* Provide that Emergency Services be rendered without the requirement of PA.

m. *Confidentiality.* Require that Enrollee information be kept confidential, as defined by State and federal laws, regulations, and policy.

n. *Record Keeping.* Require Participating Providers to maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates, and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Enrollees and their representatives shall be given access to and can request copies of the Enrollees' medical records to the extent and in the manner provided under State or federal law.

o. *Record Availability.* Require Participating Providers to maintain all records related to services provided to Enrollees for a ten (10) year period. In addition, require Providers to make all Enrollee medical records or other service records available for any quality reviews that may be

conducted by the Contractor, OHCA, or its designated Agent(s) during and after the term of the Provider Agreement.

p. *Professional Standards for Health Records.* In accordance with 42 C.F.R. § 438.208(b)(5), require Participating Providers furnishing services to Enrollees to maintain and share Enrollee health records in accordance with professional standards.

q. *Vaccines for Children, as applicable.* If the Participating Provider is eligible for participation in the Vaccines for Children program, the Contractor shall require the Provider to comply with all program requirements as defined by OHCA.

r. *Facility and Record Access for Evaluation, Inspection or Auditing Purposes.* Include a provision that Authorized Representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Provider Agreement.

s. *Release of Information for Monitoring Purposes.* Include a provision that the Participating Provider shall release to the Contractor any information necessary to monitor Participating Provider performance on an ongoing and periodic basis.

t. *Enrollee Cost Sharing.* Specify the Participating Provider's responsibilities and prohibited activities regarding SoonerSelect Program Cost Sharing. When the covered service provided requires a Co-payment, as allowed by the Contractor, the Participating Provider may charge the Enrollee only the amount of the allowed Co-payment, which cannot exceed the Co-payment amount allowed by OHCA. The Participating Provider shall accept payment made by the Contractor as payment in full for covered services, and the Participating Provider shall not solicit or accept any surety or guarantee of payment from the Enrollee, OHCA, or the State.

u. *Third-Party Liability.* Include a provision for Participating Provider responsibility with respect to Third-Party Liability, including:

    i. The Participating Provider's obligation to identify Enrollee Third-Party Liability coverage, including Medicare and long-term care insurance as applicable; and

    ii. Except as otherwise required, the Participating Provider shall seek such Third-Party Liability payment before submitting claims to the Contractor.

v. *Reimbursement Rates and Risk Assumptions.* Include the reimbursement rates and risk assumptions, if applicable.

w. *Claims Submission and Payment.* Provide for prompt submission of claims information needed to make payment within six (6) months of the covered service being provided to an Enrollee.

x. *Value-based Provider Payments/Incentive Plans.* Describe, as applicable, any performance-based Provider payment(s)/incentive plan(s) to which the Participating Provider is subject.

y. *Quality Management/Quality Improvement (QM/QI) Participation.* The Contractor shall monitor utilization of the quality of services delivered under the Provider Agreement. The Provider Agreement shall require the Participating Provider's participation and cooperation in any

internal and external QM/QI monitoring, utilization review, peer review, and/or Appeal procedures established by OHCA and/or the Contractor and require the Participating Provider's participation in any corrective action processes that will be taken where necessary to improve quality of care.

z. *Data and Reporting.* Provide for the timely submission of all reports, clinical information and Encounter Data required by the Contractor and OHCA.

aa. *Indemnify and Hold Harmless.* Specify that at all times during the term of the Provider Agreement, the Participating Provider shall indemnify and hold OHCA harmless from all claims, losses, or suits relating to activities undertaken by the Provider pursuant to the Provider Agreement.

bb. *Non-discrimination.* Require Participating Providers to:

i. Agree that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of the Contractor's program or otherwise subjected to discrimination in the performance of the Provider Agreement with the Contractor or in the employment practices of the Participating Provider;

ii. Identify Enrollees in a manner which will not result in discrimination against the Enrollee in order to provide or coordinate the provision of covered services; and

iii. Not use discriminatory practices with regard to Enrollees such as separate waiting rooms, separate appointment Days or preference to private pay patients.

cc. *Access and Cultural Competency.* Require Participating Providers to take adequate steps to promote the delivery of services in a culturally competent manner to Enrollees, including those with LEP and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation, or gender identity.

dd. *Database Screening and Criminal Background Check of Employees.* Require Participating Providers to comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Enrollees and/or access to Enrollees' PHI. The Contractor and/or Participating Providers are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid, or any federal health care program as further detailed at Section 1.20.10: "Prohibited Affiliations and Exclusions" of this Contract. The Contractor shall require Participating Providers to conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. The Participating Provider shall be required to immediately report to the Contractor any exclusion information discovered. OHCA reserves the right to deny enrollment or terminate a Provider Agreement with a Participating Provider as provided under State and/or federal law.

OHCA reserves the right to amend these requirements as it deems necessary.

1.14.1.2 Network Provider Agreement Limitations/Restrictions and Assurances

The Contractor shall not include any of the following limitations or restrictions in any Provider Agreement:

a. *Non-Compete Clause*. Prohibit a Participating Provider from entering into a contractual relationship with another CE (i.e., no covenant-not-to-compete) or include any compensation terms (i.e., incentive or disincentive) that encourages a Participating Provider not to enter into a contractual relationship with another CE.

b. *Interference with Provider-Patient Relationship*. In accordance with 42 C.F.R. § 438.102(a)(1)(i)-(iv), the Provider Agreement shall not contain any provisions that prohibit or otherwise restrict Participating Providers acting within the scope of the Participating Provider's license from advising or advocating on behalf of Enrollees for the following:

   i. Enrollee health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

   ii. Any information an Enrollee needs to decide among all relevant treatment options;

   iii. The risks, benefits and consequences of treatment or non-treatment; or

   iv. The Enrollee's right to participate in decisions regarding the Enrollee's health care, including the right to refuse treatment and to express preferences about future treatment decisions.

c. The right to request resolution or support to file a Grievance or Appeal on behalf of an Enrollee if authorized by the Enrollee to do so. The Contractor must include assurances in any Provider Agreement, including single case agreements in Section 1.14.1.4: "Single Case Agreements" of this Contract that it will take no punitive action against a Provider who either requests an expedited resolution or supports an Enrollee's Appeal.

1.14.1.3 Provider Agreement Requirements for Specific Provider Types

The Contractor shall include the following provisions in its Provider Agreements, as applicable to the specific Provider types in this Section.

1.14.1.3.1 PCP Provider Agreements

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 include PCP responsibilities in all Agreements with PCPs. At a minimum, PCP responsibilities specified in the Provider Agreement shall include:

a. Delivering primary care services and follow-up care;

b. Utilizing and practicing evidence-based medicine and clinical decision supports;

c. Screening Enrollees for behavioral health disorders and conditions;

d. Making referrals for specialty care, Behavioral Health Services, and other covered services and, when applicable, working with the Contractor to allow Enrollees to directly access a Specialist as appropriate for an Enrollee's condition and identified needs;

e. Maintaining a current medical record for the Enrollee;

f. Using health information technology to support care delivery;

g. Providing Care Coordination in accordance with the Enrollee's Care Plan, as applicable based on the Contractor's Risk Stratification Level Framework, and in cooperation with the Enrollee's Care Manager;

h. Ensuring coordination and continuity of care with Providers, including but not limited to Specialists and behavioral health Providers;

i. Engaging active participation by the Enrollee and the Enrollee's family, Authorized Representative, or personal support, when appropriate, in health care decision-making, feedback, and Care Plan development;

j. Providing access to medical care twenty-four (24) Hours per day, seven (7) Days a week, either directly or through coverage arrangements made with other Providers, clinics, and/or local hospitals;

k. Providing enhanced access to care, including extended office Hours outside normal Business Hours, and facilitating use of open scheduling and same-day appointments where possible; and

l. Participating in continuous quality improvement and voluntary performance measures established by the Contractor and/or OHCA.

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/CDCPAForms/arc_CDCPA_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.

1.14.1.3.3 Laboratory Testing Sites

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 laboratory testing sites providing services under this Contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

The Contractor shall maintain a comprehensive Network of independent and other laboratories that ensures laboratories are accessible to all Enrollees.

Providers performing laboratory tests are required to be certified under the CLIA. OHCA will continue to update the Provider file with CLIA information. This will make laboratory certification information available to the Contractor on the Medicaid Provider file.

1.14.1.4 Single Case Agreements

The Contractor may enter into a single case agreement with any Provider performing covered services who is not willing to become a Participating Provider with the Contractor. The Contractor must ensure that the Provider is an OHCA Provider. In instances where a single case agreement is needed, and the Provider is not an OHCA Provider, OHCA must approve the single case agreement prior to Contract execution.

1.14.2 Credentialing

All CEs 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.

1.14.2.1 Credentialing and Recredentialing Timeframes

Prior to entering into a Network Provider Agreement, the Contractor shall ensure that Providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications

and requirements for participation in the Oklahoma's Medicaid Program. All applications must be credentialed and the Contractor's claim systems must be able to recognize the Provider as a SoonerSelect Program Network Provider, no later than forty-five (45) Days of receipt of a completed application. The Contractor may request an extension of fifteen (15) Days from OHCA on a case-by-case basis.

If an application does not include required information, the Contractor must provide the Provider written notice of all missing information no later than five (5) Business Days after receipt. For new Providers, the Contractor must complete the credentialing process prior to the effective date of the Network Provider Contract. The recredentialing process must take into consideration Provider performance data including Enrollee Grievance and Appeal, quality of care, and UM. The Contractor shall ensure all credentialed Providers are loaded into the Contractor's Provider files and claims system within fifteen (15) Calendar Days of receipt from the CVO.

The Contractor must review and approve the credentials of all applicable licensed and unlicensed Participating and contracted Providers who participate in the Contractor's Provider Network at least once every three (3) years.

1.14.2.2 Ongoing Monitoring and Peer Review

The Contractor shall complete ongoing monitoring and peer review of Provider compliance, Grievances, and quality issues between recredentialing cycles. The Contractor shall collect and review relevant information and take appropriate and prompt action against Providers when the Contractor identifies occurrences of poor quality.

1.14.2.3 Non-Licensed Providers

When individuals providing services under this Contract are not required to be licensed or certified, the Contractor shall ensure, based on applicable State regulations, rules and/or program standards, that the individuals are appropriately educated, trained, qualified, and competent to perform their job responsibilities. In addition, the Contractor shall perform background checks and database screening in accordance with State and federal laws to ensure the Provider has not been excluded or debarred from participation in Medicare, Medicaid, or any federal health care program or employed/contracted with an individual/entity that has been excluded or debarred from these health care programs. This provision also applies to agency Providers that employ or hire non-licensed staff.

1.14.3 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;

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.

1.14.3.1 PCP Provider Standards

The Contractor shall provide and maintain an adequate Network of PCPs, to ensure that Enrollees have access to all primary care services in SoonerSelect Program benefit package. The Contractor shall ensure that each Enrollee has a PCP.

PCPs include the following Provider types:

a. Physicians licensed in the state where they practice and who are engaged in a general practice or in family medicine, general internal medicine, or general Pediatrics;

b. Indian Health Care Providers;

c. Advanced practice nurses licensed in the state where they practice and have prescriptive authority;

d. Physician assistants licensed in the state where they practice; and

e. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Provider groups, physicians, advanced practice nurses, and physician assistants who meet the descriptions above and are authorized within their scope of practice under state law to provide these services.

The Contractor may allow Enrollees to select a Specialist or subspecialist as the Enrollees' PCP, where medically appropriate, and provided that the selected Specialist Provider is willing to perform all responsibilities of a PCP.

The Contractor shall meet the following access standards for PCPs:

Provider Type	Measure	Standard
Distance		
Adult PCP Pediatric PCP	Urban Distance	Within ten (10) miles of an Enrollee's residence
Adult PCP Pediatric PCP	Rural Distance	Within thirty (30) miles of an Enrollee's residence
Appointment Time		
Adult PCP Pediatric PCP	a. Not to exceed thirty (30) Days from date of the Enrollee's request for routine appointment. b. Within seventy-two (72) Hours for Non-Urgent Sick Visits. c. Within twenty-four (24) Hours for Urgent Care. d. Each PCP shall allow for at least some same-day appointments to meet acute care needs.	

1.14.3.2 Obstetrics and Gynecology (OB/GYN) Provider Standards

The Contractor's Participating Provider Network shall include a sufficient number of OB/GYN Providers to ensure that Enrollees have access to all OB/GYN services in the SoonerSelect Program benefit package and to meet program access standards for adequate capacity.

The Contractor shall meet the following access standards for OB/GYN Providers:

Provider Type	Measure	Standard
Distance		
OB/GYN	Urban Distance	Within ten (10) miles of an Enrollee's residence
OB/GYN	Rural Distance	Within forty-five (45) miles of an Enrollee's residence
Appointment Time		
OB/GYN	OB/GYN: a. Not to exceed thirty (30) Days from date of the Enrollee's request for routine appointment. b. Within seventy-two (72) Hours for Non-Urgent Sick Visits. c. Within twenty-four (24) Hours for Urgent Care. Maternity Care: a. First Trimester – Not to exceed fourteen (14) Calendar Days b. Second Trimester – Not to exceed seven (7) Calendar Days c. Third Trimester – Not to exceed three (3) Business Days	

1.14.3.3 Specialty Provider Standards

The Contractor's Participating Provider Network shall include a sufficient number and type of adult and Pediatric specialty Providers to ensure that Enrollees have access to all specialty care services in the SoonerSelect Program benefit package and to meet program access standards for adequate capacity. The Contractor shall provide Enrollees with access to Network care for at least the following specialty Provider types:

a. Physician (MD/DO) Specialists and subspecialists to provide specialty care services as required in the benefit package;

b. Anesthesiologist assistants;

c. Audiologists;

d. Nutritionists;

e. Opticians;

f. Optometrists;

g. Podiatrists; and

h. Therapists to provide specialty care services as required in the SoonerSelect Program benefit package.

The Contractor shall analyze the clinical needs of the enrolled membership to identify additional specialty Provider types to include as part of the Contractor's Network.

The Contractor shall meet the following access standards for Specialty Providers:

Provider Type	Measure	Standard
Distance		
Adult Specialty Pediatric Specialty	Urban Distance	Within fifteen (15) miles of an Enrollee's residence
Adult Specialty Pediatric Specialty	Rural Distance	Within sixty (60) miles of an Enrollee's residence
Appointment Time		
Adult Specialty Pediatric Specialty	a. Not to exceed sixty (60) Days from date of the Enrollee's request for routine appointment. b. Within twenty-four (24) Hours for Urgent Care.	

1.14.3.4 Behavioral Health Provider Standards

The Contractor's Participating Provider Network shall include a sufficient number and type of behavioral health Providers to ensure that Enrollees have access to all Behavioral Health Services in the benefit package outlined in Section 2: "Behavioral Health Benefits" of Appendix 1G: "Covered Benefits" of this Contract and to meet program access standards. To further Enrollee access to behavioral health Providers, the Contractor shall develop incentive plans to recruit and retain behavioral health professionals and medical practitioners in the Contractor's Network. The Contractor also shall provide for the delivery of Behavioral Health Services via Telehealth, if Enrollee requested, to the extent possible for OHCA-defined services that are reimbursable through Telehealth.

The Contractor's Network shall include all the following Medicaid behavioral health Provider types:

a. Acute and Residential Treatment facilities;

b. Case Management and Psychosocial Rehabilitation Services Providers;

c. MAT Providers;

d. Community Mental Health Centers (CMHCs);

e. Certified Community Behavioral Health Clinics (CCBHCs);

f. Inpatient Psychiatric Hospitals;

g. Licensed Behavioral Health practitioners;

h. Licensure Candidates;

i. Opioid Treatment Programs;

j. Crisis Intervention and Crisis Stabilization Facilities;

k. Behavioral Health Urgent Care Clinics;

l. Outpatient Behavioral Health Agencies, Clinics and Facilities;

m. Programs for Assertive Community Treatment (PACTs);

n. Psychiatrists and Psychologists;

o. Outpatient, Residential, and Medically Supervised Withdrawal Management SUD Treatment Providers; and

p. Therapeutic Behavioral Services, Family Support and Training and Peer Recovery Support Providers.

The Contractor shall meet the following access standards for Behavioral Health Providers, including adult and Pediatric mental health and adult and Pediatric SUD Providers, in accordance with 42 C.F.R. § 438.68(b). The Contractor shall document and make available to OHCA, upon request, any waiting lists preventing the Contractor's Network from admitting an Enrollee to treatment in the prescribed timeframe, if applicable.

Provider Type	Measure	Standard
Distance		
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	Urban Distance	a. Within ten (10) miles of an Enrollee's residence for outpatient visits b. Within sixty (60) miles of an Enrollee's residence for all other treatment settings
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	Rural Distance	a. Within thirty (30) miles of an Enrollee's residence for outpatient visits b. Within ninety (90) miles of an Enrollee's residence for all other treatment settings

Provider Type	Measure	Standard
Appointment Time		
Adult and Pediatric Mental Health Adult and Pediatric Substance Use	a. Not to exceed thirty (30) Days from date of the Enrollee's request for routine appointment. b. Within seven (7) Days for residential care and Hospitalization. c. Within twenty-four (24) Hours for Urgent Care.	

1.14.3.5 Pharmacy Provider Standards

The Contractor's Participating Provider Network shall include a sufficient number of pharmacies to ensure that Enrollees have access to all prescription drug and pharmacy-based medical supplies in the SoonerSelect Program benefit package and to meet program access standards.

The Contractor shall not require as a condition for participation in its pharmacy Network any limitations that would exclude independent retail pharmacies. The Contractor or its PBM shall not steer or require any Providers or Enrollees to use a specific pharmacy for regular prescriptions, refills, or specialty drugs. The Contractor's pharmacy Network under this Contract must be contracted and administered separately from the Contractor's or Subcontractor's commercial network.

In accordance with OAC 535:15-3-9, any pharmacy located outside the State of Oklahoma providing pharmacy services to Oklahoma residents must be licensed by the Oklahoma State Board of Pharmacy. Additionally, the pharmacist in charge must also be licensed by the Oklahoma State Board of Pharmacy.

The Contractor may utilize mail-order pharmacies in its Participating Provider Network but shall not require or incentivize Enrollees to use a mail-order pharmacy, including through different Enrollee Cost Sharing. Enrollees who elect to use this service must not be charged fees, including postage and handling fees. The Contractor or its Subcontractor as part of their coordination of care shall provide oversight and confirm the Enrollees who elect to utilize mail-order pharmacies must initiate the prescription fill, or refill, prior to billing OHCA or if the pharmacy Provider initiates the fill or refill the Enrollee must provide approval for the prescription fill or refill to be processed prior to billing OHCA.

The Contractor or their Subcontractor shall not require Enrollees to use pharmacies that are directly or indirectly owned by the PBM or Contractor, including all regular prescriptions, refills, or specialty drugs regardless of day supply.

The Contractor or their Subcontractor shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital, or other Providers unless it specifically lists all pharmacies, hospitals and Providers participating in the pharmacy network.

The Contractor shall meet the following access standards for Pharmacy Providers, in accordance with the Oklahoma Patient's Right to Pharmacy Choice Act at 36 O.S. §§ 6958, *et seq*. Mail-order pharmacies shall not be used to meet these standards.

Provider Type	Measure	Standard
Distance		
Pharmacy	Urban service area, meaning a five (5) digit zip code in which the population density is greater than 3,000 individuals per square mile	At least ninety percent (90%) of Enrollees reside within two (2) miles of a retail pharmacy participating in the PBM's retail pharmacy network
	Suburban service area, meaning a five-digit zip code in which the population density is between 1,000 and 3,000 individuals per square mile	At least ninety percent (90%) of Enrollees reside within five (5) miles of a retail pharmacy in the PBM's retail pharmacy network
	Rural service area, meaning a five-digit zip code in which the population density is less than 1,000 individuals per square mile	At least seventy (70%) of Enrollees reside within fifteen (15) miles of a retail pharmacy in the PBM's retail pharmacy network
Mail Order Pharmacy	Not applicable	Not applicable
Appointment Time		
Pharmacy	Not Applicable	

1.14.3.6 Indian Health Care Provider Standards

The Contractor shall comply with the Network adequacy requirements of Section 1.17.4: “Indian Health Care Providers (IHCPs)” of this Contract.

1.14.3.7 Hospitals and Essential Community Provider Standards

The Contractor’s Network shall include a sufficient number and type of hospitals and essential community Providers to ensure that Enrollees may access a range of covered physical and mental health services in the setting most appropriate for the Enrollee’s treatment needs.

1.14.3.7.1 Hospitals

Hospitals include the following Provider types:

a. Disproportionate share hospital (DSH) and DSH-eligible hospitals;

b. Children’s hospitals;

c. Sole community hospitals;

d. Critical access hospitals (CAHs); and

e. Level 1 Trauma Centers.

The Contractor shall demonstrate sufficient access to Essential Hospital Services to serve the expected Enrollment and to meet, at minimum, the following:

Provider Type	Measure	Standard
Distance		
Hospitals	Urban Distance	Within ten (10) miles of an Enrollee's residence
Hospitals	Rural Distance	Within forty-five (45) miles of an Enrollee's residence
Appointment Time		
Hospitals	Not applicable	

1.14.3.7.2 Essential Community Providers

Essential community Providers include the following Provider types:

a. FQHCs and RHCs;

b. Family planning Providers (Title X family planning clinics and Title X "look-alike" family planning clinics);

c. IHCPs;

d. County health departments or city-county health departments;

e. Government-funded/operated CMHCs/CCBHCs;

f. Government-operated state mental health hospitals;

g. State agencies, including but not limited to OJA, OSDH, and OHS;

h. Local, regional, and state educational services agencies;

i. Local health departments;

j. Long Term Care Hospitals Serving Children (LTCHs-C);

k. A teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust;

l. A Provider employed by or contracted with, or otherwise a member of the faculty practice plan of a public, accredited medical school in this State or a hospital/health care entity directly or indirectly owned or operated by the University Hospitals Trust or the Oklahoma State University Medical Trust;

m. A Provider employed by or contracted with a primary care residency program accredited by the Accreditation Council for Graduate Medical Education;

n. A comprehensive community addiction recovery center;

o. A hospital licensed by the State of Oklahoma including all hospitals participating the in the Supplemental Hospital Offset Payment Program;

p. Certified Community Behavioral Health Clinics (CCBHCs); and

q. Other entities certified by CMS as an essential community as specified under 45 C.F.R. § 156.235.

At its discretion, OHCA may add additional Providers as essential community Providers if the Provider either offers services that are not available from any other Provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by the Enrollees within the region during the last three (3) years, and the combined capacity of other service Providers in the region is insufficient to meet the total needs of the Enrollees.

The Contractor shall Contract with essential community Providers in the Contractor's service area to the extent possible and practical. If the Contractor is unable to Contract with essential community Providers as required below, the Contractor shall demonstrate to OHCA that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected Enrollment in the Contractor's service area without contracting with essential community Providers. The Contractor shall demonstrate that its Participating Provider Network includes sufficient family planning Providers to ensure timely access to covered services.

Provider Type	Measure	Standard
Distance		
Essential Community Providers	Urban Distance	Within ten (10) miles of an Enrollee's residence
Essential Community Providers	Rural Distance	Within forty-five (45) miles of an Enrollee's residence
Appointment Time		
Essential Community Providers	Not specified	

1.14.3.8 Department of Health

Upon award of this Contract, the Contractor shall extend an offer to all OSDH County Health Departments, including any applicable OSDH mobile clinics, to become a Participating Provider with reimbursement for services at OHCA FFS rates, and any updates thereto, at minimum. In accordance with 63 O.S. §§ 1-105e, when OSDH provides a covered service to any Enrollee, the OSDH may submit a claim for said service to the Contractor. Upon receipt of the claim, the Contractor shall reimburse OSDH for the service provided in accordance with OHCA FFS rates, and any updates thereto, at minimum. The

Contractor shall recognize the public health service delivery model utilized by OSDH as an appropriate Provider of services for reimbursement.

1.14.3.9 Local Oklahoma Provider Organizations (LOPOs)

Pursuant to 56 O.S. § 4002.4, the Contractor must contract with at least one (1) LOPO for a model of care containing Care Coordination, Care Management, UM, disease management, Network management, or another model of care as approved by the Authority. Such contractual arrangements must be in place within twelve (12) months of the effective date of the Contracts awarded.

The Contractor must notify OHCA in writing within five (5) Business Days after contract execution with a LOPO. The notification must include the executed contract, description of the scope of services, and any related incentive payments.

1.14.4 Network Adequacy Exception Process

OHCA shall allow a Contractor to submit to OHCA a formal written request for a waiver of the distance standards in Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract where there are no Participating Providers within the required driving distance, or the Contractor is unable to enter into a Provider Agreement with a particular Provider type.

OHCA will consider requests for waivers to the access standards for all Provider types under limited circumstances. In accordance with 42 C.F.R. § 438.68(d)(1)(ii), the standard by which the exception will be evaluated and approved by OHCA, at minimum, will be based on the number of Providers in that specialty in which the Contractor is requesting the waiver that are practicing in the Contractor's service area. Each waiver request must be supported by information and documentation, as specified by the Reporting Manual.

In accordance with 42 C.F.R. § 438.68(d)(2), OHCA will monitor Enrollee access to the Provider type for which any waiver is granted on an ongoing basis and include the findings to CMS in the managed care program assessment report required under 42 C.F.R. § 438.66 and in the manner and format required in the Reporting Manual.

1.14.5 Provider Agreement Termination

1.14.5.1 Participating Provider Contract Termination

The Contractor and its Participating Providers shall have the right to terminate the Contracts entered into with each other via a Provider Agreement. The Contractor and its Participating Providers may terminate the Provider Agreement for cause with thirty (30) Days advance written notice to the other party and without cause with sixty (60) Days advance written notice to the other party.

The Contractor shall terminate its Provider Agreement with the Participating Provider immediately under the following circumstances:

a. To protect the health and safety of Enrollees;

b. Upon conviction of credible allegation of Fraud on the part of the Participating Provider;

c. When the Participating Provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the Provider to provide services under this Contract; or

d. Upon request of OHCA.

If OHCA terminates a Provider from SoonerCare participation, OHCA shall notify the Contractor. The Contractor shall be responsible for monitoring all relevant State registries to review any Participating Providers that are terminated by OHCA and subsequently excluded from participation in the Contractor's Participating Provider Network.

The Contractor shall follow a process to be defined by OHCA for notification, facilitation of Enrollee records transfer and any other assistance necessary for an orderly transition of health care from a Provider whose Provider Agreement has been terminated.

1.14.5.2 Notification of Participating Provider Network Changes

1.14.5.2.1 Notification to OHCA of Participating Provider Network Changes

The Contractor shall notify OHCA when a Provider Agreement is terminated with:

a. A hospital, FQHC, IHCP facility or any practitioner who is actively serving one hundred (100) or more of the Contractor's SoonerSelect Program Enrollees; or

b. Any Participating Provider whose termination has the potential to compromise the Contractor's ability to meet one (1) or more Network access standards under this Contract.

In such an event, the Contractor shall provide OHCA with a CAP. OHCA reserves the right to Enrollees affected by the termination of the Provider to disenroll from the Contractor's CE in accordance with the provisions of Section 1.26.3.4: "Non-Compliance Remedies" of this Contract.

The Contractor shall work with the terminated Provider to ensure that any Enrollee records and information are provided to the Contractor to facilitate an orderly transition of Enrollee care.

1.14.5.2.2 Notification to Authorities of Provider Agreement Termination

If the Contractor terminates a Provider Agreement, the Contractor must report the Provider's termination to the appropriate authorities, as required by law or regulation, including the National Practitioner Data Bank (NPDB), State licensing agencies, and any other entity designated by OHCA.

1.14.5.2.3 Notification to Enrollees of Participating Provider Network Changes

The Contractor shall notify Enrollees of Provider disenrollment in accordance with Section 1.12.13.3: "Notification of PCP Termination" of this Contract.

1.14.5.3 Participating Provider Contract Termination Appeal Rights

The Contractor shall handle Provider Appeals of Provider Agreement terminations using a process substantially the same as the process and requirements set forth in OAC 317:2-1-12. The Contractor shall develop, implement, and maintain a system for tracking Appeals related to Provider Agreement contracting issues. Within this process, the Contractor shall respond fully and completely to each Provider's Appeal and establish a tracking mechanism to document the status and final disposition of each. Such documentation shall be made available to OHCA upon request.

OHCA reserves the right to include an independent review process established by OHCA for final determination on these disputes.

1.14.6 Submission of Provider Disenrollment Data to OHCA

The Contractor shall notify OHCA, in a manner specified by OHCA, of the Contractor's intent to disenroll a Participating Provider at least ten (10) Business Days in advance of sending the notice of disenrollment to the impacted Provider. The Contractor shall also notify OHCA within five (5) Days of the Contractor's receipt of notice from a Participating Provider that the Provider intends to disenroll from the Contractor's Network. The Contractor shall submit Participating Provider enrollment data to OHCA in in the manner and format required in the Reporting Manual.

1.14.7 Direct Access to Specialists

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

1.15 Provider Services

The Contractor shall develop and implement a comprehensive Provider services function within the Contractor's organization that shall include responsibility for, at minimum, the Provider communication and training requirements outlined in this Section of the Contract.

1.15.1 Policies and Procedures

The Contractor shall develop and submit written Provider services policies and procedures to OHCA during Readiness Review and upon request for review and approval as specified in the Reporting Manual. All approved policies and procedures must be maintained for the duration of the Contract. At minimum, the Contractor's Provider services topics shall include:

a. Provider services call center policies and procedures that address, at minimum:

   i. Call center staffing;

   ii. Call center staff training;

   iii. Call center Hours of operation; and

   iv. Call center access and response standards, monitoring of calls and compliance with standards;

b. Provider website policies and procedures that address, at minimum:

   i. Website content;

   ii. Frequency of website updates; and

   iii. Ongoing monitoring of accuracy information provided on the website;

c. Provider manual content review and distribution;

d. Provider training and education, including targeted training and education for Behavioral Health Services; and

e. Provider Complaint System, including Provider reconsiderations and Appeals.

1.15.2 Provider Services Call Center

1.15.2.1 Availability

The Contractor shall maintain a Provider Services Call Center in accordance with the location requirements outlined in Section 1.4.5: "Oklahoma Presence" of this Contract. The Provider Services Call Center shall operate a toll-free telephone line to respond to Provider questions, comments, inquiries, and requests for PAs.

The Contractor may operate an overflow call center within the United States for the purposes of meeting the performance requirements listed in this Contract for the Provider Services Call Center.

The Contractor shall ensure that the Provider Services Call Center is staffed adequately to respond timely to Providers' questions at a minimum from 8:00 am to 5:00 pm Central Time, Monday through Friday, except for State Holidays, pursuant to 25 O.S. § 82.1 and Oklahoma Governor's Executive Order regarding Holidays, which is updated annually.

Pharmacy call center shall be available at a minimum from 8:00 am to 7:00 pm Central Time, Monday through Friday, 9:00 am to 5:00 pm Central Time Saturday, and 11:00 am to 4:00 pm Central Time Sunday except for State Holidays, pursuant to 25 O.S. § 82.1 and Oklahoma Governor's Executive Order regarding Holidays, which is updated annually.

The Contractor shall have an automated system available during business and non-Business Hours. The automated system shall include, at minimum, a voice mailbox for callers to leave messages. In addition, the Contractor shall return all messages on the next Business Day.

1.15.2.2 Provider Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Provider Services Call Center activities and performance. The Contractor shall ensure the Provider Services Call Center meets the following minimum performance requirements:

a. Call abandonment rate shall be less than five percent (5%);

b. No incoming call shall receive a busy signal;

c. Eighty percent (80%) of calls shall be answered by a live voice within sixty (60) seconds of the first ring;

d. Average wait time shall not exceed thirty (30) seconds;

e. Blocked call rate shall not exceed one percent (1%); and

f. The overflow call center must not receive more than five percent (5%) of all incoming calls to the Call Center.

The Contractor shall have the capability to track these Provider Services Call Center metrics and issue reporting to OHCA in the timeframe and format specified in the Reporting Manual. Provider Services Call Center reporting shall break down performance by:

a. The Contractor's main Provider Services Call Center;

b. Overflow call center, if applicable;

c. Pharmacy call center; and

d. Applicable Subcontractors.

At the end of each Contract Year, the Contractor shall issue to OHCA an annual report that details performance of the Provider Services Call Center and maps out improvement strategies for the following year. At the discretion of OHCA, the Contractor may be subject to a CAP to resolve any outstanding issues.

1.15.2.3 Provider Services Call Center Training

The Contractor shall develop a program to train newly hired staff and retrain current Provider Services Call Center staff. This training program shall address topics that include, at minimum:

a. The populations covered under the SoonerSelect Programs;

b. SoonerSelect Program covered and non-covered services;

c. PA requirements and processes;

d. Claims submission requirements and processes, including a focus on how to correct claims that have been denied due to Provider submission errors;

e. Care Management;

f. Access to Behavioral Health Services including the Contractor's PA requirements that comport with requirements for parity in mental health and SUD benefits in 42 C.F.R. § 438.910(d);

g. Common billing concerns and issues that may be specific to behavioral health Providers;

h. Services for AI/AN Enrollees;

i. Cultural and linguistic competency;

j. Out-of-State services;

k. How to triage any calls related to pharmacy benefits and implement first call resolution when possible;

l. Filing a Provider Complaint; and

m. Filing a Grievance or Appeal on behalf of an Enrollee.

OHCA reserves the right to amend these requirements as it deems necessary.

1.15.3 Provider Website

1.15.3.1 General Website Requirements

The Contractor shall maintain a website that is accessible to Providers. The Contractor shall:

a. Ensure the website is accessible via mobile devices;

b. Maintain a separate and distinct section on its website for its SoonerSelect Program information if the Contractor markets other lines of business;

c. Ensure posted information is current and accurate;

d. Review and update website content at least monthly;

e. Include a date stamp on each page within the website with the date the page was last updated;

f. Clearly label any links;

g. Comply with HIPAA requirements and all other state and federal statutory and regulatory privacy requirements when providing Enrollee eligibility or Enrollee identification on the website, including Provider portal(s); and

h. Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

As part of this website, the Contractor must include a Provider portal that includes functionalities to support Provider services. All SoonerSelect Program Contractors must align and utilize the same single vendor for a comprehensive SoonerSelect Program Provider engagement portal. The vendor must be approved by OHCA. Functionality shall include but not be limited to:

a. Patient management;

b. Claims management;

c. Provider engagement; and

d. Authorization and referral management.

OHCA reserves the right to amend these requirements as it deems necessary.

1.15.3.2 Website Content

The website shall include all pertinent information including, at least, the following:

a. Provider Manual;

b. Sample Provider Agreements;

c. How to contact the Contractor and its Provider Services department;

d. Functionality to allow Providers to make inquiries and receive responses from the Contractor regarding care for Enrollees, including real-time eligibility information and electronic PA request and approval;

e. How to track the status of claims online;

f. Grievance, Appeal, and State Fair Hearing procedures; and

g. How to file Provider Complaints, including policies and procedures on Provider reconsiderations and Appeals.

OHCA reserves the right to amend these requirements as it deems necessary.

1.15.4 Provider Manual

1.15.4.1 General Provider Manual Requirement

The Contractor shall develop, provide, and maintain a written Provider Manual for use by the Contractor's Participating Provider Network, which is subject to OHCA review and approval. The Contractor shall issue a Provider Manual at time of Provider application. The Provider Manual shall be made available electronically, and in hard copy format (upon Provider request), to all Participating Providers, without cost.

1.15.4.2 Provider Manual Content

The Provider Manual shall include, at minimum, the following topics:

a. Introduction to the Contractor, its organization and administrative structure;

b. Requirements for updating Participating Provider demographic data, including the process and timeframes for updating;

c. Expectations for appointment access standards, by Provider type, as outlined in Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract;

d. Requirements for tracking and following-up on referrals for other services (e.g., Specialist referrals);

e. Listing and description of covered and non-covered services, requirements, and limitations, including applicable EPSDT requirements;

f. Coordination of benefits with other Providers, any Subcontractors and OHCA's contractors;

g. How and where to access any benefits provided by the State, including any Cost Sharing, and how transportation is provided;

h. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, what benefits are not covered and how Enrollees can obtain information on and access to those services;

i. PA, UM, second opinion, and referral processes, which shall include the Contractor's mechanism to allow Enrollees to directly access a Specialist as appropriate for an Enrollee's condition and identified needs;

j. For female Enrollees, direct access to a women's health Specialist within the Contractor's Participating Provider Network for covered care necessary to provide women's routine and

preventive Health Care Services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health Specialist;

k. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers;

l. Medical Necessity standards and Clinical Practice Guidelines;

m. The extent to which, and how, after-hours coverage is provided;

n. Any restrictions on the Enrollee's freedom of choice among Participating Providers;

o. Cost Sharing and the Contractor's tracking systems for aggregate limits;

p. Enrollee rights and responsibilities;

q. Confidentiality and privacy requirements, including, but not limited to HIPAA, with which the Provider must comply;

r. Provider rights for advising and advocating on behalf of Enrollees, including the right to file a Grievance or Appeal on behalf of an Enrollee as their Authorized Representative;

s. Provider non-discrimination information;

t. The process of selecting and changing the Enrollee's PCP;

u. Grievance, Appeal, and State Fair Hearing procedures and timeframes;

v. How to file Provider Complaints, including policies and procedures for filing Provider reconsiderations and Appeals;

w. Advance Directives;

x. How to access auxiliary aids and services, including additional information in alternative formats or languages for patients;

y. The Contractor and State contact information, including addresses and phone numbers;

z. Information on how to report any potential Fraud, Waste and Abuse;

aa. Information on how to report any potential cases of neglect, abuse, and Exploitation of Enrollees;

bb. Policies and procedures for Third-Party Liability and other collections;

cc. Protocols for Encounter Data reporting and records applicable to Providers for whom the Contractor reimburses via a capitated arrangement;

dd. Billing, claims submission/filing protocols and standards;

ee. Payment policies;

ff. Credentialing and recredentialing information;

gg. Performance standards;

hh. Information about the Contractor's Care Management model;

ii. The Contractor's Quality Assessment and Performance Improvement program; and

jj. Requirements regarding use of the Contractor's EVV system and Provider's responsibility in monitoring and immediately addressing Service Gaps, including the use of back-up staff.

OHCA reserves the right to amend these requirements, as necessary.

1.15.5 Provider Education, Training and Technical Assistance

The Contractor shall establish and maintain a Participating Provider training, education, and technical assistance plan. The Contractor shall update the plan annually and shall submit the plan and updates to OHCA, as specified in the Reporting Manual. The Contractor shall maintain a record of its training, education, and technical assistance activities and shall make this information available to OHCA in the manner and format required in the Reporting Manual.

1.15.5.1 Training Frequency

The Contractor shall provide initial and ongoing, at a minimum semi-annual, education and training to its Participating Provider Network. The Contractor shall provide trainings in varying geographic locations based on Participating Provider Network concentration and need. The Contractor shall provide a virtual option for trainings, in addition to in-person trainings.

1.15.5.2 Training Content

In addition to the items identified in Section 1.4.6.8: "Staff Training" of this Contract, the Contractor shall provide the following information, at minimum, in Participating Provider trainings and educational materials and upon request of a Participating Provider:

a. Conditions of participation with the Contractor;

b. Participating Provider responsibilities to the Contractor and to Enrollees;

c. PA, UM, second opinion, and referral processes, including the Contractor's mechanism to allow Enrollees to directly access a Specialist as appropriate for an Enrollee's condition and identified needs;

d. For female Enrollees, direct access to a women's health Specialist within the Contractor's Participating Provider Network for covered care necessary to provide women's routine and preventive Health Care Services. This is in addition to the Enrollee's designated source of primary care if that source is not a women's health Specialist;

e. The extent to which, and how, Enrollees may obtain benefits, including Family Planning Services and Supplies, from Non-Participating Providers;

f. Behavioral Health Services, including:

   i. How Participating PCPs shall screen Enrollees for and identify behavioral health disorders and conditions;

   ii. The Contractor's referral process for Behavioral Health Services; and

   iii. Clinical coordination requirements for Behavioral Health Services;

g. How to update the Participating Provider's demographic or facility information with the Contractor and under what timeline;

h. Billing requirements, rate structures, and amounts;

i. Claims submission and dispute resolution processes;

j. Encounter submission and encounter rejection remediation process for Providers for whom the Contractor reimburses via a capitated arrangement;

k. Cultural and linguistic competency and resources, including AI/AN cultural competency;

l. Critical Incident reporting requirements and timeframes;

m. Credentialing and recredentialing processes;

n. Grievance, Appeal, and State Fair Hearing processes;

o. Policies and procedures surrounding Provider Complaints;

p. Information on how to report any potential cases of abuse, neglect, and Exploitation of Enrollees;

q. Advance Directives;

r. Information about the Contractor's Care Management model;

s. Information, as applicable, about the SoonerSelect Program and SoonerSelect Program Provider responsibilities, including but not limited to Care Management responsibilities;

t. The Contractor's Quality Assessment and Performance Improvement program; and

u. Other training and education as required/requested by OHCA or any other State or federal agency.

OHCA reserves the right to amend these requirements as it deems necessary.

1.15.5.3 Provider Technical Assistance

The Contractor shall provide technical assistance to Participating Providers when determined necessary by the Contractor or OHCA or as requested by Participating Providers. Technical assistance includes, but is not limited to, in-person and telephonic one-on-one meetings. All technical assistance shall be provided in a culturally competent manner.

The Contractor shall have targeted technical assistance for Participating Behavioral Health Services Providers that request technical assistance or that are identified by the Contractor as having significant issues with claims submission requirements or other billing concerns in order to educate the Provider and assist in resolving potential ongoing billing issues. The Contractor shall ensure that it provides a sufficient number of dedicated representatives to conduct office visits and training to address this targeted behavioral health technical assistance requirement.

1.15.5.4 State Sponsored Provider Outreach Activities

OHCA reserves the right to require that the Contractor coordinate with OHCA and ODMHSAS for State-sponsored Provider outreach activities.

1.15.6 Provider Complaint System

A Participating or Non-Participating Provider who is not satisfied with the Contractor's policies and procedures or a decision made by the Contractor that does not impact the provision of services to Enrollees may file a Provider Complaint. The Contractor shall have written policies and procedures, approved by OHCA, for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Provider Complaints. The Contractor shall establish a Provider Complaint system to track the receipt and resolution of Provider Complaints, including requests for reconsideration or Appeals, as detailed in Sections 1.15.6.1: "Provider Reconsiderations" and 1.15.6.2: "Provider Appeals" of this Contract, respectively. The Contractor shall:

a. Have sufficient ability to receive Provider Complaints by telephone, in writing or in person;

b. Have staff designated to receive, process, and resolve Provider Complaints;

c. Thoroughly investigate each Provider Complaint;

d. Ensure an escalation process is in place;

e. Furnish the Provider timely written notification of resolution or results; and

f. Maintain a tracking system capable of generating reports to OHCA at least weekly during implementation and monthly thereafter on Provider Complaint volume and resolution, in accordance with reporting requirements specified in Section 1.23: "Reporting" of this Contract. OHCA reserves the right to update reporting frequency if needed and will be reflected in the Reporting Manual.

