The Oklahoma Health Care Authority

SoonerHealth+ Program

Request for Proposals

Solicitation Number 8070000933

Issued November 30, 2016

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Section 1 – Introduction and Solicitation Overview

1.1 Background and Principles

1.1.1 SoonerCare Program Background

SoonerCare is the State of Oklahoma's Medicaid program. The Oklahoma Health Care Authority (OHCA) is the single state agency responsible for administration of the Medicaid program.

SoonerCare operates under the authority of a Section 1115 research and demonstration waiver from the federal government originally granted in 1996. At the time of the program's implementation, the OHCA enrolled AFDC (TANF) and related Medicaid beneficiaries into two managed care models – SoonerCare Plus and SoonerCare Choice. Beneficiaries residing in the metropolitan areas of Oklahoma City, Tulsa and Lawton were enrolled into fully-capitated SoonerCare Plus health plans. Beneficiaries residing in the remainder of the State were enrolled in the SoonerCare Choice primary care case management (PCCM) model under which participating providers received a monthly capitation payment for office visits and office-based lab and X-ray services while other care continued to be reimbursed on a fee-for-service basis.

In 1999, both managed care models were expanded to include the Medicaid-only Aged, Blind and Disabled (ABD) population. Residents of long term care facilities, members served in a Home- and Community-Based Services (HCBS) waiver, members with private Health Maintenance Organization (HMO) coverage and children in State or tribal custody were excluded from managed care.

In 2002 and 2003, a number of the health plans participating in SoonerCare Plus exited the program. In 2004, the OHCA discontinued SoonerCare Plus and expanded the SoonerCare Choice program statewide. In 2009, the OHCA transitioned the SoonerCare Choice payment model from partial capitation to a monthly case management fee coupled with fee-for-service reimbursement for office visits.

The SoonerCare Choice program has continued to evolve in recent years through introduction of initiatives directed at the OHCA's overarching goals of providing accessible, high quality and cost effective care to the Oklahoma Medicaid population. Several of these initiatives have been implemented in partnership with vendors and Oklahoma providers.

In 2008, the OHCA implemented the SoonerCare "Health Management Program," (HMP) a holistic person-centered care management program for members with chronic conditions who have been identified as being at high risk for both adverse outcomes and increased

health care expenditures. The SoonerCare HMP is administered by a private vendor responsible for undertaking practice facilitation at participating provider sites and offering practice-based and telephonic health coaching to enrolled members. The program emphasizes development of member self-management skills and provider adherence to evidence-based guidelines and best practices.

In 2009, the OHCA introduced the "patient centered medical home" model (PCMH), under which members are aligned with a primary care provider responsible for meeting strict access and quality of care standards. PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet. The OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers also can earn "SoonerExcel" quality incentives for meeting performance targets, such as for preventive care, member use of the Emergency Room (ER) and prescribing of generic drugs.

In 2010, the OHCA expanded upon the PCMH model by contracting with three "health access network" (HAN) provider systems. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers. There are currently 10,665 ABD members receiving care coordination through the HANs.

In addition to these vendor- and provider-based initiatives, the OHCA operates a Population Care Management (PCM) Unit to coordinate the needs of SoonerCare members with complex medical needs. The goals of the PCM Unit are to achieve better health care, better health and reduced costs by facilitating and coordinating the delivery of quality health care to SoonerCare members. The PCM Unit houses a Chronic Care Management Unit and Case Management Unit. (The PCM also oversees the Health Management Program vendor.)

Nurses in the Chronic Care Management Unit (CCMU), called Exceptional Needs Coordinators (ENCs), provide telephonic case management to targeted members with conditions who are not in a practice with an HMP health coach. The Case Management Unit (CMU) provides episodic or event-based case management services and certain supportive eligibility determinations and utilization management functions to other areas of the OHCA.

In December 2015, there were 2,465 ABD members receiving care management through the HMP, 215 through the CCMU and 367 through the CMU. ABD members will discontinue receiving services through these initiatives when enrolled in the SoonerHealth+ Program. The SoonerCare Choice program and the OHCA care management initiatives will continue to operate for populations not enrolling in the SoonerHealth+ Program.