1.15.6.1 Provider Reconsiderations

The Contractor shall operate a reconsiderations process whereby Providers may request the Contractor reconsider the decision the Contractor has made or intends to make that is adverse to the Provider. At minimum, this shall include reconsiderations of Program Integrity Provider audit findings and Provider Agreement termination. Such policies and procedures shall be provided in writing:

a. In the Provider Manual detailed in Section 1.15.4: "Provider Manual" of this Contract;

b. On the Contractor's website detailed in Section 1.15.3: "Provider Website" of this Contract;

c. At the time the Provider enters into a Provider Agreement or subcontract with the Contractor; and

d. Upon Provider request.

The Contractor shall require the Provider to submit a request for reconsideration within the timeframe determined by OHCA and pursuant to OAC 317:2-3-10. The Contractor shall resolve all requests for reconsideration within OHCA-determined timeframe. The Contractor shall send a reconsideration resolution notice to the Provider within the timeframe determined by OHCA and including the following, at minimum:

a. The date of the notice;

b. The action the Contractor has made or intends to make;

c. The reasons for the action;

d. The date the action was made or will be made;

e. If the action is based upon a statute, regulation, policy or procedure, the Contractor shall provide the statute, regulation, policy, or procedure supporting the action;

f. An explanation of the Provider's ability to submit an Appeal request to the Contractor within thirty (30) Calendar Days of the date of the notice;

g. The address and contact information for submission of an Appeal;

h. The procedures by which the Provider may request an Appeal regarding the Contractor's action;

i. The specific change in federal or State law that requires the action, if applicable;

j. The Provider's ability to request a Provider Appeal following completion of the Contractor's reconsideration process where the decision is adverse to the Provider; and

k. Any other information required by Oklahoma statute or regulation, if applicable.

1.15.6.2 Provider Appeals

The Contractor shall implement and operate a system for Provider Appeals of the Contractor's audit findings related to Program Integrity efforts and for cause and immediate Provider Agreement termination.

The Contractor shall operate a process whereby Providers may Appeal a decision the Contractor has made or intends to make that is adverse to the Provider. Such policies and procedures shall be provided in writing:

a. In the Provider Manual detailed in Section 1.15.4: "Provider Manual" of this Contract;

b. On the Contractor's website detailed in Section 1.15.3: "Provider Website" of this Contract;

c. At the time the Provider enters into a Provider Agreement or subcontract with the Contractor; and

d. Upon Provider request.

The Contractor shall require the Provider to submit an Appeal request in writing within thirty (30) Calendar Days. The Contractor shall resolve all Appeals within OHCA-determined timeframe. The Contractor shall send an Appeal resolution notice to the Provider within thirty (30) Calendar Days and including the following, at minimum:

a. The date of the notice of Appeal resolution;

b. The results of the resolution process;

c. The date of the Appeal resolution;

d. Any other information required by Oklahoma statute or regulation, if applicable; and

e. For decisions not wholly in the Provider's favor:

    i. An explanation of the Provider's ability to request an OHCA Administrative Appeal following receipt of the Contractor's notice of Appeal resolution;

    ii. How to request an Administrative Appeal;

    iii. An explanation that any request for an Administrative Appeal must be requested within thirty (30) Calendar Days of the notice of Appeal resolution;

    iv. The address and contact information for submission of the Administrative Appeal request; and

    v. Details on the right to be represented by counsel at the Administrative Appeal.

The Contractor shall furnish a litigation summary to OHCA including all information to be specified by OHCA as prescribed in the Reporting Manual within fifteen (15) Calendar Days of a Provider's request for an Administrative Appeal before OHCA.

1.16 Provider Payment

1.16.1 Provider Payment Rates

1.16.1.1 Participating Provider Payment

The Contractor shall ensure that rates for Participating Providers are reasonable to ensure Enrollee access to services, specified at Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract, and that they comply with all State and federal provisions regarding rate setting. Pursuant to 56 O.S. § 4002.12, until July 1, 2026, the Contractor must adopt the OHCA established fee schedule at one hundred percent (100%) for the rate in effect when the service was rendered as the minimum rates of reimbursement for Participating Providers who have elected not to enter into value-based payment arrangements or other alternative payment agreements.

The Contractor shall adhere to State and federal requirements pertaining to payments of specific Provider types as described in Sections 1.16.1.2: "Payment to Non-Participating Provider" through 1.16.1.12: "Value-Based Payments" of this Contract.

The Contractor's Provider rate setting in the aggregate must align with the provisions of Section 1.16.1.12: "Value-Based Payments" of this Contract.

1.16.1.2 Payment to Non-Participating Provider

If the Contractor is unable to provide covered services to an Enrollee within the Contractor's Network of Participating Providers, the Contractor must adequately and timely arrange for the provision of these services by Non-Participating Providers, in accordance with 42 C.F.R. § 438.206(b)(4). Pursuant to 42 C.F.R. § 438.206(b)(5), the Contractor shall ensure that, if applicable, the cost to the Enrollee is no greater than it would have been if the services were furnished by a Participating Provider. Except as otherwise precluded by law and/or specified for IHCPs, FQHCs, RHCs, and CCBHCs, the Contractor shall reimburse Non-Participating Providers for covered services provided to Enrollees at a minimum of ninety percent (90%) of the current Medicaid fee schedule/payment rate, unless the Contractor and the Non-Participating Provider agree to a different reimbursement amount.

1.16.1.3 Balance Billing

In accordance with § 1932(b)(6) of The Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), the Contractor shall ensure that an Enrollee is held harmless by the Provider for the costs of covered services except for any applicable Co-payment amount allowed by OHCA. The Contractor shall ensure no balance billing by Providers, referral Providers, and Subcontractors to any Enrollees for services covered under this Contract.

1.16.1.4 Payment for Emergency Services

The Contractor shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services is a Participating or Non-Participating Provider, in accordance with federal requirements at § 1932(b)(2) of The Act and 42 C.F.R. § 438.114(c)(1)(i). In accordance with § 1932(b)(2)(D) of The Act, the Contractor shall pay Non-Participating Providers for Emergency Services no more than the amount that would have been paid by OHCA under FFS.

1.16.1.5 Payments to IHCPs

The Contractor shall reimburse IHCPs in accordance with the requirements of Section 1.17.4.3: "IHCP Payments" of this Contract.

1.16.1.6 Payments to FQHCs

Notwithstanding the provisions of Section 1.16.1.1: "Participating Provider Payment," the Contractor shall provide payment for the provision of covered services provided by contracted FQHCs at the Prospective Payment System (PPS) Rate and methodology as employed by OHCA for Eligibles not enrolled in the SoonerSelect Program as per the currently approved State Plan, unless a separate payment rate and methodology is negotiated between the Contractor and the Participating Provider and is approved by OHCA. The Contractor's payment to a contracted FQHC shall not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a Participating Provider that is not a FQHC, in accordance with § 1903(m)(2)(A)(ix) of The Act.

1.16.1.7 Payments to RHCs

A Contracted Entity shall offer all RHCs Contracts that reimburse RHCs using the methodology in place for each specific RHC prior to January 1, 2023, including any and all annual rate updates. The Contracted Entity shall comply with all federal program rules and requirements, and the transformed Medicaid delivery system shall not interfere with the program as designed.

1.16.1.8 Payments to Pharmacy Providers

Notwithstanding the provisions of Section 1.16.1.1: "Participating Provider Payment" of this Contract, the rate paid to pharmacy Participating Providers shall use the FFS payment rate employed by OHCA for the SoonerCare program as stated in the payment methodology at OAC 317:30-5-78. The Contractor or PBM drug pricing file should be updated to reflect current pricing at least every seven (7) Days.

The Contractor or their Subcontractor shall not engage in spread pricing, which occurs when PBMs charge the Contractor or OHCA more for a prescription drug than what they reimburse to the pharmacy and keep the difference. All payments to pharmacies will follow a transparent, pass-through model in accordance with 42 C.F.R. § 438.6(d). The Contractor or their Subcontractor will not retroactively deny or retroactively reduce reimbursement to Providers through the use of direct or indirect fees or clawbacks or other methods after adjudication of the claim unless the claim was fraudulent, billed incorrectly, or otherwise identified as incorrect through an audit.

The Contractor or their Subcontractor shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for: (i) the submission of a claim; (ii) enrollment or participation in a retail pharmacy network; or (iii) the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network.

The Contractor or their Subcontractor shall not reimburse a contracted pharmacy or pharmacist an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the

pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy.

The Contractor or their Subcontractor may not deny a pharmacy the opportunity to participate in any pharmacy Network if the pharmacy is willing to accept the terms and conditions that the PBM has established for all other pharmacies.

The Contractor or Subcontractor will not retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless: (i) the original claim was submitted fraudulently; or (ii) to correct errors identified in an audit, so long as the audit was conducted in compliance with 59 O.S. §§ 356.2 and 356.3.

The Contractor or Subcontractor will not fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a PBM network. PADs shall be reimbursed at the FFS payment rate employed by OHCA for the SoonerCare program.

1.16.1.9 Payments to CCBHCs

CCBHC Providers will be reimbursed at a rate that is at least the OHCA's established rates and methodologies under the Medicaid State Plan.

1.16.1.10 Payments to Medicaid Ground Transportation Providers

In accordance with 56 O.S. § 4002.12.H, Medicaid ground transportation services provided by licensed Oklahoma emergency medical services shall be reimbursed at no less than the OHCA published rate. The Contractor shall comply with all OHCA established reimbursement policies for ambulance. All currently published Medicaid Healthcare Common Procedure Coding System (HCPCS) codes paid by OHCA shall be paid by the Contractor. The CE shall comply with all reimbursement policies established by OHCA for the ambulance Providers. CEs shall accept the modifiers established by the CMS currently in use by Medicare at the time of the transport of a member that is dually eligible for Medicare and Medicaid.

1.16.1.11 Primary Care Payment Requirement

By no later than the end of the fourth year of the contracting period, the Contractor shall spend not less than eleven percent (11%) of the total health care expenses on primary care services.

1.16.1.12 Value-Based Payments

The Contractor must implement VBP strategies to align payments between payers and Providers to incentivize quality, health outcomes, and value over volume to achieve the goals of better care, smarter spending, and healthier people. OHCA will withhold a portion of the Contractor's Capitation Payments according to the schedule outlined below. Contractor performance will be assessed annually per the timeframes listed. OHCA will issue one (1) assessment and payment, if applicable, per SoonerSelect Program CE per State Fiscal Year (SFY).

VBP Withhold Payment Schedule

Contract Year	VBP Performance Period	VBP Withhold
1. *Oct 2023 -Jun2024	*Oct 2023 -Jun 2024	Not Applicable
2. Jul 2024 - Jun 2025	Jul 2024 - Jun 2025	Up to 1%
3. Jul 2025 - Jun 2026	Jul 2025 - Jun 2026	Up to 1%
4. Jul 2026 - Jun 2027	Jul 2026 - Jun 2027	Up to 1%
5. Jul 2027 – Jun 2028	Jul 2027 – Jun 2028	Up to 1%

*Date of award through June 30, 2024

The potential payout for this determination is equal to the amount withheld during each Contract Year. OHCA reserves the right to adjust the percentage of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Section 1.2.8: “Amendments or Modifications” of the Contract.

The Contractor may earn the VBP withhold amount for submitting VBP Deliverables and meeting VBP targets specified by OHCA. A minimum percentage of the Contractor’s total payments to Providers (both VBP and non-VBP, Participating Providers) excluding State directed payments paid outside of capitation (e.g., lump-sum directed payments), shall be governed by VBP strategies according to the table below:

VBP Target Requirements by Contract Year

Contract Year	VBP Target Requirement
1. *Oct 23 -June 24	No VBP Requirement
2. July 24 - June 25	20% of total medical Provider payments made under the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Category 2B (Pay for Reporting) or higher
3. July 25 - June 26	35% of total medical Provider payments made under HCPLAN APM Model Category 2B (Pay for Reporting) or higher, with at least 50% of the 35% made under APM Category 2C (Pay for Performance)
4. July 26 - June 27	50% of total medical Provider payments made under APM Category 2C (Pay for Performance) or higher
5. July 27 – June 28	50% of total medical Provider payments made under APM Category 2C (Pay for Performance) or higher, with at least 50% of the 50% made under APM Category 3A (Shared Savings) or APM Category 3B (Shared Savings with Downside Risk) or higher (excluding models that do not link payments to quality)

*Date of award through June 30, 2024

The VBP targets will be calculated using a numerator consisting of total payments made by the Contractor to Participating Providers under VBP Contracts with the relevant APM Categories and a denominator consisting of all Participating Provider payments. Pharmacy, FQHC and RHC Provider payments, will be excluded from the calculation. The Contractor shall be eligible to earn a portion of the withhold if it demonstrates to OHCA’s satisfaction, partial compliance with the VBP targets.

In order to count toward meeting the qualifying criteria, VBP Contracts shall include APM requirements within Provider Agreements. For those Contracts executed prior to October 1 of each Contract Year, OHCA shall count the VBP strategies for the time period in the Contract Year for which the Contract is in effect. For those Contracts executed after October 1 of each Contract Year, OHCA shall count the value of the VBP strategies for the time period from the execution date forward for which the Contract is in effect.

The Contractor's qualifying VBP strategies as discussed in this subsection shall be based on the HCPLAN model.[3] These include the following categories and strategies: 1. FFS – No Link to Quality & Value 2. FFS – Link to Quality & Value a. Foundational Payments for Infrastructure and Operations, b. Pay for Reporting, and c. Pay for Performance. 3. APMs Built on FFS Architecture a. APMs with Shared Savings, and b. APMs with Shared Savings and Downside Risk. 4. Population Based Payment a. Condition-Specific Population-Based Payment, b. Comprehensive Population-Based Payment, and Integrated Finance & Delivery Systems.

The Contractor shall submit an annual VBP Plan to OHCA in a format and on a schedule to be defined by OHCA in the Reporting Manual. The VBP Plan shall detail the Contractor's strategy for meeting the targets set forth in this Contract, including specifying the Contractor's intermediate targets in year two (2) and year three (3) of this Contract. The VBP Plan also shall describe the Contractor's methodology or methodologies by type of Participating Provider. The VBP Plan shall be submitted to OHCA for review and approval prior to implementation. The Contractor shall submit VBP reports on a quarterly basis to OHCA in a format defined by OHCA and detailing the specific payments for that quarter.

To earn the full VBP withhold amount, the Contractor shall submit annually to OHCA a report on its VBP use for the prior Contract Year. If the Contractor did not meet the VBP targets, the Contractor shall describe why the VBP targets were not met.

As part of its Provider Agreements with Providers related to VBP, the Contractor shall:

a. Not hold Providers accountable for meeting a higher target for the incentive-based measure than the target to which OHCA holds the Contractor for the same measure unless the Provider is already performing above the benchmark set by OHCA for Contractor performance on the incentive-based measure;

b. Align VBP arrangements with measures listed in Appendix 1C: "Quality Performance Withhold Program" of this Contract; and

c. Use performance measure specifications in its VBP arrangements that align with the OHCA specifications for measures in Appendix 1C: "Quality Performance Withhold Program" of this Contract when the Contractor is utilizing any measure included in Appendix 1C: "Quality Performance Withhold Program" of this Contract to increase simplification and consistency in Provider performance data reporting.

[3] Health Care Payment Learning & Action Network (HCPLAN): https://hcp-lan.org/apm-framework/.

In accordance with 42 C.F.R. § 438.3(i) and Section 1903(m)(2)(A)(x) of The Act, such value-based payment arrangements, as applicable, must meet the physician incentive plan requirements of 42 C.F.R. §§ 422.208 and 422.210, including:

a. The Contractor shall not make a payment, directly or indirectly, to a Participating Provider as an inducement to reduce or limit covered services furnished to an Enrollee; and

b. If the Contractor's VBP arrangement puts a physician/physician group at substantial financial risk, as determined at 42 C.F.R. § 422.208(d), for services not provided by the physician/physician group, the Contractor must ensure that the physician/physician group has adequate stop-loss protection.

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, 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.

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.

1.16.1.12.3 Directed Payments Adjustment

The Contractor is prohibited from making any changes to the DPP reimbursement levels unless at the direction of OHCA.

No retroactive adjustments to the Directed Payments may be issued by the Contractor to the Qualified Providers unless such retroactive adjustment was approved by OHCA.

1.16.2 Prohibited Payments

1.16.2.1 Overpayments

The Contractor shall report Overpayments to OHCA and recover Overpayments the Contractor identifies from its Participating Providers as specified in Section 1.20.6: "Reporting Overpayments" of this Contract.

1.16.2.2 Suspension of Payments

The Contractor shall suspend payments to a Participating Provider for which the State determines there is a credible allegation of Fraud in accordance with Section 1.20.7: "Suspension of Payments for Credible Allegation of Fraud" of this Contract and in accordance with 42 C.F.R. § 455.23.

1.16.2.3 Providers Ineligible for Payment

The Contractor shall ensure that no payments using Medicaid funds are made for services or items as provided in Section 1.20.10: "Prohibited Affiliations and Exclusions" of this Contract.

1.16.2.4 Provider-Preventable Conditions

In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the Contractor shall not make any payment to a Provider for Provider-Preventable Conditions as defined at 42 C.F.R. § 447.26(b). Provider-preventable Conditions for which payment shall not be made include:

a. Health-acquired conditions occurring in any inpatient hospital setting, identified as a health-acquired condition by the Secretary of HHS under § 1886(d)(4)(D)(iv) of The Act for purposes of the Medicare program identified in the State Plan as described in § 1886(d)(4)(D)(ii) and (iv) of The Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in Pediatric and obstetric patients; and

b. Conditions meeting the following criteria:

   i. Is identified in the State Plan;

   ii. Has been found by OHCA, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

   iii. Has a negative consequence for the Enrollee;

iv. Is auditable; and

v. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient.

1.16.3 Payment Assurance

Pursuant to 42 C.F.R. § 438.60, OHCA ensures that no payment is made to a Participating Provider other than by the Contractor for services covered under this Contract, except when these payments are specifically required to be made by the State in Title XIX of The Act, Title 42 of the C.F.R., or when OHCA makes direct payments to Participating Providers for graduate medical education costs approved under the Medicaid State Plan. OHCA reserves the right to review any and all Contractor policies and procedures to ensure compliance with this assurance.

1.16.4 Claims Processing

1.16.4.1 Claims Processing System and Methodology

The Contractor shall maintain a claims payment system, in accordance with 56 O.S. § 4002.7, capable of processing and paying claims in an accurate and timely manner and in full compliance with all State and federal laws, including but not limited to HIPAA requirements. The Contractor's claim processing system shall comport with all the information exchange provisions outlined in Section 1.21: "Information Technology" of this Contract.

The Contractor shall ensure that either Provider claims submissions or checks/warrants payable be printed, in boldface type, with the language specified in 42 C.F.R. § 455.18 or 42 C.F.R. § 455.19, respectively.

This system shall store claim information in accordance with the record retention requirements at Section 1.2.14: "Inspection and Audit Rights" of this Contract. At a minimum, these records shall include:

a. The identity of the Provider submitting the claim;

b. Date stamp of day received;

c. Type of claim;

d. Amount billed;

e. All adjustments;

f. Dates of all relevant action taken on the claim, including payment and denial;

g. Amount paid;

h. Service code;

i. Provider involved in claim, including ordering, referring, and rendering;

j. Service location;

k. Application of coordination of benefits and subrogation of claims; and

l. Information on the units of service rendered so that OHCA may collect information for the purposes of UM.

The claims processing system used by the Contractor shall be equipped to receive and adjudicate claims submitted electronically and by mail, within a timeframe established by OHCA. The Contractor shall ensure that the electronic claims submission process is usable with a standard internet connection. Providers must be able to track the status of submitted claims online and contact a representative of the Contractor for resolution of claims questions.

The Contractor's and Subcontractors' payment cycle for newly submitted claims shall run at least weekly, on the same day each week, as determined by the Contractor and approved in writing by OHCA.

The claims processing system shall be equipped with system edits for the following, at minimum:

a. Confirming Enrollee eligibility as claims are submitted on the basis of the eligibility information provided by OHCA applicable to the period in which the charges on the claim were incurred;

b. Ensuring that claims are only paid if received from Providers that are eligible to render the services for which the claim was submitted;

c. Reviewing for Third-Party Liability and reducing claims payment based on payments by a third-party for any part of a service;

d. Reviewing for duplicate claims and flagging possible duplicate claims for further review or denial;

e. Reviewing for PA requirement, and, if applicable to the service(s) for which the claim is submitted, PA approval;

f. Reviewing for Medical Necessity, including that the services are appropriate in amount, duration, and scope;

g. Verifying that the service is a covered service under this Contract and is eligible for payment;

h. Ensuring that Enrollee benefit limits are factored into the claim adjudication and payment determination;

i. Ensuring compliance with National Correct Coding Initiative (NCCI) editing;

j. Ensuring that the date(s) of service on the claim are valid, including, but not limited to:

    i. Date(s) are not in the future; and

    ii. Date of admission is earlier than date of discharge;

k. Identifying missing, invalid, or mismatched Provider NPIs, and/or Taxpayer Identification Numbers (TINs)/Employer Identification Numbers (EINs).

OHCA reserves the right to add additional minimum required system edits at its discretion.

Each financial adjustment to each claim shall be recorded, including Third-Party Liability adjustments, interest, and Co-payments.

The Contractor's claims processing system shall track the error rates in claims and Encounter Data received from the Provider or a third-party prior to a claim or encounter being adjudicated and submitted to OHCA.

1.16.5 Timely Claims Filing and Processing

1.16.5.1 Timely Claims Filing Requirements

The Contractor shall adjudicate Provider claims in accordance with timely filing limits specified in OAC 317:30-3-11. The Contractor shall require the Provider to submit all claims within six (6) months from the date of service. The Contractor may not impose requirements to file claims within a shorter period.

The Contractor shall require claims to be resubmitted, when applicable, within an additional six (6) months from the date of service. The only exceptions to the resubmission deadline are the following:

a. Administrative correction or action by the Contractor taken to resolve a dispute;

b. Reversal of eligibility determination;

c. Investigation for Fraud or Abuse of the Provider; or

d. Court order or hearing decision.

1.16.5.2 Timely Payment Requirements

The Contractor shall observe the following requirements in adjudicating Clean Claims:

a. Ensure that ninety percent (90%) of Clean Claims received from all Providers are paid within fourteen (14) Days of receipt; and

b. Ensure that ninety-nine percent (99%) of Clean Claims received from all Providers are paid within ninety (90) Days of receipt.

In accordance with 42 C.F.R. § 447.45(d), all claims shall be paid within twelve (12) months of date of receipt by the Contractor, except in the following cases:

a. The time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;

b. The time limitation does not apply to claims from who are then involved in a state or Federal investigation based on allegations of violating state or Federal Fraud and Abuse laws; and

c. The Contractor may make payments at any time in accordance with a court order, to carry out hearing decisions or OHCA/Contractor corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

The Contractor shall develop and submit its policies and procedures governing the processing of claims to OHCA during Readiness Review for review and approval. At minimum, these policies and procedures should cover the format in which claims are to be submitted, the speed with which the Participating Provider or Subcontractor can expect them to be processed, and compliance with State and federal laws.

The Contractor shall pay its Participating Providers and Subcontractors consistent with Section 1902(a)(37)(A) of The Act.

1.16.5.3 Date of Receipt and Date of Payment

The following definitions shall apply for the purpose of determining timely payment of Clean Claims in accordance with §§ 1902(a)(37)(A) and 1932(f) of The Act:

a. In accordance with 42 C.F.R. §§ 447.45(d)(5) and 447.46(c)(1), the date of receipt, for purposes of Section 1.16.5: "Timely Claims Filing and Processing" of this Contract, shall be the date the Contractor received the claim as indicated by its date stamp on the claim.

b. In accordance with 42 C.F.R. §§ 447.45(d)(6) and 447.46(c)(1), the date of payment, for purposes of Section 1.16.5: "Timely Claims Filing and Processing" of this Contract, shall be considered to be the date of the check or other method of payment to the Provider from the Contractor.

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 62 O.S. § 34.72. This interest rate shall be prorated on a daily basis.

1.16.5.5 Treatment of Unclean Claims

If the Contractor receives a claim submission that does not include all the necessary documentation or information to be determined a Clean Claim in order to pay the claim, resulting in a denial or partial denial of the claim, the Contractor shall notify the Provider who submitted the claim in writing within seven (7) Days of receipt and explain what further documentation is needed for the Contractor to adjudicate the claim. Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

1.16.5.6 Claim Corrections and Resubmissions

Any corrections or resubmissions of existing, paid claims shall be submitted as adjustments to the existing claim.

1.16.6 Claims Format

The Contractor shall accept HIPAA-compliant formats for electronic claims submission. The Contractor shall comply with the following standardized paper billing forms and formats, and any updates thereto:

a. Professional claims: CMS 1500 claim form; and

b. Institutional claims: CMS 1450/UB04.

The Contractor shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms. These shall include, but not be limited to, HIPAA-based standards and federally required safeguard requirements.

1.16.7 Remittance Advice

The Contractor shall send a remittance advice with the claim payment unless payment is executed electronically. If the payment is electronic, the Contractor shall send the remittance advice the same Day, either electronically in 835 format or via download on the Provider portal.

1.16.8 Claims Inquiries and Disputes

The Contractor shall develop and submit policies and procedures governing claims inquiries and disputes to OHCA during Readiness Review for review and approval. The claims dispute resolution process developed by the Contractor shall include at least two (2) levels for Providers to dispute the nature of Medical Necessity, with the second level including review by a medical professional with the same or similar specialty to the medical area that is the topic of the dispute. The Contractor shall systematically capture the status and resolution of all claim disputes, as well as all associated documentation.

1.17 American Indian/Alaska Native Population and Indian Health Care Providers

OHCA is committed to preserving the protections afforded to AI/AN Enrollees under federal law, while expanding access to person/family-centered Care Coordination. OHCA is also committed to preventing disruption in payments to IHCPs, while encouraging opportunities for creative partnerships between the Contractor and IHCP community.

OHCA and the Contractor will pursue these objectives and maintain open communication with AI/AN stakeholders through the processes outlined in this section and in compliance with the Oklahoma Medicaid State Plan, in accordance with the range of Indian managed care protections established by CMS through its 2016 Final Rule (See, 81 Fed. Reg. 88 (May 6, 2016) (codified at 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495), and the guidance issued through the Center for Medicaid and CHIP Services (CMCS) Informational Bulletin (CIB 12-14-16) published December 14, 2016. The Contractor shall utilize the "Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)" for all IHCPs seeking enrollment into the Contractor's Network. Nothing in the Contractor's Network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or Tribal sovereign immunity.

Contractors and IHCPs may refer to the "Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)" by visiting the following CMS web address: https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.

A reference copy will also be made available on the OHCA and Contractor websites at all times during the Contract period.

1.17.1 Tribal Government Liaison

As a part of Key Staff, the Contractor shall employ a full-time Tribal Government Liaison (as described in Section 1.4.6.2: "Key Staff") to conduct outreach to the AI/AN community and to serve as a resource for Enrollees and Providers with questions or issues. The Tribal Government Liaison will develop policy and lead Tribal consultation with Tribal governments and Tribal health care Providers in Oklahoma.

The Contractor shall develop and submit a Tribal outreach plan to OHCA during Readiness Review for review and approval. The Tribal Government Liaison will also be responsible for communicating with and advising Contractor's Key Staff on topics regarding issues and concerns raised by IHCPs and AI/AN Enrollees including but not limited to, reimbursement, claims payments, access to care, and Enrollment, etc. The Tribal Government Liaison will also coordinate cultural competency training for Contractor's staff.

1.17.2 OHCA Tribal Government Relations Unit

OHCA Tribal Government Relations unit acts as an AI/AN liaison between OHCA and CMS, Indian Health Service, Urban Indian facilities, and Indian Tribes of Oklahoma for State and national level issues, including (without implied limitation) AI/AN work groups, policy development and compliance, Tribal consultation, payment issues, and elimination of health disparities. The Contractor's Tribal Government Liaison shall serve as a single point-of-contact for OHCA Tribal Government Relations Unit and shall attend Tribal consultation meetings, workgroups, and trainings held by OHCA.

1.17.3 AI/AN Enrollees

1.17.3.1 Enrollment and Disenrollment

OHCA or its designee will provide Choice Counseling and OHCA's Enrollment materials will advise eligible AI/AN Enrollees that they have the option to enroll in the SoonerSelect Program. Enrollees who opt-in will be subject to the Enrollment provisions specified in Section 1.6: "Enrollment and Disenrollment" of this Contract, except that AI/AN Enrollees may disenroll from the SoonerSelect Program without cause. If an AI/AN Eligible elects not to enroll or enrolls and then chooses to disenroll from the SoonerSelect Program, the AI/AN Eligible shall have a new opportunity to enroll at the next Open Enrollment Period.

1.17.3.2 IHCP Primary Care Provider

In accordance with 42 C.F.R. § 438.14(b)(3), unless the Contractor is an Indian Managed Care Entity (IMCE), the Contractor shall permit AI/AN Enrollees to receive services from an IHCP primary care Provider who is a Participating Provider and to choose that IHCP as the AI/AN Enrollee's PCP if that Provider has capacity to provide the services.

1.17.3.3 Access to Out-of-Network IHCPs and Referrals under Purchased and Referred Care

Pursuant to 42 C.F.R. § 438.14(b)(4), the Contractor shall permit AI/AN Enrollees to obtain services covered under the Contract from out-of-Network IHCPs from whom the AI/AN Enrollee is otherwise eligible to receive such services. In accordance with 42 C.F.R. § 438.14(b)(6), the Contractor shall also permit an out-of-Network IHCP to refer an AI/AN Enrollee to a Participating Provider. This includes services furnished by an out-of-Network IHCP or through referral under purchase and referred care.

1.17.3.4 Enrollee Cost Sharing

AI/AN Enrollees are exempt from Cost Sharing in accordance with the requirements of Section 1.19.2: "Cost Sharing Exempt Populations" of this Contract.

1.17.3.5 Care Management

The Contractor shall include AI/AN Care Managers within its Care Management staffing. The Contractor shall inquire of AI/AN Enrollees as to their preference, if any, and shall offer AI/AN Enrollees the option of receiving Care Management from an AI/AN Care Manager to the extent practicable.

1.17.4 Indian Health Care Providers (IHCPs)

1.17.4.1 Sufficient IHCP Participation

In accordance with 42 C.F.R. § 438.14(b)(1), the Contractor shall demonstrate there are sufficient IHCPs participating in the Contractor's Network to ensure timely access to services available under the Contract from such Providers for AI/AN Enrollees who are eligible to receive services. The Contractor shall provide OHCA with Network accessibility reports that are specific to its AI/AN Enrollees and IHCP network, in accordance with Reporting Manual requirements.

1.17.4.2 Timely Access to IHCPs

If timely access to covered services cannot be ensured due to few or no IHCPs in the State, the Contractor will be considered to have met the IHCP Network requirement if AI/AN Enrollees are permitted by the Contractor to access out-of-State contracted IHCPs.

This circumstance shall also be deemed to be good cause for Disenrollment from both the Contractor and the SoonerSelect Program in accordance with 42 C.F.R. § 438.56(c).

1.17.4.3 IHCP Payments

All Contractor payments to IHCPs shall be made in accordance with 42 C.F.R. § 438.14. OHCA will reimburse for services that are eligible for one hundred percent (100%) federal reimbursement and are provided by an IHS or 638 Tribal facility to AI/AN Enrollees who are eligible to receive services through an IHS or 638 Tribal facility. Encounters for SoonerCare services billed by IHS or 638 Tribal facilities and eligible for 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 these services. The Contractor shall also facilitate the development of Care Coordination agreements between IHCP and other non-IHS/Tribal Providers as necessary to support the provision of services for AI/AN Enrollees.

1.17.4.4 Indian Managed Care Entity (IMCE)

Pursuant to 42 C.F.R. § 438.14(d), an IMCE may restrict its Enrollment to AI/ANs in the same manner as Indian Health Programs may restrict the delivery of services to AI/ANs, as defined in 25 U.S.C. § 1603(12), without being in violation of the requirements in 42 C.F.R. § 438.3(d).

1.18 Enrollee Grievance and Appeal

1.18.1 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 any Enrollee or Provider that is adversely affected by such determination 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.

1.18.1.1 Enrollee Grievance and Appeal System

In accordance with 42 C.F.R. §§ 438.402, 438.228(a), and 438.228(b), the Contractor shall operate an Enrollee Grievance and Appeal System to handle Appeal of an Adverse Benefit Determination and Grievance, as well as the processes to collect and track information about them. At all times, the Enrollee Grievance and Appeal System shall comply with the requirements in all applicable State and federal laws, regulations, and sub-regulatory guidance or policies required by OHCA.

1.18.1.2 Receipt of Grievance and Appeal

The Contractor shall acknowledge receipt of each Grievance and Appeal of an Adverse Benefit Determination, in accordance with 42 C.F.R. § 438.406(b)(1). The process and timeframe by which the Contractor shall meet this requirement shall be determined by OHCA.

1.18.1.3 Decision Makers on Grievance or Appeal

In accordance with 42 C.F.R. § 438.406(b)(2), the Contractor shall:

a. Ensure that any individuals making a decision on an Enrollee Grievance or Appeal were not involved in, nor a subordinate of any individual involved in, any previous level of review or decision-making; and

b. Ensure that any individual making a decision on an Enrollee Grievance or Appeal of an Adverse Benefit Determination are individuals with appropriate clinical expertise, as determined by OHCA, in treating the Enrollee's condition or disease when the decision involves the following:

    i. An Appeal of a denial that is based on lack of Medical Necessity;

    ii. A Grievance regarding denial of expedited resolution of an Appeal; or

    iii. A Grievance or Appeal that involves clinical issues.

The Contractor's decision makers on Enrollee Grievance or Appeal shall, in accordance with 42 C.F.R. § 438.406(b)(2)(iii), take into account all comments, documents, records, and other information submitted by the Enrollee or the Enrollee's Authorized Representative without regard to whether such information was submitted or considered by the Contractor in the initial Adverse Benefit Determination, and without regard as to its admissibility in a court of competent jurisdiction.

1.18.1.3.1 Presentation of Evidence

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(4), provide the Enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b)-(c) for Appeal and expedited Appeal.

1.18.1.3.2 Access to Enrollee Case Files

The Contractor shall, in accordance with 42 C.F.R. § 438.406(b)(5), provide the Enrollee the Enrollee's Case File, including all medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the Contractor's direction, in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframes at 42 C.F.R. § 438.408(b) and (c) for Appeal and expedited Appeal.

1.18.1.3.3 Parties

In accordance with 42 C.F.R. § 438.406(b)(6), the Contractor's Grievance and Appeal System shall include the following as parties to an Appeal:

a. The Enrollee or the Enrollee's Authorized Representative; or

b. The legal representative of a deceased Enrollee's estate.

1.18.2 Recordkeeping

The Contractor shall, in accordance with 42 C.F.R. § 438.416, maintain records of all Grievances and Appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to OHCA's quality strategy. The Contractor shall accurately maintain the records in a manner accessible to OHCA and available upon request to CMS. Except as is established in Section 1.18.8.4: "Contractor State Fair Hearing Support" of this Contract, the Contractor shall produce records to OHCA staff no later than three (3) Business Days after the date of request, in the format (electronic or hard copy) requested. The record of each Grievance or Appeal shall contain, at minimum, the following:

a. A general description of the reason for the Grievance or Appeal;

b. Date the Grievance or Appeal request was received by the Contractor;

c. Date of each review or, if applicable, review meeting;

d. Resolution at each level of the Grievance or Appeal, if applicable;

e. Date of resolution at each level, if applicable; and

f. Name of the Enrollee for whom the Grievance or Appeal was filed.

1.18.3 Written Policies Requirement

The Contractor shall develop and submit written policies and procedures on its Enrollee Grievance and Appeal System to OHCA during Readiness Review for review and approval. The Contractor's policies and procedures shall be maintained for the duration of the Contract. In accordance with the requirements of 42 C.F.R. § 438.402, the Contractor's Grievance and Appeal System shall:

a. Have only one (1) level of Appeal for Enrollees;

b. Allow an Enrollee to file a Grievance and request an Appeal with the Contractor, with the ability for the Enrollee to request a State Fair Hearing before OHCA after receiving notice pursuant to 42 C.F.R. § 438.408, and Section 1.18.6: "Adverse Benefit Determinations" of this Contract, that the Adverse Benefit Determination is upheld;

c. Allow an Enrollee to file a Grievance with the Contractor, either orally or in writing, at any time; and

d. Provide that an Enrollee, upon receiving notice of an Adverse Benefit Determination, shall have sixty (60) Days from the date on an Adverse Benefit Determination notice in which to file a request for an Appeal to the Contractor, which may be filed either orally or in writing.

1.18.4 Enrollee Grievance and Appeal System Information to be Distributed to Enrollees, Providers, and Subcontractors

The Contractor shall provide information about the Grievance and Appeal System and State Fair Hearing procedures and timeframes to Enrollees or the Enrollee's Authorized Representative, Providers, and Subcontractors consistent with all applicable State and federal laws, regulations, OHCA policy, and guidance.

The Contractor shall ensure that all notices related to Grievance and Appeal are available in the prevalent non-English languages required under Section 1.12.1.1: "Prevalent Non-English Languages and Auxiliary Aids" of this Contract. Pursuant to 42 C.F.R. § 438.10(d)(3), the Contractor shall ensure that the notices are available in alternative formats for persons with special needs, with auxiliary aids and services made available upon request at no cost.

In accordance with 42 C.F.R. § 438.406(a), the Contractor's Grievance and Appeal System shall include provision of reasonable assistance to Enrollees in completing Grievance or Appeal forms and taking other procedural steps related to the Grievance or Appeal. The Contractor's reasonable assistance to the Enrollee shall include, at minimum:

a. Availability of Enrollee Care Support Staff; and

b. Auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

In accordance with 42 C.F.R. § 438.10(g)(2)(xi), the Contractor's Enrollee Handbook shall include Grievance, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 C.F.R. Subpart F. At minimum, this information shall include:

a. Enrollee Grievance, Appeal, and State Fair hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and in Section 1.18: "Enrollee Grievance and Appeal" of this Contract;

b. The Enrollee's right to file Grievance and Appeal and the requirements and timeframes for filing;

c. The availability of assistance to the Enrollee with filing Grievance and Appeal;

d. The Enrollee's right to request a State Fair Hearing after the Contractor has made a determination on an Enrollee's Appeal which is adverse to the Enrollee; and

e. The Enrollee's right to request continuation of benefits, as described in Section 1.18.9: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes. The Enrollee may be liable for the cost of any continued benefits while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor's determination that is adverse to the Enrollee.

At a minimum, the Contractor shall include information on the Grievance and Appeal System in:

a. Applicable Enrollee written notifications;

b. The Contractor's Enrollee Handbook; and

c. Any other materials as required by State or federal laws, regulations, and OHCA.

1.18.5 Enrollee Grievance and Appeal System Information for Providers and Subcontractors

In accordance with 42 C.F.R. §§ 438.414 and 438.10(g)(2)(xi), the Contractor shall provide the following information, at minimum, to all Providers and Subcontractors at the time they enter into a contract or Provider Agreement with the Contractor:

a. Enrollee Grievance, Appeal, and State Fair Hearing procedures and timeframes as specified in 42 C.F.R. §§ 438.400 - 438.424 and described in Section 1.18: "Enrollee Grievance and Appeal" of this Contract;

b. The Enrollee's right to file Grievance and Appeal and the requirements and timeframes for filing;

c. The availability of assistance to the Enrollee with filing Grievance and Appeal;

d. The Enrollee's right to request a State Fair Hearing after the Contractor has made an Adverse Determination on an Enrollee's Appeal; and

e. The Enrollee's right to request continuation of benefits, as described in Section 1.18.9: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Contract, that the Contractor seeks to reduce or terminate during an Appeal or State Fair Hearing filing, if filed within allowable timeframes. The Enrollee may be liable for the cost of any continued benefits

while the Appeal or State Fair Hearing is pending if the final decision upholds the Contractor's determination that is adverse to the Enrollee.

At minimum, the Contractor shall include this information in:

a. Provider and Subcontractor contracts with the Contractor;

b. The Contractor's Provider Manual;

c. Applicable Provider and Subcontractor training materials; and

d. Any other materials as required by State or Federal laws, regulations, and guidance.

1.18.6 Adverse Benefit Determinations

1.18.6.1 General Requirements

The Contractor shall provide Enrollee with timely and adequate written notice of an Adverse Benefit Determination consistent with 42 C.F.R. § 438.404(a). The written notice shall include all information required in Section 1.18.6.2: "Notice and Content" of this Contract and meet the timing requirements set forth in Section 1.18.6.3: "Timeframes for Notice Adverse Benefit Determination" of this Contract.

In accordance with 42 C.F.R. § 438.210(c), the Contractor shall notify the requesting Provider, and give the Enrollee written notice meeting the requirements of 42 C.F.R. § 438.404, of any decision rendered by the Contractor to deny a PA request, or to authorize a service in an amount, duration, or scope that is less than requested by the Provider.

1.18.6.2 Notice and Content

OHCA will work with the Contractor after the award of this Contract to develop model notices of Adverse Benefit Determinations. The written notice shall include, at minimum, the following content set forth at 42 C.F.R. § 438.404(b):

a. The Adverse Benefit Determination the Contractor has made or intends to make;

b. The reasons for the Adverse Benefit Determination, including the Enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination. Such information shall include necessary criteria, processes, strategies, or evidentiary standards in setting coverage limits;

c. Information on how to request reasonable access to and copies of all documents, records, and other information relevant to the Enrollee's Adverse Benefit Determination;

d. If an Adverse Benefit Determination is upheld, the Enrollee must be informed of exhausting the Contractor's one (1) level of Appeal and the right to request a State Fair Hearing;

e. The conditions in which an Enrollee may request an expedited Appeal process and how the Enrollee may request it;

f. The Enrollee's right to continued benefits pending the resolution of the Appeal, how continued benefits may be requested, consistent with OHCA's policy, and notifying the Enrollee that the Enrollee may be required to pay the costs of these services should the Adverse Benefit Determination be upheld; and

g. The Enrollee's rights and procedures available pursuant to 42 C.F.R. § 438.404(b).

The notice shall comply with all information requirements at 42 C.F.R. § 438.10 and, consistent with 42 C.F.R. § 438.10(d)(3) and Section 1.12.1.4: "Taglines" of this Contract, contain taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

1.18.6.3 Timeframes for Notice Adverse Benefit Determination

The Contractor shall mail the written notice of an Adverse Benefit Determination within the following timeframes set forth in Sections 1.18.6.1: "General Requirements" through 1.18.6.8: "Untimely Prior Authorization Decisions" of this Contract, in accordance with 42 C.F.R. § 438.404(c).

1.18.6.4 Termination, Suspension, or Reduction of Previously Authorized Covered Services

When the action for which the notice of Adverse Benefit Determination is being provided is a termination, suspension, or reduction of previously authorized Medicaid-covered services, the Contractor shall send the written notice at least ten (10) Calendar Days before the date of action, in accordance with 42 C.F.R. §§ 431.211 and 438.404(c)(1). The Contractor shall also send the written notice of an Adverse Benefit Determination via mail and by electronic notice at least ten (10) Calendar Days before the date of action when the Enrollee's location and address is unknown, based on returned mail with no forwarding address, in accordance with OAC 317:35-5-67.

Exceptions to the ten (10) Calendar Day advance written notice requirement for termination, suspension, or reduction of previously authorized Medicaid-covered services shall be, as follows:

a. Notice Timeframe for Probable Enrollee Fraud: In accordance with 42 C.F.R. §§ 431.214 and 438.404(c)(1), the Contractor may shorten the written notice of Adverse Benefit Determination to as few as five (5) Calendar Days before the date of action if the Contractor has verified, if possible, through secondary sources, facts that indicate Enrollee Fraud.

b. Notice Timeframe for Voluntary or Involuntary Enrollee Eligibility or Service Reduction: In accordance with 42 C.F.R. §§ 431.213 and 438.404(c)(1), the Contractor shall provide Enrollees with written notice of an Adverse Benefit Determination no later than the date of the action in the notice in any of the following circumstances:

    i. The Contractor has factual information confirming the Enrollee's death;

    ii. The Enrollee submits a signed written statement requesting service termination;

iii. The Enrollee submits a signed written statement including information that requires service termination or service reduction and indicates that the Enrollee understands that service termination or service reduction will result from supplying the information;

iv. The Enrollee has been admitted to an institution in which they are ineligible for further services;

v. The Enrollee's address is determined unknown based on returned mail with no forwarding address;

vi. The Contractor has information establishing that the Enrollee has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

vii. The Enrollee's physician prescribes a change in the level of medical care; or

viii. The notice involves an Adverse Determination with regard to preadmission screening requirements of Section 1919(e)(7) of The Act.

1.18.6.5 Payment Denial

In accordance with 42 C.F.R. § 438.404(c)(2), when the action for which the notice of Adverse Benefit Determination is being provided is denial of payment, the Contractor shall provide the notice at the time of any action affecting the claim.

1.18.6.6 Prior Authorization Denial or Limitation

In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d)(1), when the action for which the notice of Adverse Benefit Determination is being provided is standard PA decisions that deny or limit services, the Contractor shall provide the notice as expeditiously as the Enrollee's condition requires and not to exceed fourteen (14) Calendar Days following receipt of the request for service. The Contractor may extend the fourteen (14) Calendar Day PA notice timeframe up to an additional fourteen (14) Calendar Days when requested by the Enrollee or Provider as Authorized Representative.

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, 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.

1.18.6.7 Expedited Prior Authorization Denial

In accordance with 42 C.F.R. §§ 438.404(c)(6) and 438.210(d)(2), and in cases in which a Provider indicates or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the Enrollee's life, health, or Enrollee's ability to attain, maintain, or regain maximum function, the Contractor shall expedite the authorization decision and provide notice as expeditiously as the Enrollee's health condition requires no later than seventy-two (72) Hours after receipt of the request for service. The Contractor shall also provide verbal and electronic communication

for all expedited authorization decisions. The Contractor may extend the seventy-two (72) Hour time period for written notice by up to fourteen (14) Calendar Days if:

a. The Enrollee requests an extension; or

b. The Contractor justifies to OHCA, upon request, a need for additional information and how the extension is in the Enrollee's interest.

1.18.6.8 Untimely Prior Authorization Decisions

In accordance with 42 C.F.R. § 438.404(c)(5), the Contractor shall give notice on the date that the timeframes expire, when PA decisions are not reached within the applicable timeframes for either standard or expedited PAs, which constitutes a denial and is thus an Adverse Benefit Determination, as set forth in Sections 1.18.6.6: "Prior Authorization Denial or Limitation" and 1.18.6.7: "Expedited Prior Authorization Denial" of this Contract.

1.18.6.9 Grievance

As detailed in Section 1.18.1.1: "Enrollee Grievance and Appeal System" of this Contract, an Enrollee may file a Grievance with the Contractor, either orally or in writing at any time.

1.18.6.10 Enrollee Requirement to File Grievance with Contractor

The Enrollee shall be required to file a Grievance directly with the Contractor and shall not file with OHCA, in accordance with OHCA's policy as allowed under 42 C.F.R. § 438.402(c)(3).

1.18.6.11 Timeframe for Resolution of Grievance

The Contractor shall resolve each Grievance and provide notice, as expeditiously as the Enrollee's health condition requires, which shall be within thirty (30) Calendar Days from the date the Contractor receives the Grievance, in accordance with 42 C.F.R. § 438.408(a) and (b)(1).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to an additional fourteen (14) Calendar Days if:

a. The Enrollee or Provider as Authorized Representative requests an extension; or

b. The Contractor shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the Enrollee's interest.

If the Contractor extends the timeframe for resolution of a Grievance, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(ii):

a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay; and

b. Give the Enrollee written notice of the reason for the decision to extend the timeframe within two (2) Calendar Days and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision.

1.18.6.12 Grievance Resolution Notice Format, and Content

The Contractor shall provide written notice of resolution of a Grievance to the impacted Enrollee within three (3) Calendar Days of the resolution of the Grievance. In accordance with 42 C.F.R. § 438.408(d)(1) and Section 1.12.4: "New Enrollee Materials and Outreach" of this Contract, OHCA shall establish the content the Contractor must include in the notice. The notice shall be in a format and language that, at a minimum, meet the requirements of 42 C.F.R. § 438.10, including taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

1.18.7 Appeals

1.18.7.1 Authority and Format for Requesting Appeal

As detailed in Section 1.18.1.1: "Enrollee Grievance and Appeal System" of this Contract, an Enrollee, Provider, or Authorized Representative acting on behalf of the Enrollee as permitted by State Law, may file an Appeal with the Contractor orally or in writing.

In accordance with 42 C.F.R. § 438.402(c)(3), the Contractor must ensure an oral request seeking to appeal an Adverse Benefit Determination is treated as an Appeal.

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 to file an Appeal to the Contractor within sixty (60) Calendar Days from the date on the Adverse Benefit Determination notice.

1.18.7.3 Timeframe for Standard Appeal Resolution

The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, which shall be within thirty (30) Calendar Days from the date the Contractor receives the Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(2).

In accordance with 42 C.F.R. § 438.402(c)(1)(B) and 56 O.S. § 4002.6(J), OHCA may offer and arrange for an external medical review for the Contractor's Adverse Benefit Determination if the following conditions are met:

a. The review must be at the Enrollee's option and must not be required before or used as a deterrent to proceed to the State Fair Hearing;

b. The review must be independent of both OHCA and the Contractor;

c. The review must be offered without any cost to the Enrollee; and

d. The review must not extend any of the timeframes specified in 42 C.F.R. § 438.408 and must not disrupt the continuation of benefits in 42 C.F.R. § 438.420.

However, in accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to fourteen (14) Calendar Days if:

a. The Enrollee or Provider as Authorized Representative requests an extension; or

b. The Contractor shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the Enrollee's interest.

If the Contractor extends the timeframe for resolution of an Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

b. Give the Enrollee written notice of the reason for the decision to extend the timeframe within two (2) Calendar Days and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

c. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

1.18.7.4 Timeframe for Expedited Resolution

In accordance with 42 C.F.R. § 438.410(a), the Contractor shall establish and maintain an expedited review process for Appeals, for cases in which the Contractor determines, or when the Provider as the Enrollee's Authorized Representative indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The Contractor shall resolve each expedited Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, which shall be within seventy-two (72) Hours from the date the Contractor receives the expedited Appeal, in accordance with 42 C.F.R. § 438.408(a) and (b)(3).

In accordance with 42 C.F.R. § 438.408(c)(1), the resolution timeframe may be extended by the Contractor by up to fourteen (14) Calendar Days if:

a. The Enrollee or Provider as Authorized Representative requests an extension; or

b. The Contractor shows to the satisfaction of OHCA, upon request, a need for additional information and how the delay is in the Enrollee's interest.

If the Contractor extends the timeframe for resolution of an expedited Appeal, pursuant to the preceding language and 42 C.F.R. § 438.408(c)(1), and such extension was not at the request of the Enrollee, the Contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

a. Make reasonable efforts to give the Enrollee prompt oral notice of the delay;

b. Give the Enrollee written notice of the reason for the decision to extend the timeframe within two (2) Calendar Days and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

c. Resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

If the Contractor denies a request for expedited Appeal resolution, the Contractor must transfer the Appeal to the standard Appeal resolution timeframe in accordance with 42 C.F.R. § 438.408(b)(2).

1.18.7.5 Appeal Resolution Notice Format and Content

For all Appeals, the Contractor shall provide written notice of resolution to the impacted Enrollee, in accordance with 42 C.F.R. § 438.408(d)(2), in a format and language that, at a minimum, meet the standards described at 42 C.F.R. § 438.10. The notice shall contain taglines in each State-established prevalent non-English language as well as large print explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free and TTY/TDD telephone number of the entity providing customer service.

In accordance with 42 C.F.R. § 438.408(d)(2)(ii), the Contractor, in addition to the written notice requirements of the preceding paragraph, shall also make reasonable efforts, as determined by OHCA, to provide oral notice to the Enrollee for resolution of an expedited Appeal.

OHCA intends to work with the Contractor to develop model notices upon award of this Contract. In accordance with 42 C.F.R. § 438.408(e)(1)-(2), the notice shall include the results of the resolution process and the date it was completed, and for Appeals not resolved wholly in favor of the Enrollee, the notice shall include the following:

a. The right to request a State Fair Hearing;

b. How to request a State Fair Hearing;

c. The right to request and receive continuation of benefits while the State Fair Hearing is pending, as detailed in 1.18.9: "Continuation of Benefits Pending Appeal and State Fair Hearing" of this Contract;

d. How to request the continuation of benefits while the State Fair Hearing is pending; and

e. Notice that the Enrollee may, consistent with OHCA policy, be held liable for the cost of those benefits if the State Fair Hearing decision upholds the Contractor's Adverse Benefit Determination.

1.18.8 Access to State Fair Hearings and Contractor Role

1.18.8.1 Authority and Timeline for State Fair Hearing Request

Pursuant to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1), an Enrollee may request a State Fair Hearing under Subpart E of 42 C.F.R. Part 431 only after receiving notice from the Contractor upholding an

Adverse Benefit Determination. The Enrollee shall have one-hundred twenty (120) Calendar Days from the date of the Adverse Benefit to request a State Fair Hearing.

1.18.8.2 Deemed Exhaustion of Appeals Process

If the Contractor fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the Enrollee is deemed to have exhausted the Contractor's Appeal process and the Enrollee may initiate a State Fair Hearing, pursuant to 42 C.F.R. §§ 438.402(c)(1)(i)(A) and 438.408(f)(1)(i).

1.18.8.3 Parties to State Fair Hearing

In accordance with 42 C.F.R. § 438.408(f)(3), parties to the State Fair Hearing shall include the Contractor and the Enrollee and/or the Enrollee's Authorized Representative or the representative of a deceased Enrollee's estate.

1.18.8.4 Contractor State Fair Hearing Support

The Contractor shall maintain a sufficient level of trained staff to provide support in the State Fair Hearing process, including all of the following, at minimum:

a. The Contractor shall provide OHCA with a summary setting forth the following information:

   i. Name and address of the Enrollee, which includes the Enrollee's Authorized Representative, if applicable;

   ii. A summary statement concerning why the Enrollee is filing a request for a State Fair Hearing;

   iii. A brief chronological summary of the Contractor's action in relationship to the Enrollee's request for a State Fair Hearing;

   iv. A statement of the basis of the Contractor's decision;

   v. A citation of the applicable policies relied upon by the Contractor;

   vi. A copy of the notice which notified Enrollee of the decision in question;

   vii. Any applicable correspondence; and

   viii. The name and title of the Contractor's staff who will serve as witnesses at the State Fair Hearing.

b. This summary must be received by OHCA within fifteen (15) Calendar Days after notification of the request for a State Fair Hearing.

c. Summarizing the arguments presented by the Enrollee, which includes the Enrollee's Authorized Representative, if applicable, and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Enrollee and Contractor are clearly identified. The Contractor

shall state the legal basis upon which any dismissal requests are based and include regulations or statutes in support, at minimum, meeting the regulations at 42 C.F.R. § 431.244.

d. Ensuring timely delivery to the Enrollee, which includes the Enrollee's Authorized Representative, if applicable, OHCA, and the Office of Administrative Hearings of State Fair Hearing documentation, as required.

OHCA reserves the right to amend the Contractor State Fair Hearing responsibilities within the confines of the federal regulations, including setting performance targets for State Fair Hearing requests that are resolved upholding the Contractor's original determination, as it deems necessary and appropriate under this Contract.

1.18.9 Continuation of Benefits Pending Appeal and State Fair Hearing

1.18.9.1 When the Contractor Shall Continue Benefits

In accordance with 42 C.F.R. § 438.420 and OAC 317:2-1-2.6, the Contractor shall continue an Enrollee's benefits under the Contract when all of the following occur:

a. The Enrollee files the request for an Appeal within sixty (60) Calendar Days following the date on the Adverse Benefit Determination notice in accordance with 42 C.F.R. §§ 438.402(c)(1)(ii) and (c)(2)(ii);

b. The Appeal involves the termination, suspension, or reduction of previously authorized services;

c. The services were ordered by an authorized Provider;

d. The period covered by the original authorization has not expired; and

e. The Enrollee timely files for continuation of benefits, meaning on or before the later of the following:

   i. Within ten (10) Calendar Days of the Contractor sending the notice of Adverse Benefit Determination; or

   ii. The intended effective date of the Contractor's proposed Adverse Benefit Determination.

If the Enrollee fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within sixty (60) Calendar Days of the Adverse Benefit Determination, services shall be continued or reinstated. Notwithstanding the foregoing, continuation or reinstatement of benefits shall not occur under the following circumstances:

a. The Enrollee has exceeded the limit applicable to the services; or

b. When a Provider has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

The Contractor shall also continue or reinstate benefits if the Enrollee:

a. Files a request for a State Fair Hearing within one hundred twenty (120) Days of the Adverse Resolution notice; and

b. Files a request for continuation of benefits within thirty (30) Calendar Days of the Adverse Resolution notice.

The Contractor shall continue or reinstate benefits until the State Fair Hearing decision or the Enrollee withdrawals the State Fair Hearing request, refer to Section 1.18.9.2: "Duration of Continued or Reinstated Benefits" of this Contract.

1.18.9.2 Duration of Continued or Reinstated Benefits

If the Contractor continues or reinstates the Enrollee's benefits at the Enrollee's request while the Appeal or State Fair Hearing is pending, the benefits must be continued until one (1) of following occurs:

a. The Enrollee withdraws the Appeal or request for State Fair Hearing;

b. The Enrollee fails to request a State Fair Hearing and continuation of benefits within ten (10) Calendar Days after the Contractor sends the notice of an Adverse Resolution to the Enrollee's Appeal under 42 C.F.R. §§ 438.420(c)(2), and 438.408(d)(2); or

c. A State Fair Hearing officer issues a hearing decision adverse to the Enrollee.

1.18.10 Contractor Recovery

The Contractor shall not recover from the Enrollee the costs of services furnished to the Enrollee during the period of continued or reinstated benefits pending a final resolution of an Appeal or State Fair Hearing. The Contractor shall not recover from the Enrollee the costs of continued or reinstated benefits upon the final resolution of the Appeal or State Fair Hearing when the final resolution upholds the Contractor's Adverse Benefit Determination.

1.18.11 Effectuation of Reversed Enrollee Appeal Resolutions

1.18.11.1 Authorization of Services Not Furnished While Enrollee Appeal is Pending

In accordance with 42 C.F.R. § 438.424(a), when services are not furnished to the Enrollee while the Enrollee's Appeal or State Fair Hearing is pending, and the Contractor or State Fair Hearing officer reverses the decision to deny, limit, or delay services, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires. This shall be no later than seventy-two (72) Hours from the date the Contractor receives notice reversing the initial determination to deny, limit, or delay the services.

1.18.11.2 Payment for Services Furnished While Appeal is Pending

In accordance with 42 C.F.R. § 438.424(b), the Contractor shall pay for disputed services received by the Enrollee while the Enrollee's Appeal or State Fair Hearing is pending, and the Contractor or State Fair

Hearing officer reverses the initial decision to deny authorization of the services. Payment shall be made by the Contractor in accordance with the terms of this Contract.

1.19 Cost Sharing

1.19.1 Compliance with State Plan Requirements

Any Cost Sharing imposed by the Contractor on any Enrollee shall be in accordance with Medicaid FFS requirements as outlined in the OHCA State Plan and 42 C.F.R. §§ 447.50 through 447.57.

1.19.2 Cost Sharing Exempt Populations

The Contractor shall not impose Premiums on any Enrollees. In accordance with 42 C.F.R. §§ 447.56, 447.52(h), and 447.51(a)(2), the Contractor shall not impose Cost Sharing upon any of the following:

a. Enrollee under twenty-one (21) years of age;

b. Children for whom Child Welfare Services are made available under Part B of Title IV of The Act on the basis of being a child in Foster Care and individuals receiving benefits under Part E of that Title, without regard to age;

c. Pregnant Women;

d. Any Enrollee whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;

e. Enrollee receiving hospice care, as defined in Section 1905(o) of The Act;

f. An AI/AN who is eligible to receive or has received an item or service furnished by an Indian Health Care Provider or through referral under purchased and referred care is exempt from Cost Sharing requirements. AI/ANs who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under purchased and referred care are exempt from all Cost Sharing; and

g. Enrollee receiving Medicaid due to a diagnosis of breast or cervical cancer in accordance with 42 C.F.R. § 435.213.

1.19.3 Cost Sharing Exempt Services

In accordance with 42 C.F.R. § 447.56, the Contractor shall implement processes to ensure Cost Sharing is not imposed on any of the following services:

a. Emergency Services;

b. Family Planning Services and Supplies;

c. Preventive Services, which includes, at minimum the services specified at 42 C.F.R. § 457.520 provided to Children under eighteen (18) years of age regardless of family income, which reflect the well-baby and well childcare and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics (AAP);

d. Pregnancy-Related Services;

e. Provider-Preventable Services; and

f. Additional services as directed by OHCA and/or CMS.

1.19.4 Claims Payment Reductions

The Contractor shall reduce the payment made to a Provider by the amount of the Enrollee's Cost Sharing obligation, regardless of whether the Provider has collected the payment or waived the Cost Sharing. Notwithstanding the foregoing, the Contractor shall not reduce payments to Providers, including IHCPs, for items and services provided to AI/ANs who are exempt from Cost Sharing.

1.19.5 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 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 Program Integrity

1.20.1 General Program Integrity and Compliance Requirements

The Contractor and its Subcontractors shall comply with all State and federal laws, regulations, and mandates including but not limited to 42 C.F.R. § 438.608 related to program integrity, compliance, and disclosure requirements. This includes all current State and federal laws and regulations as well as any future laws and regulations that may be required.

1.20.1.1 Administrative and Management Arrangements or Procedures

The Contractor and its Subcontractors shall implement and maintain administrative and management arrangements or procedures that are designed to detect and prevent Fraud, Waste, and Abuse. The Contractor's Fraud, Waste and Abuse policies and procedures shall be coordinated with those of OHCA's Program Integrity and Accountability Unit. In accordance with 42 C.F.R. § 438.608, the Contractor's arrangements, policies, and procedures must include, but not be limited to, the following, as further detailed in Section 1.20.2: "Compliance Program" of this Contract:

a. A compliance program, as described in Section 1.20.2: "Compliance Program" of this Contract;

b. Prompt referral of any potential Fraud, Waste, or Abuse to OHCA's Program Integrity and Accountability Unit and Office of General Counsel, in writing using a form as prescribed by OHCA in the Reporting Manual and as described in Section 1.20.1.2: "Referral to OHCA Program Integrity and Accountability Unit and OHCA Office of General Counsel" of this Contract;

c. Collaboration with OHCA and the Oklahoma Medicaid Fraud Control Unit (MFCU) as described in Section 1.20.1.3: "Collaboration with OHCA and MFCU" of this Contract;

d. Prompt notification to OHCA regarding changes in an Enrollee's circumstance that may affect SoonerSelect Program eligibility, as prescribed in the Reporting Manual, and as described in Section 1.20.3.1: "Reporting Enrollee Changes in Circumstance" of this Contract;

e. Notification to OHCA regarding changes in a Provider's circumstances that may affect SoonerSelect Program eligibility, as prescribed in the Reporting Manual, and as described in Section 1.20.3.2: "Reporting Provider Changes in Circumstance" of this Contract;

f. Method to verify Enrollee's receipt of covered services, as described in Section 1.20.4: "Verifying Delivery of Services" of this Contract;

g. Written policies and procedures to prevent Fraud, Waste, and Abuse and employee whistleblower protections, as described in Section 1.20.5: "False Claims Act Policies and Whistleblower Protection" of this Contract;

h. Prompt reporting of all Overpayments, as prescribed in the Reporting Manual and as described in Section 1.20.6: "Reporting Overpayments" of this Contract; and

i. Suspending payments to Participating Providers when there is a credible allegation of Fraud, as described in Section 1.20.7: "Suspension of Payments for Credible Allegation of Fraud" of this Contract.

1.20.1.2 Referral to OHCA Program Integrity and Accountability Unit and OHCA Office of General Counsel

In accordance with 42 C.F.R. § 438.608(a)(7), the Contractor shall make a prompt referral of any potential Fraud, Waste, or Abuse that the Contractor, or its Subcontractor to the extent that the Subcontractor is delegated responsibility for coverage of services and payment of claims, to OHCA's Program Integrity and Accountability Unit and Office of General Counsel Division, in writing using a form as prescribed by OHCA in the Reporting Manual. The referral shall be made within three (3) Business Days of the Contractor's identification of the activity at issue.

1.20.1.3 Collaboration with OHCA and MFCU

The Contractor shall collaborate with the Oklahoma MFCU and OHCA as necessary to ensure integrity of the SoonerSelect Program. At minimum, the Contractor shall:

a. Participate in good faith at monthly program integrity meetings held jointly with MFCU and OHCA;

b. Provide responses to specific requests made by MFCU within three (3) Business Days of receipt of the request; and

c. Provide MFCU access to the Contractor's claims payment data and other applicable records.

OHCA reserves the right to amend these requirements or timeframes as necessary to address program integrity concerns identified by OHCA, MFCU, or the Contractor.

1.20.1.4 Audit Requirements and Provider Rights

The Contractor shall cooperate in any audit activity performed by OHCA, OHCA's Program Integrity and Accountability Unit, Medicaid recovery audit contractor, CMS and/or Payment Error Rate Management, and the CMS audit Medicaid integrity contractors. The Contractor, its Subcontractors and Participating Providers shall, upon request, make available any and all administrative, financial, and medical records relating to the delivery of items or services for which State or federal monies are expended, unless otherwise provided by law. Any audit of a Participating Provider that is a pharmacy shall comply with the requirements of 59 O.S. § 356.2.

1.20.2 Compliance Program

In accordance with 42 C.F.R. § 438.608(a)(1)(i)-(vii) and OHCA policy, the Contractor, as well as its Subcontractors that are delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall have a compliance program that includes, at minimum, all of the following elements:

a. Written policies, procedures, and standards of conduct that articulate the Contractor and Subcontractor's commitment to comply with all applicable requirements and standards under this Contract and all applicable State and federal requirements. All compliance program written policies, procedures, and standards of conduct shall be submitted to OHCA during Readiness Review and upon request for review and approval;

b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the CEO and the Governing Body;

c. The establishment of a Regulatory Compliance Committee on the Governing Body and at the senior management level charged with overseeing the Contractor or Subcontractor's compliance program and its compliance with requirements under this Contract;

d. At a minimum, the Contractor shall utilize a full-time, single Lead Investigator based in Oklahoma to identify risk and guard against Fraud, Waste, and Abuse, monitor aberrant Providers, and refer potential Fraud, Waste, and Abuse to OHCA by conducting Fraud, Waste, and Abuse investigations, and preparing investigatory reports;

    i. The Lead Investigator shall be dedicated solely to OHCA program integrity work and meet the following qualifications:

        a) A minimum of two (2) years working in health care Fraud, Waste, and Abuse investigations and audits;

        b) A Bachelor's degree or an associate degree with an additional two (2) years working in health care Fraud, Waste, and Abuse investigations and audits. OHCA will accept experience and certifications commensurate with the educational requirements. OHCA will evaluate the experience and certifications in lieu of educational requirements; and

        c) Ability to understand and analyze health care claims and coding;

    ii. The Lead Investigator shall collaborate with OHCA Program Integrity and Accountability Unit and OHCA Office of General Counsel in areas such as Fraud referrals, audits and investigations, Overpayments, Provider terminations, as well as attend any required meetings as prescribed by OHCA, including, but not limited to, OHCA's monthly program integrity meeting with MFCU; and

    iii. In addition to the Lead Investigator, the Contractor shall, at a minimum, utilize one (1) full-time investigator for every 75,000 enrolled Enrollees. These investigators shall be based in Oklahoma to identify risk and guard against Fraud, Waste, and Abuse, monitor aberrant Providers, and refer potential Fraud, Waste, and Abuse to OHCA by conducting Fraud, Waste, and Abuse investigations, and preparing investigatory reports;

e. A system for training and education for the Compliance Officer and Lead Investigator, the Contractor's senior management and employees for the State and federal standards and requirements under this Contract, as described in Section 1.20.2.2: "Compliance Education and Training" of this Contract;

f. Effective lines of communication between the Compliance Officer and the Contractor's employees;

g. Enforcement of standards through well-publicized disciplinary guidelines;

h. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract;

i. The establishment and implementation of procedures for proactive specific controls in place to detect Fraud, Waste, and Abuse and erroneous payments, including review of Provider records and technology used to identify:

   i. Aberrant billing patterns;

   ii. Pre/post-payment claims edits;

   iii. Post-processing review of claims;

   iv. Provider profiling and credentialing used to aid program and payment integrity reviews;

   v. Surveillance and/or UM protocols used to safeguard against unnecessary or inappropriate use of covered services;

   vi. Provisions in Subcontractor and Provider Agreements that ensure integrity of Provider credentials; and

   vii. Enrollee record reviews;

j. The establishment of policies and procedures for reporting all allegations of Fraud, Waste, and Abuse to OHCA's Program Integrity and Accountability Unit and Legal Unit, in writing as prescribed in the Reporting Manual, including:

   i. Designating the Contractor's staff responsible for reporting Fraud to OHCA's Program Integrity and Accountability Unit; and

   ii. Providing a process for timely, complete, and consistent exchange of information and collaboration with OHCA's Program Integrity and Accountability Unit, designated Agents and contracted EQRO;

k. The development of policies and implementation of a process to:

   i. Timely suspend all Provider payments, as outlined in Section 1.20.7: "Suspension of Payments for Credible Allegation of Fraud" of this Contract when notified by the OHCA Office of General Counsel and other State and federal agencies to suspend payments because of credible allegation(s) of Fraud;

   ii. Comply with requests from the OHCA Program Integrity and Accountability Unit, OHCA Office of General Counsel, and other State and federal agencies to access and receive copies of any records kept by the Contractor;

l. Staff that are qualified and adequate in number and training to effectively monitor this Contract;

m. Development and implementation of a process for the confidential reporting of Contractor violations, including:

   i. Hotline and/or electronic method for reporting violations, as described in Section 1.20.2.3: "Compliance Hotline" of this Contract;

   ii. Designation of an individual to receive reports of violations; and

   iii. Independent reporting paths for the reporting of violations so that such reports cannot be diverted by any supervisors or other personnel;

n. Establishment of protections to ensure that:

   i. No individual who reports cases or suspected cases of a program integrity violation, Fraud, Waste, or Abuse is retaliated against by anyone who is employed by or contracted with the Contractor; and

   ii. The identity of the individual(s) reporting violations or suspected violations be kept confidential to the extent possible;

o. Development and implementation of an internal and external process for conducting investigations and follow-up of any suspected or confirmed Fraud, Waste, or Abuse or compliance violations;

p. Coordination with OHCA and other CEs on proactive detection of Fraud, Waste, and Abuse and erroneous payments, including:

   i. Providing a monthly and quarterly list of audit activities to OHCA, in writing as prescribed in the Reporting Manual, in order to reduce or prevent overlap;

   ii. Participating in monthly meeting with OHCA Program Integrity and Accountability Unit to discuss all active referrals, investigations, and audits;

   iii. Reporting audit activities and audit outcomes to OHCA as prescribed in the Reporting Manual in order to facilitate OHCA follow-up on the audit activity as needed;

   iv. Timely correspondence necessary with CEs as directed by OHCA to prevent or detect potential Fraud, Waste, or Abuse of Medicaid funds under the SoonerSelect Program; and

   v. Monthly check for exclusions of the Contractor's employees, owners, Agents, and database to capture identifiable information.

1.20.2.1 Compliance Plan

The Contractor shall have a written Compliance Plan that addresses, at minimum, the items described in Section 1.20.2: "Compliance Program" of this Contract. The Contractor shall submit a copy of the

Compliance Plan to OHCA's Program Integrity and Accountability Unit for review and approval a minimum of sixty (60) Calendar Days prior to the Contract start date and annually thereafter as prescribed in the Reporting Manual. The initial Compliance Plan must be approved by OHCA's Program Integrity and Accountability Unit prior to implementation by the Contractor.

The Contractor shall submit any request(s) for revision(s) to the Compliance Plan for review to OHCA's Program Integrity and Accountability Unit as prescribed in the Reporting Manual, and a minimum of sixty (60) Calendar Days prior to the requested implementation date of the revision(s). Revisions must be approved by OHCA's Program Integrity and Accountability Unit prior to implementation by the Contractor.

1.20.2.2 Compliance Education and Training

The Contractor shall educate and train all employees, including management, and any Subcontractors/Agents about:

a. Provisions of 42 C.F.R. § 438.610 regarding prohibited Contractor affiliations and all relevant State and federal laws, regulations, policies, procedures, and guidance, including updates and amendments to these documents or any such standards;

b. The Contractor's Compliance Program, as described in Section 1.20.2: "Compliance Program" of this Contract;

c. The Contractor's code of conduct; and

d. Privacy and security, including but not limited to HIPAA.

The Contractor shall conduct training for new hires within thirty (30) Calendar Days of employment and conduct training annually for all employees. The Contractor shall maintain evidence of completed education and training efforts. The Contractor shall provide such evidence upon request by OHCA.

1.20.2.3 Compliance Hotline

The Contractor shall maintain a toll-free compliance hotline number. The Contractor's hotline and OHCA's hotline shall be accessible by employees, Subcontractors/Agents, Participating Providers and Enrollees to report compliance concerns, including suspected Fraud, Waste, and Abuse. The Contractor shall ensure that the Contractor's hotline number and OHCA's hotline number, as well as an explanatory statement, are distributed to its employees, Subcontractors/Agents, Participating Providers, and staff.

1.20.3 Reporting Changes in Circumstance

1.20.3.1 Reporting Enrollee Changes in Circumstance

The Contractor shall promptly notify OHCA, in a notification manner approved by OHCA and as prescribed in the Reporting Manual, when the Contractor, or the Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, receives information about changes in an Enrollee's circumstances that may affect the Enrollee's SoonerSelect Program eligibility, in accordance with 42 C.F.R. § 438.608(a)(3) and in accordance with the provisions of

Section 1.6.9: “Enrollee Status Changes” of this Contract. Changes required to be promptly reported include, at minimum:

a. Changes in the Enrollee’s residence or notification of the Enrollee’s mail that is returned as undeliverable; and

b. Death of the Enrollee.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within five (5) Business Days of the Contractor’s receipt of the information.

1.20.3.2 Reporting Provider Changes in Circumstance

In accordance with 42 C.F.R. § 438.608(a)(4), the Contractor shall promptly notify OHCA, in a notification manner approved by OHCA and as prescribed in the Reporting Manual, when the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, receives information about a change in a Provider’s circumstances that may affect the Provider’s eligibility to participate in the SoonerSelect Program, including termination of the Provider Agreement with the Contractor.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three (3) Business Days of the Contractor’s receipt of the information. The Contractor shall provide the information required under this Section inclusive of, at minimum, the Provider’s name, address, and NPI to an OHCA designated email.

1.20.4 Verifying Delivery of Services

1.20.4.1 General Requirement

In accordance with 42 C.F.R. § 438.608(a)(5), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall have a method to verify whether services represented as delivered by Participating Providers were actually received by Enrollees. The Contractor may conduct verification by telephone, electronic correspondence, or writing. The Contractor shall report the results of this monitoring to OHCA on a quarterly basis, as outlined in the Reporting Manual.

1.20.4.2 Explanation of Benefits (EOBs)

The Contractor shall develop and distribute EOBs to verify the delivery of services consistent with the requirements of 42 C.F.R. § 438.608(a)(5). The EOBs shall be distributed using a methodology approved by OHCA that ensures all services and Provider types are sampled regularly.

The EOB developed and distributed by the Contractor shall conform to all requirements of 42 C.F.R. §§ 455.20 and 433.116. The Contractor shall ensure that EOBs are accessible electronically via the Enrollee Portal as set forth at Section 1.12.7.3: “Enrollee Website Portal” of this Contract and shall also ensure telephonic, written, or other electronic EOB access for Enrollee’s unable to access the Enrollee Portal. The EOB should list the services delivered, name of the Provider claiming the service, date on which it was claimed to have been delivered, service location, and amount of payment. An Enrollee shall be

instructed to call the listed phone number if the services are incorrect. In the event the Contractor receives notice from an Enrollee that services listed on the EOB were not received, the Contractor shall follow the requirements of Section 1.20: "Program Integrity" of this Contract to determine if referral due to potential Fraud is necessary.

The Contractor shall oversample if a specific service or class of Provider justifies closer oversight.

1.20.5 False Claims Act Policies and Whistleblower Protection

In accordance with 42 C.F.R. § 438.608(a)(6), the Contractor shall establish and implement written policies for all employees, including management, and any Subcontractor or Agent of the Contractor's that provide detailed information about preventing and detecting Fraud, Waste, and Abuse in federal health care programs. This information shall include, at minimum:

a. The False Claims Act, 31 U.S.C. § 3729;

b. Other federal laws described in § 1902(a)(68) of The Act and 42 U.S.C. § 1396a;

c. Non-Compliance Remedies for false claims and statements;

d. State laws pertaining to civil or criminal penalties for false claims and statements, including 63 O.S. §§ 5053 - 5054;

e. Whistleblower protection under such laws, including the rights of employees to be protected as whistleblowers; and

f. The Contractor's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

In addition, the Contractor shall include this information in its Employee Handbook. The Contractor shall submit its Fraud, Waste, and Abuse policies and procedures to OHCA during Readiness Review and upon request for review and approval as specified in the Reporting Manual.

1.20.6 Reporting Overpayments

In accordance with 42 C.F.R. § 438.608(a)(2), the Contractor, or its Subcontractor to the extent the Subcontractor is delegated responsibility for coverage of services and payment of claims, shall promptly report all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, to OHCA in a manner and format, as specified in the Reporting Manual.

For purposes of meeting this requirement, prompt notification to OHCA is defined as within three (3) Business Days of the Contractor's identification or recovery of the Overpayment.

1.20.7 Suspension of Payments for Credible Allegation of Fraud

The Contractor, or its Subcontractor to the extent the Subcontractor is delegated claims payment responsibility, shall timely suspend payments to a Participating Provider for which OHCA determines there is a credible allegation of Fraud in accordance with 42 C.F.R. §§ 438.608(a)(8) and 455.23. OHCA shall determine whether payments should be suspended or if an exception is appropriate. OHCA shall notify the Contractor of payment suspensions, and the Contractor must then immediately suspend

further payments to the Provider. The Contractor must ensure that no Medicaid dollars are received by a Provider whose payments are suspended or that has been terminated by OHCA.

After a credible allegation of Fraud, unless prior written approval is obtained from OHCA, the Contractor may not take any of the following actions:

a. Contact the subject of the investigation concerning any matter related to the investigation;

b. Institute any interventions, sanctions, or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension, or termination;

c. Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the Provider;

d. File any civil action based upon the suspected Fraud against the subject of the investigation;

e. Enter into or attempt to negotiate any settlement or agreement regarding the suspected Fraud; or

f. Accept any money or other thing of value offered by the subject of the investigation in connection with suspected Fraud.

If the Contractor thinks that it is appropriate to initiate a recoupment or withholding action against a Provider under these circumstances, the Contractor shall consult with OHCA and OHCA's Program Integrity and Accountability Unit to ensure whether such action is permissible. In the event that the Contractor obtains funds from an action when recoupment or withholding is prohibited, the Contractor shall return the funds to the Provider.

1.20.8 Provider Screening and Enrollment

In accordance with 42 C.F.R. § 438.608(b), the Contractor shall ensure that all of the Contractor's Participating Providers are enrolled with OHCA as a Medicaid Provider and periodically revalidated consistent with the Provider disclosure, screening, and Enrollment requirements of 42 C.F.R. §§ 438.602, 455.100-106 and 455.400-470.

1.20.9 Written Disclosures

The Contractor shall submit to OHCA the following disclosures and reports, as set forth at 42 C.F.R. § 438.608(c):

a. Written disclosure of any prohibited affiliation under 42 C.F.R. § 438.610, as detailed in Section 1.20.10: "Prohibited Affiliations and Exclusions" of this Contract;

b. Written disclosures of information on ownership and control required under 42 C.F.R. § 455.104, as detailed in Section 1.20.9.1: "Required Ownership, Controlling Interest and Managing Employee Disclosures" of this Contract; and

c. Report of Capitation Overpayment as prescribed in the Reporting Manual within thirty (30) Calendar Days when the Contractor has identified the Capitation Payments or other payments in

excess of amounts specified in this Contract, as detailed in Section 1.3.3: "Report of Capitation Overpayment" of this Contract.

1.20.9.1 Required Ownership, Controlling Interest and Managing Employee Disclosures

In accordance with the requirements at 42 C.F.R. §§ 438.604(a)(6), 438.608(c)(2), and 455.104, the Contractor shall submit to OHCA the following information:

a. The name of any Person with an Ownership or Control Interest in the Contractor or its Subcontractors;

b. The address of a Person with an Ownership or Controlling Interest in the Contractor or its Subcontractors, which, for corporations shall include, as applicable, the following:

   i. Primary business address;

   ii. Every business location; and

   iii. Post Office Box address;

c. The date of birth of any individual Person with an Ownership or Controlling interest in the Contractor or its Subcontractors;

d. The Social Security Number of any individual Person with an Ownership or Controlling Interest in the Contractor or its Subcontractors;

e. Other TIN of any corporate Person with an Ownership or Controlling Interest in the Contractor or its Subcontractors;

f. TIN of any Subcontractor in which the Contractor has a five percent (5%) or more interest;

g. Information on whether a Person with an Ownership or Controlling Interest in any Subcontractor in which the Contractor has a five percent (5%) or more interest is related to another person with Ownership or Controlling interest in the Contractor as a spouse, parent, child, or sibling;

h. The name of any Other Disclosing Entity in which an owner of the Contractor is a Person with an Ownership or Controlling Interest; and

i. The name, address, date of birth, and Social Security Number of any Managing Employee of the Contractor.

1.20.9.2 Persons with an Ownership or Controlling Interest

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2), 455.100-455.104, and 42 C.F.R. § 455.104(c)(3), as well as § 1124(a)(2)(A) of The Act, the Contractor and its Subcontractors shall disclose to OHCA, and OHCA shall review the submitted disclosures, any Persons with an Ownership or Controlling Interest in the Contractor that:

a. Has a Direct Ownership Interest, Indirect Ownership Interest, or combined Direct/Indirect Ownership Interest of five percent (5%) or more of the Contractor's equity;

b. Owns five percent (5%) or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least five percent (5%) of the value of the Contractor's assets;

c. Is an officer or director of the Contractor if the Contractor is organized as a corporation;

d. Is a partner in the Contractor if the Contractor is organized as a partnership; or

e. Is a member or manager of the Contractor if the Contractor is organized as a limited liability company.

1.20.9.3 When Disclosures of Persons with An Ownership or Controlling Interest Are Required

In accordance with requirements at 42 C.F.R. §§ 438.608(c)(2), 455.100-455.103, and 42 C.F.R. 455.104(c)(3), as well as § 1124(a)(2)(A) of The Act, the Contractor and its Subcontractors shall make the disclosures required in Section 1.20.9.1: "Required Ownership, Controlling Interest and Managing Employee Disclosures" of this Contract at the following times:

a. When the Contractor submits a Proposal in accordance with the State's procurement process;

b. When the Provider or Disclosing Entity submits a Provider application;

c. When the Provider or Disclosing Entity executes a Provider Agreement with OHCA;

d. Upon request of the State during revalidation of Provider Enrollment;

e. When the Contractor executes a Contract with OHCA;

f. When OHCA renews or extends this Contract; and

g. Within thirty-five (35) Calendar Days after any change in ownership of the Contractor or of the Disclosing Entity.

1.20.10 Prohibited Affiliations and Exclusions

1.20.10.1 Providers Excluded from Participation in Federal Health Care Programs

The Contractor, in accordance with 42 C.F.R. § 438.214(d)(1), shall not employ or contract with Providers excluded from participation in federal health care programs.

1.20.10.2 Sanctioned Individual

The Contractor shall not allow a sanctioned individual under § 1128(b)(8) of The Act to have Controlling Interest in the Contractor, in accordance with 42 C.F.R. § 438.808.

1.20.10.3 Other Prohibited Affiliations

The Contractor:

a. Shall not contract for the administration, management, or provision of medical services (or the establishment of policies or provision of operational support for such services), either directly or indirectly:

   i. With an individual convicted of crimes described in § 1128(b)(8)(B) of The Act, in accordance with 42 C.F.R. §§ 438.808(a) and 438.808(b)(2);

   ii. With any individual or entity that is (or is affiliated with a person/entity that is) debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), 438.610(a); or

   iii. With any individual or entity that is excluded from participation in any federal health care program under § 1128 or 1128A of The Act, pursuant to 42 C.F.R. §§ 438.808(a), 438.808(b)(2), and 438.610(b);

b. Shall not employ or contract, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services:

   i. With any individual or entity that is (or is affiliated with a person/entity that is), or would provide those services through an individual or entity that is debarred, suspended, or excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(a); or

   ii. With any individual or entity that is excluded or would provide those services through an individual or entity who is excluded, from participation in any Federal health care program under § 1128 or 1128A of The Act, in accordance with 42 C.F.R. §§ 438.808(a), 438.808(b)(3)(i)-(ii), and 438.610(b).

For Agents, Subcontractor(s), Subsidiaries, and Affiliates, the Contractor shall not employ or contract, directly or indirectly, with:

a. Any person who has been involved in any manner in the development of this Contract while employed by the State of Oklahoma shall be employed by the Contractor to fulfill any of the services provided under this Contract, in accordance with 74 O.S. § 85.42(B);

b. Any such person or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal, state, local department, or agency;

c. Any such person or entity that has been convicted of or had a civil judgment rendered against it for commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) contract; or for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property within three (3) years of the CE's Contract with the person or entity;

d. Any such person or entity that is presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in the previous paragraph; or

e. Any such person or entity that has had one (1) or more public (federal, state, or local) contracts terminated for cause or default within three (3) years of the CE's Contract with the person or entity.

1.20.10.4 Written Disclosure

In accordance with 42 C.F.R. § 438.608(c), the Contractor shall provide written disclosure as prescribed in the Reporting Manual of all prohibited relationships between the Contractor and any individual, entity, or Affiliate identified in Section 1.20.10: "Prohibited Affiliations and Exclusions" of this Contract.