In February 2015, the OHCA in collaboration with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) implemented a new service delivery model of integrated care called Health Homes for Oklahomans with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). The Health Homes are person-centered systems of care that seek to achieve improved outcomes and better services and value for members with complex needs. Health Homes provide coordinated primary and behavioral health integration. The six core services provided by Health Homes are:

- Comprehensive care management
- Care coordination
- Health promotion
- Transitions of care
- Individual and family support
- Referral to community and social support services.

At the end of October 2016, 6,276 adults and 5,152 children were actively enrolled in Health Homes. Twenty-two Health Home providers are contracted, with 130 locations available to serve members statewide.

Notwithstanding the OHCA's activities on behalf of SoonerCare members over the past decade, health outcomes in Oklahoma overall remain poor. The state ranked 50th in a Commonwealth Fund Scorecard on State Health System Performance in 2015, in part due to limited access to primary care and high rates of hospitalizations for ambulatory care-sensitive conditions. Oklahoma also has high rates of chronic diseases such as diabetes and hypertension, contributing to the state's mortality rate, which is the fourth highest in the nation[1].

1.1.2 SoonerHealth+ Program

In 2015, the Oklahoma Legislature enacted, and the Governor signed, HB 1566, which states: "*The Oklahoma Health Care Authority shall initiate requests for proposals for care coordination models for aged, blind and disabled persons. Care coordination models for members receiving institutional care shall be phased in two (2) years after the initial enrollment period of a care coordination program.*"

The OHCA conducted outreach to program stakeholders in the summer and fall of 2015, to determine the most appropriate care coordination model for Oklahoma's ABD SoonerCare members. This RFP is the product of the stakeholder activities.

[1] Source: Oklahoma State Department of Health, State Innovation Model Design Grant executive summary, March 2016. Data is for the state at large and is not Medicaid-specific.

Stakeholder principles for care coordination include:

- Promoting early identification through outreach, referrals and data analysis of existing SoonerCare ABD members not receiving care coordination;
    - Providing support to existing HCBS waiver enrollees,
    - Attempting to contact all new members to conduct initial health risk screenings,
    - Informing all members about care coordination options appropriate to their needs;
- Conducting timely comprehensive assessments of medical, behavioral, functional and socio-economic needs;
    - Streamlining the comprehensive assessment process and migrating over time to electronic data sharing among care managers and providers,
    - Using an interdisciplinary team approach to needs assessment;
- Integrating all services within a comprehensive care plan, regardless of payer, including volunteered services;
    - Ensuring every member who needs a comprehensive care plan receives one, regardless of his or her specific ABD aid category,
    - Coordinating with existing programs in which a member may be enrolled (e.g., Health Homes);
- Ensuring members and members' families are central to the care planning process;
    - Promoting meaningful interdisciplinary team participation by all appropriate persons,
    - Educating members eligible for HCBS about self-directed care;
- Ensuring timely delivery of care plan services and coordinating ongoing member needs and transitions;
    - Implementing an efficient service authorization process,
    - Providing care coordination based on member need, regardless of specific ABD aid category,
    - Using electronic visit verification (EVV) to monitor service delivery for any members receiving in-home services,
    - Addressing service gaps, e.g., through initiatives to expand qualified Personal Care Assistant (PCA) capacity and use of technology, such as telehealth,
    - Addressing critical transition points, such as hospital-to-home discharges; and
- Developing a comprehensive quality monitoring process in collaboration with stakeholders;
    - Establishing a member-majority quality advisory board,
    - Incorporating nationally-validated measures that encompass the full continuum of care while addressing Oklahoma priorities,
    - Measuring quality at both the individual and system level,

- Measuring both short- and long-term performance,
- Rewarding care managers and providers who meet or exceed quality goals and taking corrective action with others where necessary.

The model Contract standards presented in section 2 and proposal submission requirements presented in section 3 are designed to advance the requirements for the care coordination model established by the OHCA and care coordination principles identified by the stakeholder community.

1.1.3 Population Counts

Two beneficiary tables are presented below for informational purposes only. The beneficiary information used in capitation rate setting is presented separately in the SoonerHealth+ Program capitation rate data book. Additional information on program beneficiaries also is provided in the Bidder's Library described in section 1.4, "Bidder's Library."

The first table provides June 2016 counts of blind/disabled children (including TEFRA children) and aged/blind/disabled adults.