1.20.10.5 State Identification of Prohibited Relationships

In accordance with 42 C.F.R. § 438.610(d), if OHCA finds that the Contractor is not in compliance with the requirements for prohibited affiliations at 42 C.F.R. § 438.610(a)-(c), set forth in this section of the Contract, OHCA shall notify the Secretary of HHS of the Contractor's noncompliance. OHCA, may continue an existing agreement with the Contractor unless the Secretary directs otherwise. OHCA shall not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary of HHS provides to OHCA and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the Contractor's prohibited affiliations.

1.20.11 Overpayments to Providers

1.20.11.1 Treatment of Recoveries Made by Contractor of Overpayments to Providers

The Contractor shall provide the following policies, procedures, timelines, and documentation requirements to OHCA during Readiness Review and upon OHCA request for review and approval:

a. Retention policies for the treatment of recoveries of all Overpayments from the Contractor to a Provider, including specifically the retention policies for the treatment of recoveries of Overpayments due to Fraud, Waste, or Abuse;

b. The process, timeframes, and documentation required for reporting the recovery of all Overpayments; and

c. The process, timeframes, and documentation required for payment of recoveries of Overpayments to OHCA in situations where the Contractor is not permitted to retain some or all of the recoveries of Overpayments.

This subsection does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

If a Fraud referral from the Contractor generates an investigation and/or legal action results in a recovery, the Contractor will be entitled to share in recovery following final resolution of the action (settlement agreement/final court judgment) and payment of recovered funds to OHCA. The State shall retain its costs of pursuing the action and its actual documented loss. The State will pay the remainder of the recovery, not to exceed the Contractor's actual documented loss, to the Contractor. If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the settlement. If final resolution of a matter does not occur until after this Contract has expired, these policies shall survive expiration.

If OHCA makes a recovery where the Contractor has sustained a documented loss, but the case did not result from a referral made by the Contractor, OHCA shall not be obligated to repay any monies recovered to the Contractor but may do so at its discretion.

1.20.11.2 Overpayments Resulting from Audits Conducted by the Contractor

The Contractor retains recovery of Overpayments resulting from Waste or Abuse audits that originated from the Contractor.

1.20.11.3 Overpayments Resulting from Audits Conducted by OHCA

If an Overpayment to a Provider made by the Contractor is identified by OHCA rather than by the Contractor, OHCA may recover the Overpayments from the Contractor. The Contractor may then recover the Overpayment from the Provider at their discretion.

If OHCA makes a recovery where the Contractor has sustained a documented loss, but the case did not result from a referral made by the Contractor, OHCA will not be obligated to repay any monies recovered to the Contractor but may do so at its discretion.

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

d. The Contractor fails to complete the recovery within sixty (60) Days from the date the Provider notified the Contractor of the Overpayment.

1.20.11.5 Overpayments Resulting from MFCU

If a Fraud referral from the Contractor generates an investigation and/or legal action results in a recovery, the Contractor will be entitled to share in recovery following final resolution of the action, settlement agreement or final court judgment, and payment of recovered funds to OHCA. The State will retain its costs of pursuing the action and its actual documented loss. The State will pay the remainder of the recovery, not to exceed the Contractor's actual documented loss, to the Contractor. If the State determines it is in its best interest to resolve the matter under a settlement agreement, the State has final authority concerning the settlement. If final resolution of a matter does not occur until after the Contract has expired, these policies will survive expiration.

1.20.11.6 Overpayment Reporting Mechanism for Participating Providers

In accordance with 42 C.F.R. § 438.608(d)(2), the Contractor shall have a mechanism for a Participating Provider to report to the Contractor when the Participating Provider has received an Overpayment, to return the Overpayment to the Contractor within sixty (60) Days after the date on which the Overpayment was identified and to notify the Contractor in writing of the reason for the Overpayment. The Contractor shall require Participating Providers to use this reporting mechanism.

1.20.12 Fraudulent or Abusive Enrollee Conduct

Fraudulent or abusive Enrollee conduct may include, but is not limited to, the following:

a. Overutilization, such as:

   i. Concurrently obtaining services from two (2) or more Providers of the same specialty, not in the same group practice, with no referrals;

   ii. Concurrently using two (2) or more prescribing physicians and/or dentists to obtain drugs from the same therapeutic class of medication;

   iii. Two (2) or more occurrences of having prescriptions for the same therapeutic class of medication filled two (2) or more times on the same or subsequent day by the same or different Providers; or

   iv. Concurrently using two (2) or more pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer's maximum recommended dosage as approved by the FDA;

b. Fraud, such as:

   i. Purchasing drugs on a forged prescription; or

ii. Loaning the Enrollee's SoonerSelect Program ID card to another individual to obtain Medicaid-reimbursed services;

c. Engaging in threatening or abusive conduct to Providers.

Enrollees may be identified through UM, chart review, or by referral from Participating Providers. The Contractor shall notify OHCA of Enrollees who have been identified as participating in fraudulent or abusive conduct within three (3) Business Days of the Contractor identifying or being informed of the Enrollee's conduct.

The Contractor shall also take additional steps in accordance with OHCA's guidance. OHCA shall work with the Contractor and the Enrollee based on the specific circumstances of the fraudulent or abusive activity.

The Contractor, with OHCA's approval, shall provide the Enrollee with written notification and supporting documentation of the identified fraudulent or abusive behavior. The Contractor shall provide education to the Enrollee regarding the Enrollee's behavior. The Contractor shall document all efforts made and correspondence to and from Enrollees regarding identified fraudulent or abusive behavior.

The Contractor may request initiation of Disenrollment of Enrollees for fraudulent behavior in accordance with the provisions of Section 1.6.7.1: "Contractor Request" of this Contract.

1.20.13 Transactions with Parties in Interest

1.20.13.1 Reporting Transactions

The Contractor shall report to OHCA, as prescribed in the Reporting Manual, a description of transactions between the Contractor and a Party in Interest, as defined in § 1318(b) of the Public Health Service Act at 42 U.S.C. §§ 201, *et seq*., (Party in Interest), including the following transactions:

a. Sale or exchange, or leasing of any property between the Contractor and a Party in Interest;

b. Furnishing for consideration of goods, services (including management services), or facilities between the Contractor and a Party in Interest, not including salaries paid by the Contractor to employees for services provided in the normal course of employment; and

c. Lending of money or an extension of credit between the Contractor and any Party in Interest.

1.20.13.2 Availability of Reports

In accordance with §1903(m)(4)(B) of The Act, the Contractor shall make any reports of transactions identified in Section 1.20.13.1: "Reporting Transactions" of this Contract between the Contractor and Parties in Interest that are provided to OHCA, the Secretary, the Inspector General of HHS, or the Comptroller General, or other agencies available to Enrollees upon reasonable request.

1.21 Information Technology

1.21.1 General Requirements

The Contractor shall maintain a MIS in full compliance with all requirements of the HIPAA, requirements set forth in the HITECH Act in 42 U.S.C. § 17931, § 6504(a) of the Affordable Care Act and all other applicable State and federal laws and regulations.

In accordance with 42 C.F.R. § 438.242, the Contractor's information system shall collect, analyze, integrate, and report data as set forth in this Contract. The Contractor shall make all information and data collected by the Contractor's information system available (in usable format specified) to OHCA and, upon request, to the CMS, in accordance with 42 C.F.R. § 438.242(b)(4). Pursuant to 42 C.F.R. § 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act, which requires the State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of Section 1903(r)(1)(F) of The Act.

At minimum, the Contractor's MIS shall:

a. Collect data on Enrollee and Provider characteristics as specified in Section 1.21: "Information Technology" of this Contract and any subsequent OHCA requirements, and on all services furnished to Enrollees through an Encounter Data system, described in Section 1.21.7: "Enrollee Encounter Data" of this Contract;

b. Ensure that data received from Providers is accurate and complete by:

    i. Verifying the accuracy and timeliness of reported data, including data from Participating Providers the Contractor is compensating on the basis of Capitation Payments;

    ii. Screening the data for completeness, logic, and consistency; and

    iii. Collecting data from Participating Providers in a standardized format or formats, to the extent feasible and appropriate, including secure information exchanges and technologies utilized for SoonerSelect Program quality improvement and Care Coordination efforts;

c. Implement an Application Programming Interface (API) as specified in 42 C.F.R. § 431.70 as if such requirements applied directly to Contractor and include all Encounter Data, including Encounter Data from any Network Providers Contractor is compensating based on Capitation Payments and adjudicated claims and Encounter Data from any Subcontractors;

d. Implement and maintain a publicly accessible standards-based API described in 42 C.F.R. § 431.70, which must include all information specified in 42 C.F.R. § 438.10(h)(1) and (2);

e. The Contractor shall conform to HIPAA-compliant standards for information exchange and shall demonstrate this capability during Readiness Review. Batch and online transaction types are as follows:

i. Batch transaction types:

a) ASC X12N 820 Premium Payment;

b) ASC X12N 834 Benefit enrollment and Maintenance;

c) ASC X12N 835 Claims Payment Remittance Advice;

d) ASC X12N 837I Health Care Claim: Institutional;

e) ASC X12N 837P Health Care Claim: Professional; and

f) National Council for Prescription Drug Programs (NCPDP) D.0 Pharmacy Claim;

ii. Online transaction types:

a) ASC X12N 270/271 Eligibility Coverage or Benefit Inquiry/Response;

b) ASC X12N 276/277 Health Care Claim Status Inquiry/Response;

c) ASC X12N 278 Health Care Services Review Inquiry/Response; and

d) NCPDP D.0 Pharmacy Claim;

iii. OHCA reserves the right to require additional batch and online transaction types at its discretion.

As a part of its MIS solution, the Contractor shall provide for an electronic document management system, ensuring that documents received from Enrollees or Providers maintain logical relationships to certain key data such as Enrollee identification and Provider identification numbers when the Contractor houses indexed images of documents used by Enrollees and Providers to transact with the Contractor.

The Contractor shall also be required to demonstrate sufficient data analysis and ability to interface with OHCA systems. The Contractor shall ensure medical information will be kept confidential at all times, through security protocol, and with heightened sensitivity as data relates to personal identifiers and sensitive services.

The Contractor shall ensure that its MIS is compliant with any future State or Federal regulations within the timeframe stipulated by the respective regulatory body. This includes, but is not limited to, all requirements for Medicaid Managed Care Plans from the “21st Century Cures Act: Interoperability, Information Blocking, and the Office of the National Coordinator for Health Information Technology (ONC) Health Information Technology (IT) Certification Program” final rule (ONC 21st Century Cures Act final rule), by the Office of the National Coordinator for Health Information Technology, published in the FR on May 1, 2020.

In accordance with 42 C.F.R. § 438.242(c)(3), the Contractor shall collect and submit all data required for T-MSIS reporting and other CMS required reporting.

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. 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.

1.21.3 Care Management Requirements

The Contractor shall interface with the OHCA Care Management system to enable data sharing between OHCA and the Contractor for TOC events or at the request of OHCA. The Contractor will provide bi-directional interface(s) with the OHCA Care Management system to share Care Management case data, continuity of care documents, and predictive analytics information. The interfaces shall utilize standard clinical and administrative data formats.

1.21.4 Ongoing Maintenance of IT Solutions

The Contractor shall maintain its MIS as reviewed and approved during the Readiness Review process described at Section 1.4.8: "Readiness Review" of this Contract during the life of this Contract. The Contractor shall timely correct any defects identified and will notify OHCA if the defects impact Provider or Enrollee portals or any functionality that supports the delivery of Enrollee or Provider services. The Contractor shall submit a report as prescribed in the Reporting Manual of such defect corrections to OHCA monthly, at minimum. The Contractor shall submit an IT Maintenance and Operations plan to OHCA during Readiness Review for review and approval, and as specified in the Reporting Manual.

The Contractor shall develop and maintain an IT Roadmap, which shall show any planned upgrades to any component of the IT solution proposed. The IT Roadmap shall be delivered to OHCA at a minimum twice per year, as specified in the Reporting Manual. The Contractor shall notify OHCA at least sixty (60) Days in advance of:

a. Any proposed release upgrades for any Commercial Off the Shelf (COTS) products in use; and

b. Any changes to non-COTS products requiring custom coding to address a system issue or enhance existing system functionality.

The notification shall include an impact statement including what the upgrade will provide and the risks associated with the implementation. OHCA reserves the right to require a delay of no more than sixty (60) Days in the implementation of any planned upgrades.

The Contractor shall participate in OHCA IT defect resolution meetings with OHCA-contracted MMIS vendor(s) as required by OHCA.

1.21.5 Operations

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.

1.21.6 Communications with OHCA

The Contractor shall transmit all data directly to OHCA in accordance with 42 C.F.R. § 438.242. If the Contractor utilizes Subcontractors for services, the Contractor shall ensure all data from the Subcontractors is provided to the Contractor and the Contractor shall transmit the Subcontractors' data to OHCA in a format specified by OHCA. The Contractor's MIS shall be capable of utilizing formats specified by OHCA and shall be capable of sharing information directly with OHCA's systems. The Contractor shall be responsible for ensuring a working interface between OHCA's and the Contractor's system to facilitate exchange of relevant Enrollee and Provider data.

The Contractor shall operate a functional email server that is compatible with the systems maintained by OHCA and OHCA's contracted Fiscal Agent. This server shall be capable of sending and receiving confidential encrypted messages.

The Contractor shall have the ability to meet OHCA's security standards in all communication, including encryption of confidential data and materials.

1.21.7 Enrollee Encounter Data

Many aspects of the Medicaid program rely on complete, accurate, and timely submission of Enrollee Encounter Data. OHCA requires the Contractor understand and acknowledge that OHCA collects and uses Encounter Data for many reasons, including but not limited, to federal reporting as set forth at 42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, managed care quality improvement, utilization patterns and access to care, hospital rate setting, and research studies. For this reason, time is of the essence regarding all Encounter Data requirements and submissions. Failure to submit Encounter Data in compliance with this Contract, or applicable State and federal law, will result in program disruption, delay, as well as financial loss and damage to OHCA. Consequently, OHCA may institute non-punitive, monetary and/or non-monetary sanctions upon the Contractor as described in this section to cure any existing non-compliance and prevent future non-compliance.

1.21.7.1 Encounter Data Detail and Format

In accordance with the terms of this Contract, 42 C.F.R. § 438.242(c), and all applicable State and federal laws, the Contractor shall collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers any items(s) or service(s) to Enrollees under this Contract.

In accordance with 42 C.F.R. § 438.818(a)(1), the Contractor shall have a comprehensive automated and integrated Encounter Data system that complies with HIPAA standards and is capable of meeting the requirements in the subsections below.

At minimum, the Contractor shall:

a. Collect and maintain sufficient Enrollee Encounter Data to identify the Provider who delivers any item(s) or service(s) to Enrollees under this Contract;

b. Collect and maintain collected data in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for OHCA quality improvement and Care Coordination efforts;

c. Collect and submit to the State MMIS, Enrollee service level Encounter Data for all covered, not covered, and denied services;

d. Screen Encounter Data received from Providers for completeness, logic, and consistency;

e. Submit Enrollee Encounter Data to the State at a frequency and level of detail to be specified by CMS and the State, based on program administration, oversight, and program integrity needs;

f. Submit all Enrollee Encounter Data, including allowed amount and paid amount, that the State is required to report to CMS under 42 C.F.R. § 438.818;

g. Submit complete, accurate, and timely HIPAA-compliant Encounter Data in the level of detail and format to be specified by OHCA;

h. Submit all Encounter Data required by the State for T-MSIS submission under 42 C.F.R. § 438.242(c)(3);

i. Submit Encounter Data to the State in standardized ASC X12N 837 (P – Professional; I – Institutional) and NCPDP formats (Pharmacy services), and the ASC X12N 835 format as appropriate. Amounts paid shall be provided; and

j. Ensure Encounter Data is certified and submitted in accordance with 42 C.F.R. § 438.606 and Section 1.23.1.3: "Certification Requirements" of this Contract.

A threshold report and the encounter submission reports will generate once weekly after the Contractor's weekly encounters submission.

Additionally, the Contractor shall implement and maintain a publicly accessible, standards-based API, as described in 42 C.F.R. § 431.70, and that meets the criteria specified at 42 C.F.R. § 431.60 to include:

a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and Provider remittances and Enrollee Cost Sharing pertaining to such claims, no later than one (1) Business Day after a claim is processed;

b. Encounter Data, including Encounter Data from any Network Providers the Contractor is compensating on the basis of Capitation Payments and adjudicated claims and Encounter Data from any subcontractors no later than one (1) Business Day after receiving the data from Providers;

c. Clinical data, including laboratory results, if the Contractor maintains any such data, no later than one (1) Business Day after the data is received by the State; and

d. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) Business Day after the effective date of any such information or updates to such information.

The Contractor shall submit complete, accurate, and timely HIPAA-compliant Encounter Data in the level of detail and format to be specified by OHCA. The Contractor's Encounter Data shall be submitted to the State MMIS in the standard HIPAA transaction formats, including the ASC X12N 837 transaction formats (P – Professional, I – Institutional) and, for pharmacy services, in the NCPDP format. Contractor paid amounts shall be provided. The Contractor shall collect, and submit to the State MMIS, Enrollee service level Encounter Data for all covered, not covered, and denied services. Encounter Data will include servicing Provider data.

The Contractor shall be held responsible for errors or noncompliance resulting from its actions or the actions of an Agent authorized to act on its behalf for all submission of data including Encounter Data.

Encounter Data shall be certified and submitted in accordance with 42 C.F.R. § 438.606 and Section 1.23.1.3: "Certification Requirements" of this Contract. The Encounter Data shall include fully

adjudicated claims from the previous seven Days as well as any corrections from previous encounter submissions. OHCA reserves the right to alter the level of detail or format in which the Encounter Data is submitted. Should this occur, the Contractor shall comply with any such changes. The Contractor's Enrollee Encounter Data submitted to OHCA shall meet all requirements and include all information that the State is required to report to CMS under 42 C.F.R. § 438.818 and shall be submitted to OHCA in the ASC X12N 837, NCPDP formats and the ASC X12N 835 format, as appropriate. Collection, maintenance, submission, and specifications of Enrollee Encounter Data shall be compliant with 42 C.F.R. § 438.242.

The Contractor and its Provider Network shall accept and use the State assigned Provider IDs for Encounter Data submissions. The Contractor and its Provider Network shall accept and use State Enterprise Master Person Index (eMPI) Analysis/Medicaid IDs for SoonerCare Eligibles. The Contractor will provide unique CE identifiers for Encounter Data submission.

Specific to Drug Rebates, the Contractor must, in accordance with 42 C.F.R. § 438.3(s)(2) and § 1927(b)(1)(A) of The Act, report:

a. Drug utilization data that is necessary for the State to bill manufacturers for rebates no later than thirty (30) Calendar Days after the end of each quarterly rebate period. Data will include drugs billed under the prescription drug program and PADs.

b. Drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the Contractor.

Claims for drug products obtained and/or administered in an office/clinic or other non-institutional setting and processed via the Contractor's medical benefit shall contain a valid eleven (11) digit NDC and all other necessary information, including HCPCS codes and appropriate billable units for the actual drug and quantity administered to allow for State submission of rebates for these products.

1.21.7.2 Timely Submission of Accurate, Complete Encounter Data and Reconciliation

The Contractor shall require all Providers and any delegated Subcontractors to submit Encounter Data and claims data in sufficient detail to support detailed utilization tracking and financial reporting. The Contractor shall submit all Encounter Data to OHCA.

1.21.7.3 Timeliness

The Contractor shall collect and submit Encounter Data within seven (7) Days of adjudication to the OHCA MMIS. Only Completed Encounter Claims should be submitted. All adjusted or voided encounters must be submitted monthly. Fully denied claims do not need to be submitted to the State in a separate encounter denial file. OHCA reserves the right to alter the frequency of required data submission. Should this occur, the Contractor shall comply with any such changes.

1.21.7.4 Timeliness Remediation

Within thirty (30) Days of receipt of notice by OHCA of encounters being denied or rejected, the Contractor must accurately resubmit one hundred percent (100%) of all encounters.

1.21.7.5 Accuracy

Accurate means that no less than ninety-five percent (95%) of the Contractor's Encounter Data submissions pass system edits as specified by OHCA. Submitted encounters and encounter records must pass all OHCA system edits sent out in communications from OHCA to the Contractor

1.21.7.6 Completeness

Complete means that the Contractor must submit encounters for ninety-five percent (95%) of the services provided to its Enrollees and the Encounter Data is adjudicated and has all of the necessary data, including a valid Medicaid member ID number required to submit an Encounter to OHCA and State's Designated Entity for Health Information Exchange (SDE-HIE).

The Encounter Data submitted by the Contractor to OHCA shall include the Encounter Data from all Subcontractors and be sufficient to determine which Provider provided a service(s) or item(s) to an Enrollee. Data submitted regarding a Provider interaction shall include the appropriate NPI and service location code. Encounter Data shall be submitted for all of the following types of claims processed by the Contractor or Subcontractors:

a. Paid;

b. Denied;

c. Corrected;

d. Voided; and

e. Zero dollars paid.

The Contractor's Encounter Data shall be submitted to the State MMIS in the standard HIPAA transaction formats, including the ASC X12N 837 transaction formats.

1.21.7.7 Contractor Review of Encounter Data

The Contractor must implement and maintain review procedures to validate the successful loading of encounter files by OHCA's Fiscal Agent's electronic data interchange (EDI) clearinghouse. The Contractor must use the EDI response (acknowledgement) files to determine if files were successfully loaded. Within seven (7) Days of the original submission attempt, the Contractor must correct and resubmit files that fail to load.

1.21.7.8 OHCA Review of Encounter Data

A threshold report and the encounter submission reports will generate once weekly after the Contractor's weekly encounters submission. In accordance with 42 C.F.R. § 438.242(d), OHCA shall review and validate that the Encounter Data collected, maintained, and submitted to OHCA by the Contractor meets the requirements of 42 C.F.R. § 438.242. If OHCA determines that the Contractor Encounter Data submission does not meet timeliness, accuracy, and completeness standards or is denied by OHCA for another reason, it shall require the Contractor to correct the Encounter Data and

resubmit it to OHCA within thirty (30) Days. OHCA may audit the data for timeliness, accuracy, and/or completeness at any time. The Contractor shall support OHCA's Encounter Data Validation activities.

The Contractor acknowledges that complete and validated Encounter Data is critical for OHCA to meet the CMS' reporting and rate setting requirements. The Contractor shall collaborate with OHCA and OHCA's designated technology vendor(s) to make adjustments to the Contractor's Encounter Data processing system to meet the requirements of the technology vendor(s) and to assist OHCA in pursuing FFP and any other funding.

1.21.8 Health Information Exchange

As required by OHCA, the Contractor shall participate in the SDE-HIE for submission of Encounter Data and exchange of clinical information in order to improve the quality and efficiency of health care delivery in numerous ways, including: reducing medical errors, decreasing duplicative or unnecessary services. improving data quality for public health research, promoting population health management, reducing manual, labor-intensive monitoring and oversight, and reducing Fraud and Abuse.

The Contractor shall develop, implement, and participate in HIT and data sharing initiatives in order to improve the quality, efficiency, and safety of health care delivery in the State. The Contractor may assign staff to participate in the governance of the SDE-HIE. The purpose of this participation is to enhance the data submission requirements and improve the accuracy, quality, and completeness of the Encounter Data submission to the SDE-HIE.

The Contractor shall be subject to 63 O.S. §§ 1-133 as if they were a Provider and shall comply with the law and subsequently promulgated rules related to this SDE-HIE Participation mandate. This includes reporting data to the SDE-HIE and utilizing the SDE-HIE, as well as ensuring that proof of compliance is provided to the Office of Statewide HIE. The Contractor must be a participant in good standing of the SDE-HIE and elect a subscription to the quality measures required by OHCA for the SoonerSelect Program each year and may optionally elect to the social determinants of health screening program.

The Contractor's participation shall include ensuring the compliance of their Participating Providers with 63 O.S. §§ 1-133. In addition, Contractor shall ensure that all Participating Providers comply with subsequently promulgated rules implementing said mandate. As it applies to this RFP, the Contractor's Participating Providers shall become compliant with 63 O.S. §§ 1-133 if not already compliant.

The Contractor shall submit to the SDE-HIE, Enrollee rosters and Provider attributions as well as service level Encounter Data for all covered, not covered, and denied services. Encounter Data will include servicing Provider data as required by 42 C.F.R. § 438.242(c). The Contractor's Roster, attribution, and Encounter Data shall be submitted to the SDE-HIE in the standard HIPAA transaction formats defined on the Office of the State Coordinator for HIE website. In the event the Contractor accepts paper claims, or other proprietary formats, the Contractor shall convert all data to the appropriate HIPAA-electronic compliant formats before sending to the SDE-HIE.

The Contractor shall submit all data identified within this section and any updates to this data to the SDE-HIE within a timeframe approved by the State. The Contractor shall collect and submit Encounter Data to the SDE-HIE within thirty (30) Business Days of adjudication. All adjusted encounters must be submitted within thirty (30) Business Days of adjustment.

1.21.9 Enrollment Data

The Contractor shall maintain an eligibility and Enrollment subsystem that is continuously updated with information both received from OHCA and received directly from an Enrollee. This subsystem shall have the ability to interface with the Contractor's claims processing and Care Management systems and maintain information at a detail level to be specified by OHCA. The Contractor shall be responsible for verifying Enrollee eligibility data and reconciling with Capitation Payments for each eligible Enrollee. The Contractor shall reconcile its eligibility and capitation records monthly. OHCA shall determine the terms for reconciling eligibility and underpayments of capitation back to the Contractor. The Contractor shall be financially responsible for the Enrollee's SoonerSelect Program covered benefits that are the responsibility of the Contractor under this Contract if the Contractor receives either Enrollment information or a Capitation Payment. OHCA reserves the right to alter the frequency of required eligibility and capitation record reconciliation. Should this occur, the Contractor shall comply with any such changes.

The Contractor shall accept Enrollment data in electronic format, via secure file transfer protocol (SFTP), as directed by OHCA and as detailed in OHCA Program Companion Guide – 834 Contractor Benefit enrollment and Maintenance Transaction (834 Companion Guide), which shall be updated by OHCA or its designated third-party MMIS vendor. OHCA reserves the right to amend the 834 Companion Guide. The Contractor shall be responsible for loading all eligibility information into its system within one (1) Business Day of receipt.

The Contractor's database shall have the capability to identify an individual Enrollee across multiple demographic and clinical data sets. The system must also be able to utilize a unique Oklahoma based Master Patient Index (MPI).

The Contractor shall develop and maintain policies and procedures to ensure the accuracy and completeness of the data submitted to OHCA. The Contractor shall continuously update the subsystem with data submitted by OHCA and the Enrollee. OHCA reserves the right to audit data submitted by the Contractor for validity and completeness at any time. The Contractor shall screen the data for completeness, logic, and consistency. The Contractor's system shall maintain audit trails for this purpose.

1.21.10 Preferred Drug List

OHCA shall make available a file of preferred drugs, prior authorized drugs, and drugs with step therapy on a monthly basis for the Contractor or the Subcontractor's use in processing prescription drug claims. This file shall be loaded by the Contractor or its Subcontractor for claims processing within 24 Hours of receipt.

OHCA will develop a file of preferred physician-administered drugs for use by the Contractor or its Subcontractor in paying medical benefit drug claims.

1.21.11 State Maximum Allowable Cost List

OHCA will provide a Maximum Allowable Cost file in a frequency to be determined by OHCA for use in processing prescription drug claims. This file shall be loaded by the Contractor or its Subcontractor for claims processing within 24 Hours of receipt.

1.21.12 System Security

The Contractor shall support and ensure all relevant compliance with Federal and State Medicaid and Health Benefit Exchange laws, regulations, and policies relevant to System security, confidentiality, and safeguarding of information. External Contractor responsibilities include, but are not limited to:

a. Patient Protection and ACA, Public Law 111–148;

b. HIPAA Privacy Rule, 45 C.F.R. Part 160 and Subparts A and E of Part 164, established under the HIPAA, Public Law 104-191 (42 U.S.C. § 1320d);

c. HIPAA Security Rule, 45 C.F.R. Part 160 and Subparts A and C of Part 164;

d. Health Insurance Portability and Accountability Act of 1996 (HIPAA), pursuant to sections 1104 and 1501 of ACA, including the privacy, security, and transaction requirements;

e. Federal Information Security Management Act (FISMA) of 2002;

f. Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009;

g. Minimum Acceptable Risk Safeguards for Exchanges (MARS-E) Ver.2.2;

h. Federal Enterprise Architecture Security and Privacy Profile, version 3.0; and

i. Federal Information Processing Standards (FIPS), Publication 140-3.

The most recent versions for standards and specifications shall be applicable. Where policies overlap, the System shall always strive to attain the more stringent policy.

The Contractor shall maintain systems, policies and procedures that ensure State and federal standards for compliance and security are met and to protect the integrity of all business and technical components of the Contractor's operations under this Contract. This includes, but is not limited to, a requirement that Contractor must comply with the most current version of the suite of documents entitled the MARS-E or the new upcoming version being retitled to Acceptable Risk Controls for ACA, Medicaid, and Partner Entities (ARC-AMPE), once made available and required by CMS. Alternatively, Contractor agrees to implement and maintain equivalent standards that meet or exceed these requirements should an alternative be approved. For example, HiTrust Common Security Framework (CSF)/R2 will be considered an acceptable framework and certification in place of the current MARS-E. Contractor further agrees to maintain a level of security that is commensurate with the risk and magnitude of the harm that could result from, but not limited to, the loss, misuse, disclosure, or modification of the information contained within the system. If at any time, Contractor plans to implement and maintain security standards other than MARS-E, the Contractor must submit the specific details of the planned change to OHCA for approval not later than sixty (60) Days before the date of planned implementation. Contractor is prohibited from implementing different security standards that would reduce the level of protection provided or that would cause OHCA to fall out of compliance with any applicable laws, regulations, or requirements of government agencies with jurisdiction or enforcement authority over OHCA.

The Contractor shall notify OHCA Security of new security assessment certification results within sixty (60) Days of receipt, and prior to start of new contract, and make the original raw unredacted report, penetration test, and automated security scan of systems within scope of this agreement available upon request. Limited redaction requests may be allowed in special situations at OHCA's discretion and must be approved by OHCA Security in advance of submission. Any findings deemed High or above shall be notified to OHCA along with a status and anticipated completion date at the end of each calendar quarter until remediated. A full independent security control assessment or certification evaluation of controls shall be performed in a regular cycle, not to exceed a three (3) year period and include at least an annual attestation of controls being in place by the Chief Security Official over the scoped systems for years not incorporating an independent evaluation. Penetration testing shall be performed annually (every 365 Days) on a Production-like environment by an Independent and fully qualified third party. Testing shall minimally include, but not limited to, credentialed and uncredentialed application and Network tests, Open Web Application Security Project (OWASP) Top 10 validations, Automated and Manual testing techniques.

The Contractor shall ensure access to data systems is restricted using Minimum Necessary Rule concepts and employing automated access management functions to ensure individual identities are properly authenticated and logged when accessing the data. The Contractor shall ensure access to information is based on job functions with the overarching concept of access to information across development and operational cycles required for adequate performance of the job function (e.g., users permitted inquiry privileges only will not be permitted to modify information if not applicable to the requirements of the job the individual is performing).

The Contractor shall ensure data at rest or in motion has all appropriate protections employed for confidentiality, integrity, and availability. The Contractor shall be responsible for providing physical safeguards to its data processing center, operations center and any related information or systems. These safeguards shall remain in place for the duration of the Contractor's relationship with OHCA. The Contractor shall grant authorized OHCA and CMS personnel and any designees access to its facilities upon request.

The Contractor shall maintain data online for no less than three (3) years; and shall retain additional archive history for no less than ten (10) years and the Contractor shall ensure such data is retrievable within 48 Hours.

The Contractor shall provide OHCA with a list of all staff with access to identifying Enrollee data upon request from OHCA.

The Contractor shall make available identifying Enrollee data to authorized and designated State and Federal employees and designees.

The Contractor agrees to provide OHCA Security reasonable access to review security related materials upon request and in a timely manner for the purpose of confirming security posture and monitoring performance of this agreement. OHCA agrees to keep information confidential and not disclose to third-parties without prior mutual agreement, unless required by law. The Contractor further agrees to accept any comments made by OHCA reviews and appropriately address any concerns raised in accordance with regulations and best practices.

The Contractor shall report, as prescribed in the Reporting Manual, all suspected or known privacy and security incidents to designated OHCA contacts for incident in accordance with Section 1.2.16.3: "Obligations of the Contractor" of this Contract.

The Contractor shall maintain audit trails on individual Enrollee documentation and have the ability to determine who has accessed or viewed an Enrollee's personal medical information.

The Contractor shall abide by the current State of Oklahoma Security Standards at: https://oklahoma.gov/content/dam/ok/en/global/cio/documents/infosecppg.pdf and any updates thereto. The Contractor recognizes that it may be necessary for OHCA to require the Contractor to adhere to additional or modified security standards which may be more stringent than the State of Oklahoma Security Standards, in order to maintain compliance with applicable laws, rules, regulations, legal requirements, and industry best practices. In the event OHCA determines additional or modified security standards to be necessary, it will give the Contractor at least sixty (60) Days advance written notice of any changes in requirements, and the Contractor agrees to timely implement and comply with the same.

The Contractor shall require Multi-Factor Authentication (MFA) for all privileged users, defined as those users that have access to PHI, across all of the Contractor's systems.

The Contractor shall complete State of Oklahoma Security and Accreditation Assessment form attached hereto, based on proposed system environment as a part of Proposal submission.

If State data is to be stored or hosted by the vendor, the Contractor shall complete and execute OMES Hosting Agreement form and meet or exceed terms therein. To the extent the Contractor requests to use a third-party hosting vendor, that vendor is subject to OHCA's approval and must satisfactorily complete the State's Certification and Accreditation Review and any supplemental requests by OHCA. Contractor agrees not to migrate OHCA's data or otherwise utilize a different third-party hosting vendor in connection with key business functions that are Contractor's obligations under the Contract until OHCA approves the third-party hosting vendor's State Certification and Accreditation Review. In the event the third-party hosting vendor is not approved by OHCA, Contractor acknowledges and agrees it may not utilize such third-party vendor in connection with key business functions that are Contractor's obligations under the Contract, until such third-party meets OHCA requirements.

Contractor shall maintain a Security and Privacy Program in accordance with the Contract, associated requirements, and best industry practices at all times.

1.21.13 Disaster Preparation and Data Recovery

The Contractor shall submit a plan that addresses disaster recovery and business continuity related to emergency situations to OHCA during Readiness and annually for review and approval as specified in the Reporting Manual.

The plan shall align with best practices and content identified under the latest revision of NIST Special Publication (SP) 800-34 Contingency Planning Guide for Federal Information Systems, Moderate Impact, or better.

Each aspect included within the disaster recovery plan must describe both the Contractor and OHCA's responsibilities. For purposes of this requirement, "disaster" means an occurrence of any kind that

adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its Subcontractors' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. Disasters may include natural disasters, human error/malfeasance/neglect, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall take all steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. OHCA and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status.

The Contractor shall notify OHCA via phone and email to critical OHCA contacts identified for your emergency communications plan within two (2) Hours of discovering a disaster or other significant disruption to continuity of normal business operations. If there is no response from OHCA, the Contractor shall also contact the twenty-four (24) Hour OMES Help Desk to create an appropriate ticket to OHCA of the event. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as claims processing, eligibility and Enrollment processing, PA management, Provider enrollment and data management, Encounter Data management, and any other processing affecting the Contractor's capability to interface with OHCA or OHCA's contractors. If all information required herein is not available within the required time frame for reporting, Contractor shall not delay the initial report, but shall provide as much information as is available at the time and shall continue to update OHCA with additional information at least every four (4) Hours until complete information is provided. OHCA, in its discretion, may require the Contractor to provide a detailed plan for resuming operations.

The Contractor shall develop Information system contingency planning in accordance with the requirements of this Section and with 45 C.F.R. § 164.308, which relates to administrative safeguards. Contingency plans shall include data backup plans; disaster recovery plans; and emergency mode of operation plans. Application and Data Criticality analysis and testing and revisions procedures shall also be addressed within the Contractor's contingency plan documents. The Contractor shall be responsible for executing all activities needed to recover and restore operation of information systems, data, and software at an existing or alternative location under emergency conditions within forty-eight (48) Hours of identification of a business continuity or disaster event, or as mutually agreed upon with OHCA based on details of the event. The Contractor shall protect against hardware, software, and human error. The Contractor shall maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software and shall back up on tape or optical disk and store its data in an off-site location approved by OHCA.

In the event of a catastrophic or natural disaster, including, but not limited to fire, flood, earthquake, storm, hurricane, war, invasion, act of foreign enemies, or terrorist activities, the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) Calendar Days from the date of the catastrophic event or natural disaster.

The Contractor may include resources outside Oklahoma but within the United States as part of this plan. The plan must satisfy all requirements for State and federal certification.

The plan shall be maintained and updated by the Contractor throughout the term of this Contract and shall be available for review by State or Federal officials on request. The Contractor shall certify to OHCA that the disaster recovery plan has been tested at least annually and has passed all aspects of testing.

The Contractor shall have a contingency plan specific to operating information systems in a disaster situation.

The data system shall be accessible remotely and offsite. The offsite system shall be capable of providing basic system functions in the event of a disaster incapacitating another system site.

The Contractor and its Subcontractors' responsibilities include, but are not limited to:

a. Supporting immediate restoration and recovery of lost or corrupted data or software;

b. Establishing and maintaining, in an electronic format, a weekly back-up and a daily back-up that are adequate and secure for all computer software and operating programs; database tables; files; and system, operations and user documentation;

c. Demonstrating an ability to meet back-up requirements by submitting and maintaining data backup and disaster recovery plans that address:

    i. Checkpoint and restart capabilities and procedures;

    ii. Retention and storage of back-up files and software;

    iii. Hardware back-up for the servers;

    iv. Hardware back-up for data entry equipment;

    v. Network back-up for telecommunications; and

    vi. Developing coordination methods for disaster recovery activities with OHCA and its contractors to ensure continuous eligibility, Enrollment, and delivery of services;

d. Providing OHCA with business resumption documents, reviewed and updated at least annually, but not limited to:

    i. Disaster recovery plans;

    ii. Business continuity and contingency plans;

    iii. Facility plans; and

    iv. Any other related documents as identified by OHCA.

At no additional charge to OHCA, the Contractor shall be required to have in a place a comprehensive, fully tested IT business continuity/disaster recovery (BCDR) plan with respect to the system and services it provides to OHCA under this Contract. The BCDR plan will, at a minimum, meet the requirements of NIST SP 800-34 and its successor publications once made final.

The State and the Contractor will mutually agree on reasonable Recovery Point Objectives and Recovery Time Objectives reflective of the State's business requirements and the critical nature of the Contractor's systems and services in support of the associated State business operations:

a. At a minimum, the Recovery Time Objectives will be no more than forty-eight (48) Hours; and

b. At a minimum, the Recovery Point Objectives will be no more than twenty-four (24) Hours.

These Objectives will be reviewed and, as necessary, modified on an annual basis.

The Contractor shall coordinate its BCDR plan with OHCA's IT BCDR plans, including other State solutions with which the Contractor's system interfaces to assure appropriate, complete, and timely recovery.

The Contractor agrees to coordinate the development, updating, and testing of its BCDR plan with the State in the State's development, updating, and testing of its Continuity of Operations Plan (COOP), as required by State policy and Homeland Security Presidential Directive (HSPD) 20.

The BCDR plan will be based on the agreed upon Recovery Point Objectives and Recovery Time Objectives, and a comprehensive assessment of threat and risk to be performed by the Contractor, with such threat and risk assessment updated no less than annually by the Contractor, reflecting technological changes, Contractor business changes, OHCA business operations changes, and other appropriate factors agreed upon by the Contractor and OHCA.

The Contractor shall test its BCDR plan no less than annually, with such testing being comprehensive in nature and scope assuring point-to-point testing in meeting the agreed upon Recovery Point Objectives and Recovery Time Objectives.

The Contractor will conduct annual (every 365 Days BCDR plan) exercises in accordance with best practices. A simulation exercise is required at least once every three (3) years and within one (1) year of a new system. The results and/or after-action report shall be made available to OHCA upon request. The latest BCDR plan exercise results and after-action report shall be submitted to OHCA prior to production operations of this agreement.

1.21.14 Back-up Plan

The Contractor shall develop a back-up plan for maintaining provisional functionality of the information technology and data management systems in the event of any failure that incapacitates main systems. The plan shall articulate the data management strategy in place to ensure the Contractor can meet the Recovery Point Objectives mentioned in the BCDR plan as required pursuant to Section 1.21.13: "Disaster Preparation and Data Recovery" of this Contract.

The Contractor shall submit this back-up plan to OHCA during Readiness Review for review and approval as specified in the Reporting Manual. OHCA retains the right to veto, change or request revisions to the back-up plan.

1.21.15 Accessibility

The Contractor shall ensure that Enrollees and Providers have continuous access to information to be designated by OHCA. Internet accessibility shall comply with requirements in Section 1.12: "Enrollee Services" of this Contract, Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. The Contractor shall ensure Information is available twenty-four (24) Hours a day, seven (7) Days per week via the Enrollee

portal, Provider portal, and/or toll-free phone-based functions and including, but not limited to: confirmation of Enrollment, electronic claims management, Enrollee services and Provider services. The exceptions to this requirement include during periods of scheduled system unavailability for maintenance or updates during specific time periods agreed upon by OHCA and the Contractor and unavailability caused by events outside of the Contractor's scope of control.

The Contractor shall ensure that all system functions used for Enrollment, Disenrollment, claims or transaction submission/receipt/processing, transaction viewing or searches, and interfacing/exchanging data for Enrollees, Providers and State staff are accessible between 7:00 am and 7:00 pm Central Time, Monday through Friday with the exception of State Holidays, 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.

The URL for the Contractor's public website shall be submitted to OHCA to embed in agency websites. The URL may not be changed without OHCA's approval.

The Contractor shall maintain a point of contact with OHCA should OHCA staff require assistance interfacing/exchanging data with Contractor's system.

1.21.16 System Performance Requirements

The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm Central Time, Monday through Friday for all applicable system functions except for the following:

a. During periods of scheduled downtime agreed upon by OHCA and the Contractor;

b. During periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's scope of control; or

c. Enrollee and Provider portal and phone-based functions, such as Enrollee eligibility and Enrollment and electronic claims submission that are expected to be available twenty-four (24) Hours a day, seven (7) Days a week.

1.21.16.1 Record Search Time

The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of OHCA System Access Devices.

1.21.16.2 Record Retrieval Time

The retrieval time shall be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of OHCA System Access Devices.

1.21.16.3 On-line Adjudication Response Time

The response time shall be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices.

1.21.16.4 Screen Display Time

The system screen display time shall be within two (2) seconds for ninety-five percent (95%) of the time as measured from a representative sample of user System Access Devices. Screen Display Time is the time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with errors highlighted on the monitor.

1.21.16.5 New Screen Page Time

The new screen page time shall be within two (2) seconds for ninety-five percent (95%) of the time as measured from a representative sample of user System Access Devices. New screen page time is the time elapsed from the time a new screen is requested until the data from the screen appears or loads to completion on the monitor.

1.21.16.6 System Performance Notification and Reporting

The Contractor shall develop an automated method of monitoring the online performance and responsiveness of all systems, including web portals. The monitoring method shall separately monitor for availability and performance/response time each component of the systems named in Section 1.21.5: “Operations” of this Contract.

Upon discovery of any issues within its scope of control that may jeopardize system availability and performance as defined in this Section 1.21, the Contractor shall notify OHCA Business Enterprises in person, via phone and electronic mail, followed by mail notification.

The Contractor shall deliver notification as soon as possible, but no later than two (2) Hours after the problem occurs.

The Contractor shall resolve unscheduled system unavailability, caused by the failure of systems and telecommunications technologies within the Contractor’s scope of control, and shall implement the restoration of services, within thirty (30) minutes of the Contractor’s discovery of system unavailability. The Contractor shall resolve unscheduled system unavailability to all other Contractor system functions caused by systems and telecommunications technologies outside of the Contractor’s scope of control and shall implement the restoration of services within four (4) Hours of the Contractor’s discovery of system unavailability.

Cumulative system unavailability caused by systems and telecommunications technologies within the Contractor’s scope of control shall not exceed one (1) Hour during any continuous five (5) Calendar Day period.

Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify OHCA as prescribed in the Reporting Manual within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on system unavailability protocols.

The Contractor shall provide to OHCA, information on system unavailability events, as well as status updates on problem resolution as specified in the Reporting Manual. These updates shall be provided, via electronic mail, within two (2) Hours, with a follow up every four (4) Hours until incident is resolved, followed by a monthly report.

1.22 Financial Standards and Third-Party Liability

1.22.1 Financial Stability

The Contractor shall maintain a financially stable operation in accordance with all State and federal laws, regulations, and guidance. The Contractor shall meet and comply with all policies and administration of these processes. The Contractor shall maintain a fiscally solvent operation per federal regulations and Oklahoma Insurance Department (OID) requirements for a minimum net worth and risk-based capital including the following requirements:

a. Initial and continuing net worth;

b. Paid-in capital;

c. Determination of liabilities;

d. Risk-based capital investments; and

e. Additional reserve or surplus protections as may be required by the OID.

OHCA and the OID will monitor the Contractor's financial performance. OHCA will include OID findings in its monitoring activities. The Contractor shall copy OHCA on required filings with the OID and shall provide separate financial information pertaining to this Contract upon submission, as specified in the Reporting Manual. Further responsibilities may also be required following the Contract award date.

1.22.2 Insolvency Protection

The Contractor shall comply with State and federal requirements for protection against insolvency, including 42 C.F.R. § 438.106 and 42 C.F.R. § 438.116. The Contractor shall develop and maintain an Insolvency Plan pursuant to 36 O.S. § 6913(E) and have a process in place to review and authorize Contracts established for reinsurance and Third-Party Liability, as applicable. Unless the Contractor is a federally qualified HMO (as defined in 42 U.S.C. § 300e), the Contractor shall comply with 42 C.F.R. § 438.116, which requires the Contractor:

a. Provide satisfactory assurances to OHCA showing that its provision against the risk of insolvency is adequate to ensure that Enrollees will not be liable for the Contractor's debts should it become insolvent; and

b. Meet the solvency standards established by the HMO Act of 2003, 36 O.S. §§ 6901, *et seq*. (Oklahoma State Courts Network (OSCN) 2016).

In accordance with 42 C.F.R. § 438.106, the Contractor shall also ensure Enrollees are not held liable for any of the following:

a. The Contractor's debts in the event of the Contractor's insolvency;

b. Covered services provided to the Enrollee for which OHCA does not pay the Contractor, or for which OHCA or the Contractor does not pay the Provider that furnished the service under a contractual, referral, or other arrangement; and

c. Payments for covered services furnished under a Contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Enrollee would owe if the Contractor covered the services directly.

1.22.3 Eligible Investments

The Contractor shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in 36 O.S. §§ 1601, *et seq*.

1.22.4 Modified Current Ratio

The Contractor must maintain current assets, plus long-term investments that can be converted to cash within five (5) Business Days without incurring a penalty of more than twenty percent (20%) that equal or exceed current liabilities.

If a penalty for conversion of long-term investments is applicable, only the value excluding the penalty may be counted for the purpose of compliance with this requirement. Provided they are not issued by or include an interest in an Affiliate, the types of long-term investments that may be counted, consistent with above requirements, are prescribed in 36 O.S. §§ 1601, *et seq*.

1.22.5 Prior Approval of Payments to Affiliates

The Contractor shall not pay money or transfer any assets that may interfere with the requirements in in Section 1.22: “Financial Standards and Third-Party Liability” of this Contract.

The Contractor shall not pay money or transfer any assets to an Affiliate without prior approval from OHCA except for payment of a claim for a medical product or service that was provided to an Enrollee and paid in accordance with a written Provider contract and this Contract. To obtain authorization, the Contractor must demonstrate to OHCA that the Contractor:

a. Meets specified risk-based capital requirements as of the close of the most recent year for which the due date for filing the annual unaudited OID financial report has passed;

b. Complies with the Contract financial stability and solvency protection requirements as of the last Day of the most recent quarter for which the due date for filing OID financial reports has passed; and

c. Remains in compliance with the Contract's financial stability and solvency protection requirements following the proposed transaction.

OHCA may require repayment of amounts involved in the transaction if subsequent audit or other adjustments determine that the Contractor did not comply with the Contract’s financial stability and solvency protection requirements after the transaction took place.

1.22.6 Medical Loss Ratio

The Contractor shall calculate and report to OHCA its MLR for each MLR Reporting Year in accordance with and as defined by the requirements under 42 C.F.R. § 438.8 and the following methodology:

a. The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)).

b. Each Contractor expense shall be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple Contracts or populations, or Contracts other than those being reported, must be reported on pro rata basis.

c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

d. Shared expenses, including expenses under the terms of a management Contract, must be apportioned pro rata to the Contract incurring the expense.

e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

f. Consequential and liquidated damages, Provider Overpayment remittance to the State, and interest assessments, if any, are unallowable costs and are neither medical expenses nor Premium payments.

g. The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible.

h. The Credibility Adjustment is added to the reported MLR calculation before calculating any remittances.

i. The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Fully Credible.

j. If the Contractor's experience is Non-Credible, it is presumed to meet or exceed the MLR calculation standards.

k. The Contractor shall aggregate data for all Medicaid eligibility groups covered under the Contract, with the exception that the Contractor shall separately report the MLR for Expansion Adults. The MLR calculation will be done across all population groups, except a separate calculation will be done for the Medicaid expansion population.

The Contractor shall submit an MLR report to OHCA in accordance with the Reporting Manual requirements, which shall be within nine (9) months of the end of the MLR Reporting Year, and that includes for each MLR Reporting Year, the following, in accordance with 42 C.F.R. § 438.8:

a. Total incurred claims;

b. Total directed payments under 42 C.F.R. § 438.6(c);

c. Expenditures on quality improving activities;

d. Expenditures related to activities compliant with program integrity requirements;

e. Non-Claims Costs;

f. Premium revenue;

g. Taxes;

h. Licensing fees;

i. Regulatory fees;

j. Methodology(ies) for allocation of expenditures;

k. Any Credibility Adjustment applied;

l. The calculated MLR;

m. Any remittance owed to OHCA, if applicable;

n. A comparison of the information reported with the audited financial report required under 42 C.F.R. § 438.8(3)(m);

o. A description of the aggregation method used to calculate total incurred claims; and

p. The number of Member months.

The Contractor must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within one hundred eighty (180) Days of the end of the MLR Reporting Year or within thirty (30) Days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting in accordance with 42 C.F.R. § 438.8(k)(3).

In the event OHCA makes a retroactive change to the Capitation Payments for an MLR Reporting Year where the MLR report has already been submitted to OHCA, the Contractor shall re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR report in accordance with 42 C.F.R. § 438.8(m).

In accordance with 42 C.F.R. §§ 438.606 and 438.8(n), the MLR report submission must be certified based on best information, knowledge, and belief, and the data, documentation, and information provided in the report is accurate, complete, and truthful. The certification must be signed by the Contractor's CEO, CFO, or an individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. MLR report submissions without the required certification will not be accepted.

The MLR report must be conducted by external auditors utilizing an Agreed Upon Procedures (AUP) method of review by the Contractor's auditors. The Contractor shall also provide the Auditor's engagement letter and detailed scope of work for the MLR AUP upon OHCA request. OHCA shall review

and approve the Auditor's MLR AUP scope of work prior to commencement in accordance with 42 C.F.R. § 438.8(m).

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	Contractor Share of Gain/Loss in the Corridor	OHCA/CMS Share of the Gain/Loss in the Corridor
MLR of less than 85%	0%	100%
MLR equal to or greater than 85% and less than 88%	50%	50%
MLR equal to or greater than 88% and less than 92%	100%	0%
MLR equal to or greater than 92% and less than 95%	50%	50%
MLR equal to or greater than 95%	0%	100%

OHCA reserves the right to modify the target MLR and associated corridor in future Contract Years, in accordance with Section 1.2.8: "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 Program, in the event the Contractor is terminated or not renewed.

If the CE determines that payment of the remittance will cause the CE's risk-based capital to fall below levels required by 36 O.S. § 6937, *et seq*., the CE'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 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 Enrollee third-party resources via the ANSI ASC X 12 834 electronic transactions. 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 make every reasonable effort to:

a. Determine the liability of third-parties to pay for services rendered to 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 which will remain the responsibility of OHCA. 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 1.16.4.1: "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.

1.22.8.1 Third-Party Liability Procedures

The Contractor shall develop and implement policies and procedures to meet its obligations regarding Third-Party Liability cost avoidance and recovery when the third-party pays a benefit for an Enrollee.

1.22.8.2 Third-Party Payment to Subcontractors

If Third-Party Liability exists for part or all of the services provided to an Enrollee by a Subcontractor or a Provider, and the third-party will make payment within one hundred twenty (120) Days, the Contractor may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's or Provider's allowable claim exceeds the amount of Third-Party Liability.

1.22.8.3 Determination of Third-Party Payment

If probable existence of Third-Party Liability has been established, as provided by 42 C.F.R. § 433.139(b) at the time a claim is filed, the Contractor must reject the claim and return it to the Provider for a determination of the amount of any Third-Party Liability. The Contractor shall provide Third-Party Liability data to any Provider having a claim denied by the Contractor based upon Third-Party Liability.

Notwithstanding the forgoing, in accordance with 42 C.F.R. § 433.139(b), the Contractor shall pay claims for the following and then bill the responsible third-party:

a. Preventive Pediatric services, including EPSDT; and

b. For a service provided to an Enrollee on whose behalf child support enforcement is being carried out if the third-party coverage is through an absent parent and the Provider certifies that, if the Provider has billed a third-party, the Provider has waited one hundred (100) Days from the date of service without receiving payment before billing Medicaid.

1.22.8.4 Third-Party Payment Denial

In accordance with 42 C.F.R. § 433.139, the Contractor shall deny payment on a claim that has been denied by a third-party payer when the reason for denial is the Provider or Enrollee's failure to follow claims and payment procedures specified by the third-party. The basis for such denials may include the failure to obtain PA, receive care from a Participating Provider and timely submit claims for payment according to submission procedures.

1.22.8.5 Third-Party Payment Recovery

The Contractor shall retain third-party payment recoveries, except as otherwise specified in this section. The Contractor shall post all third-party payments to claim level detail by Enrollee.

1.22.8.6 Estate Recovery Activities

OHCA shall be solely responsible for estate recovery activities and shall retain any funds recovered through these activities.

1.22.8.7 Third-Party Subrogation and Recovery

The Contractor shall identify potential subrogation cases using a list of OHCA-approved diagnosis and treatment codes, consistent with 42 C.F.R. § 433.138(e). When subrogation is identified, the Contractor shall notify OHCA in the timeframe and manner required by OHCA as prescribed in the Reporting Manual. OHCA will be responsible for pursuing subrogation and will retain all subrogation recoveries.

1.22.8.8 Third-Party Payment Exclusions

The Contractor shall not consider allowable Enrollee Cost Sharing and Enrollee payment responsibilities as permitted under the Contract as a Third-Party Liability source.

1.22.8.9 Third-Party Payment Resource Information

The Contractor must cooperate with OHCA or its cost-recovery vendor, in recovering benefits provided by Enrollee's access to other insurance.

OHCA may require a contracted Third-Party Liability vendor to review paid claims that are over ninety (90) Days old and pursue Third-Party Liability (excluding subrogation) for those claims that do not indicate recovery amounts in the Contractor's reported Encounter Data. OHCA has sole right of recovery after three hundred sixty-five (365) Calendar Days. In accordance with 63 O.S. § 5051.2(E), the Contractor shall make appropriate payments to OHCA provided the claim is submitted for consideration within three (3) years from the date the service was furnished. Any action by OHCA to enforce the payment of the claim shall be commenced within six (6) years of the submission of the claim by OHCA.

If the Contractor operates or administers any non-Medicaid CE or other lines of business, the Contractor shall assist OHCA in a manner to be specified with identification of Enrollees with access to other insurance.

1.23 Reporting

1.23.1 General Reporting Obligations

In accordance with 42 C.F.R. § 438.604(b), the Contractor shall submit any data, documentation or information relating to the Contractor's performance as required by OHCA or the United States Secretary of Health and Human Services. OHCA intends to publish a Reporting Manual outlining the Contractor's performance reporting obligations including Encounter Data reporting as specified in Section 1.21.7: "Enrollee Encounter Data" of this Contract. Data shall be provided in the format(s) specified by OHCA in the Reporting Manual. Examples may include but are not limited to API, extensible markup language (XML), Flat File, and Microsoft Excel. The Contractor shall comply with all Reporting Manual requirements and submit all requested data completely and accurately within the timeframes and format prescribed by OHCA.

Failure to comply with reporting requirements as outlined in the Reporting Manual, or via ad hoc request from OHCA, may subject the Contractor to Non-Compliance Remedies. At any time that a submitted report is rejected for non-compliance other than timeliness, the Contractor shall revise the report and cure the reason for rejection within five (5) Business Days of notification from OHCA or as otherwise specified. Any revisions to previously submitted reports must be re-submitted in the format specified by OHCA.

If the Contractor delegates any activities or obligations under the Contract, the Subcontractor, individual or entity accepting delegation shall also perform the Contractor's reporting responsibilities and obligations in compliance with the Contract and Reporting Manual.

The Contractor shall provide access to OHCA, upon request, of all source data utilized to generate reports required under the Contract to permit OHCA to validate reports.

1.23.1.1 Modifications to Reporting Requirements

OHCA reserves the right to modify the Reporting Manual at its sole discretion. Additionally, OHCA may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

1.23.1.2 Initial Program Implementation Reporting

OHCA will require more frequent Contractor reporting during Initial Program Implementation to:

a. Monitoring requirements to include but not limited to 42 C.F.R. § 438.66;

b. Permit adequate OHCA oversight and corrections of any identified problems as necessary; and

c. Ensure satisfactory levels of Enrollee and Provider services.

1.23.1.3 Certification Requirements

In accordance with 42 C.F.R. § 438.606(a), all data, documentation, or information submitted by the Contractor to OHCA under 42 C.F.R. § 438.604 shall be certified by one (1) of the following:

a. The Contractor's CEO;

b. The Contractor's CFO; or

c. An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification.

The Contractor shall submit this certification concurrently with the data, documentation, or information submission. The certifying officer must attest that, based on the certifying officer's best information, knowledge, and belief, the data, documentation, and information submitted are accurate, complete, and truthful.

1.23.1.4 Audit Rights and Remedies

OHCA reserves the right to audit the Contractor's self-reported data at any time and may require corrective action or other remedies as specified in Section 1.25: "Remedies and Disputes" of this Contract for Contractor non-compliance.

1.23.1.5 Continuous Process Improvement

The Contractor shall review all reports submitted to OHCA to identify instances and patterns of non-compliance as discussed in 42 C.F.R. § 438.2, determine, and analyze the reasons for non-compliance, identify and implement actions to correct non-compliance and identify and implement quality improvement activities to improve performance and ensure ongoing compliance.

1.23.1.6 Required Data Collection and Reports

In accordance with 42 C.F.R. § 438.66(c), and as further delineated in the following subsections, the Contractor shall submit data to OHCA on the following:

a. Enrollment and Disenrollment data;

b. Enrollee Grievance and Appeal logs;

c. Provider Complaint and Appeal logs;

d. Results of Enrollee satisfaction surveys conducted by the Contractor;

e. Results of Provider satisfaction surveys conducted by the Contractor;

f. Performance on required quality measures;

g. Medical management committee reports and minutes;

h. Annual quality improvement plan;

i. Audited financial and Encounter Data;

j. MLR summary reports;

k. Customer service performance data; and

l. Any other data related to the provision of LTSS not otherwise reported.

OHCA will utilize findings from this data collection to improve the performance of the SoonerSelect Program.

1.23.1.7 Contractor Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.3: "Payments to Contractor" of this Contract. Contractor payment reports shall include, at minimum:

a. *Capitation Reconciliation*: Monthly reconciliation of Enrollment and Capitation Payments.

b. *Capitation Overpayment*: Report of Capitation Payment Overpayments.

1.23.1.8 Administrative Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.4: "Administrative Requirements" of this Contract. Administrative reports shall include, at minimum:

a. *Accreditation:* Status reports while undergoing accreditation and copy of accreditation review findings in accordance with requirements of 42 C.F.R. § 438.332(b).

b. *Subcontractor Compliance:* Reports documenting known or anticipated value of contracted or subcontracted services, the Contractor's oversight of its Subcontractors and any applicable performance issues or corrective actions.

c. *Implementation Plan:* Status reports on key implementation activities prior to initial Enrollee Enrollment.

d. *Hiring and Staffing Plan*: Contractor's plan to meet staffing requirements and ongoing reporting of changes in Key Staff.

e. *Governing Body:* Notification of changes in Governing Body.

1.23.1.9 Enrollment and Disenrollment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.6: "Enrollment and Disenrollment" of this Contract. Enrollment and Disenrollment reports shall include, at minimum a report on Enrollee Disenrollment Requests, which are reports documenting volume of and reason for Enrollee requests for Disenrollment.

1.23.1.10 Covered Benefits Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.7: "Covered Benefits" of this Contract. Benefits reports shall include, at minimum:

a. IMD Waiver: Data and reporting necessary for OHCA to comply with CMS 1115 IMD demonstration waiver reporting requirements.

b. Drug Rebates: Pharmacy utilization and other data necessary for OHCA to bill manufacturers for drug rebates.

c. Pharmacy Benefit Financial Disclosures: Documentation to demonstrate compliance with pharmaceutical transparency and pass-through requirements as outlined in Section 1.7.2.4.3: "Pharmacy Benefit Financial Disclosures" of this Contract.

d. Annual DUR Board Report: Annual report on the operation of the Contractor's DUR program.

e. EPSDT: Data required to comply with CMS EPSDT performance on the Form CMS-416.

f. Value-Added Benefits: Report documenting all Value-Added Benefits offered by the Contractor and the utilization rates of each.

g. NEMT Utilization Reports: Report documenting the number of Enrollees who received NEMT, number of trips approved, denied, provided, no shows, waiting time and mileage reimbursement.

h. Social Determinants of Health: Report documenting Enrollee referrals to social services and activities surrounding Contractor partnerships with community-based organizations and social service Providers.

i. Immunizations: Data matching and Validation with OSIIS.

1.23.1.11 Medical Management Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.8: "Medical Management" of this Contract. Medical management reports shall include, at minimum:

a. PA: Report documenting PA processing timeliness, approvals, pending requests and denial rates.

b. ER Utilization: Report documenting the Contractor's ER UM activities and outcomes, including utilization breakout by Enrollees in different Care Management levels based on the Contractor's Risk Stratification Level Framework.

c. Medical Management Program: Report documenting the Contractor's Medical Management Program description, work plan and program evaluation.

d. Utilization Reports: Reports documenting elements such as inpatient admissions, readmissions, non-emergent use of the ER, drug utilization. The Contractor may be required to provide breakout by Enrollees in different Care Management levels based on the Contractor's Risk Stratification Level Framework.

e. Out of State Services: Report documenting approved out of State services to include detailed verification of unavailability of in-State services.

1.23.1.12 Care Management and Population Health Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.9: "Care Management and Population Health" of this Contract. Care Management and population health reports shall include, at minimum:

a. Care Management Staffing Plan: Report addressing Care Management staffing plan and staffing levels, by role and care program.

b. Care Management Staffing, actual: Report addressing actual Care Management staffing by role, by care program (full-time equivalent (FTE) count/time spent to serve specific populations).

c. Health Risk Screening: Report documenting timely completion of Health Risk Screenings.

d. Health Risk Screening Unreachable Enrollees: Report documenting Enrollees the Contractor was unable to reach to complete the Health Risk Screening, including Enrollee name, number of outreach attempts, type of attempt and the Enrollee's contact information.

e. Comprehensive Assessment and Reassessment: Report documenting timely completion of Comprehensive Assessments in accordance with the Contractor's Risk Stratification Level Framework to include type of assessment, mode of assessment, and disposition, for Enrollees assessed for care/health management.

f. Enrollees in Care Management: Report documenting new, closed, and total cases of Enrollee's assigned to Care Management based on the Contractor's Risk Stratification Level Framework.

g. Care Management Activities: Report documenting assignment to a Care Manager, caseload, contacts, and success based on the Contractor's Risk Stratification Level Framework.

h. Care Plan: Report documenting the number of Care Plans initiated, revised, completed, reviewed, and reduced.

i. Ad hoc outreach campaigns: Report summarizing ad hoc outreach campaigns initiated.

1.23.1.13 Transition of Care (TOC) Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.10: "Transition of Care (TOC)" of this Contract. TOC reports shall include, at minimum, Contractor activity surrounding the following transitions:

a. Care Manager transitions;

b. Age transitions;

c. Transitions from inpatient settings; and

d. Transitions between CEs.

1.23.1.14 Quality Improvement Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.11: "Quality" of this Contract. The Contractor shall be capable of providing reports broken out by race, ethnicity, or other relevant demographics as directed by OHCA. Quality reports shall include, at minimum:

a. *Quality Rating System:* Reporting necessary to comply with the quality rating system required in accordance with 42 C.F.R. § 438.334.

b. *Annual QAPI Plan:* An annual QAPI program description and work plan addressing the Contractor's strategies for performance improvement and quality management activities, which addresses all elements in Section 1.11.3: "Quality Assessment and Performance Improvement (QAPI) Program" of this Contract and in accordance with 42 C.F.R. § 438.66(c)(8).

c. *CAHPS®:* Annual reports for each of the audited CAHPS® surveys required under Section 1.11.4.1: "Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys" of this Contract.

d. *Provider Satisfaction Survey:* Annual report documenting the results of the annual Participating Provider Survey as described in Section 1.11.4.2: "Provider Satisfaction Surveys" of this Contract.

e. *Quality Performance Measures:* Reporting on all required measures as described in Section 1.11.5: "Quality Performance Measures" of this Contract.

f. *Performance Improvement Projects:* Reports on the Contractor's PIPs as required under Section 1.11.6: "Performance Improvement Projects (PIPs)" of this Contract.

g. *Provider Profiling:* Provider performance monitoring reports in accordance with Section 1.11.8: "Provider Profiling" of this Contract.

h. *Critical Incidents*: Reporting on all Critical Incidents as described in Section 1.11.9.3: "Critical Incident Reporting System" of this Contract.

1.23.1.15 Enrollee Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.12: "Enrollee Services" of this Contract. Enrollee Services reports shall include, at minimum:

a. *Failure to Contact*: Report documenting Enrollees the Contractor failed to reach following initial Enrollment with the Contractor in accordance with Section 1.12.4: "New Enrollee Materials and Outreach" of this Contract.

b. *Enrollee Services Call Center*: Report documenting the performance of the Enrollee Services Call Center, such as call volume, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate and overflow call center data. Also includes annual evaluation and planned improvement activities.

c. *Enrollee Services Call Center Training*: Report documenting the training received by Enrollee Services Call Center staff.

d. *Behavioral Health Services hotline*: Report documenting the performance of the Behavioral Health Services hotline, such as call volume, call abandonment rate, live-voice answer rate, and volume of calls patched to 911 and 988.

e. *Advisory Board*: Reports on activities of the quarterly Advisory Board meetings.

f. *Behavioral Health Advisory Board*: Reports on activities of the quarterly Behavioral Health Advisory Board meetings.

g. *PCP Assignments*: Reports on PCP assignment rates, differentiated by Enrollee selection versus Contractor assignment.

h. *PCP Changes*: Reports on the volume of PCP changes and reasons.

i. *Website*: Reports documenting website utilization data.

j. *Marketing*: Documents the Contractor's Marketing plan and activities.

1.23.1.16 Provider Network Development Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.13: "Provider Network Development" of this Contract. Provider Network development reports shall include, at minimum:

a. *Network Adequacy*: In accordance with 42 C.F.R. § 438.604, the Contractor shall submit documentation for which OHCA will base its certification that the Contractor has complied with requirements for availability and accessibility of services, including adequacy of the Participating Provider Network, as set forth in 42 C.F.R. § 438.206.

b. *Geo-Access Reports*: Showing compliance with time and distance standards to Participating Providers as outlined in Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract.

c. *Provider Network Development and Management Plan*: As required in accordance with the requirements of Section 1.13.1.5: "Provider Network Development and Management Plan" of this Contract.

d. *Provider enrollment and disenrollment*: Showing Participating Providers, including enrollments and disenrollments.

e. *Provider Application Denials*: Showing all Providers for whom the Contractor has denied request to become a Participating Provider.

f. *Credentialing:* Showing the timeliness of all Provider credentialing and recredentialing activities.

g. *24-Hour Availability Audit:* Showing Participating Provider's compliance with requirement to be accessible to Enrollees 24 Hours per day, seven (7) Days per week including corrective actions implemented for Participating Providers failing to meet the requirement.

h. *Network Adequacy Exceptions Report*: In accordance with Section 1.14.4: "Network Adequacy Exception Process" of this Contract, including date of approval, description of the exception, how the Contractor is assuring Enrollees residing in the applicable geographic area are receiving the necessary care and Contractor efforts and progress in addressing the deficiency.

1.23.1.17 Provider Services Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.15: "Provider Services" of this Contract. Provider services reports shall include, at minimum:

a. *Provider Services Call Center*: Report documenting the performance of the Provider Services Call Center, such as call volume, calls handled, average call handle time, call reasons, call abandonment rate, live-voice answer rate, average wait time, blocked call rate, overflow call center data and customer satisfaction indicators. Also includes annual evaluation and planned improvement activities.

b. *Provider Services Call Center Training:* Report documenting the training received by Provider Services Call Center staff.

c. *Participating Provider Training, Education and Technical Assistance Plan*: Report documenting the training provided including details such as training topics covered, the date of the trainings and the participants, by the Contractor to its Participating Providers, in accordance with Section 1.15.5: "Provider Education, Training and Technical Assistance" of this Contract.

d. *Provider Complaints*: Report documenting the type, volume, timely processing and resolution status of Provider Complaints, reconsiderations, and Appeals.

1.23.1.18 Provider Payment Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.16: "Provider Payment" of this Contract. Provider payment reports shall include, at minimum:

a. *Value-Based Provider Payments:* Report documenting the plan, volume of and details surrounding value-based payments made by the Contractor to Participating Providers.

b. *Provider-Preventable Conditions:* The Contractor shall require Providers to report Provider-Preventable Conditions associated with claims for payment or Enrollee treatments for which

payment would otherwise be made. The Contractor shall report all identified Provider-Preventable conditions to OHCA as required under the Reporting Manual.

c. *Claims Activity:* Report documenting claims activities, including the number of claims received, denied, and paid, total amount paid and any adjustments or edits to claims.

d. *Claims Payment Accuracy:* Report documenting claims payment and denial accuracy by claim type and Provider type. The report shall be compiled by the Contractor through an audit of the accuracy of a random sample of claims payments processed in the relevant reporting period. The report shall document the results of the audit, including the number and percentage of claims and dollars that were paid accurately.

e. *Claims Timeliness:* Report documenting the timeliness of claims paid by claim type and Provider type. The report shall include the number and percentage of claims processed for the reporting period that were paid within thirty (30) Days of service date, within sixty (60) Days of service date, within ninety (90) Days of service date, those left pending, those that were submitted in previous quarters but paid in the reporting quarter and suspended claims.

1.23.1.19 AI/AN Population and Indian Health Care Providers Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.17: "American Indian/Alaska Native Population and Indian Health Care Providers" of this Contract. These reports shall include, at minimum, a report on Network Accessibility, which documents Network accessibility specific to the Contractor's AI/AN Enrollee membership and the IHCP network.

1.23.1.20 Grievance and Appeal Reports

The Contractor shall submit monthly reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.18: "Enrollee Grievance and Appeal" of this Contract. Enrollee Grievance and Appeal reports shall include, at minimum:

a. *Enrollee Grievances*: Documents the volume, timely processing, and reasons for Enrollee Grievances.

b. *Enrollee Appeals*: Documents the volume, timely processing, decision overturn rate and reasons for Enrollee Appeals.

c. *State Fair Hearings*: Documents the volume of Appeals escalating to the State Fair Hearing process and the rate of Contractor decisions overturned.

1.23.1.21 Cost Sharing Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.19: "Cost Sharing" of this Contract. Cost Sharing reports shall include, at minimum, a report on the five percent (5%) limit documenting the volume of Enrollees reaching the five percent (5%) Cost Sharing limit described in Section 1.19.5: "Five Percent (5%) Cost Sharing Limit" of this Contract.

1.23.1.22 Program Integrity Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.20: "Program Integrity" of this Contract. Program integrity reports shall include, at minimum:

a. *Compliance Plan:* The plan developed in accordance with the requirements of Section 1.20.2.1: "Compliance Plan" of this Contract and all associated reporting.

b. *Verifying Delivery of Services:* Reports documenting the activities of the Contractor to verify service delivery in accordance with Section 1.20.4: "Verifying Delivery of Services." in this Contract. Report shall detail the number of EOBs distributed, Enrollee responses and resolution of Enrollee responses.

c. *Overpayments:* In accordance with 42 C.F.R. § 438.608(d)(3), the Contractor shall report monthly to OHCA on recoveries of Overpayments. Prompt reporting of all Overpayments to occur in accordance with Section 1.20.6: "Reporting Overpayments" of this Contract.

d. *Transactions with Parties in Interest*: Reporting in accordance with the requirement of Section 1.20.13: "Transactions with Parties in Interest" of this Contract.

e. *Investigations Opened:* Provides documentation on the program integrity investigations initiated and cases ultimately referred to the State.

1.23.1.23 Information Technology Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual and Section 1.21: "Information Technology" of this Contract, to demonstrate compliance with Contract requirements. Information Technology reports shall include, at minimum, the following:

a. Encounter Data;

b. Encounter Data and Financial Summary Reconciliation;

c. Information Security Breach;

d. System Performance Reports;

e. System Unavailability Reports;

f. Disaster Preparation and Recovery Plan;

g. BCDR Incidence Reports;

h. Back-up Plan;

i. Initial and Bi-annual IT Roadmap; and

j. Maintenance and Operations Plan.

1.23.1.24 Financial Performance Reports

The Contractor shall submit reports, in the manner and format required in the Reporting Manual, to demonstrate compliance with Section 1.22: "Financial Standards and Third-Party Liability" of this Contract. Reports shall include, at minimum:

a. *Base Data:* In accordance with 42 C.F.R. § 438.604, the Contractor shall submit data on the basis of which OHCA certifies the actuarial soundness of Capitation Rates, including base data generated by the Contractor.

b. *Insurance Department* Filings: Copy of all OID required filings provided to OHCA.

c. *Audited Financial Reports*: In accordance with 42 C.F.R. § 438.3(m), the Contractor shall submit audited financial reports specific to the Contract on an annual and quarterly basis. The Contractor shall ensure the audit is conducted in accordance with generally accepted accounting principles and standards.

d. *Change in Independent Actuary or Independent Auditor*: The Contractor must provide OHCA with notice within ten (10) Days of expiration of the Contractor's contract with an independent auditor or actuary. The notice must include: the date and reason for the change or termination; the name of the replacement auditor or actuary; and if the change or termination resulted from a disagreement or dispute, the nature of the disagreement or dispute at issue.

e. *Disclosure of Fiduciary Relationships and Bonding Reports*: The Contractor shall disclose each person who qualifies as a fiduciary as defined by 36 O.S. § 6906(A). The Contractor shall provide OHCA with evidence of the Contractor's Fidelity Bond or Certificate of Fidelity Insurance in the manner prescribed by 36 O.S. § 6906(A). The Contractor shall not make payment regarding amounts expended for Home Health Care Services provided by any agency or organization, unless the agency or organization provides OHCA with a surety bond as specified in 42 U.S.C. § 1395x(o)(7).

f. *Third-Party Payments*: Reports documenting cost avoidance values, recoveries from third-parties, potential subrogation cases and third-party resource information.

g. *Rate Cell Financial Reports*: Certified financial reports as specified by OHCA reflecting cost experience at the rate cell level.

h. *MLR Reports*: Data on the basis of which OHCA will determine the Contractor's compliance with the MLR requirements described in 42 C.F.R. § 438.8 and Section 1.22.5: "Medical Loss Ratio" of this Contract.

i. *Insolvency Protection*: Data on the basis of which OHCA will determine the Contractor has made adequate provision against the risk of insolvency, as required under 42 C.F.R. § 438.116.

1.24 Contractor Performance Standards

1.24.1 Full Compliance

The Contractor shall perform all of the covered benefits and shall develop, produce and deliver to OHCA all of the statements, policies, reports, data, accounting, claims, and documentation described and required by the provisions of this Contract, and OHCA shall make payments to the Contractor on a capitated basis as described in this Contract. If the Contractor does not comply with provisions of this Contract, the Contractor shall be subject to remedies described in Section 1.25: "Remedies and Disputes" of this Contract for failure to meet performance requirements.

1.24.2 Value-Based Contracting

The Contractor and OHCA agree that the SoonerSelect Program shall be administered in accordance with the tenets of value-based contracting, including:

a. Defining quality of care, quality of life, and health outcomes objectives for Enrollees;

b. Measuring the Contractor's progress in meeting performance objectives; and

c. Rewarding the Contractor for achievement of performance objectives and applying Non-Compliance Remedies on the Contractor for non-compliance or failure to achieve performance objectives, through the methods described in this Section and Section 1.25: "Remedies and Disputes" of this Contract.

The data set shall incorporate mandatory reports as described in Section 1.23: "Reporting" of this Contract and shall include performance benchmarks related to service accessibility and utilization, quality improvement, and non-clinical functions. OHCA shall have sole authority for establishing final benchmarks.

1.24.3 Monitoring and Evaluation of Contractor Performance

1.24.3.1 OHCA Monitoring Methods

The Contractor shall cooperate fully to support OHCA's performance of monitoring activities as set forth in 42 C.F.R. § 438.66. OHCA will monitor the Contractor's performance and compliance with Contract participation requirements in accordance with 42 C.F.R. § 438.66 and 56 O.S. § 4002.10 through multiple methods, including but not limited to:

a. The Readiness Review;

b. Ongoing operational and financial reviews, to be conducted on-site at the Contractor's Oklahoma- based office required under Section 1.4.5: "Oklahoma Presence" of this Contract and through desk audits;

c. Review of the Contractor's reports required under Section 1.23: "Reporting" of this Contract and the Reporting Manual;

d. Review of the Contractor's quality improvement measures and performance improvement project outcomes, as described in Section 1.11: "Quality" of this Contract;

e. Assessment of the Contractor's performance against uniform performance monitoring benchmarks;

f. Findings from the annual EQR as described in Section 1.11.2: "External Quality Review" of this Contract and as set forth in 42 C.F.R. Part 438, Subpart E;

g. Quarterly meetings with OHCA and the Contractor's Key Staff;

h. Additional data concerning the Contractor's performance gathered directly by OHCA from Enrollees, Providers, and other SoonerSelect Program stakeholders; and

i. The creation of Provider scorecards. OHCA will create a quarterly scorecard that compares all SoonerSelect Program Contractors no later than one (1) year following the execution of the Contract as described in Section 1.11.1: "Quality Rating System" of this Contract and as per 56 O.S. § 4002.11.

1.24.3.2 Contractor Internal Monitoring Methods

The Contractor shall have an internal monitoring process for ensuring compliance with all Contract requirements and in accordance with 42 C.F.R. § 438.608(a).

The Contractor shall report to OHCA monthly on its compliance monitoring activities, in the manner and format required in the Reporting Manual. The Contractor shall document any self-identified area of non-compliance with Contract requirements and shall describe the actions being taken to correct the deficiency. At its discretion, OHCA may request additional information or require submission of a formal written CAP, in accordance with the provisions of Section 1.25: "Remedies and Disputes" of this Contract.

1.24.3.3 Treatment of Self-Reported Deficiencies in Assessment of Damages

If the Contractor identifies and reports an area of non-compliance (deficiency) that falls within a category for which consequential or liquidated damages apply, as described in Section 1.25: "Remedies and Disputes" of this Contract, OHCA, at its sole discretion, may waive the damages subject to the Contractor remedying the deficiency in a manner and on a schedule acceptable to OHCA.

OHCA's standard policy shall be not to waive monetary damages, if applicable, when an area of non-compliance (deficiency) is identified by OHCA without first being reported by the Contractor.

1.24.3.4 Consideration of Contractor Performance in Auto Assignments

It is OHCA's intent to modify the assignment algorithm in future Contract Years of the SoonerSelect Program to take into consideration the Contractor's performance on improving health outcomes. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with Section 1.2.8: "Amendments or Modifications" of this Contract.

1.24.3.5 Consideration of Contractor Performance in Re-Contracting

It is OHCA's intent to include data on the Contractor's performance in any future procurement conducted prior to the expiration of the current Contract, including any extension periods.

1.25 Remedies and Disputes

1.25.1 Understanding and Expectations

The remedies described in this Section are directed to the Contractor's timely and responsive performance of the services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The Contractor is expected to meet or exceed all OHCA objectives and standards, as set forth in this Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by OHCA. Performance reviews may be conducted at the sole discretion of OHCA at any time and may relate to any responsibility and/or requirement of the Contractor as set forth in this Contract. Any and all responsibilities and/or requirements not fulfilled may be subject to damages and remedies provisions as set forth in the Contract.

The Non-Compliance Remedy applied by OHCA will depend upon the nature, severity, and duration of the Contractor's non-compliance. OHCA shall only apply those Non-Compliance Remedies it determines, in its sole discretion, to be appropriate for the deficiencies identified. If OHCA elects not to exercise a Non-Compliance Remedy in a particular instance of Contractor non-compliance, this decision shall not be construed as a waiver of OHCA's right to pursue future assessment of that performance requirement and associated Non-Compliance Remedies, including those that, under the terms of the Contract, may be retroactively assessed.

1.26 Termination

1.26.1 Early Termination

The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this section.

Upon termination of this Contract, for any reason, the Contractor shall return to OHCA all items belonging to OHCA. This may include, but is not limited, to computers, equipment, badges, and electronic documents or files.

In the event of the termination of this Contract during the Contract duration, Enrollees impacted by the termination will be enrolled with a remaining Contractor with demonstrated performance and capability. If no remaining Contractor can assume management for such members, OHCA may assist Enrollees in selecting another Contractor by application.

In accordance with 42 C.F.R. § 438.722 and 42 U.S.C. § 1396u-2(e)(4), after OHCA notifies a Contractor that it intends to terminate the Contract, OHCA may give the Contractor's Enrollees written notice of OHCA's intent to terminate the Contract and allow Enrollees to disenroll immediately without cause.

1.26.2 Termination for Mutual Consent

OHCA and the Contractor may terminate the Contract by mutual written agreement.

1.26.3 Tailored Remedies

1.26.3.1 Understanding of the Parties

The Contractor agrees and understands that OHCA may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, OHCA may apply or pursue one (1) or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. OHCA's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that OHCA may have at law or equity.

1.26.3.2 Notice and Opportunity to Cure for Nonmaterial Breach

OHCA will notify, in accordance with Section 1.2.4: "Notices" of this Contract, the Contractor in writing of specific areas of the Contractor performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of OHCA, do not result in a material deficiency or delay in the implementation or operation of the Services.

The Contractor will, within five (5) Business Days (or the date specified by OHCA) of receipt of written notice of a non-material deficiency, provide OHCA a written response that:

a. Explains the reasons for the deficiency, the Contractor's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

b. If the Contractor disagrees with OHCA's findings, its reasons for disagreeing with OHCA's findings.

The Contractor's proposed cure of a non-material deficiency is subject to the approval of OHCA. The Contractor's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

1.26.3.3 Corrective Action Plan

At its option, OHCA may require the Contractor to submit to OHCA a written CAP under signature of the Contractor's CEO to correct or resolve a material breach of the Contract, as determined by OHCA.

The CAP must provide:

a. A detailed explanation of the reasons, if any, for the cited deficiency;

b. The Contractor's assessment or diagnosis of the cause; and

c. A specific proposal with a specific timeline to cure or resolve the deficiency.

The CAP must be submitted by the deadline set forth in OHCA's request for a CAP. The CAP is subject to approval by OHCA, which will not unreasonably be withheld.

OHCA will notify the Contractor in writing of OHCA's final disposition of OHCA's concerns. If OHCA accepts the Contractor's proposed CAP, OHCA may:

a. Condition such approval on completion of tasks in the order or priority that OHCA may reasonably prescribe;

b. Disapprove portions of the Contractor's proposed CAP; or

c. Require additional or different corrective action(s) or timelines/time limits. Notwithstanding the submission and acceptance of a CAP, the Contractor remains responsible for achieving all written performance criteria.

OHCA's acceptance of a CAP under this Section will not:

a. Excuse the Contractor's prior substandard performance;

b. Relieve the Contractor of its duty to comply with performance standards; or

c. Prohibit OHCA from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

1.26.3.4 Non-Compliance Remedies

At its discretion, OHCA may apply one (1) or more of the following Non-Compliance Remedies for each item of material non-compliance. OHCA may take into account the scope and severity of the non-compliance in the assessment of the appropriate remedy.

a. Conduct accelerated monitoring of the Contractor. Accelerated monitoring includes more frequent or more extensive monitoring by OHCA or its designee;

b. Require additional, more detailed, financial and/or programmatic reports to be submitted by the Contractor;

c. Decline to renew or extend the Contract;

d. Require forfeiture of all or part of the Contractor's Performance Bond or other substitute; or

e. Terminate the Contract in accordance with Section 1.26: "Termination" of this Contract.

For purposes of the Contract, an item of material non-compliance means a specific action of the Contractor that:

a. Violates a substantive term of the Contract;

b. Fails to meet an agreed upon measure of performance; or

c. Represents a failure of the Contractor to be reasonably responsive to a reasonable request of OHCA relating to the Services for information, assistance, or support within the timeframe specified by OHCA.