Segment	Members
Children	18,759
Adults	136,036
Total Members	**154,795**

The second table provides SFY 2016 counts of beneficiaries served at any point during the year in one of the long-term care waivers being incorporated into the SoonerHealth+ Program. (The beneficiaries shown in the second table are a subset of the first table.)

Note that members with individuals with intellectual disabilities (IID) served through one of the three IID long-term care waivers will be enrolled in SoonerHealth+ starting in month 13 of the program. The long-term care waivers are described in detail in section 2 of the RFP.

Waiver Program	Serves	Total
ADvantage	Aged and Adult Disabled	21,727
Medically Fragile	Adults	83
Community	IID	3,102

Waiver Program	Serves	Total
In-Home Supports for Adults	IID	1,617
In-Home Supports for Children	IID	288

In addition to individuals with ID served through one of the IID waivers, in October 2016 there were 7,442 children and adults on a waiver waiting list maintained by the Oklahoma Department of Human Services (Oklahoma DHS). Within this group, approximately 65 percent were enrolled in SoonerCare and receiving State Plan benefits. SoonerCare members who are on the waiting list and receiving State Plan benefits will be enrolled in SoonerHealth+ at the start of the program. These beneficiaries are a subset of the first table above.

1.1.4 Alignment with State Innovation Model

The Oklahoma State Department of Health (OSDH) was awarded a State Innovation Model (SIM) grant in December 2014. Representatives from OSDH and partner agencies, including the OHCA, have developed recommendations for improving quality of care and the health of Oklahomans through value-based purchasing.

Although these are separate initiatives, the SoonerHealth+ Program is aligned with SIM objectives in terms of quality improvement measures and performance-based contracting standards. Additional information on the development and structure of the Oklahoma State Innovation Model can be found at:

https://www.ok.gov/health/Organization/Center_for_Health_Innovation_and_Effectiveness/Oklahoma_State_Innovation_Model_(OSIM)/.

1.1.5 Investing in the Health of Oklahomans

One of the goals of the SoonerHealth+ Program is to reduce State expenditures over time, versus what would have been spent absent the program. It is the State's intent to reinvest a portion of any such savings toward improving the health of Oklahomans covered under the program. This includes, but is not limited to the State using a portion of its savings to reduce the waiting list for long-term care waiver programs serving individuals with ID.

The OHCA also will take into consideration the commitment of potential Contractors to the State and the health of its ABD population when making awards under this solicitation. This includes, but is not limited to evaluating Bidder proposals to offer cost effective, value-

added services, as well as evaluating the portion of the Bidder's operations that will be located within the State.

1.1.6 Future Reform

Pursuant to 63 OS § 5028, ABD members will enroll in managed care. Specific ABD population groups are being phased in at certain times, allowing for adequate planning and preparation of their entry into a system where care is effectively coordinated and managed. Nearly all groups of the ABD population are envisioned to be included in such a system at some point in the future. Any such changes would be implemented through the procurement or contract amendment process.

The State may also undertake other reforms in the future that require coordination with SoonerHealth+ or modification of contract standards, including but not limited to participation in the Delivery System Reform Incentive Payment (DSRIP) program described in 36 OS § 1416. Any modification of standards would be implemented through the procurement or contract amendment process.

1.2 General Solicitation Information

1.2.1 Solicitation Scope

The purpose of this solicitation is to secure Contracts with qualified organizations that have the necessary experience and demonstrated quality to perform all of the duties outlined in section 2, "Model Contract Requirements." The OHCA adheres to the concept of best-value contracting, which takes into consideration both past performance and proposed methods when determining a Bidder's capacity to meet Contract standards.

1.2.2 OHCA Sole Point of Contact

The OHCA is the issuing agency for this competitive bid RFP. The sole point of contact for the RFP is listed below. All RFP-related inquiries must be directed to this individual. Failure to abide by this provision may result in a Bidder's disqualification.

Sole Point-of-Contact:

Sheila Killingsworth
Senior Contracts Coordinator
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105
sheila.killingsworth@okhca.org
Tel – 405-522-7846
Fax - 405-530-3206

1.2.3 Definitions

Appendix 1 to the RFP contains definitions of key words and acronyms used in the solicitation.

1.2.4 Geographic Scope of Contracts

The OHCA has defined two SoonerHealth+ regions with approximately equal numbers of members. Contracts awarded through this RFP will be for one or both regions (statewide award). No other geographic designations will be considered.