1.26.3.5 Intermediate Sanctions

In accordance with 42 C.F.R. §§ 438.700(b), 438.726, 438.730(e), and Section 1903(m)(5)(B)(ii) of The Act, OHCA may establish Intermediate Sanctions if it determines that the Contractor:

a. Fails substantially to provide Medically Necessary services that the Contractor is required to provide, under law or under its contract with OHCA, to an Enrollee covered under the Contract;

b. Imposes on Enrollee Premiums or charges that are in excess of the Premiums or charges permitted under the Medicaid program;

c. Acts to discriminate among Enrollees on the basis of their health status or need for Health Care Services;

d. Misrepresents or falsifies information that it furnishes to CMS or to OHCA; and

e. Misrepresents or falsifies information that it furnishes to an Enrollee, potential Enrollee, or Provider.

In accordance with 42 C.F.R. § 438.702, OHCA may impose the following Intermediate Sanctions:

a. Civil Money Penalties in the amounts specified in 42 C.F.R. § 438.704;

b. Grant Enrollee(s) the right to terminate Enrollment without cause and notifying the affected Enrollees of their right to disenroll;

c. Suspend all new Enrollment of Enrollee(s), including default Enrollment, after the date OHCA notifies the Contractor of a determination of a violation of any requirement under § 1903(m) or § 1932 of The Act;

d. Suspend or recoup Capitation Payments to the Contractor for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur;

e. Impose additional sanctions provided for under State statutes or regulations to address noncompliance in accordance with 42 C.F.R. § 438.702(b); and

f. Appoint temporary management in accordance with 42 C.F.R. § 438.706 if OHCA has determined:

   i. There is continued egregious behavior by the Contractor;

   ii. There is substantial risk to Enrollee health; or

   iii. The sanction is necessary to ensure the health of the Contractor's Enrollees while improvements are made to remedy violations that require sanction, or until there is an orderly termination or reorganization of the Contractor.

OHCA must apply temporary management if it finds the Contractor has repeatedly failed to meet substantive requirements in 42 U.S.C. §§ 1396b(m) or 1396u-2(e)(2). OHCA may not delay the imposition of temporary management to provide a hearing. OHCA will not terminate temporary management until it determines, at its sole discretion that the Contractor can ensure the non-compliant behavior will not recur in accordance with 42 U.S.C. § 1396u-2(e)(2)(B)(ii).

When temporary management is imposed, OHCA will notify and grant Enrollees the right to terminate Enrollment with the Contractor without cause, as described in 42 C.F.R. § 438.702(a)(3). If temporary management is imposed, the Contractor shall cooperate fully in the transition process to ensure any disruption to Enrollees and Providers is minimized.

OHCA or its designees shall have full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to Enrollees pending the Contractor's termination from the SoonerSelect Program or remedying of the underlying deficiency. OHCA shall have the authority to hire staff, execute any instrument in the name of the Contractor and to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party during the temporary management period.

The Contractor shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Program, including but not limited to attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor.

1.26.3.6 Notice

OHCA will provide timely written notice to the Contractor of the application of a Non-Compliance Remedy or Intermediate Sanction in accordance with 42 C.F.R. § 438.710(a)(1) and this Section, with the exception of accelerated monitoring, which may be unannounced. The notice explains the basis and nature of the sanction and any other appeal rights that the State elects to provide in accordance 42 C.F.R. § 438.710(a). OHCA may require the Contractor to file a written response in accordance with this Section.

The Parties agree that a State or federal statute, rule, regulation, or federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

1.26.3.7 Damages

OHCA will be entitled to actual, consequential, and liquidated damages in accordance with Tit. 23 O.S. § 21, resulting from the Contractor's failure to comply with any of the terms of the Contract. In some cases, the actual damage to OHCA or State of Oklahoma as a result of the Contractor's failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy.

Therefore, consequential and liquidated damages will be assessed in writing against and paid by the Contractor in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by OHCA in Appendix 1E: "Consequential and Liquidated Damages" of this Contract. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the Contractor, including the Contractor's Subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its Agents. If at any time, OHCA determines the Contractor has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, OHCA reserves the right to waive all or part of the consequential and liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of OHCA.

The consequential and liquidated damages prescribed in this Contract are not intended to be in the nature of a penalty but are intended to be reasonable estimates of OHCA's projected financial loss and damage resulting from the Contractor's nonperformance but not limited to financial loss as a result of project delays. Accordingly, in the event the Contractor fails to perform in accordance with the Contract, OHCA may assess consequential and liquidated damages as provided in this Contract.

If the Contractor fails to perform any of the Services described in the Contract, OHCA may assess consequential or liquidated damages for each occurrence of a consequential or liquidated damages event, to the extent consistent with OHCA's tailored approach to remedies and Oklahoma law.

1.26.3.7.1 Collection and Offset

OHCA may elect to assess actual, consequential, and liquidated damages or other amounts due as a result of Remedies, together with any amounts due under the Contractor's indemnification obligations or for breach of this Contract:

a. Through direct assessment and demand for payment delivered to the Contractor; or

b. Through set-off against payments then due to the Contractor or payments that become due to the Contractor. OHCA will make deductions until the full amount payable by the Contractor is received by OHCA.

1.26.3.8 Equitable Remedies

The Contractor acknowledges that, if the Contractor breaches (or attempts or threatens to breach) its material obligation under the Contract, OHCA may be irreparably harmed. In such a circumstance, OHCA may proceed directly to court to pursue equitable remedies, subject any requirement of OAC 260:115-9-1 and 317:10-1-3.

If a court of competent jurisdiction finds that the Contractor breached, or attempted or threatened to breach any such obligations, the Contractor agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by the Contractor and restraining it from any further breaches or attempted or threatened breaches.

1.26.3.9 Suspension of Contract

OHCA may suspend or hold in abeyance performance of all or any part of the Contract if:

a. OHCA determines that the Contractor has failed to carry out a substantive term of the Contract;

b. OHCA has reason to believe that the Contractor has committed, assisted in the commission of Fraud, Waste, or Abuse, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

c. OHCA determines that the Contractor knew, or should have known, of Fraud, Waste, or Abuse, malfeasance, or nonfeasance by any party concerning the Contract, and the Contractor failed to take appropriate action; or

d. OHCA determines that suspension of the Contract in whole or in part is in the best interests of the State of Oklahoma or OHCA.

OHCA will notify the Contractor in writing of its intention to suspend the Contract in whole or in part. Such a notice will:

a. Be delivered in writing to the Contractor;

b. Include a concise description of the facts or matter leading to OHCA's decision; and

c. Unless OHCA is suspending the Contract for convenience, request a CAP from the Contractor or describe actions that the Contractor may take to avoid the contemplated suspension of the Contract.

1.26.3.10 Denial of Payment for New Enrollees

Capitation Payments to the Contractor will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). CMS may deny payment to

OHCA for new Enrollees if its determination is not contested timely by the Contractor. OHCA will define in writing to the Contractor the conditions for lifting the payment denials.

1.26.4 Termination for Convenience

OHCA may terminate the Contract, in whole or in part, for convenience if it is determined that termination is in OHCA's best interest. In the event of a termination for convenience, Contractor will be provided at least sixty (60) Days written notice of termination in accordance with OAC 317:55-3-13(b)(2). Any partial termination of the Contract shall not be construed as a waiver of, and shall not affect, the rights and obligations of any party regarding portions of the Contract that remain in effect.

Upon receipt of notice of such termination, Contractor shall immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice. If a purchase order or other payment mechanism has been issued and a product or service has been accepted as satisfactory prior to the effective date of termination, the termination does not relieve an obligation to pay for the product or service but there shall not be any liability for further payments ordinarily due under the Contract or for any damages or other amounts caused by or associated with such termination. Such termination shall not be an exclusive remedy but shall be in addition to any other rights and remedies provided for by law. Any amount paid to Contractor in the form of prepaid fees that are unused when the Contract or certain obligations are terminated shall be refunded. Termination of the Contract under this section, in whole or in part, shall not relieve the Contractor of liability for claims arising under the Contract.

1.26.5 Termination for Default

OHCA may terminate the Contract, in whole or in part, if at any time the Contractor fails to carry out or otherwise comply with any of the terms of the Contract. In addition to and in no way limiting any and all remedies available to it, OHCA may, at its election, assign Enrollees to another CE or provide benefits through other State Plan authority if the Contractor has breached this Contract and is unable or unwilling to cure such breach within the period of time as specified in writing by OHCA as provided below.

The Contractor shall also be in default, and the provisions in this section shall apply, if Contractor terminates early without the mutual consent of OHCA.

Upon determination by OHCA that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities, the Contractor shall be notified in writing of the failure and of the time period which has been established by OHCA to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, in accordance with 42 C.F.R. § 438.710, OHCA will provide the Contractor with written notice of its intent to terminate, the reason for termination and the time and place of a pre-termination hearing. After the hearing, OHCA shall provide the Contractor with written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination. For an affirming decision, OHCA shall give Enrollees of the Contractor notice of termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

In the event of termination for default, in full or in part as provided under this clause, OHCA may procure, upon such terms and in such manner as is deemed appropriate by OHCA, supplies or services

similar to those terminated and the Contractor shall be liable for any costs associated for such similar supplies or services and for all other damages allowed by law. In addition, the Contractor shall be liable to OHCA for administrative costs incurred to procure such similar supplies or services as are needed to continue operations and for administrative costs incurred to transition Enrollees from the Contractor.

In the event of a termination for default, the Contractor shall be paid for any outstanding Capitation Payments due less any assessed damages. If damages exceed Capitation Payments due, collection will be made from the Contractor's performance bond, cash deposit, letter of credit or substitute security, as described in Section 1.2.20.10: "Performance Bond or Substitutes" of this Contract.

The rights and remedies of OHCA provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

1.26.6 Termination for Unavailability of Funds

In the event funding from Federal, State, or other sources is not sufficiently appropriated, or is withdrawn, reduced, or limited in any way after the effective date of the Contract, OHCA may terminate this Contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.

1.26.7 Termination for Lack of Authority

In the event that any necessary Federal or State approval or authority to operate the SoonerSelect Program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with a CE for the provision of health care for Eligibles or Enrollees, OHCA may terminate this Contract immediately, effective on the close of business on the day specified.

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

1.26.8 Termination for Financial Instability

In the event that OHCA deems, in its sole discretion, that the Contractor is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

In the event OHCA elects to terminate the Contract under this provision, the Contractor shall be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise OHCA. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

1.26.9 Termination for Debarment

In accordance with 42 C.F.R. § 438.610, the Contractor may not knowingly have an individual or Affiliate, as defined in the FAR at 48 C.F.R. § 2.101, who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the FAR or from participating in non-procurement activities under regulations issued under Executive Order No. 12549, appearing at 51 FR 6370, or under guidelines implementing Executive Order No. 12549. The prohibited relationships include:

a. A director, officer or partner of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended, or excluded from participation in federal health care programs;

b. A Subcontractor of the Contractor who is (or is affiliated, as defined in the FAR, with a person/entity that is) debarred, suspended, or excluded from participation in federal health care programs;

c. A person with beneficial ownership of five percent (5%) or more of the Contractor's equity who is (or is affiliated, as defined in the FAR, with a person/entity that is) debarred, suspended, or excluded from participation in federal health care programs;

d. A Participating Provider or persons with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Contract with the State who is (or is affiliated, as defined in the FAR, with a person/entity that is) debarred, suspended, or excluded from participation in federal health care programs;

e. An individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of The Act;

f. Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program; or

g. Any individual or entity listed on the State or Federal Excluded Provider Lists.

The Contractor shall not have a relationship with an individual that is excluded from participation in any Federal health care program under 42 U.S.C. § 1320a-7.

OHCA must notify CMS of any prohibited relationship and terminate a Contract with an entity that is found to be out of compliance with 42 C.F.R. § 438.610 if directed by the CMS, and OHCA cannot renew or otherwise extend the existing Contract for such an organization unless the CMS determines that compelling reasons exist for doing so.

1.26.10 Transition Period Obligations

A Transition Period shall begin upon any of the following triggering events:

a. Notice issued by OHCA of intent to terminate the Contract;

b. Notice issued by the Contractor or OHCA of intent not to extend the Contract for a subsequent extension period; or

c. If the Contract has no remaining extension periods, one hundred eighty (180) Days before the Contract termination date.

The Contractor shall remain financially responsible for and continue to serve or arrange for the provision of services to Enrollees for up to forty-five (45) Calendar Days from the Contract termination or expiration date or until the Enrollees can be transferred, whichever is longer. The Transition Period ends upon the transition of Enrollees to another CE or OHCA-designated service delivery system. Upon completion of the Transition Period, the Contractor shall comply with all obligations outlined in Section 1.26.11: "Post-Transition Contract Obligations" of this Contract.

The Contractor shall submit a written Transition Plan to OHCA for approval. The Transition Plan shall document the Contractor's plan to ensure the orderly transition of Enrollees and to meet all Transition Period and Post-Transition obligations. The Contractor shall revise the Transition Plan at the request of OHCA. The Contractor shall execute, adhere to, and provide the services set forth in the OHCA-approved Transition Plan. All changes to the Transition Plan are subject to OHCA approval.

The Contractor shall cooperate in good faith with OHCA and its employees, Agents, and independent contractors and comply with all duties and/or obligations under the Contract. During the Transition Period, the Contractor shall:

a. Appoint a liaison to serve as the single point of contact for all Transition Period activities;

b. Maintain sufficient staffing levels to meet all Contract obligations;

c. Transfer all applicable clinical information on file, including but not limited to approved and outstanding PA requests and a list of Enrollees to OHCA and/or the successor CE in the timeframe and manner required by OHCA;

d. Coordinate the continuation of care for Enrollees who are undergoing treatment for an acute condition;

e. Notify all Enrollees and Participating Providers about the Contract termination or expiration and the process by which Enrollees will continue to receive medical care. The notice shall be sent according to a timeline established by OHCA. The Contractor shall be responsible for all expenses associated with Enrollee and Participating Provider notification. These notices are subject to OHCA approval; and

f. Take whatever other actions are necessary to ensure the efficient and orderly transition of Enrollees from coverage under this Contract to coverage under any new arrangement developed by OHCA in accordance with 42 C.F.R. § 438.62(b).

1.26.11 Post-Transition Contract Obligations

Termination or expiration of the Contract does not discharge the obligations of the Contractor with respect to services or items furnished prior to Contract termination or expiration. The Contractor shall work in good faith with OHCA to carry out all Post-Transition obligations. Upon any termination or expiration of the Contract, the Contractor shall:

a. Appoint a liaison to serve as the single point of contact for all Post-Transition activities;

b. Provide OHCA, or its designee, all records related to the Contractor's activities undertaken pursuant to the Contract, in the format and within the timeframes set forth by OHCA. Such records shall be provided at no expense to OHCA or its designee;

c. Participate in the External Quality Review, as required in accordance with 42 C.F.R. Part 438, Subpart E, for the final year of the Contract;

d. Submit all performance data and reports with a due date following the termination or expiration of the Contract which cover a reporting period prior to termination or expiration. This includes, at minimum, CAHPS® and HEDIS® data;

e. Remain responsible for resolving Grievance and Appeal related to dates of service prior to the Contract termination or expiration;

f. Remain responsible for State Fair Hearings related to dates of service prior to the Contract termination or expiration. This includes providing records and representation at State Fair Hearings. In the event the State Fair Hearing officer reverses the Contractor's decision to deny authorization of services and the Enrollee received the disputed services while the State Fair Hearing was pending, the Contractor must pay for those services;

g. Remain financially responsible for all claims with dates of services through the Day of Contract termination or expiration. The Contractor shall maintain claims processing functions as necessary for a minimum of twelve (12) months in order to adjudicate all claims for services delivered prior to the Contract termination or expiration;

h. Submit Encounter Data for all claims incurred prior to the Contract termination or expiration;

i. Provide OHCA with all outstanding drug rebate disputes with a manufacturer and an action plan to resolve the disputes; and

j. Comply with the requirements of Section 1.2.16.3: "Obligations of Contractor" of this Contract with respect to PHI received from OHCA, or created, maintained, or received by the Contractor on behalf of OHCA.

OHCA retains authority to withhold the Contractor's Capitation Payments until the Contractor has received OHCA approval of its Transition Plan and completed the activities set forth in its Transition Plan, and any other OHCA required activities, to the satisfaction of OHCA. OHCA retains sole authority for determining whether the Contractor has satisfactorily completed the Contractor's transition responsibilities.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

CONTRACTOR

By: Date: _

Title: _

OKLAHOMA HEALTH CARE AUTHORITY

By: Date: _

Title: _

Approved as to Form and Legal Sufficiency:

By: Date: _

Title: _

Appendix 1A: Acronyms

AA – Adoption Assistance

AAAHC – Accreditation Association for Ambulatory Health Care

AAP – American Academy of Pediatrics

ABD – Aged, Blind, and Disabled

ABP – Alternative Benefit Plan

ACA – Affordable Care Act

ADL – Activities of Daily Living

AHRQ – Agency for Health Care Research and Quality

AI/AN – American Indian/Alaska Native

ALJ – Administrative Law Judge

ANSI – American National Standards Institute

API – Application Programming Interface

APM – Alternative Payment Model

ARC-AMPE – Acceptable Risk Controls for ACA, Medicaid, and Partner Entities

ASAM – American Society of Addiction Medicine

ASC – Accredited Standards Committee

ASFRA – Assisted Suicide Funding Restriction Act

ASL – American Sign Language

AUP – Agreed Upon Procedures

AWOL – Absence Without Official Leave

BCDR – Business Continuity/Disaster Recovery

BIN – Bank Identification Number

CAH – Critical Access Hospital

CAHPS® – Consumer Assessment of Healthcare Providers and Systems

CAP – Corrective Action Plan

CCBHC – Certified Community Behavioral Health Clinic

CCC – Children with Chronic Conditions

CE – Contracted Entity

CEO – Chief Executive Officer

CFO – Chief Financial Officer

CGM – Continuous Glucose Monitor

CHIP – Children's Health Insurance Program

CIB – Center for Medicaid and CHIP Services Informational Bulletin

CLIA – Clinical Laboratory Improvement Amendments

CMCS – Center for Medicaid and CHIP Services

CMHC – Community Mental Health Center

CMS – Centers for Medicare and Medicaid Services

COO – Chief Operating Officer

COOP – Continuity of Operations Plan

COPD – Chronic Obstructive Pulmonary Disease

COTS – Commercial Off the Shelf

CPD – Central Purchasing Division

CSF – Common Security Framework

CVO – Credential Verification Organization

C.F.R. – Code of Federal Regulations

DDoS – Distributed Denial of Service

DIR – Direct and Indirect Remuneration

DME – Durable Medical Equipment

DO – Doctor of Osteopathy

DPP – Directed Payment Program

DRG – Diagnosis-Related Group

DSH – Disproportionate Share Hospital

DUR – Drug Utilization Review

DVT – Deep Vein Thrombosis

ECHO – Experience of Care & Health Outcomes

EDI – Electronic Data Interchange

EFT – Electronic Funds Transfer

EIN – Employer Identification Number

EITA – Electronic and Information Technology Accessibility

eMPI – Enterprise Master Person Index

EOB – Explanation of Benefits

ePHI – Electronic PHI

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

ESI – Employee Sponsored Insurance

EQR – External Quality Review

EQRO – External Quality Review Organization

ER – Emergency Room

EVV – Electronic Visit Verification

FAR – Federal Acquisition Regulation

FCC – Foster Care Child(ren)

FDA – Food and Drug Administration

FEIN – Federal Employer Identification Number

FFCC – Former Foster Care Child(ren)

FFCRA – Families First Coronavirus Response Act

FFS – Fee-for-Service

FIPS – Federal Information Processing Standards

FISMA – Federal Information Security Management Act

FPL – Federal Poverty Level

FTE – Full-Time Equivalent

FQHC – Federally Qualified Health Center

FR – Federal Register

HAN – Health Access Network

HB – House Bill

HCPCS – Healthcare Common Procedure Coding System

HCPLAN - Health Care Payment Learning & Action Network

HEDIS® – Healthcare Effectiveness Data and Information Set

HHS – The United States Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act (of 1996)

HIT – Health Information Technology

HITECH – Health Information Technology for Economic and Clinical Health

HMO – Health Maintenance Organization

HMP – Health Management Program

HSPD – Homeland Security Presidential Directive

IADL – Instrumental Activities of Daily Living

ICF-IID – Intermediate Care Facilities for Individuals with Intellectual Disabilities

ID – Identification

IDEA – Individuals with Disabilities Education Act

IEP – Individualized Education Program

IHCP – Indian Health Care Provider

IHS – Indian Health Service

IMCE – Indian Managed Care Entity

IMD – Institutions for Mental Disease

IT – Information Technology

I/T/Us – Indian Tribe, Tribal Organization, or Urban Indian Organization or IHS, Tribal Program, and Urban Health Clinics as described at OAC 317:30-5-1086

JJ – Juvenile Justice

LOC – Level of Care

LOPO – Local Oklahoma Provider Organization

LEP – Limited English Proficiency

LTCHs-C – Long Term Care Hospitals Serving Children

LTSS – Long-Term Services and Supports

MAC – Medical Advisory Committee

MAGI – Modified Adjusted Gross Income

MARS-E – Minimum Acceptable Risk Safeguards for Exchanges

MAT – Medication Assisted Treatment

MCO – Managed Care Organization

MD – Medical Doctor

MFA – Multi-Factor Authentication

MFCU – Medicaid Fraud Control Unit

MHPAEA – Mental Health Parity and Addiction Equity Act

MIS – Management Information System

MLR – Medical Loss Ratio

MME – Morphine Milligram Equivalents

MMIS – Medicaid Management Information System

MOE – Maintenance of Effort

MPI – Master Patient Index

NCCI – National Correct Coding Initiative

NCPDP – National Council for Prescription Drug Programs

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NEMT – Non-Emergency Medical Transportation

NIST – National Institute of Standards and Technology

NPDB – National Practitioner Data Bank

NPI – National Provider Identifier

NQTL – Non-Quantitative Treatment Limit

NR – Not Reported

NRT – Nicotine Replacement Therapy

OAC – Oklahoma Administrative Code

OBRA – Omnibus Budget Reconciliation Act

OB/GYN – Obstetrics and Gynecology

ODMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services

ODOC – Oklahoma Department of Corrections

OHCA – Oklahoma Health Care Authority

OHS – Oklahoma Human Services

OID – Oklahoma Insurance Department

OIG – Office of Inspector General

OJA – Office of Juvenile Affairs

OMES – Office of Management and Enterprise Services

ONC – Office of the National Coordinator for Health Information Technology

O.S. – Oklahoma Statute

OSCN – Oklahoma State Courts Network

OSDE – Oklahoma State Department of Education

OSDH – Oklahoma State Department of Health

OSIIS – Oklahoma State Immunization Information System

OTH – Oklahoma Tobacco Helpline

OWASP – Open Web Application Security Project

PA – Prior Authorization

PACT – Program for Assertive Community Treatment

PAD – Physician Administered Drug

PASRR – Pre-admission Screening and Resident Review

PBA – Pharmacy Benefit Administrator

PBM – Pharmacy Benefit Manager

PBN – Processor Control Number

PCCM – Primary Care Case Management

PCMH – Patient Centered Medical Home

PCP – Primary Care Physician or Provider

PDF – Portable Document Format

PDL – Preferred Drug List

PE – Pulmonary Embolism

PHE – Public Health Emergency

PHI – Protected Health Information

PHP – Partial Hospitalization Program

PII – Personally Identifiable Information

PIP – Performance Improvement Project

PLE – Provider-Led Entity

PPS – Prospective Payment System

PRTF – Psychiatric Residential Treatment Facility

QAPI – Quality Assessment and Performance Improvement

QDW – Qualified Disabled Worker

QHP – Qualified Health Plan

QI – Qualified Individual

QIC – Quality Improvement Committee

QMB – Qualified Medicare Beneficiary

QM/QI – Quality Management/Quality Improvement

QRTP – Qualified Residential Treatment Program

RFP – Request for Proposal

RHC – Rural Health Clinic

SA&I – State Auditor and Inspector

SBIRT – Screening Brief Intervention and Referral to Treatment

SDE-HIE – State's Designated Entity for Health Information Exchange

SDLC – System Development Lifecycle

SEC – Securities and Exchange Commission

SED – Serious Emotional Disturbance

SFTP – Secure File Transfer Protocol

SFY – State Fiscal Year

SLMB – Specified Low-Income Medicare Beneficiary

SMI – Serious Mental Illness

SP – Special Publication

SUD – Substance Use Disorder

SUPPORT – Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment

TANF – Temporary Assistance for Needy Families

TDD – Telecommunications Device for the Deaf

TIN – Tax Identification Number

T-MSIS – Transformed Medicaid Statistical Information System

TOC – Transition of Care

TPL – Third-Party Liability

TSET – Tobacco Settlement Endowment Trust

TTY – Teletypewriter

UCAT – Uniform Comprehensive Assessment Tool

UM – Utilization Management

URL – Uniform Resource Locator

US/U.S. – United States

U.S.C – United States Code

VBP – Value-Based Payment

WCAG – Web Content Accessibility Guidelines

XML – Extensible Markup Language

Appendix 1B: Definitions

1. Interpretation of Definitions

Listed below are the definitions used in this Contract. These terms shall be construed and/or interpreted as follows, unless this Contract otherwise expressly requires a different construction and/or interpretation.

Terms used in this Contract that are not otherwise explicitly defined shall be understood to have the definition laid out in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

The following terms shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor and Use.

Unsecured PHI shall have the same meaning as in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

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 CMS-recognized 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, 2024. 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; auto-assignment suspension; Contract termination; and remedies under Section 1.26.3.4: "Non-Compliance 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 (e), 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. **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.

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

175. **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.

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

177. **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.

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

179. **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).

180. **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.

181. **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.

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

183. **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.

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

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

186. **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.

187. **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.

188. **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.

189. **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.

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

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

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

193. **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.

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

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

196. **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.

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

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

199. **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.

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

201. **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.

202. **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.

203. **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.

204. **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 OHCA-designated service delivery system.

205. **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.

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

207. **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.

208. **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.

209. **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.

210. **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.

211. **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.

SoonerSelect

Appendix 1C: Quality Performance Withhold Program

1. Overview

OHCA is committed to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets and appropriately rewards advancement of quality goals. In furtherance of these objectives, OHCA will withhold a portion of the Contractor's Capitation Payments, as set forth in this Appendix. The Contractor shall be eligible to receive retrospectively some or all of the withheld Capitation Payments based on the Contractor's performance in the areas outlined in Section 5 of this Appendix.

2. Quality Performance Withhold

OHCA will withhold a portion of the Contractor's Capitation Payments according to schedule outlined below. Contractor performance will be assessed annually per the timeframes listed. OHCA will issue one (1) assessment and payment, if applicable, per SoonerSelect Program CE per State Fiscal Year (SFY).

The measurement period used for the performance withhold measures is by each calendar year (CY), according to the following:

a. Performance Baseline Measurement: CY 2024

b. Measurement Year One (1): CY 2025

c. Measurement Year Two (2): CY 2026

d. Measurement Year Three (3): CY 2027

e. Measurement Year Four (4): CY 2028

Quality Withhold Payment Schedule

Contract Year	Quality Performance Period	Quality Withhold Percentage	SoonerSelect Program CE Reporting
1. *Oct 2023 -Jun 2024	Jan – Dec 2024	Not Applicable	Not Applicable
2. Jul 2024 - Jun 2025	Jan – Dec 2025	1%	June 15, 2026
3. Jul 2025 - Jun 2026	Jan – Dec 2026	1.5%	June 15, 2027
4. Jul 2026 - Jun 2027	Jan – Dec 2027	1.5%	June 15, 2028
5. Jul 2027 – Jun 2028	Jan – Dec 2028	1.5%	June 15, 2029

*Date of award through June 30, 2024

3. Potential Payment

The potential payout for this Contractor quality performance determination is equal to the amount quality withheld during each Contract Rating Period.

OHCA reserves the right to adjust the percent of Capitation Payments withheld in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Section 1.2.8: “Amendments or Modifications” of the Contract.

4. SoonerSelect Program Performance Measures

The Contractor shall be responsible for reporting on the health performance measures in relation to the Performance Withhold in the table below. These measures are subject to change.

SoonerSelect Program Performance Measures

Performance Measures	Frequency	Definition	Measure Set
Childhood Immunization Status (CIS-CH) Combination Three (3)	Annual	The percentage of Children two (2) years of age who had a four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one (1) measles, mumps, and rubella (MMR); three (3) haemophilus influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday. Combination 3 (DTAP, IPV, MMR, HIB, Hepatitis B, VZV and PCV).	CMS Child Core
Well-Child Visits in the First Thirty (30) Months of Life (W30-CH)	Annual	Well-Child Visits in the First Thirty (30) Months of Life: Assesses Children who turned fifteen (15) months old during the measurement year and had at least six (6) well-child visits with a primary care physician during their first fifteen (15) months of life. Assesses Children who turned thirty (30) months old during the measurement year and had at least two (2) well-child visits with a primary care physician in the last fifteen (15) months.	CMS Child Core
Immunizations for Adolescents (IMA-CH) Combination One (1)	Annual	Assesses adolescents thirteen (13) years of age who had one (1) dose of meningococcal vaccine, one (1) Tdap vaccine and the complete human papillomavirus vaccine series by their thirteenth birthday.	CMS Child Core

Performance Measures	Frequency	Definition	Measure Set
Child and Adolescent Well-Care Visits (WCV-CH)	Annual	Child and Adolescent Well-Care Visits: Assesses Children three (3) – twenty-one (21) years of age who received one (1) or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.	CMS Child Core
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Annual	Timeliness of Prenatal Care. The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the Enrollment start date or within forty-two (42) Days of Enrollment in the organization.	CMS Child Core
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Annual	Postpartum Care. The percentage of deliveries in which women had a postpartum visit on or between seven (7) and eighty-four (84) Days after delivery.	CMS Adult Core
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Annual	Assesses the rate of ED visits per one thousand (1,000) beneficiary months for Children and adolescents in each state.	CMS Child Core
Emergency Department Utilization (EDU)	Annual	Assesses emergency department (ED) utilization among commercial (eighteen (18) and older) and Medicaid (eighteen (18) and older) CE members.	NCQA HEDIS®
Follow-Up After Hospitalization for Mental Illness: Ages Six (6) to Seventeen (17) (FUH-CH)	Annual	Assesses the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients ages six (6) years to seventeen (17) that resulted in follow-up care with a mental health Provider within seven (7) and thirty (30) Days.	CMS Child Core
Follow-Up After Emergency Department Visit for Mental Illness: Age Eighteen (18) and Older (FUM-AD)	Annual	The percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients ages eighteen (18) years and older that resulted in follow-up care with a mental health Provider within seven (7) and thirty (30) Days.	CMS Core
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Annual	Percentage of patients eighteen (18) – seventy-five (75) years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	CMS Adult Core

Performance Measures	Frequency	Definition	Measure Set
Plan All-Cause Readmissions (PCR-AD)	Annual	Assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within thirty (30) Days after discharge among commercial (18 to 64), Medicaid (18 to 64) and Medicaid (18 and older) members.	CMS Adult Core

5. Outcome Measures and Payment Structure

During the first Contract Rating Period, the Contractor will not be subject to a Performance Withhold and shall put in place all required quality programs, PIPs, and reporting. The Contractor shall have a Performance Withhold in Contract Year 2 (See Section 2: "Performance Withhold" of this Appendix). Calendar year 2024 will be used as the performance measurement baseline year. Withhold payment opportunities have been established based on OHCA priority areas.

The Contractor shall earn Quality Withholds by meeting Annual Target Criteria for each measure, as determined by either of the below:

a. *Improvement:* Two (2) percentage point improvement over the Contractor's previous year performance; Or

b. *Benchmark:* Meeting or exceeding the OHCA identified benchmark.

Performance Withhold Amounts and Criteria

Measure	Measurement Set	Amount of Capitation Quality Withhold	CY 2024 Baseline Rate	Annual Target Criteria
Childhood Immunization Status (CIS-CH) Combination Three (3)	CMS Child Core	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting or exceeding OHCA identified benchmark

Measure	Measurement Set	Amount of Capitation Quality Withhold	CY 2024 Baseline Rate	Annual Target Criteria
Well-Child Visits in the First Thirty (30) Months of Life (W30-CH)	CMS Child Core	Ten percent (10%) of total capitation quality withhold (Two (2) measures, Five percent (5%) each)	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Immunizations for Adolescents (IMA-CH) Combination One (1)	CMS Child Core	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Child and Adolescent Well-Care Visits (WCV-CH) Total	CMS Child Core	Ten percent (10%) of total capitation quality withhold (Two (2) measures, Five percent (5%) each)	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	CMS Child Core	Five percent (5%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	CMS Adult Core	Five percent (5%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	CMS Child Core	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark

Measure	Measurement Set	Amount of Capitation Quality Withhold	CY 2024 Baseline Rate	Annual Target Criteria
Emergency Department Utilization (EDU)	NCQA HEDIS®	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Follow-Up After Hospitalization for Mental Illness: Ages Six (6) to Seventeen (17) (FUH-CH)	CMS Child Core	Five percent (5%) of total capitation quality withhold (Two (2) measures, Two and a half percent (2.5%) each)	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Follow-Up After Emergency Department Visit for Mental Illness: Age Eighteen (18) and Older (FUM-AD)	CMS Adult Core	Five percent (5%) of total capitation quality withhold (Two (2) measures, Two and a half percent (2.5%) each)	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	CMS Adult Core	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA identified benchmark
Plan All Cause Readmissions (PCR-AD)	CMS Adult Core	Ten percent (10%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement over previous year or meeting OHCA designated benchmark

OHCA reserves the right to adjust the measures, number of measures, weighting of measures and performance targets in future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Section 1.2.8: “Amendments or Modifications” of the Contract.

6. Timing of Quality Withhold Determination

OHCA will make its best efforts to distribute a report identifying Contractor performance and eligibility for payment of withheld Capitation Payments within six months of the end of each established Report Period, as defined in Section 2: “Performance Withhold” of this Appendix. Given that unforeseen

circumstances may impact the timing of this determination, OHCA reserves the right to revise the time frame in which this report is issued.

7. Federal Compliance

In accordance with 42 C.F.R. § 438.6, the performance withhold program:

a. Will not be renewed automatically;

b. Will be made available to both public and private SoonerSelect Program CEs under the same terms of performance;

c. Does not condition Contractor participation in the withhold arrangement on the Contractor entering into or adhering to intergovernmental transfer agreements;

d. Is necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives specified in the State's managed care quality strategy required under 42 C.F.R. § 438.340; and

e. Will measure performance for a fixed period of time during the Rating Period under the Contract in which the incentive arrangement is applied.

8. Contractor Eligibility

The Contractor may, in OHCA's sole discretion, lose eligibility for its compensation under the performance withhold program if:

a. OHCA has suspended, in whole or in part, Capitation Payments or Enrollment to the Contractor;

b. OHCA has assigned, in whole or in part, the membership and responsibilities of the Contractor to another participating SoonerSelect Program CE Contractor;

c. OHCA has assumed or appointed temporary management with respect to the Contractor;

d. The Contract has been terminated;

e. The Contractor has, based on the sole determination of OHCA, failed to execute a smooth transition at the end of the Contract term, including failure to comply with the Contractor responsibilities set forth in Section 1.26.11: "Post-Transition Contract Obligations" of the Contract; or

f. OHCA has imposed upon the Contractor a consequential or liquidated damage as described in Section 1.25: "Remedies and Disputes" of this Contract during the performance withhold measurement year.

OHCA may, at its discretion, reinstate the Contractor's eligibility for participation in the SoonerSelect Program CE performance withhold program once the Contractor has properly cured all prior instances of non-compliance of its obligations under the Contract and OHCA has satisfactory assurances of acceptable future performance.

Appendix 1D: Contract Minimum Insurance Requirements

The following table includes the minimum insurance requirement wits as outlined in Section 1.2.19: "Insurance" of the Contract. OHCA will not make any exceptions to minimum insurance requirements listed herein.

Minimum Insurance Requirements

Type of Insurance	Contract Reference	Minimum Insurance Requirements
Professional Liability	Section 1.2.19.1	$1,000,000 per occurrence
Commercial General Liability Insurance	Section 1.2.19.2	$25,000,000 per occurrence
Automobile Insurance	Section 1.2.19.2	$5,000,000 per accident
Property Damage Insurance	Section 1.2.19.2	$500,000 per occurrence
Directors and Officers Liability Insurance	Section 1.2.19.3	$5,000,000 per occurrence
Cyber Liability Insurance	Section 1.2.19.4	$50,000,000 per occurrence
Errors and Omissions Insurance	Section 1.2.19.5	$50,000,000 per occurrence
Workers Compensation and Employer's Liability Insurance	Section 1.2.19.6	In accordance with and to the extent required by applicable law
Reinsurance	Section 1.2.19.7	Optional

Appendix 1E: Consequential and Liquidated Damages

The Contractor understands and agrees that the consequential and liquidated damages described herein are not construed as penalties and are pursuant to 42 C.F.R. §§ 438.704 and 438.700(b). OHCA retains authority to seek other remedies and take other actions as appropriate to ensure compliance, satisfy contractual obligations and/or safeguard Enrollees' rights and interests.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Medically Necessary Services	The Contractor fails to substantially provide Medically Necessary services to an Enrollee that the Contractor is required to provide under law or the Contract.	OHCA may assess a liquidated damage of up to $25,000 for each failure to provide services.
Premiums Not in Excess of Medicaid	The Contractor imposes Premiums or charges on Enrollees that are in excess of those permitted in the Medicaid program.	OHCA may assess a liquidated damage of up to $25,000 or double the amount of the excess Premiums or charges, whichever is greater.
Compliance with State and Federal Anti-Discrimination Laws	The Contractor discriminates among Enrollees on the basis of their health status or need for medical services.	OHCA may assess a liquidated damage of up to $100,000 for each determination of discrimination. OHCA may assess a liquidated damage of up to $15,000 for each Eligible Applicant the Contractor did not enroll because of a discriminatory practice, up to the $100,000 maximum.
Information Requirements - State and Federal	The Contractor falsifies or misrepresents information that it furnishes to CMS or to OHCA.	OHCA may assess a liquidated damage of up to $100,000 for each instance of misrepresentation.
Information Requirements – SoonerSelect Program Enrollee, Eligible, and Provider	The Contractor falsifies or misrepresents information it issues, including but not limited to Marketing Materials that it furnishes to an Enrollee, Eligible, or Provider.	OHCA may assess a liquidated damage of up to $25,000 for each instance of misrepresentation.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.2.16: "Confidentiality; Health Insurance Portability and Accountability Act (HIPAA) and Business Associate Requirements"	The Contractor fails to ensure all data containing Personally Identifiable Information (PII), including but not limited to Protected Health Information (PHI), is secured in accordance with all applicable State and federal privacy and security requirements, including but not limited to HIPAA, 42 U.S.C. § 290dd-2; 42 C.F.R. §§ 2.1 – 2.67, and 43A O.S. § 1-109.	In addition to any remedies available to OHCA pursuant to the terms of this Contract or available at law, if OHCA deems credit monitoring and/or identity theft safeguards are needed to protect Enrollees whose PII/PHI was placed at risk by the Contractor's failure to comply with Contract terms, the Contractor shall be liable for all costs associated with the provision of such monitoring and/or safeguard services.
Section 1.2.20.5: "Compliance with Law"	The Contractor fails to meet implementation deadlines for mandates and/or laws as directed by CMS, CDC, or other government entity.	OHCA may assess a liquidated damage of $2,500 per Business Day.
Section 1.3.2: "Capitation Reconciliation"	The Contractor fails to perform monthly reconciliation of Enrollment roster data against Capitation Payments.	Refund of any detected Overpayments or duplicate payments as identified through OHCA or federal review and resulting from the Contractor's failure to properly perform reconciliation. OHCA may assess a liquidated damage of $5,000 per Day that the Contractor remains out-of-compliance with reconciliation requirement.
Section 1.4.2: "Accreditation"	The Contractor fails to be accredited by an Accrediting Entity within eighteen (18) months of Contract award.	Achievement of provisional status shall require a CAP within thirty (30) Calendar Days of receipt of notification from Accrediting Entity and may result in termination of this Contract. OHCA may assess a liquidated damage of $100,000 per month for every month the Contractor is non-complaint.
Section 1.4.6.2: "Key Staff"	The Contractor fails to fill Key Staff positions. The Contractor is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties.	OHCA may assess a liquidated damage of $1,000 per Calendar Day for each Key Staff position that remains vacant after ninety (90) Days.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.4.8: "Readiness Review"	The Contractor fails to satisfactorily pass the Readiness Review by the deadline imposed by OHCA.	OHCA may delay Enrollment of Eligibles with the Contractor and/or apply other Non-Compliance Remedies, including, but not limited to, Contract termination. The Contractor shall be responsible for all costs incurred by OHCA as a result of the delay of Enrollment of Eligibles with the Contractor.
Section 1.4.8: "Readiness Review"	The Contractor fails to submit Readiness Review documentation timely and/or accurately.	OHCA may assess a liquidated damage of $5,000 per Business Day, per Readiness Review Deliverable, that has not been submitted correctly, complete, on time and in the OHCA-defined format.
Section 1.8.6.3: "Timeliness Standards"	The Contractor fails to comply with timeliness requirements for processing PAs.	OHCA may assess liquidated damages of: a. $5,000 for each calendar month the Contractor fails to adjudicate all PA requests within seventy-two (72) Hours. b. $10,000 for each calendar month the Contractor fails to adjudicate all urgent PA requests within twenty-four (24) Hours. c. $5,000 for each calendar month the Contractor fails to conduct all retrospective reviews within fourteen (14) Days.
Section 1.12.4: "New Enrollee Materials and Outreach"	The Contractor fails to distribute an Enrollee Handbook or ID Card in the required timeframe.	OHCA may assess liquidated damages of: a. $500 for each instance where the Contractor fails to distribute an Enrollee Handbook within ten (10) Days of an Enrollee's Enrollment with the Contractor. b. $500 for each instance where the Contractor fails to distribute an Enrollee ID Card within seven (7) Days of an Enrollee's Enrollment with the Contractor.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.12.8: "Enrollee Services Call Center"	The Contractor fails to meet Enrollee Call Center performance standards.	For any calendar month where the call abandonment rate is equal to or greater than five percent (5%), liquidated damages of $10,000 for each full percentage point equal to or greater than five percent (5%). For any calendar month where less than eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds of the first ring, liquidated damages of $10,000 for each full percentage point below eighty-five percent (85%). For any calendar month where the average wait time exceeds two (2) minutes, liquidated damages of $10,000. For any calendar month where the blocked call rate exceeds one percent (1%), liquidated damages of $10,000 for each percentage point above one percent (1%).
Section 1.14.2: "Credentialing"	The Contractor fails to meet timeliness standards for Provider credentialing.	OHCA may assess a liquidated damage of $500 per Calendar Day where the Contractor fails to credential a Provider within forty-five (45) Days of receipt of a complete application.
Section 1.14.3: "Time and Distance and Appointment Access Standards"	The Contractor fails to meet time and distance standards for Network adequacy for any of the following Provider types: a. Adult PCPs b. Pediatric PCPs c. OB/GYN d. Adult mental health e. Adult SUD f. Pediatric mental health g. Pediatric SUD h. Adult Specialists i. Hospitals j. Pharmacies k. Essential community Providers	OHCA may assess a liquidated damage of $10,000 for each calendar month, for each Provider type, where the Contractor fails to meet the time and distance standards. Submission of CAP to OHCA. More frequent submission of Network adequacy reports at the direction of OHCA until Contractor compliance is demonstrated for sixty (60) consecutive Days. OHCA may require the Contractor to maintain an open Network for the Provider type(s) for which the Contractor demonstrates non- compliance. Non-compliance with Network adequacy standards for three (3) consecutive months shall result in auto-assignment suspension until such time as the Contractor successfully demonstrates compliance.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.15.2: "Provider Services Call Center"	The Contractor fails to meet Provider Services Call Center performance standards.	For any calendar month where the call abandonment rate is equal to or greater than five percent (5%), liquidated damages of $10,000 for each full percentage point equal to or greater than five percent (5%). For any calendar month where less than eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds of the first ring, liquidated damages of $10,000 for each full percentage point below eighty-five percent (85%). For any calendar month where the average wait time exceeds two (2) minutes, liquidated damages of $10,000. For any calendar month where the blocked call rate exceeds one percent (1%), liquidated damages of $10,000 for each percentage point above one percent (1%).
Section 1.15.6: "Provider Complaint System"	The Contractor fails to resolve ninety-eight percent (98%) of Provider reconsiderations within thirty (30) Calendar Days of receipt of the request for reconsideration. The Contractor fails to resolve one hundred percent "100%" of Provider reconsiderations within sixty (60) Calendar Days of receipt of the request for reconsideration.	OHCA may assess a liquidated damage of $10,000 for each quarter the Contractor is non-compliant.
Section 1.15.6: "Provider Complaint System"	The Contractor fails to resolve ninety-eight percent (98%) of Provider Appeals within thirty (30) Calendar Days of receipt of the Appeal. The Contractor fails to resolve one hundred percent (100%) of Provider Appeals within sixty (60) Calendar Days of receipt of the Appeal.	OHCA may assess a liquidated damage of $10,000 for each quarter the Contractor is non-compliant.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.15.6: "Provider Complaint System"	The Contractor fails to send one hundred percent (100%) of notices of resolution of Provider reconsiderations within five (5) Calendar Days of resolution of the reconsideration. The Contractor fails to send one hundred percent (100%) of notice of resolution of Provider Appeals within five (5) Calendar Days of resolution of the Appeal.	OHCA may assess a liquidated damage of $10,000 for each quarter the Contractor is non- compliant.
Section 1.16.1.12: "Value-Based Payments"	The Contractor fails to comply with the physician incentive plan requirements.	OHCA may assess a liquidated damage of up to $25,000 for each failure to comply.
Section 1.16.5: "Timely Claims Filing and Processing"	The Contractor fails to meet timely claims payment standards.	OHCA may assess liquidated damages of: a. $10,000 for any calendar month where the Contractor fails to pay ninety percent (90%) or more of Clean Claims within fourteen (14) Days for each deficient claim type. b. $10,000 for any calendar month where the Contractor fails to pay ninety-nine percent (99%) or more of Clean Claims within ninety (90) Days for each deficient claim type. For the purposes of this requirement, there are six (6) claim types: professional paper claims, professional electronic claims, facility paper claims, facility electronic claims, pharmacy paper claims and pharmacy electronic claims.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.18: "Enrollee Grievance and Appeal"	The Contractor fails to resolve ninety-eight percent (98%) of Enrollee Grievances within thirty (30) Calendar Days from the date the Grievance is received. The Contractor fails to resolve one hundred percent (100%) of Enrollee Grievances within sixty (60) Calendar Days from the date the Grievance is received. The Contractor fails to provide impacted Enrollee written notice of resolution three (3) Calendar Days of the resolution of the Grievance.	OHCA may assess a liquidated damage of $10,000 for each quarter the Contractor is non-compliant.
Section 1.18: "Enrollee Grievance and Appeal"	The State will monitor performance and set performance targets for each Contractor regarding the percentage of State Fair Hearing requests that are resolved without a change to the original determination. When performance targets are identified, the State will inform the Contractor as to the required performance and increment of measurement.	Starting with the quarter following notification, OHCA may assess a liquidated damage of $50,000 for each increment of non-compliance with the performance target.
Section 1.18.8.4: "Contractor State Fair Hearing Support"	The Contractor fails to maintain a sufficient level of staff training to competently perform the functions, requirements, roles, and duties involved in State Fair Hearing support.	OHCA may assess a liquidated damage of $1,000 per Day from the time the training deficiency is identified by the State and until the Contractor resolves the situation to the State's approval.
Section 1.18.8.4: "Contractor State Fair Hearing Support"	The Contractor fails to provide the State the required summary information within fifteen (15) Calendar Days after notification of the request for a State Fair Hearing.	OHCA may assess liquidated damages of: a. 1-3 months at less than 95%: $3,000 b. 4-6 months at less than 95%: $6,000 c. 7-9 months at less than 95%: $9,000 d. 10-12 months at less than 95%: $12,000
Section 1.18.8.4: "Contractor State Fair Hearing Support"	The Contractor fails to provide timely delivery to the Appellant, the State, and the Office of Administrative Hearings State Fair Hearing documentation, as required.	OHCA may assess liquidated damages of: a. 1-3 months at less than 95%: $3,000 b. 4-6 months at less than 95%: $6,000 c. 7-9 months at less than 95%: $9,000 d. 10-12 months at less than 95%: $12,000

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.18.8.4: "Contractor State Fair Hearing Support"	The Contractor fails to summarize the arguments presented by the Appellant and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Appellant and Contractor are clearly identified. The Contractor shall state the legal basis upon which dismissal requests are based and include regulations or statutes in support.	OHCA may assess liquidated damages of: a. 1-3 months at less than 95%: $3,000 b. 4-6 months at less than 95%: $6,000 c. 7-9 months at less than 95%: $9,000 d. 10-12 months at less than 95%: $12,000
Section 1.20.1.3: "Collaboration with OHCA and MFCU"	The Contractor fails to provide information responsive to specific requests made by OHCA, MFCU, or other authorized State and federal authorities (including, but not limited to, requests for records of Enrollee and Provider interviews), within three (3) Business Days of said request, unless otherwise agreed upon by OHCA.	OHCA may assess a liquidated damage of $1000 per Day.
Section 1.20.1.3: "Collaboration with OHCA and MFCU"	The Contractor fails to refer credible allegations of Fraud to OHCA's Legal Division in writing within three (3) Business Days of discovery.	OHCA may assess a liquidated damage of $1,000 per Day.
Section 1.20.1.3: "Collaboration with OHCA and MFCU"	The Contractor fails to participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.	OHCA may assess a liquidated damage of $1,000 per Day.
Section 1.20.2: "Compliance Program"	The Contractor fails to participate in good faith at monthly meetings with OHCA Program Integrity and Accountability Unit.	OHCA may assess a liquidated damage of $1,000 per Day

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.20.2: "Compliance Program"	The Contractor fails to provide by close of the last Calendar Day of each month, a monthly report of all open program integrity related audits and investigations related to Fraud, Waste, and Abuse activities for identifying and collecting potential Overpayments, utilization review, and Provider compliance. The report shall include, but is not limited to, audits and investigations performed, Overpayments identified, Overpayments recovered, and other program integrity actions taken, such as, CAPs, Provider education, consequential and liquidated damages, and Non-Compliance Remedies required of a Provider.	OHCA may assess a liquidated damage of $1,000 per Day
Section 1.20.7: "Suspension of Payments for Credible Allegation of Fraud"	If credible allegation of Fraud exists, the Contractor fails to immediately suspend all payments to the Provider as instructed by OHCA within twenty-four (24) Hours of receipt of said instruction.	OHCA may assess a liquidated damage of $1,000 per Day
Section 1.20.9.3: "When Disclosures of Persons with An Ownership or Controlling Interest Are Required"	The Contractor fails to disclose any change in ownership and control information to OHCA within thirty-five (35) Calendar Days in accordance with 42 C.F.R. § 455.104 and Subcontractors as governed by 42 C.F.R. § 438.230.	OHCA may assess a liquidated damage of $1,000 per Day

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.20.9.3: "When Disclosures of Persons with An Ownership or Controlling Interest Are Required"	As required by 42 C.F.R. § 455.105, the Contractor fails to submit to OHCA or HHS, within thirty-five (35) Calendar Days of request, full and complete information about: The ownership of any Subcontractor with whom the Contractor had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and Any significant business transactions between the Contractor and any wholly owned supplier, or between the Provider and any Subcontractor, during the five (5) year period ending on the date of request.	OHCA may assess a liquidated damage of $1,000 per Day
Section 1.21.7: "Enrollee Encounter Data	The Contractor fails to submit weekly Encounter Data timely.	For failure to submit Encounter Data by the deadline established by OHCA, consequential damages equal to fifteen percent (15%) of Capitation Payment paid for the month previous to month in which Encounter Data was due.
Section 1.21.7: "Enrollee Encounter Data	The Contractor fails to submit Encounter Data in accordance with OHCA accuracy standards, as determined through encounter Validation studies conducted by OHCA or its designee.	OHCA may assess consequential damages as follows: a. For error rate of 5.1 to 7.0 percent: Five percent (5%) of Capitation Payment paid in Validation study period. b. For error rate of 7.1 to 10 percent: Ten percent (10%) of Capitation Payment paid in Validation study period. c. For error rate of 10.1 percent or greater: Fifteen percent (15%) of Capitation Payment paid in Validation study period.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.21.13: "Disaster Preparation and Data Recovery"	The Contractor fails to restore operations in a disaster situation.	If the Contractor's failure to restore operations requires OHCA to transfer Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor as a result of the Enrollee transfer. Additionally, the Contractor shall pay any costs OHCA incurs to accomplish the transfer of Enrollees.
Section 1.21.15 "Accessibility"	The Contractor fails to ensure that all system functions are accessible as required.	OHCA may assess a liquidated damage of $5,000 per Day.
Section 1.21.15 "Accessibility"	The Contractor fails to provide its URL to OHCA or changes the URL without OHCA'S approval.	OHCA may assess a liquidated damage of $500 per occurrence.
Section 1.21.15 "Accessibility"	The Contractor fails to maintain a point of contact to provide assistance interfacing/exchanging data.	OHCA may assess a liquidated damage of $1,000 per Day.
Section 1.21.15 "Accessibility"	The Contractor fails to provide continuous access to information as required.	OHCA may assess a liquidated damage of $5,000 per Day.
Section 1.21.16 "System Performance Requirements"	The Contractor fails to satisfy any response, retrieval, or display time requirement.	OHCA may assess a liquidated damage of $1,000 per Day.
Section 1.21.16.6 "System Performance Notification and Reporting"	The Contractor fails to give OHCA the required system performance notification.	OHCA may assess a liquidated damage of $1,000 per occurrence.
Section 1.21.16.6 "System Performance Notification and Reporting"	The Contractor fails to resolve unscheduled system unavailability as required.	OHCA may assess a liquidated damage of $5,000 per Day.
Section 1.22 "Financial Standards and Third-Party Liability"	The Contractor fails to comply with Oklahoma Insurance Department requirements for minimum net worth and risk-based capital.	Submission of CAP to OHCA. If the Contractor fails to meet the financial performance standards or otherwise comply with the CAP by the date specified by OHCA, OHCA may freeze Enrollee Enrollment to the Contractor.

Contract Requirement	Performance Standard	Consequential and Liquidated Damages
Section 1.23 "Reporting"	The Contractor fails to submit a required report timely and/or accurately.	OHCA may assess a liquidated damage of $2,500 per Business Day per report that has not been submitted correctly, complete, on time and in the OHCA-defined format. If reporting non-compliance impacts OHCA's ability to monitor the Contractor's solvency, and the Contractor's financial position requires OHCA to transfer Enrollees to another Contractor, the Contractor shall pay any difference between the Capitation Rates that would have been paid to the Contractor and the actual rates being paid to the replacement Contractor as a result of the Enrollee transfer. Additionally, the Contractor shall pay any costs OHCA incurs to accomplish the transfer of Enrollees.
Miscellaneous Damages	The State is herein provided an administrative procedure to address general Contract compliance issues not defined elsewhere in this Contract. The State may identify a condition resulting from the Contractor's non-compliance with the Contract through monitoring activities. If this occurs, the State will notify the Contractor in writing of the contractual non-compliance. The Contractor shall provide a written response to the notification within five (5) Business Days of receipt of the notice. The State will recommend, when appropriate, a reasonable period of time within which the Contractor shall remedy the non-compliance. This liquidated damage may be independent or combined with any of the liquidated damages listed within this Appendix.	If the non-compliance is not corrected by the specified date, the State reserves the right to assess liquidated damages in an amount not to exceed $500 per Business Day per occurrence after the due date until the non-compliance is corrected.

Appendix 1F: List of Deliverables to OHCA

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
1	1115 IMD Waiver Data and Reports	1.7.1.7 - 1115 IMD Waiver 1.23.1.10 - Covered Benefits Reports	N/A	N/A
2	24-Hour Availability Audit	1.23.1.16 - Provider Network Development Reports	RM	RM
3	508 Compliance Accessibility Report	1.12.7.4 - 508 Compliance	Upon Request	Upon Request
4	Accreditation / Accreditation Status Reports	1.4.2 - Accreditation 1.23.1.8 - Administrative Reports	Within eighteen (18) months of Operations Start Date	RM
5	Ad Hoc Outreach Campaigns Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
6	Advance Directives Policies and Procedures	1.7.13 Advance Directives	Within thirty (30) Days of change in State Law	N/A
7	Advisory Board Membership Proposal	1.12.9 - Advisory Board	Prior to convening the first Advisory Board meeting	RM
8	Advisory Board Report	1.12.9 - Advisory Board 1.23.1.15 - Enrollee Services Report	Upon Request	TBS
9	AI/AN Eligibles and Enrollees Federal Funding Report	1.17.4.3 – IHCP Payments	RM	RM
10	AI/AN Enrollees and IHCP Network Accessibility Reports	1.17.4.1 - Sufficient IHCP Participation 1.23.1.19 - AI/AN Population and Indian Health Care Providers Report	RM	RM
11	Annual Quality Improvement Plan	1.23.1.6 - Required Data Collection and Reports	N/A	N/A

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
12	Applicable Clinical Information Data	1.26.10 - Transition Period Obligations	N/A	N/A
13	Audited Financial and Encounter Data	1.23.1.6 - Required Data Collection and Reports 1.23.1.23 - Information Technology Reports 1.23.1.24 – Financial Performance Reports	RM	RM
14	Audited HEDIS® results	1.11.5 - Quality Performance Measures	N/A	Annually
15	Auditor's Engagement Letter	1.22.5 - Medical Loss Ratio	Upon Request	Upon Request
16	Authorization Process Policies and Procedures	1.8.6 - Authorization Process	Readiness Review	RM
17	Back-up Plan	1.21.13 - Disaster Preparation and Data Recovery 1.21.14 - Back-up Plan 1.23.1.23 - Information Technology Reports	Readiness Review	RM
18	Base Data Report	1.2.13 - Record Retention 1.23.1.24 - Financial Performance Reports	RM	RM
19	BCDR Incidence Reports	1.23.1.23 - Information Technology Reports	RM	RM
20	Behavioral and Physical Health Strategy/Policy Integration	1.4.7 - Policies and Procedures 1.7.1.3 - Behavioral and Physical Health Integration	Readiness Review	RM
21	Behavioral Health Advisory Board Report	1.12.9.1 - Behavioral Health Advisory Board 1.23.1.15 - Enrollee Services Report	Upon Request	TBS

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
22	Behavioral Health Services Hotline Report	1.23.1.15 - Enrollee Services Report	RM	RM
23	Breach Notice Draft Letter	1.2.16.3.1 - Breach	Within ten (10) Days from receipt of notice from OHCA	Upon Request
24	Breach of Unsecured PHI Notice	1.2.16.3 - Obligations of the Contractor	Within one (1) Hour from discovery	RM
25	Business Relationship Disclosure	1.4.4 Business Relationship Disclosure	N/A	N/A
26	CAHPS® Survey Reports	1.11.4.1 - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys 1.23.1.14 - Quality Improvement Reports	No later than June 15th of each year	Annually
27	Capitation Overpayment	1.3.3 - Report of Capitation Overpayment 1.20.9 - Written Disclosures 1.23.1.7 - Contractor Payment Reports	Within thirty (30) Days when it has identified Capitation Payments or payments in excess of amounts specified in the Contract	RM
28	Capitation Reconciliation	1.3.2 – Capitation Reconciliation 1.23.1.7 - Contractor Payment Reports	TBS	Monthly
29	Care Coordination Agreements between IHCP and other non-IHS/Tribal Providers	1.17.4.3 – IHCP Payments	RM	RM
30	Care Management Activities Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
31	Care Management and Population Health Model	1.9 - Care Management and Population Health	N/A	N/A
32	Care Management and Population Health Monitoring Program	1.9.7 Monitoring Service Delivery	N/A	N/A
33	Care Management Staffing Actual Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
34	Care Management Staffing Plan	1.4.6.3 - Care Management 1.9.5.1 - Staffing Levels 1.23.1.12 - Care Management and Population Health Reports	RM	RM
35	Care Managers Training Plan and Materials	1.9.5.4 - Training	Upon Request	Upon Request
36	Care Plan Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
37	Certificate of Authority	1.4.1 - Licensure	Upon Contract award	N/A
38	Certificates of Insurance	1.2.19 - Insurance	Within thirty (30) Days of official notice of Contract award and prior to commencement of service delivery to Medicaid beneficiaries	Annually
39	Certification Statement	1.23.1.3 - Certification Requirements	Attached with every data, documentation, or information submission	N/A

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
40	Change in Independent Actuary or Independent Auditor Report	1.23.1.24 - Financial Performance Reports	RM	RM
41	Claims Activity Report	1.23.1.18 - Provider Payment Reports	RM	RM
42	Claims and Encounter Data Error Rates Report	1.16.4.1 - Claims Processing System and Methodology	N/A	N/A
43	Claims Inquiries and Disputes Policies and Procedures	1.16.5.2 - Timely Payment Requirements 1.16.8 – Claims Inquires and Disputes	Readiness Review	N/A
44	Claims Payment Accuracy Report	1.23.1.18 - Provider Payment Reports	RM	RM
45	Claims Processing Policies and Procedures	1.16.5.2 - Timely Payment Requirements	Readiness Review	N/A
46	Claims Timeliness Report	1.23.1.18 - Provider Payment Reports	RM	RM
47	Compliance Education and Training Documentation	1.20.2.2 - Compliance Education and Training	Upon Request	Upon Request
48	Compliance Plan	1.20.2.1 - Compliance Plan 1.23.1.22 - Program Integrity Reports	Within a minimum of sixty (60) Calendar Days prior to the Contract start date	Annually
49	Compliance Program Policies, Procedures, and Standards of Conduct	1.20.2 - Compliance Program	Readiness Review	Upon Request

KEY: N/A = Not Addressed; TBS = To Be Stated; RM = Reporting Manual				
#	Deliverable Name	Requirement Location(s)	Due Date	Frequency
50	Comprehensive Assessment	1.9.3 - Comprehensive Assessment	N/A	N/A
51	Comprehensive Assessment and Reassessment Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
52	Comprehensive Assessment Process and Timeline	1.9.2.3 - Timeline for Completion	Prior to Initial Program Implementation	N/A
53	Contractor Internal Compliance Monitoring Activities Report	1.24.3.2 - Contractor Internal Monitoring Methods	RM	Monthly
54	Contractor Materials Effectiveness Tracking Report	1.12.3.9 - Monitoring Effectiveness of Contractor Materials 1.23.1.15 - Enrollee Services Report	RM	Quarterly
55	Contractor Payment Reports	1.23.1.7 - Contractor Payment Reports	RM	RM
56	Contractor State Fair Hearing Summary Report	1.18.8.4 - Contractor State Fair Hearing Support	Within fifteen (15) Calendar Days after notification of the request for a State Fair Hearing	N/A
57	Contractor's Activities Records	1.26.11 - Post-Transition Contract Obligations	N/A	N/A
58	Coordination with Other SoonerCare Program Policies and Procedures	1.9.6 - Coordination with Other SoonerCare Programs	N/A	N/A
59	Credentialing Report	1.23.1.16 - Provider Network Development Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
60	Critical Incidents Report	1.11.9.3 - Critical Incident Reporting System 1.23.1.14 - Quality Improvement Reports	RM	RM
61	Cultural Competency and Sensitivity Plan	1.12.2 - Cultural Competency	Readiness Review	N/A
62	Customer Service Performance Data	1.23.1.6 - Required Data Collection and Reports	N/A	N/A
63	Defect Corrections Report	1.21.4 - Ongoing Maintenance of IT Solutions	RM	At minimum monthly
64	Delivery of Services Verification Report	1.20.4.1 - General Requirement 1.23.1.22 - Program Integrity Reports	RM	Quarterly
65	Designated Record Set	1.2.16.3.1 - Breach	Upon Request	Upon Request
66	Directed Payments Report	1.16.1.14.1 - Directed Payments Reporting	Within thirty (30) Calendar Days of receipt of payment of the Directed Payments from OHCA	Quarterly
67	Disaster Preparation and Recovery Plan	1.2.20.4 - Force Majeure 1.21.13 - Disaster Preparation and Data Recovery 1.23.1.23 - Information Technology Reports	Readiness Review	Annually
68	Discharge Planning Policies and Procedures	1.10.11 - Transitions from Inpatient/Residential Settings	N/A	N/A
69	Disclosure of Fiduciary Relationships and Bonding Reports	1.23.1.24 - Financial Performance Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
70	Distance Standards Waiver	1.14.4 - Network Adequacy Exception Process	N/A	N/A
71	Drug Utilization Data	1.21.7.1 - Encounter Data Detail and Format 1.23.1.10 - Covered Benefits Reports	RM	RM
72	Drug Utilization Program Policies and Materials	1.7.2.4.5 - Drug Utilization Review	Prior to implementation by the Contractor or its PBM	N/A
73	Encounter Data and Financial Summary Reconciliation	1.23.1.23 - Information Technology Reports	RM	RM
74	Enrollee Changes in Circumstances Reports	1.20.1.1- Administrative and Management Arrangements or Procedures 1.20.3.1 - Reporting Enrollee Changes in Circumstance	RM	RM
75	Enrollee Encounter Data	1.21.7.1 - Encounter Data Detail and Format 1.21.7.2 - Timely Submission of Accurate, Complete Encounter Data and Reconciliation 1.21.7.3 - Timeliness 1.21.7.6 - Completeness 1.21.8 - Health Information Exchange 1.23.1 - General Reporting Obligations 1.23.1.23 - Information Technology Reports	RM	RM
76	Enrollee Encounter Remediation Data	1.21.7.4 - Timeliness Remediation 1.21.7.8 - OHCA Review of Encounter Data	Within thirty (30) Days of receipt of notice by OHCA of encounters being denied or rejected	N/A

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
77	Enrollee Enrollment and Disenrollment Reports	1.6.7.1 - Contractor Request 1.23.1.9 - Enrollment and Disenrollment Reports	TBS	TBS
78	Enrollee Enrollment and Reimbursement Policies and Procedures	1.12.10 - PCP Selection and Assignment	N/A	N/A
79	Enrollee Grievance and Appeal Logs	1.2.13 - Record Retention 1.18.2 - Recordkeeping 1.23.1.6 - Required Data Collection and Reports 1.23.1.20 - Grievance and Appeal Reports	RM	RM
80	Enrollee Grievance and Appeal System Policies and Procedures	1.18.3 - Written Policies Requirement	Readiness Review	N/A
81	Enrollee ID Card Sample	1.12.6 - Enrollee ID Card	Readiness Review	N/A
82	Enrollee Information Accessibility Plan	1.12.1 - Accessibility of Enrollee Information	Readiness Review	N/A
83	Enrollee Marketing Materials	1.12.3.2 - Prior Approval Process 1.12.16.4 - OHCA Review and Approval Process	Ninety (90) Days prior to intended use	N/A
84	Enrollee Rights	1.12.8.7 - Enrollee Rights	N/A	N/A
85	Enrollee Roster and Provider Attribution Submission	1.21.8 - Health Information Exchange	Within thirty (30) Business Days of adjudication	N/A
86	Enrollee Satisfaction Survey Results	1.11.1 - Quality Rating System 1.23.1.6 - Required Data Collection and Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
87	Enrollee Services Call Center Report	1.12.8.2 - Enrollee Services Call Center Performance Standards 1.23.1.15 - Enrollee Services Report	RM	Annually
88	Enrollee Services Call Center Training Program	1.12.8.2 - Enrollee Services Call Center Performance Standards	RM	Annually
89	Enrollee Services Call Center Training Report	1.12.8.2 - Enrollee Services Call Center Performance Standards 1.23.1.15 - Enrollee Services Report	RM	RM
90	Enrollees in Care Management Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
91	EPSDT Data	1.11.5 - Quality Performance Measures 1.23.1.10 - Covered Benefits Reports	RM	RM
92	EPSDT Protocols	1.7.11 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	N/A	N/A
93	ER Utilization Data	1.8.6.8 - Emergency Room (ER) Utilization 1.23.1.11 - Medical Management Reports	RM	Every six (6) months or as otherwise required in the RM
94	Explanation of Benefits (EOB)	1.20.4.2 - Explanation of Benefits (EOBs)	N/A	N/A
95	Failure to Contact Report	1.12.4.1 - Failure to Contact 1.23.1.15 - Enrollee Services Report	RM	RM
96	Five Percent (5%) Cost Sharing Limit Report	1.23.1.21 - Cost Sharing Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
97	Fraud, Waste, and Abuse and Whistleblower Protection Policies and Procedures	1.20.1.1 - Administrative and Management Arrangements or Procedures 1.20.2 - Compliance Program 1.20.5 - False Claims Act Policies and Whistleblower Protection	RM	RM
98	Fraud, Waste, or Abuse Written Referral	1.20.1.2 - Referral to OHCA Program Integrity and Accountability Unit and OHCA Office of General Counsel	Within three (3) Business Days of the Contractor's identification of the activity at issue	RM
99	Geo-Access Reports	1.23.1.16 - Provider Network Development Reports	RM	RM
100	Governing Body Report	1.4.6.7 - Changes in Governing Body and Key Staff 1.23.1.8 - Administrative Reports	RM	RM
101	Health Equity Accreditation Verification (NCQA Review)	1.4.2 - Accreditation	Within two (2) years from the Operations Start Date	Maintain throughout the term of the Contract
102	Health Risk Screening Methodology	1.9.2.2 - Methods of Completion	N/A	N/A
103	Health Risk Screening Outreach Attempts Documentation	1.9.2.2 - Methods of Completion 1.23.1.12 - Care Management and Population Health Reports	RM	RM
104	Health Risk Screening Timely Completion Report	1.23.1.12 - Care Management and Population Health Reports	RM	RM
105	Health Risk Screening Tool	1.9.2.1 - Screening Tool	N/A	N/A

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
106	HIPAA-compliant Business Associate Agreement	1.2.16.3.1 - Breach	Upon Request	Upon Request
107	Homeless Enrollee Handbook Distribution Strategies and Policies	1.12.5.2 - Distribution Methods	N/A	N/A
108	Immunization Data	1.23.1.10 - Covered Benefits Reports	RM	RM
109	Incentive Plans to Recruit Behavioral Health Professionals	1.14.3.4 - Behavioral Health Provider Standards	N/A	N/A
110	Information Security Breach Report	1.23.1.23 - Information Technology Reports	RM	RM
111	Innocuous Security Incidents Summary Statement	1.2.16.3 - Obligations of the Contractor 1.21.12 - System Security	Not more than every sixty (60) Days	Upon Request
112	Insolvency Protection Data	1.23.1.24 - Financial Performance Reports	RM	RM
113	Insurance Department Filings	1.22.1 - Financial Stability 1.23.1.24 - Financial Performance Reports	RM	RM
114	Interpretation Services Accessibility Plan	1.12.8.4 - Multilingual Representatives	N/A	N/A
115	Inter-Rater Reliability Report	1.8.4 - Qualified Staff	Upon Request	Upon Request
116	Investigations Opened Documentation	1.23.1.22 - Program Integrity Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
117	IT Changes Notification and Impact Statement	1.21.4 - Ongoing Maintenance of IT Solutions	At least sixty (60) Days in advance of implementation of any planned upgrades	N/A
118	IT Maintenance and Operations Plan	1.21.4 - Ongoing Maintenance of IT Solutions 1.23.1.23 - Information Technology Reports	Readiness Review	RM
119	IT Roadmap	1.21.4 - Ongoing Maintenance of IT Solutions 1.23.1.23 - Information Technology Reports	RM	At minimum twice a year
120	List of All Staff with Access to Identifying Enrollee Data	1.21.12 - System Security	Upon Request	Upon Request
121	List of Audit Activities	1.20.2 - Compliance Program	RM	Monthly and Quarterly
122	List of Authorized Signatories	1.2.5 - Notification of Material Change and Authorized Signatories	Within three (3) Business Days of any change to the Contractor's assigned Contract Officer	N/A
123	Litigation Summary	1.15.6.2 - Provider Appeals	Within fifteen (15) Calendar Days of a Provider's request for an Administrative Appeal	RM
124	Local Oklahoma Provider Organizations (LOPO) Written Notice	1.14.3.9 - Local Oklahoma Provider Organizations (LOPOs)	Within five (5) Business Days after LOPO contract execution	N/A

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
125	Long-Term Services and Support Data	1.23.1.6 - Required Data Collection and Reports	N/A	N/A
126	Managed Care Program Assessment Report	1.14.4 - Network Adequacy Exception Process	RM	RM
127	Marketing Plan	1.12.16.7 - Marketing Plan 1.23.1.15 - Enrollee Services Report	RM	RM
128	Marketing Representative Training	1.12.16.2 - Training Curriculum	Upon Request	Upon Request
129	Material Breach CAP	1.26.3.3 - Corrective Action Plan	TBS	TBS
130	Materials for Enrollment Choice Counseling	1.6.2.2 - Materials for Enrollment Choice Counseling	TBS	TBS
131	Medical Management Committee Reports and Minutes	1.23.1.6 - Required Data Collection and Reports	N/A	N/A
132	Medical Management Program Criteria, Standards, and Protocol	1.8.3 - Medical Management Program Components	Prior to implementation	N/A
133	Medical Management Program Reports	1.8.3 - Medical Management Program Components 1.8.6.5 - Concurrent Review 1.8.6.6 - Retrospective Review 1.23.1.11 - Medical Management Reports	TBS	During Readiness Review, Annually, and at times specified by OHCA

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#	Deliverable Name	Requirement Location(s)	Due Date	Frequency
134	Medical Management Staff Training Plan and Materials	1.8.4 - Qualified Staff	Upon Request	Upon Request
135	Medical Management Staffing Plan	1.8.4 - Qualified Staff	Readiness Review	N/A
136	Medication Assisted Treatment (MAT) Strategies	1.7.1.4 - Medication Assisted Treatment (MAT)	N/A	N/A
137	Mental Health Parity Report	1.7.1.1 - Mental Health Parity	RM	RM
138	MLR AUP Detailed Scope of Work	1.22.5 - Medical Loss Ratio	Upon Request	Upon Request
139	MLR Report	1.2.13 - Record Retention 1.22.65 - Medical Loss Ratio 1.23.1.6 - Required Data Collection and Reports 1.23.1.243 -– Financial Performance Information Technology Reports	Within nine (9) months of the end of the MLR Reporting Year	RM
140	Monthly Social Media Calendar	1.12.7.7 - Social Media and Mobile Applications	RM	RM
141	NCQA-approved Vendor Contract	1.11.5 - Quality Performance Measures	N/A	N/A
142	NEMT Scheduling Policies and Procedures	1.7.7 - Non-Emergency Medical Transportation (NEMT)	N/A	N/A
143	NEMT Utilization Reports	1.23.1.10 - Covered Benefits Reports	RM	RM
144	Network Adequacy Exceptions Report	1.23.1.16 - Provider Network Development Reports	RM	RM

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#	Deliverable Name	Requirement Location(s)	Due Date	Frequency
145	Network Adequacy Report	1.23.1.16 - Provider Network Development Reports	RM	RM
146	New Hire Completed Education and Training Efforts	1.20.2.2	Upon Request	Upon Request
147	Non-material Deficiency Report	1.26.3.2 - Notice and Opportunity to Cure for Nonmaterial Breach	Within five (5) Business Days (or the date specified by OHCA) of receipt of written notice of a non-material deficiency	N/A
148	Offer to OSDH to become Participating Provider	1.14.3.8 - Department of Health	N/A	N/A
149	Out of State Services	1.23.1.11 - Medical Management Reports	RM	RM
150	Overpayments Policies, Policies, Timelines, and Documentation	1.20.11.1 - Treatment of Recoveries Made by Contractor of Overpayments to Providers	Readiness Review	Upon Request
151	Overpayments Report	1.16.2.1 - Overpayments 1.20.1.1 - Administrative and Management Arrangements or Procedures 1.20.6 - Reporting Overpayments 1.23.1.22 - Program Integrity Reports	RM	RM
152	Ownership and Control Disclosures	1.20.9 - Written Disclosures 1.20.9.1 - Required Ownership, Controlling Interest and Managing Employee Disclosures	N/A	N/A

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#	Deliverable Name	Requirement Location(s)	Due Date	Frequency
153	Participating Provider Corrective Action Plan	1.14.5.2.1 - Notification to OHCA of Participating Provider Network Changes	N/A	N/A
154	Participating Provider Enrollment and Disenrollment Data	1.14.6 - Submission of Provider Disenrollment Data to OHCA 1.23.1.6 - Required Data Collection and Reports 1.23.1.16 - Provider Network Development Reports	RM	RM
155	Participating Provider Network Listing	1.13.1.6 - Participating Provider Network Listing	No later than five (5) Business Days before the end of each month	Monthly
156	Participating Provider Policies and Procedures	1.13.1.1.2 - Policies and Procedures	Readiness Review	N/A
157	Participating Provider Training, Education, and Technical Assistance Activities Report	1.15.5 - Provider Education, Training and Technical Assistance	RM	RM
158	Participating Provider Training, Education, and Technical Assistance Plan	1.15.5 - Provider Education, Training and Technical Assistance 1.23.1.17 - Provider Services Reports	RM	RM
159	Payment Cycle for Claims Submission	1.16.4.1 - Claims Processing System and Methodology	N/A	N/A
160	PBM/PBA/Claims Processor Contract	1.7.2.4.3 - Pharmacy Benefit Financial Disclosures	Upon Request	Upon Request
161	PCP Assignment Report	1.23.1.15 - Enrollee Services Report	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
162	PCP Changes Report	1.23.1.15 - Enrollee Services Report	RM	RM
163	Performance Bond or Substitute	1.2.20.10 - Performance Bond or Substitutes	Within ten (10) Days from receipt of notice from OHCA	N/A
164	Performance Data and Reports	1.26.11 - Post-Transition Contract Obligations	Due date following the termination or expiration of the Contract which cover a reporting period prior to termination or expiration	N/A
165	Performance Improvement Projects (PIPs) Proposal	1.11.6 - Performance Improvement Projects	N/A	Annually
166	Pharmacy Benefit Financial Disclosures	1.7.2.4.3 - Pharmacy Benefit Financial Disclosures	RM	RM
167	Pharmacy Benefit Management Services Policies and Procedures	1.7.2.4.1 - General	Readiness Review	N/A
168	Pharmacy Lock-In Plan and Policies	1.7.3 - Lock-In Program	Prior to adoption and implementation	N/A
169	Physician Incentive Plan Report	1.12.15 - Physician Incentive Plan Notification	RM	RM
170	PIPs Status and Results Report	1.11.6 - Performance Improvement Projects 1.23.1.14 - Quality Improvement Reports	RM	No less than annually or as needed
171	Policies and Procedures	1.4.7 - Policies and Procedures	Upon Request	Upon Request

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
172	Pre-Contract Termination or Expiration Encounter Data	1.26.11 - Post-Transition Contract Obligations	N/A	N/A
173	Prior Authorization Report	1.8.6 - Authorization Process 1.23.1.11 - Medical Management Reports	RM	RM
174	Privacy and Security Incidents Reports	1.21.12 - System Security	RM	RM
175	Prohibited Affiliation Disclosures	1.20.9 - Written Disclosures 1.20.10.4 - Written Disclosure	RM	RM
176	Proposed Breach Remediation Plan	1.2.16.3.1 - Breach	Promptly from OHCA's request	Upon Request
177	Provider Agreements	1.14.1.1 - Minimum Content Requirements	Readiness Review	Upon Request
178	Provider Application Denials Report	1.23.1.16 - Provider Network Development Reports	RM	RM
179	Provider Complaints and Appeals Log	1.15.6 - Provider Complaint System 1.15.6.2 - Provider Appeals 1.23.1.6 - Required Data Collection and Reports 1.23.1.17 - Provider Services Reports	RM	At least weekly during implement ation and monthly thereafter
180	Provider Complaints Policies and Procedures	1.15.6 - Provider Complaint System	N/A	N/A
181	Provider Directory	1.12.14.3 - Submission Process and OHCA Approval	At least thirty (30) Days prior to distribution	N/A

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#	Deliverable Name	Requirement Location(s)	Due Date	Frequency
182	Provider Manual	1.15.4.1 - General Provider Manual Requirement	N/A	N/A
183	Provider Network Development and Management Plan	1.13.1.5 - Provider Network Development and Management Plan 1.23.1.16 - Provider Network Development Reports	RM	RM
184	Provider Profiling Report	1.11.8 - Provider Profiling 1.23.1.14 - Quality Improvement Reports	RM	RM
185	Provider Reconsiderations Process	1.15.6.1 - Provider Reconsiderations	N/A	N/A
186	Provider Satisfaction Survey Results	1.11.4.2 - Provider Satisfaction Surveys 1.23.1.6 - Required Data Collection and Reports 1.23.1.14 - Quality Improvement Reports	RM	Annually
187	Provider Services Call Center CAP	1.15.2.2 - Provider Services Call Center Performance Standards	Upon Request	Upon Request
188	Provider Services Call Center Metrics Report	1.15.2.2 - Provider Services Call Center Performance Standards 1.23.1.17 - Provider Services Reports	RM	RM
189	Provider Services Call Center Performance and Improvement Report	1.15.2.2 - Provider Services Call Center Performance Standards	At the end of each Contract Year	Annually
190	Provider Services Call Center Training Report	1.23.1.17 - Provider Services Reports	RM	RM
191	Provider Services Policies and Procedures	1.15.1 - Policies and Procedures	Readiness Review	Upon Request

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
192	Provider Website	1.15.1 - Policies and Procedures	Readiness Review	N/A
193	Provider-Preventable Conditions	1.23.1.18 - Provider Payment Reports	RM	RM
194	Provider's Appeal Tracking Documentation	1.14.5.3 - Participating Provider Contract Termination Appeal Rights	Upon Request	Upon Request
195	Psychotropic Medication Utilization Report	1.7.2.1 - Pharmacy Services	RM	RM
196	QAPI Evaluation of Previous Year's Program	1.11.3.3 - QAPI Documentation	RM	Annually
197	QAPI Outcome Data	1.11.3.1 - QAPI Program	N/A	Quarterly
198	QAPI Program Description and Work Plan	1.11.3.3 - QAPI Documentation 1.23.1.6 - Required Data Collection and Reports 1.23.1.14 - Quality Improvement Reports	RM	RM
199	Quality Improvement Committee Meeting Minutes	1.11.3.2 - Oversight of QAPI Program	During on-site EQRO review or accreditation review	Upon Request
200	Quality Performance Corrective Action Plan (CAP)	1.11.5 - Quality Performance Measures	TBS	Upon Request
201	Quality Performance Measure Report	1.11.5 - Quality Performance Measures 1.23.1.6 - Required Data Collection and Reports 1.23.1.14 - Quality Improvement Reports	RM	Annually

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
202	Quality Rating System Report	1.11.1 - Quality Rating System 1.23.1.14 - Quality Improvement Reports	RM	RM
203	Rate Cell Financial Reports	1.23.1.24 – Financial Performance Reports	RM	RM
204	Rebate Procedures	1.7.2.4.4 - Rebates and Financial Reports	N/A	N/A
205	Referrals for Medically Necessary Care Policies and Procedures	1.7.8 - Referrals	Readiness Review	N/A
206	Request for Compliance Plan Revision	1.20.2.1 - Compliance Plan	Within a minimum of sixty (60) Calendar Days prior to the implementation by the Contractor	RM
207	Request to Combine Functions	1.4.6 - Staffing	Within thirty (30) Days of award	N/A
208	Resume and Job Description	1.4.6.7 - Changes in Governing Body and Key Staff	At least five (5) Days in advance of changes	RM
209	Resuming Operations Plan	1.21.13 - Disaster Preparation and Data Recovery	Upon Request	Upon Request
210	Retrospective DUR Program Outcomes	1.7.2.4.5 - Drug Utilization Review	RM	Quarterly
211	Revised Corrective Action Plan	1.24.3.2 - Contractor Internal Monitoring Methods	Upon Request	Upon Request
212	Risk Stratification Level Framework	1.9 - Care Management and Population Health	N/A	N/A
213	Screening Results	1.9.2.5 - Submission of Screening Results to OHCA	TBS	TBS

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
214	Social Determinants of Health Report	1.9.1 - Social Determinants of Health 1.23.1.10 - Covered Benefits Reports	RM	RM
215	SoonerSelect DUR Program Detailed Report	1.7.2.4.5 - Drug Utilization Review 1.23.1.10 - Covered Benefits Reports	RM	Annually
216	Staff Training Documentation	1.4.6.8 - Staff Training	Upon Request	Upon Request
217	Staffing Plan (Medicaid Management Program)	1.8.4 - Qualified Staff	N/A	N/A
218	Staffing Plan and Implementation Plan	1.4.6.6 - Staffing Plan and Implementation Plan 1.23.1.8 - Administrative Reports	No later than thirty (30) Days after Contract award	RM
219	Stakeholder Satisfaction Strategy and Tool	1.11.4.3 - Stakeholder Satisfaction Surveys	RM	RM
220	State Fair Hearing Report	1.23.1.20 - Grievance and Appeal Reports	RM	RM
221	Subcontract Compliance Report	1.4.3 - Subcontracting 1.23.1.8 - Administrative Reports	RM	RM
222	Subcontracted Services Transition Plan	1.4.3 - Subcontracting	At least thirty (30) Days in advance of any contractual changes in subcontracted services	N/A
223	Subcontracts	1.4.3 - Subcontracting	Within thirty (30) Days of award	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
224	SUD Diagnosis and Treatment Disclosure Policies and Procedures	1.2.16.7 - Confidentiality: Substance Use Disorder (SUD) Diagnosis and Treatment in Compliance with 42 C.F.R Part 2	Readiness Review	N/A
225	Survey Administration and Reporting Proposal	1.11.4.1 - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys	By November 1st of each year	Annually
226	System Performance Reports	1.21.16.6 - System Performance Notification and Reporting 1.23.1.23 - Information Technology Reports	RM	RM
227	System Unavailability Events and Problem Resolution Status Updates Report	1.21.16.6 - System Performance Notification and Reporting 1.23.1.23 - Information Technology Reports	RM	RM
228	Telehealth Policies and Procedures	1.7.22 - Telehealth	N/A	N/A
229	Third-Party Liability Collections Report	1.22.7 - Third-Party Liability	RM	RM
230	Third-Party Liability Procedures	1.22.7.1 - Third-Party Liability Procedures	N/A	N/A
231	Third-Party Payments Reports	1.23.1.24 – Financial Performance Reports	RM	RM
232	Third-Party Subrogation and Recovery	1.22.7.7 - Third-Party Subrogation and Recovery	RM	RM
233	Tobacco Cessation Outreach Plan	1.7.1.5 - Tobacco Cessation Services	N/A	N/A

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
234	Transactions with Parties in Interest Report	1.20.13.1 - Reporting Transactions 1.20.13.2 - Availability of Reports 1.23.1.22 - Program Integrity Reports	RM	RM
235	Transition of Care Policies	1.10.2 - TOC Policies and Procedures	N/A	N/A
236	Transition of Care Reports	1.23.1.13 - Transition of Care (TOC) Reports	RM	RM
237	Transition Plan	1.26.10 - Transition Period Obligations	N/A	N/A
238	Translated Materials and Certificate of Translation	1.12.3.2 - Prior Approval Process	N/A	N/A
239	Tribal Outreach Plan	1.17.1 - Tribal Government Liaison	Readiness Review	N/A
240	Updated Policies and Procedures Certification	1.4.7 - Policies and Procedures	RM	Annually
241	Utilization Reports	1.11.3.3 - QAPI Documentation 1.11.9.2 - Medical/Case Record Audits 1.23.1.11 - Medical Management Reports	RM	RM
242	Value Based Payment (VBP) Plan	1.16.1.12 - Value-Based Payments	RM	Annually
243	Value-Added Benefits Report	1.7.10 - Value-Added Benefits 1.23.1.10 - Covered Benefits Reports	RM	RM
244	Value-Based Provider Payments Report	1.23.1.18 - Provider Payment Reports	RM	RM

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#	**Deliverable Name**	**Requirement Location(s)**	**Due Date**	**Frequency**
245	Waiting Lists	1.14.3.4 - Behavioral Health Provider Standards	Upon Request	Upon Request
246	Website Pages and Content	1.12.7.2 - Website Content	Readiness Review	N/A
247	Website URL	1.21.15 - Accessibility	N/A	N/A

SoonerSelect

Appendix 1G: Covered Benefits

1. Medical and Related Benefits

The Contractor shall furnish all SoonerCare covered medical and related benefits outlined in the table below and in accordance with the State Plan, ABP, and the 1115 demonstration waiver as described in Section 1.7.1.7: "1115 IMD Waiver" of this Contract and/or OHCA rules. Annual benefit limits are tracked on a Contract Year basis.