1.2.4.1 West Region

The West Region consists of the counties listed below and shown on the accompanying map:

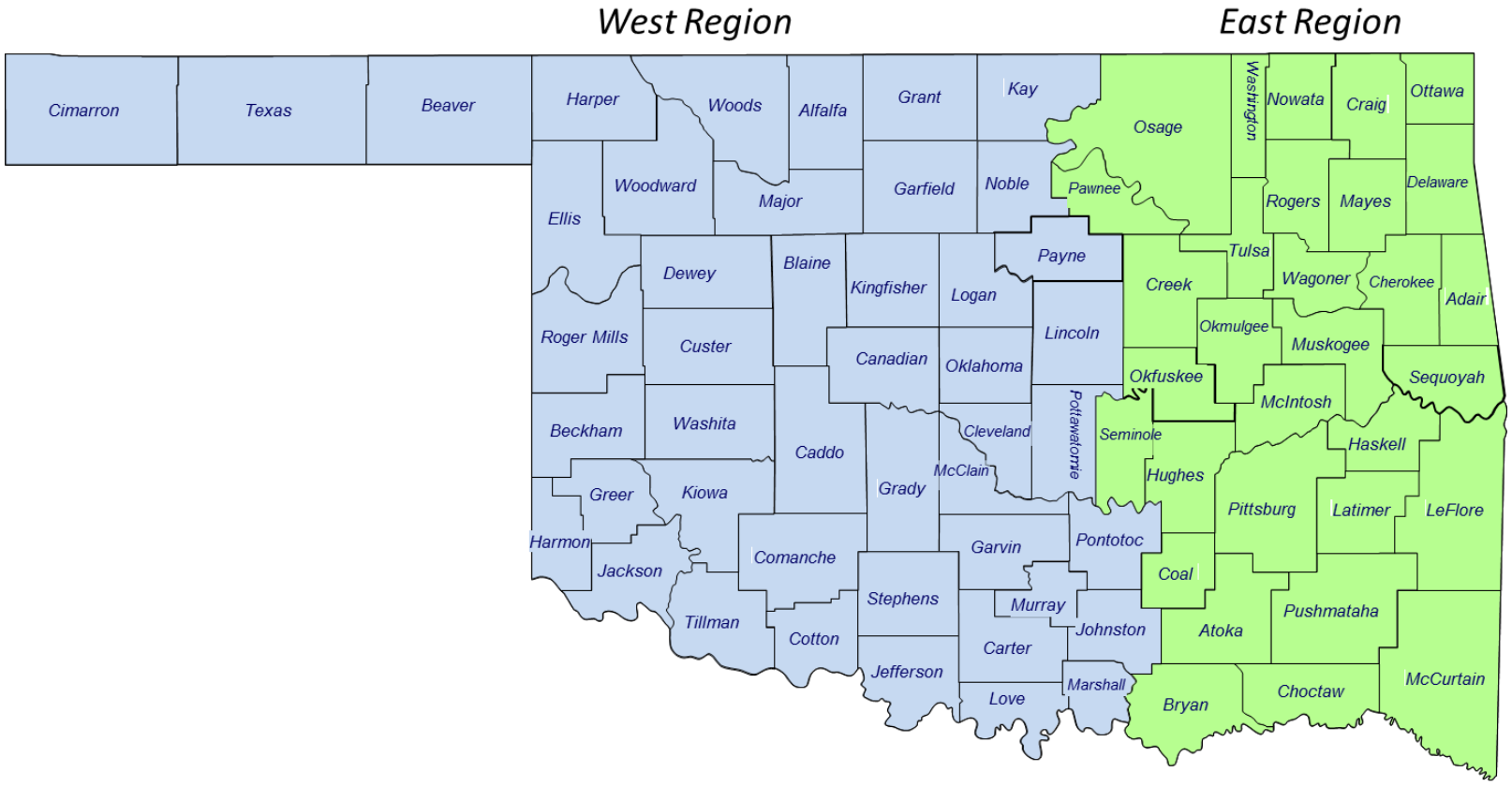
Alfalfa	Dewey	Kay	Oklahoma
Beaver	Ellis	Kingfisher	Payne
Beckham	Garfield	Kiowa	Pontotoc
Blaine	Garvin	Lincoln	Pottawatomie
Caddo	Grady	Logan	Roger Mills
Canadian	Grant	Love	Stephens
Carter	Greer	Major	Texas Co.
Cimarron	Harmon	Marshall	Tillman
Cleveland	Harper	McClain	Washita
Comanche	Jackson	Murray	Woods
Cotton	Jefferson	Noble	Woodward
Custer	Johnston		