Service	Children (under 21 years old)	Adults (21 years old and over)
Advanced Practice Registered Nurse (APRN) (317:30-5-375 – 317:30-5-376)	Covered	Covered: Four (4) outpatient visits per month. **ABP:** Limit can be exceeded based on Medical Necessity
Allergy Testing (317:30-5-14.1(a)(4))	Covered	Covered: Limited to sixty (60) tests over three (3) years. **ABP:** Limit can be exceeded based on Medical Necessity
Alternative Treatment for Pain Management (317:30-5 Part 82)	Covered	Physical Therapy when provided in a non-hospital-based setting: a. Initial evaluation covered without PA; b. Twelve (12) Hours per year requires PA Chiropractic services: a. Initial evaluation covered without PA; b. Twelve (12) visits per year requires PA Limits can be exceeded based on Medical Necessity
Ambulance or Emergency Transportation (317:30-5-335 – 317:30-5-337; 317:30-5-339; 317:30-5-344)	Covered	Covered
Ambulatory Surgical Center (317:30-5-565 – 317:30-5-568)	Covered	Covered Reimbursement is outlined in Oklahoma Medicaid State Plan

Service	Children (under 21 years old)	Adults (21 years old and over)
Bariatric Surgery (317:30-5-137 – 317:30-5-137.2; 317:30-5-140 – 317:30-5-141)	Covered upon meeting pre-surgical evaluation and weight loss requirements. PA required	Covered upon meeting pre-surgical evaluation and weight loss requirements; Not Covered for the treatment of obesity alone. PA required
Certified Registered Nurse Anesthetist and Anesthesiologist Assistants (317:30-5-605 – 317:30-5-607; 317:30-5-611; 317:30-5-612 – 317:30-5-615)	Covered	Covered
Chemotherapy (317:30-5-15 and 317:30-5-42.3)	Covered	Covered
Clinic Services (317:30-5-575 – 317:30-5-579)	Covered Some services may require PA	Covered Some services may require PA
Diabetes Education (317:30-5-1082 and 317:30-5-1083)	Covered: a. Ten (10) Hours per first year; b. Two (2) Hours per subsequent year Limits can be exceeded based on Medical Necessity and under EPSDT	Covered: a. Ten (10) Hours per first year; b. Two (2) Hours per subsequent year **ABP:** Limit can be exceeded based on Medical Necessity
Diagnostic Testing Entities (317:30-5-907 – 317:30-5-907.3)	Covered Some services may require PA	Covered Some services may require PA
Donor Human Breast Milk (Effective on or before 11.7.2022) (317:30-5-211.29)	Covered during the first year of life Services require PA	Not Covered
Durable Medical Equipment Supplies and Appliances (317:30-5-210 – 317:30-5-211.7; 317:30-5-211.10 – 317:30-5-211.28; 317:30-5-214; 317:30-5-217 – 317:30-5-218)	Covered Requires prescription by a medical Provider May require PA	Covered Requires prescription by a medical Provider May require PA

Service	Children (under 21 years old)	Adults (21 years old and over)
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Early intervention Services (Including but not limited to: health and immunization history; COVID-19 vaccine counseling; physical exams, various health assessments and counseling; lab and screening tests; and necessary follow-up care.) (317:30-3-65 – 317:30-3-65.12)	Covered Some services may require PA	Not Covered
Emergency Department (317:30-5-42.7)	Covered	Covered
Eye Care to treat a medical or surgical condition (317:30-5-10)	Covered	Covered
Family Planning Services (317:30-5-12)	Covered	Covered
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services (317:30-5-660 – 317:30-5-664.15; 317:30-5-355 – 317:30-5-363)	Covered	Covered
Genetic Counseling and Testing (317:30-5-219 – 317:30-5-223; 317:30-30-5-20; 317:30-5-100 – 317:30-5-106)	Covered for pregnant Enrollees and Enrollees meeting Medical Necessity criteria. May require PA	Covered for pregnant Enrollees and Enrollees meeting Medical Necessity criteria. May require PA
Hearing Services (317:30-5-675 – 317:30-5-678; 317:30-5-680)	Covered May require PA	Not Covered
Home Health Care Services (317:30-5-545 – 317:30-5-548)	Covered	Covered
Hospice Care (317:30-5-530 – 317:30-5-532)	Covered for Enrollees with a life expectancy of six (6) months or less.	Not Covered **ABP:** Covered for Enrollees with a life expectancy of six (6) months or less.
Immunizations as recommended by the Advisory Committee of Immunization Practices (ACIP) (317:30-5-14(a)(1)-(2))	Covered	Covered

Service	Children (under 21 years old)	Adults (21 years old and over)
Infusion Therapy (317:30-5-42.9)	Covered	Covered when Medically Necessary and not considered a compensable part of the procedure.
Inpatient Hospital Services (317:30-5-40 – 317:30-5-41.2; 317:30-5-42.1 – 317:30-5-42.20; 317:30-5-44; 317:30-5-47 – 317:30-5-47.6; 317:30-5-49 – 317:30-5-53; 317:30-5-56– 317:30-5-58; 317:30-5-110 – 317:30-5-114)	Covered	Covered a. Inpatient hospital services (inpatient stay): No limit b. Inpatient Physician Services: Covered c. Inpatient surgical services: No limit d. Inpatient rehab hospital services: Ninety (90) Days per individual per SFY ABP: a. Inpatient hospital services (inpatient stay): No limit b. Inpatient Physician Services: Covered c. Inpatient surgical services: No limit d. Inpatient rehab hospital services: Ninety (90) Days per individual per SFY Amount limits can be exceeded based on Medical Necessity
Laboratory, X-ray, Diagnostic Imaging, Imaging (CT/PET Scans; MRIs) (317:30-5-100 – 317:30-5-106; 317:30-5-24; 317:30-3-31; 317:30-5-42.13)	Covered May require PA	Covered May require PA
Lactation Consultant (317:30-5-230 – 317:30-5-235)	Covered for pregnant and postpartum Enrollees.	Covered for pregnant and postpartum Enrollees.
Lodging and Meals for the Enrollee and/or one (1) approved medical escort (317:30-3-92)	Covered if prior approved	Covered if prior approved
Long-Term Care Hospital for Children (317:30-5-60 – 317:30-5-67)	Covered	Not Covered
Mammograms (317:30-5-900 – 317:30-5-901; 317:30-5-903; 317:30-5-905)	Covered	Covered

Service	Children (under 21 years old)	Adults (21 years old and over)
Maternal and Infant LCSW Services (317:30-5-204 – 317:30-5-209)	Covered for pregnant and postpartum Enrollees.	Covered for pregnant and postpartum Enrollees.
Non-Emergency Medical Transportation (NEMT) (317:30-5-327.1)	Covered	Covered
Nurse Midwives (317:30-5-225 – 317:30-5-226; 317:30-5-229)	Covered under EPSDT	Covered
Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disorder (ICF/IID) Services (317:30-3-42)	Covered by Contractor for up to sixty (60) Days pending the level of care determination.	Covered by Contractor for up to sixty (60) Days pending the level of care determination.
Nutrition Services (Dietician) (317:30-5-1075 – 317:30-5-1076)	Covered	Covered: up to six (6) Hours per year. Nutritional services for treatment of obesity are *not* covered. Services must be expressly for diagnosing, treating, or preventing, or minimizing effects of illness. **ABP**: Limits can be exceeded based on Medical Necessity.
Orthotics (317:30-5-211.13)	Covered	Not Covered **ABP:** Covered without limitations when Medically Necessary.
Outpatient Hospital and Surgery Services (317:30-5-42.1 and 317:30-5-42.14)	Covered	Covered
Parenteral / Enteral Nutrition (317:30-5-211.14)	Covered May require PA	Covered May require PA
Personal Care (317:30-5-950 – 317:30-5-953)	Covered	Covered
Physician and Physician Assistant Services (317:30-5-1 – 317:30-5-4; 317:30-5-6 – 317:30-5-15; 317:30-5-17 – 317:30-5-25; 317:30-5-30 –317:30-5-33)	Covered	Covered: Four (4) outpatient visits per month. **ABP:** Four (4) outpatient visits per month limit can be exceeded based on Medical Necessity.

Service	Children (under 21 years old)	Adults (21 years old and over)
Podiatry (317:30-5-260 – 317:30-5-261)	Covered	Covered
Post-Stabilization Care Services (in accordance with 42 C.F.R. §§ 438.114 and 422.113(c))	Covered	Covered
Pregnancy and Maternity Services, including Prenatal, Delivery, and Postpartum (317:25-7-2, 317:25-7-10, 317:30-5-1, 317:30-5-2, 317:30-5-22, 317:30-5-22.1, 317:30-5-24, 317:30-5-41, 317:30-5-42.13, 317:30-5-226, 317:30-5-229, 317:30-5-356, 317:30-5-361, 317:30-5-664.8, 317:30-5-892, 317:30-5-1076)	Covered	Covered
Prescription Drugs (317:30-5 Part 5; see also Section 1.7.2: "Pharmacy Program" of this Contract)	Covered	Covered: a. Up to six (6) prescriptions per month, including up to two (2) brand name drugs without PA, and b. Up to three (3) brand name drugs with PA (within the six (6) prescription limit).
Preventive Care and Screening (317:30-3-57; 317-30-5-9)	Refer to EPSDT coverage	Covered as outlined in the State Plan pages for Outpatient Hospital Services, Other Laboratory and X-ray Services, Diagnosis and Treatment of Conditions Found, Clinic Services, Screening Services, and Rehabilitative Services. There is **not** a standalone preventive services benefit package for adults providing coverage for all services identified with an A or B rating by the USPSTF.

Service	Children (under 21 years old)	Adults (21 years old and over)
Private Duty Nursing (317:30-5-555 – 317:30-5-560.2)	Covered: Up to sixteen (16) Hours per day, with exceptions made to the sixteen (16) Hour limit for up to thirty (30) Days immediately following Hospitalization or the temporary incapacitation of the primary caregiver.	Not Covered **ABP:** This service is substituted with skilled nursing under the home health services benefit.
Prosthetic Devices (317:30-5-211.13)	Covered when prior authorized	Limited coverage: Only breast prosthesis and support accessories and prosthetic devices inserted during surgery are covered with required PA. **ABP:** Covered without limitations when Medically Necessary.
Public Health Clinic Services (317:30-5-1150 – 317:30-5-1161)	Covered	Covered: Four (4) visits per month **ABP:** Four (4) visits per month limit can be exceeded based on Medical Necessity.
Radiation (317:30-5-42.3)	Covered	Covered
Reconstructive Surgery (317:30-5-216); 317:30-5-8(c))	Covered May require PA	Covered: Non-cosmetic Breast reconstruction / implantation / removal is covered only when it is a direct result of a mastectomy which is Medically Necessary. May require PA
Renal Dialysis Facility Services (317:30-5-305, 317:30-5-306, 317:30-5-307)	Covered	Covered
Routine Patient Cost in Qualifying Clinical Trials (317:30-3-57.1)	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57

Service	Children (under 21 years old)	Adults (21 years old and over)
School-Based Health Related Services (317:30-5-1020 – 317:30-5-1027)	Covered	Not Covered
Telehealth (317:30-3-27)	Covered	Covered
Therapy Services: Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) (317:30-5-290.1 317:30-5-293, 317:30-5-295 –317:30-5-299, 317:30-5-675 –317:30-5-678, 317:30-5-680)	OT and PT: a. Initial evaluation covered without PA; b. Treatment requires PA. ST: a. Evaluation and treatment require PA.	Rehabilitative Services: a. Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty-five (45) visits). **ABP Limit:** Habilitative Services: b. Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty-five (45) visits). Rehabilitative Services: a. Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty-five (45) visits).
Tobacco Cessation Services (317:30-5-2(DD) and 317:30-5-72.1)	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to one hundred eighty (180) Days per twelve (12) months. Tobacco cessation products are covered without duration limits, PA, or Co-payment and do not count against monthly prescription limits. Eight (8) tobacco cessation counseling sessions (99406 – 99407) with contracted Providers per year.	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to one hundred eighty (180) Days per twelve (12) months. Tobacco cessation products are covered without duration limits, PA, or Co-payment and do not count against monthly prescription limits. Eight (8) tobacco cessation counseling sessions (99406 – 99407) with contracted Providers per year.
Transplant Services (317:30-3-57.1 and 317:30-5-41.2)	Covered when prior authorized Cornea and kidney transplants do not require PA.	Covered when prior authorized Cornea and kidney transplants do not require PA.

Service	Children (under 21 years old)	Adults (21 years old and over)
Urgent Care Centers / Facilities (317:30-5-42.4)	Covered	Covered: Up to four (4) outpatient visits per month **ABP:** Four (4) outpatient visits per month limit can be exceeded based on Medical Necessity.
Vision Services (317:30- 3-65.7 and 317:30-5-641)	Covered under EPSDT with a limit of two (2) eyeglass frames per year.	**Adults over 21 and ABP:** Coverage to treat a medical or surgical condition only; no coverage for routine eye exams.

2. Behavioral Health Benefits

In addition to the requirements and benefits in Section 1: "Medical and Related Services" in this Appendix, the Contractor shall furnish all SoonerCare covered behavioral health benefits as outlined in the table below and in accordance with the State Plan, ABP, and the 1115 demonstration waiver as described in Section 1.7.1.7: "1115 IMD Waiver" of this Contract and/or OHCA rules.

Service	Children (under 21 years old)	Adults (21 years old and over)
Applied Behavioral Analysis (317:30-5-310 – 317:30-5-316)	Covered when prior authorized	Not Covered
Certified Community Behavioral Health (CCBH) Services (317:30-5-263 - 317:30-5-268)	Covered	Covered
Day Treatment Services (317:30-5-241.2(f))	Covered when prior authorized for a minimum of three (3) Hours per day for four (4) Days per week.	Not Covered
Inpatient Hospital – Freestanding Psychiatric (317:30-5-95, 317:30-5-95.1; 317:30-5-95.4 - 317:30-5-95.50, 317:30-5-96.2 - 317:30-5-97)	Covered when prior authorized	Ages 21-64: Covered when prior authorized in accordance with the 1115 IMD waiver for a maximum of 60 Days per episode. Ages 65 and older: Covered when prior authorized
Inpatient Hospital – General Acute (317:30-5-95, 317:30-5-95.1; 317:30-5-41.1; 317:30-5-95.4 - 317:30-5-95.5, 317:30-5-96.2 - 317:30-5-97;)	Covered when prior authorized	Covered when prior authorized
Licensed Behavioral Health Provider (who can bill independently) (317:30-5-280 – 317:30-5-283)	Covered when prior authorized	Not Covered
Medication Assisted Treatment (Suboxone® (buprenorphine/ naloxone SL films), Vivitrol, Methadone) (317:30-5-241.7; 317:30-3-5; 317:30-5-72; 317:30-5-1094)	Covered	Covered
Opioid Treatment Programs (317:30-5-241.7; 317:30-3-5; 317:30-5-72; 317:30-5-1094)	Covered when prior authorized	Covered when prior authorized

Service	Children (under 21 years old)	Adults (21 years old and over)
Outpatient Behavioral Health Agency Services (317:30-5-240 – 317:30-5-241.6; 317:30-5-244 – 317:30-5-245; 317:30-5-248 – 317:30-5-249)	Covered when prior authorized	Covered when prior authorized
Partial Hospitalization (317:30-5-241.2(e))	Covered when prior authorized for a minimum of three (3) Hours per day for five (5) Days per week.	Covered when prior authorized for a minimum of three (3) Hours per day for five (5) Days per week.
Peer Recovery Support Services (317:30-5-241.5(d))	Covered for ages sixteen (16) and through twenty-one (21) when prior authorized.	Covered when prior authorized
Program for Assertive Community Treatment (PACT) Services in accordance with OAC 450:55 (317:30-5-241.5(a))	Covered for ages eighteen (18) through twenty-one (21).	Covered
Therapeutic Behavioral Services, Family Support and Training (317:30-5-241.5(b-c))	Covered for Children with SED in a systems of care wraparound team.	Not Covered
Psychiatric Residential Treatment Facility (317:30-5-95.29 - 317:30-5-95.42; 317:30-5-96.2 - 317:30-5-97)	Covered when prior authorized	Not Covered
Psychiatrist (317: 30-5-1; 317:30-5-11)	Covered	Covered
Psychologist (who can bill independently) (317:30-5-275 – 317:30-5-276, 317:30-5-278 – 317:30-5-278.1)	Covered when prior authorized	Covered when prior authorized
Substance Abuse Treatment (Outpatient, Inpatient, and Residential) (317:30-5-95.27 – 317:30-5-95.28)	Outpatient substance abuse treatment: Covered when prior authorized. Residential substance abuse treatment: Covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver.	Outpatient substance abuse treatment: Covered when prior authorized. Residential substance abuse treatment: Covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver.

Service	Children (under 21 years old)	Adults (21 years old and over)
Targeted Case Management (317:30-5-241.6)	Covered for targeted populations when prior authorized	Covered for targeted populations when prior authorized
Therapeutic Foster Care (317:30-5-110 - 317:30-5-114)	Covered when prior authorized	Not Covered

Appendix 1H: Provider Types and Specialties

For the following Provider types and specialties, the Contractor shall utilize the same respective identifiers established by OHCA to ensure appropriate data interfaces with OHCA.

	Type		Specialty
1	Hospital	10	Acute Care
1	Hospital	11	Psychiatric
1	Hospital	12	Rehabilitation
1	Hospital	13	Residential Treatment Center
1	Hospital	14	Critical Access
1	Hospital	15	Children's Rehab Specialty
1	Hospital	16	ITU Hospital
1	Hospital	17	Partial Hospitalization
1	Hospital	18	Freestanding ER Department
1	Hospital	201	Hospital Based Urgent Care
1	Hospital	204	Hospital Based Psych Level II
1	Hospital	205	Hospital Based Psych
1	Hospital	206	Hospital Based Rehab
2	Ambulatory Surgical Center	20	Ambulatory Surgical Center
2	Ambulatory Surgical Center	21	Dental Ambulatory Surgical Center
2	Ambulatory Surgical Center	22	ITU Ambulatory Surgical Center
3	Extended Care Facility	30	Nursing Facility
3	Extended Care Facility	31	ICF/IID > 6 Beds
3	Extended Care Facility	32	Pediatric Nursing Facility
3	Extended Care Facility	33	Residential Care Facility
3	Extended Care Facility	34	ICF/IID < 6 Beds
3	Extended Care Facility	35	Skilled Nursing Facility
3	Extended Care Facility	36	Respite Care - Facility Based
3	Extended Care Facility	37	Assisted Living
4	Rehabilitation Facility	40	Rehabilitation Facility
5	Home Health Agency	50	Home Health Agency
5	Home Health Agency	51	Specialized Home Nursing Services
5	Home Health Agency	52	ITU Home Health Agency
5	Home Health Agency	210	Care Coordinator for Pregnant Women
5	Home Health Agency	211	HIV Case Manager
6	Hospice	60	Hospice
7	Capitation Provider	72	ITU PCP/CM
7	Capitation Provider	74	PACE
7	Capitation Provider	75	Health Access Network
8	Clinic	80	Federally Qualified Health Clinic (FQHC)
8	Clinic	81	Rural Health Clinic (RHC)

	Type		Specialty
8	Clinic	82	Group
8	Clinic	83	Family Planning Clinic
8	Clinic	84	ITU Outpatient Clinic
8	Clinic	85	EPSDT Clinic
8	Clinic	86	Dental Clinic
8	Clinic	87	OT/PT/ST/RT Group
8	Clinic	88	Pediatric Clinic
8	Clinic	89	Tuberculosis Clinic
8	Clinic	106	ITU Inpatient Services
8	Clinic	107	Applied Behavior Analysis Group
8	Clinic	108	Mobile and Portable Dental Treatment
8	Clinic	181	Maternity
8	Clinic	182	Speech/Hearing Clinic
8	Clinic	183	Early Intervention Services
8	Clinic	184	Hospital Based Rural Health Clinic
8	Clinic	185	Free Standing Rural Health Clinic
8	Clinic	186	Podiatry Group
8	Clinic	187	Chiropractic Group
8	Clinic	188	Optometry Group
8	Clinic	189	Audiology Group
8	Clinic	191	Psychiatry Group
8	Clinic	192	Radiology Group
8	Clinic	193	Behavioral Health Group
8	Clinic	194	Urgent Care
8	Clinic	195	Oncology Clinic
8	Clinic	196	Ophthalmology
8	Clinic	197	Emergency Medicine Group
8	Clinic	198	Anesthesia/Pain Management Group
8	Clinic	199	OB/GYN Group
8	Clinic	202	Laboratory Group
8	Clinic	203	Diagnostic Sleep Study Clinic
8	Clinic	208	Diabetes Self-Management Training Group
8	Clinic	801	Hospital-Based Outpatient ITU Clinic
8	Clinic	802	Outpatient ITU Clinic/FQHC
9	Advance Practice Nurse	90	Pediatric Nurse Practitioner
9	Advance Practice Nurse	91	Obstetric Nurse Practitioner
9	Advance Practice Nurse	92	Clinical Nurse Specialist
9	Advance Practice Nurse	93	Certified Nurse Practitioner
9	Advance Practice Nurse	94	Certified Registered Nurse Anesthetist (CRNA)
9	Advance Practice Nurse	95	Certified Nurse Midwife
9	Advance Practice Nurse	96	CNP Allergist

	Type		Specialty
9	Advance Practice Nurse	210	Care Coordinator for Pregnant Women
9	Advance Practice Nurse	211	HIV Case Manager
10	Mid-Level Practitioner	100	Physician Assistant
10	Mid-Level Practitioner	101	Anesthesiology Assistant
10	Mid-Level Practitioner	102	PA Allergist
10	Mid-Level Practitioner	564	Eligible Primary Care Provider
11	Behavioral Health Provider	17	Partial Hospitalization
11	Behavioral Health Provider	100	Physician Assistant
11	Behavioral Health Provider	110	Outpatient Mental Health Clinic
11	Behavioral Health Provider	111	Community Mental Health Center (CMHC)
11	Behavioral Health Provider	112	Psychologist
11	Behavioral Health Provider	113	PASRR CMHC
11	Behavioral Health Provider	114	PACT
11	Behavioral Health Provider	115	Licensed Clinical Social Worker
11	Behavioral Health Provider	116	Family Counseling
11	Behavioral Health Provider	119	Family Training
11	Behavioral Health Provider	121	Licensed Professional Counselor
11	Behavioral Health Provider	122	Day Treatment
11	Behavioral Health Provider	123	Para Professional
11	Behavioral Health Provider	125	Health Home
11	Behavioral Health Provider	127	Certified Behavioral Health Clinic
11	Behavioral Health Provider	134	SUD Residential
11	Behavioral Health Provider	135	OP SUD
11	Behavioral Health Provider	136	OTP
11	Behavioral Health Provider	137	CCARC
11	Behavioral Health Provider	138	CBSCC
11	Behavioral Health Provider	139	Halfway House
11	Behavioral Health Provider	141	Medically Supervised Withdrawal Management
11	Behavioral Health Provider	160	Registered Nurse (RN)
11	Behavioral Health Provider	210	Care Coordinator for Pregnant Women
11	Behavioral Health Provider	211	HIV Case Manager
11	Behavioral Health Provider	533	Behavioral Health Rehab Specialist (bachelor level)
11	Behavioral Health Provider	534	Alcohol and Other Drug Treatment Professional
11	Behavioral Health Provider	535	Licensed Behavioral Practitioner
11	Behavioral Health Provider	585	Licensed Marital and Family Therapist
11	Behavioral Health Provider	586	Licensed Alcohol and Drug Counselor
12	School Corporation	120	School Corporation
12	School Corporation	126	School Based Para Professional
13	Public Health Agency	83	Family Planning Clinic
13	Public Health Agency	85	EPSDT Clinic

	Type		Specialty
13	Public Health Agency	86	Dental Clinic
13	Public Health Agency	88	Pediatric Clinic
13	Public Health Agency	89	Tuberculosis Clinic
13	Public Health Agency	114	PACT
13	Public Health Agency	116	Family Counseling
13	Public Health Agency	130	County Health Department
13	Public Health Agency	131	Children First
13	Public Health Agency	132	City/County Health Department
13	Public Health Agency	133	Community Health
13	Public Health Agency	181	Maternity
13	Public Health Agency	183	Early Intervention Services
13	Public Health Agency	281	County Health Department Lab
14	Podiatrist	140	Podiatrist
15	Chiropractor	150	Chiropractor
16	Nurse	161	Licensed Practical Nurse (LPN)
16	Nurse	162	Registered Nurse
16	Nurse	163	Skilled Nursing Agency
16	Nurse	164	Public Health Nurse
16	Nurse	210	Care Coordinator for Pregnant Women
16	Nurse	211	HIV Case Manager
29	Mobile X-Ray/IDTF	290	Independent Diagnostics Testing Facility
17	Therapist	145	Speech/Hearing Therapy Fellow
17	Therapist	170	Physical Therapist
17	Therapist	171	Occupational Therapist
17	Therapist	172	Respiratory Therapist
17	Therapist	173	Speech/Hearing Therapist
17	Therapist	174	Occupational Therapy Assistant
17	Therapist	175	Physical Therapy Assistant
17	Therapist	176	Board Certified Behavior Analyst
17	Therapist	177	Board Certified Assistant Behavior Analyst
17	Therapist	178	Registered Behavior Technician
17	Therapist	179	Speech/Hearing Therapy Assistant
18	Optometrist	180	Optometrist
19	Optician	190	Optician
19	Optician	207	ITU Optician
20	Audiologist	200	Audiologist
21	Case Manager (Targeted)	210	Care Coordinator for Pregnant Women
21	Case Manager (Targeted)	211	HIV Case Manager
21	Case Manager (Targeted)	213	E.I. Case Management
21	Case Manager (Targeted)	214	High Risk Pregnant Women
21	Case Manager (Targeted)	215	TB Case Management

	Type		Specialty
21	Case Manager (Targeted)	216	OJA Targeted Case Management
21	Case Manager (Targeted)	217	Child Welfare Targeted Case Management
21	Case Manager (Targeted)	218	DDSD/ICFMR Waiver
21	Case Manager (Targeted)	219	TCM 1st Time Mothers/Infants
21	Case Manager (Targeted)	221	MH Case Management All Ages
21	Case Manager (Targeted)	228	Case Management Agency
22	Hearing Aid Dealer	220	Hearing Aid Dealer
23	Nutritionist	230	Nutritionist
23	Nutritionist	211	HIV Case Manager
23	Nutritionist	210	Care Coordinator for Pregnant Women
24	Pharmacy	240	Pharmacy
24	Pharmacy	241	ITU Pharmacy
24	Pharmacy	250	DME/Medical Supply Dealer
25	DME/Medical Supply Dealer	220	Hearing Aid Dealer
25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer
25	DME/Medical Supply Dealer	251	Assistive Technology
25	DME/Medical Supply Dealer	252	Complex Rehab Technology Supplier
25	DME/Medical Supply Dealer	253	ITU DME/Medical Supply Dealer
25	DME/Medical Supply Dealer	277	Prosthodontist
26	Transportation Provider	260	Ambulance
26	Transportation Provider	261	Air Ambulance
26	Transportation Provider	262	Bus
26	Transportation Provider	263	Public Transportation
26	Transportation Provider	264	Common Carrier (Ambulatory)
26	Transportation Provider	265	Common Carrier (Non-ambulatory)
26	Transportation Provider	266	Family or Individual
26	Transportation Provider	267	Provider Agency
26	Transportation Provider	268	ITU Ambulance
27	Dentist	270	Endodontist
27	Dentist	271	General Dentistry Practitioner
27	Dentist	272	Oral Surgeon
27	Dentist	273	Orthodontist
27	Dentist	274	Pediatric Dentist
27	Dentist	275	Periodontist
27	Dentist	276	Oral Pathologist
27	Dentist	277	Prosthodontist
28	Laboratory	280	Independent Lab
28	Laboratory	281	County Health Department Lab
29	Mobile X-Ray/IDTF	291	Mobile X-Ray
29	Mobile X-Ray/IDTF	292	Mammography
30	End-Stage Renal Disease (RSD) Clinic	300	Free-standing Renal Dialysis Clinic

	Type		Specialty
31	Physician	150	Chiropractor
31	Physician	272	Oral Surgeon
31	Physician	310	Allergist
31	Physician	311	Anesthesiologist
31	Physician	312	Cardiologist
31	Physician	313	Cardiovascular Surgeon
31	Physician	314	Dermatologist
31	Physician	315	Emergency Medicine Practitioner
31	Physician	316	Family Practitioner
31	Physician	317	Gastroenterologist
31	Physician	318	General Practitioner
31	Physician	319	General Surgeon
31	Physician	320	Geriatric Practitioner
31	Physician	321	Hand Surgeon
31	Physician	322	Internist
31	Physician	323	Neonatologist
31	Physician	324	Nephrologist
31	Physician	325	Neurological Surgeon
31	Physician	326	Neurologist
31	Physician	327	Nuclear Medicine Practitioner
31	Physician	328	Obstetrician/Gynecologist
31	Physician	329	Oncologist
31	Physician	330	Ophthalmologist
31	Physician	331	Orthopedic Surgeon
31	Physician	332	Otologist, Laryngologist, Rhinologist
31	Physician	333	Pathologist
31	Physician	334	Pediatric Surgeon
31	Physician	335	Maternal Fetal Medicine
31	Physician	336	Physical Medicine and Rehabilitation Practitioner
31	Physician	337	Plastic Surgeon
31	Physician	338	Proctologist
31	Physician	339	Psychiatrist
31	Physician	340	Pulmonary Disease Specialist
31	Physician	341	Radiologist
31	Physician	342	Thoracic Surgeon
31	Physician	343	Urologist
31	Physician	344	General Internist
31	Physician	345	General Pediatrician
31	Physician	346	Dispensing Physician
31	Physician	347	Radiation Oncologist

	Type		Specialty
31	Physician	348	Abdominal Surgery
31	Physician	349	Adolescent Medicine
31	Physician	350	Critical Care
31	Physician	351	Diabetes
31	Physician	352	Endocrinology
31	Physician	353	Geriatric Psychiatry
31	Physician	354	Gynecological Oncology
31	Physician	355	Hematology
31	Physician	356	Hematology Oncology
31	Physician	357	Immunology
31	Physician	358	Infectious Diseases
31	Physician	359	Internal Medicine Pediatrics
31	Physician	520	Laryngology
31	Physician	521	Maxillofacial Surgery
31	Physician	522	Musculoskeletal Oncology
31	Physician	523	Neurology Child
31	Physician	524	Occupational Medicine
31	Physician	525	Pain Medicine
31	Physician	526	Pediatric Critical Care Medicine
31	Physician	527	Pediatric Emergency Med (Pediatrics)
31	Physician	528	Pediatric Endocrinology
31	Physician	529	Pediatric Gastroenterology
31	Physician	540	Pediatric Hematology Oncology
31	Physician	541	Pediatric Infectious Disease
31	Physician	542	Pediatric Nephrology
31	Physician	543	Pediatric Ophthalmology
31	Physician	544	Pediatric Orthopedics
31	Physician	545	Pediatric Otolaryngology
31	Physician	546	Pediatric Pathology
31	Physician	547	Pediatric Pulmonology
31	Physician	548	Pediatric Rheumatology
31	Physician	549	Pediatric Allergy
31	Physician	550	Pediatric Cardiology
31	Physician	551	Pediatric Surgery (Neurology)
31	Physician	552	Pediatric Urology
31	Physician	553	Psychiatry Child
31	Physician	554	Pulmonary Diseases
31	Physician	555	Rheumatology
31	Physician	556	Rhinology
31	Physician	557	Sports Medicine
31	Physician	558	Surgery Colon and Rectal

	Type		Specialty
31	Physician	559	Surgery Head and Neck
31	Physician	560	Surgery Pediatric
31	Physician	561	Surgery Traumatic
31	Physician	562	Transplant Surgery
31	Physician	563	Neonatal Perinatal Medicine
31	Physician	564	Eligible Primary Care Provider
31	Physician	565	Sleep Medicine
31	Physician	566	Medical Resident In Training
31	Physician	568	Family Practice Obstetrics
31	Physician	569	Addiction Medicine
31	Physician	592	Developmental - Behavioral Health Pediatrics
36	Personal Care Services	360	Personal Care - Individual
36	Personal Care Services	361	Personal Care - Agency
36	Personal Care Services	362	Self-Directed Support and Services
36	Personal Care Services	363	Adv. Personal Restorative Care-Agency
36	Personal Care Services	364	Adv. Personal Restorative Care-Consumer Directed
36	Personal Care Services	365	Assisted Living
37	Room and Board	370	Room and Board
38	Respite Care	380	Respite Care - Community Based
38	Respite Care	381	Respite Care - Home Based
38	Respite Care	382	Respite Care - Consumer Directed
39	Direct Support Services	390	Habilitation Training Specialist
39	Direct Support Services	391	Agency Companion
39	Direct Support Services	392	Daily Living Supports
39	Direct Support Services	393	Independent Living Skills
40	Specialized Foster Care/MR	400	Specialized Foster Care/MR
41	Adult Day Care	410	Adult Day Care
42	Employee Training Specialist	420	Employee Training Specialist
43	Homemaker Services	430	Homemaker Services
44	Architectural Modification	440	Architectural Modification
45	Foster Care Agency	450	RBMS Room and Board
45	Foster Care Agency	452	Intensive Treatment Family Care
45	Foster Care Agency	451	RBMS Therapeutic Foster Care
46	Advantage Home Delivered Meal	460	Advantage Home Delivered Meal
47	Free Standing Birthing Center	470	Free Standing Birthing Center
49	DDSD-Supportive Living Arrangements	493	DDSD-Supportive Living Arrangements
50	Group Home	500	Waiver Group Home
51	Advantage Comprehensive Health Care	510	Advantage Comprehensive Health Care

	Type		Specialty
52	State Employed Physicians	310	Allergist
52	State Employed Physicians	311	Anesthesiologist
52	State Employed Physicians	312	Cardiologist
52	State Employed Physicians	313	Cardiovascular Surgeon
52	State Employed Physicians	314	Dermatologist
52	State Employed Physicians	315	Emergency Medicine Practitioner
52	State Employed Physicians	316	Family Practitioner
52	State Employed Physicians	317	Gastroenterologist
52	State Employed Physicians	318	General Practitioner
52	State Employed Physicians	319	General Surgeon
52	State Employed Physicians	320	Geriatric Practitioner
52	State Employed Physicians	321	Hand Surgeon
52	State Employed Physicians	322	Internist
52	State Employed Physicians	323	Neonatologist
52	State Employed Physicians	324	Nephrologist
52	State Employed Physicians	325	Neurological Surgeon
52	State Employed Physicians	326	Neurologist
52	State Employed Physicians	327	Nuclear Medicine Practitioner
52	State Employed Physicians	328	Obstetrician/Gynecologist
52	State Employed Physicians	329	Oncologist
52	State Employed Physicians	330	Ophthalmologist
52	State Employed Physicians	331	Orthopedic Surgeon
52	State Employed Physicians	332	Otologist, Laryngologist, Rhinologist
52	State Employed Physicians	333	Pathologist
52	State Employed Physicians	334	Pediatric Surgeon
52	State Employed Physicians	335	Maternal Fetal Medicine
52	State Employed Physicians	336	Physical Medicine and Rehabilitation Practitioner
52	State Employed Physicians	337	Plastic Surgeon
52	State Employed Physicians	338	Proctologist
52	State Employed Physicians	339	Psychiatrist
52	State Employed Physicians	340	Pulmonary Disease Specialist
52	State Employed Physicians	341	Radiologist
52	State Employed Physicians	342	Thoracic Surgeon
52	State Employed Physicians	343	Urologist
52	State Employed Physicians	344	General Internist
52	State Employed Physicians	345	General Pediatrician
52	State Employed Physicians	346	Dispensing Physician
52	State Employed Physicians	347	Radiation Oncologist
52	State Employed Physicians	348	Abdominal Surgery
52	State Employed Physicians	349	Adolescent Medicine

	Type		Specialty
52	State Employed Physicians	350	Critical Care
52	State Employed Physicians	351	Diabetes
52	State Employed Physicians	352	Endocrinology
52	State Employed Physicians	353	Geriatric Psychiatry
52	State Employed Physicians	354	Gynecological Oncology
52	State Employed Physicians	355	Hematology
52	State Employed Physicians	356	Hematology Oncology
52	State Employed Physicians	357	Immunology
52	State Employed Physicians	358	Infectious Diseases
52	State Employed Physicians	359	Internal Medicine Pediatrics
52	State Employed Physicians	520	Laryngology
52	State Employed Physicians	521	Maxillofacial Surgery
52	State Employed Physicians	522	Musculoskeletal Oncology
52	State Employed Physicians	523	Neurology Child
52	State Employed Physicians	524	Occupational Medicine
52	State Employed Physicians	525	Pain Medicine
52	State Employed Physicians	526	Pediatric Critical Care Medicine
52	State Employed Physicians	527	Pediatric Emergency Med (Pediatrics)
52	State Employed Physicians	528	Pediatric Endocrinology
52	State Employed Physicians	529	Pediatric Gastroenterology
52	State Employed Physicians	540	Pediatric Hematology Oncology
52	State Employed Physicians	541	Pediatric Infectious Disease
52	State Employed Physicians	542	Pediatric Nephrology
52	State Employed Physicians	543	Pediatric Ophthalmology
52	State Employed Physicians	544	Pediatric Orthopedics
52	State Employed Physicians	545	Pediatric Otolaryngology
52	State Employed Physicians	546	Pediatric Pathology
52	State Employed Physicians	547	Pediatric Pulmonology
52	State Employed Physicians	548	Pediatric Rheumatology
52	State Employed Physicians	549	Pediatric Allergy
52	State Employed Physicians	550	Pediatric Cardiology
52	State Employed Physicians	551	Pediatric Surgery (Neurology)
52	State Employed Physicians	552	Pediatric Urology
52	State Employed Physicians	553	Psychiatry Child
52	State Employed Physicians	554	Pulmonary Diseases
52	State Employed Physicians	555	Rheumatology
52	State Employed Physicians	556	Rhinology
52	State Employed Physicians	557	Sports Medicine
52	State Employed Physicians	558	Surgery Colon and Rectal
52	State Employed Physicians	559	Surgery Head and Neck
52	State Employed Physicians	560	Surgery Pediatric

	Type		Specialty
52	State Employed Physicians	561	Surgery Traumatic
52	State Employed Physicians	562	Transplant Surgery
52	State Employed Physicians	563	Neonatal Perinatal Medicine
52	State Employed Physicians	564	Eligible Primary Care Provider
52	State Employed Physicians	565	Sleep Medicine
52	State Employed Physicians	568	Family Practice Obstetrics
52	State Employed Physicians	569	Addiction Medicine
52	State Employed Physicians	592	Developmental - Behavioral Health Pediatrics
53	Licensed Behavioral Health Practitioner	93	Certified Nurse Practitioner
53	Licensed Behavioral Health Practitioner	100	Physician Assistant
53	Licensed Behavioral Health Practitioner	112	Psychologist
53	Licensed Behavioral Health Practitioner	115	Licensed Clinical Social Worker
53	Licensed Behavioral Health Practitioner	119	Family Training
53	Licensed Behavioral Health Practitioner	121	Licensed Professional Counselor
53	Licensed Behavioral Health Practitioner	160	Registered Nurse (RN)
53	Licensed Behavioral Health Practitioner	530	Outpatient Substance Use
53	Licensed Behavioral Health Practitioner	531	CMHC Substance Use
53	Licensed Behavioral Health Practitioner	532	Substance Use - DMHSAS
53	Licensed Behavioral Health Practitioner	533	Behavioral Health Rehab Specialist (bachelor level)
53	Licensed Behavioral Health Practitioner	534	Alcohol and Other Drug Treatment Professional
53	Licensed Behavioral Health Practitioner	535	Licensed Behavioral Practitioner
53	Licensed Behavioral Health Practitioner	536	Under Supervision
53	Licensed Behavioral Health Practitioner	585	Licensed Marital and Family Therapist
53	Licensed Behavioral Health Practitioner	586	Licensed Alcohol and Drug Counselor
56	Diabetic Educator	567	Diabetic Educator
57	Other Service Provider	570	Genetic Counselor
57	Other Service Provider	571	Lactation Consultant
57	Other Service Provider	572	Maternal/Child Health LCSW

	Type		Specialty
58	Community Transition Services	580	Community Transition Services
58	Community Transition Services	581	Living Choice Transition Coordinator
60	Anesthesiologist Assistant	101	Anesthesiology Assistant
62	Free-standing Ambulatory Clinic	620	Free-Standing Ambulatory Clinic
63	Inpatient Psychiatric Facility	630	Psychiatric Residential Treatment Facility
63	Inpatient Psychiatric Facility	633	Children's Psychiatric Specialty
63	Inpatient Psychiatric Facility	634	Psychiatric Hospital
63	Inpatient Psychiatric Facility	635	Acute Psych Level II