1.2.4.2 East Region

The East Region consists of the counties listed below and shown on the accompanying map:

Adair	Delaware	Muskogee	Pushmataha
Atoka	Haskell	Nowata	Rogers
Bryan	Hughes	Okfuskee	Seminole
Cherokee	Latimer	Okmulgee	Sequoyah
Choctaw	LeFlore	Osage	Tulsa
Coal	Mayes	Ottawa	Wagoner
Craig	McCurtain	Pawnee	Washington
Creek	McIntosh	Pittsburg	

SOONERHEALTH+ REGIONS



1.2.5 Number of Contracts

The OHCA intends to award three Contracts per region through this RFP. At its sole discretion, the OHCA may award as few as two and as many as four Contracts.

1.2.6 Cost of Preparation

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

1.2.7 Certifications

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

- He or she is an authorized agent of the Bidder submitting the competitive bid herewith, for the purpose of certifying the facts pertaining to the existence of collusion among Bidders and between Bidders and State officials or employees, as well as facts pertaining to the giving of things of value to government personnel in return for special considerations in the awarding of any Contract pursuant to said bid;
- Is fully aware of the facts and circumstances surrounding the making of the bid to which this statement is attached and has been personally and directly involved in the proceedings leading to the submission of such bid;
- Neither the Bidder nor anyone subject to the Bidder's direction or control has been a party:
    - To any collusion among Bidders in restraint of freedom of competition by agreement to refrain from bidding,
    - To any collusion with any State official or employee as to quantity, quality or price in the prospective Contract or as to any other terms of such prospective Contract,
    - To any collusion with any State agency or political subdivision official or employee as to create a sole-source acquisition in contradiction to 74 O.S. § 85.45, nor
    - In any discussions with any State official or employee concerning exchange of money or other thing of value in return for special consideration in the awarding of a Contract; and
- If awarded the Contract, neither the Contractor nor anyone subject to the Contractor's direction or control has paid, given or donated or agreed to pay, give or donate to any officer or employee of the State of Oklahoma any money or other thing of value, either directly or indirectly, in obtaining the Contract herein.

By submitting a response to this solicitation, the Bidder and any proposed Subcontractor(s) to the best of their knowledge and belief also certify that:

- In accordance with 74 O.S. § 85.42, no 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 the Contract relating from this solicitation;
- It is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded by any federal, State or local department or agency;
- It has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against them 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;
- It is not 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; and
- It has not, within a three-year period preceding this application/proposal, had one or more public (federal, state or local) contracts terminated for cause or default.

If the Bidder or a Subcontractor is unable to certify any of the statements in this certification, an explanation must be attached to the solicitation response.

1.2.8 Bids Subject to Public Disclosure/Proprietary Information

Documents and information a Bidder submits as part of or in connection with a solicitation are public records and subject to disclosure, unless otherwise specified in applicable law. Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional copy of the bid with this information redacted, in accordance with instructions provided in section 3.5.3, “Proprietary Information”. The OHCA shall make the final determination as to whether the documentation or information is confidential.

1.2.9 Changes in Solicitation Specifications or Contract Terms

If one or more amendments to this solicitation are issued, the Bidder shall acknowledge receipt of any/all such amendment(s) by signing and returning the amendment cover page in accordance with instructions provided in section 3.6.2, “Technical Proposal Contents.” 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 the OHCA.

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

1.2.10 Waiver of Objections

The Bidder is responsible for reviewing all materials associated with this solicitation and submitting questions and comments in advance of the deadline specified in section 1.3, "Solicitation Timeline." Protests based on any matter that could have been raised prior to the deadline, but was not, will be considered waived by the OHCA.

1.2.11 Accommodations for Bidders with Disabilities

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

1.2.12 Comprehensive Primary Care Plus (CPC+)

The Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) has selected Oklahoma to participate in a five-year initiative known as Comprehensive Primary Care Plus (CPC+). CMMI's goals for CPC+ are to "improve the quality of care patients receive, improve patients' health and spend health care dollars more wisely." CPC+ seeks to achieve these goals through a "multi-payer payment redesign that gives participating practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization."

CPC+ participants include CMS, state Medicaid agencies, primary care practices and commercial health plan "payer partners". The program begins in January 2017.

It is the OHCA's expectation that the primary care practices participating in CPC+ in many instances also will be part of SoonerHealth+ Contractor primary care networks. These practices will have in their patient panels SoonerCare Choice (ABD Medicaid-only) members who will be mandatorily enrolled in SoonerHealth+.

The SoonerHealth+ Contract has been designed to ensure the two initiatives support each other in advancing common quality, outcome and cost effectiveness objectives. The processes described in the Contract may be subject to amendment as the two programs are enacted.

More information about CPC+ can be found at:
https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus

1.3 Solicitation Timeline

Key milestone dates for the solicitation and program implementation are presented in the table below. Dates are subject to change through RFP amendment. All times are Central Time.

Milestone	Day and Time
Solicitation issue date	November 30
Deadline for submission of questions – round 1 (technical)	December 9, 2:00pm
Response to round 1 questions issued	December 22
Release of capitation rates and data book	January 18
Deadline for non-binding letter of intent	January 25, 2:00pm
Actuarial bidder's conference	February 1, 1:00pm
Deadline for submission of questions – round 2 (technical and actuarial)	February 10, 2:00pm
Response to round 2 questions issued	February 17
Response due date and time	February 28, 2:00pm
Oral presentations	TBA
Announcement of awards	TBA
Readiness review for enrollment of year one populations	Fall 2017
Initiation of enrollment of year one populations	January 2018
Initiation of services to year one populations	April 1, 2018
Initiation of services to IID waiver members	April 1, 2019
Initiation of services to institutionalized members and children in the custody of DHS or in Tribal custody	April 1, 2020

Initiation of enrollment into a contracted plan will be subject to successful completion of readiness review activities, in accordance with 42 CFR § 438.66(d). This applies both to

enrollment of year one populations and subsequent enrollment of IID waiver members, institutionalized members and children in the custody of DHS or in Tribal custody in years two and three.

1.4 Bidder's Library

The OHCA has established an on-line Bidder's Library for this solicitation at http://www.okhca.org/about.aspx?id=3217. New content will be added to the Bidder's Library as appropriate throughout the solicitation. It is the Bidder's responsibility to check the library frequently for updated information. The OHCA will not routinely notify Bidders when new material has been posted to the library.

Section 2 – Model Contract

OKLAHOMA HEALTH CARE AUTHORITY

AND

[CONTRACTOR NAME]

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

2.1 General Terms and Conditions

2.1.1 Parties

2.1.1.1 Oklahoma Health Care Authority

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

2.1.1.2 Contractor

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.

2.1.2 Contract Administration

2.1.2.1 OHCA

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

In no instance shall the Contractor refer any matter to the OHCA Chief Executive Officer or any other official in Oklahoma unless initial contact regarding the matter has been presented to the Senior Contracts Coordinator or designee both verbally and in writing.

2.1.2.2 Contractor

The Contractor shall designate a Contract Officer. Such designation may be changed during the period of the Contract only by written notice. The Contract Officer shall be authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to implementation of the Contract.

2.1.3 Legal Contract

Submitted bids are rendered as a legal offer. The Contract resulting from this solicitation will consist of the following documents in order of preference:

- Contract between the OHCA and the Contractor, including but not limited to the purchase order, contract modifications, certifications and change orders;
- Approved corrective action plans submitted by the Contractor in response to deficiencies documented by the OHCA through readiness reviews, operational/financial audits, routine reporting and/or other oversight activities as described in section 2.22, "Contractor Performance Standards";
- The RFP and any RFP amendments, including only the Bidder's questions which have led to a change in Contract scope; and
- The proposal submitted by the Contractor.

The OHCA reserves the right to clarify the Contractual relationship in writing and such clarifications shall govern in case of conflict between the Contract and the requirements of the RFP. Such clarifications shall be issued solely by the OHCA's Chief Executive Officer or Senior Contracts Coordinator for this Contract.

2.1.4 Federal Approval of Contract

Under 42 USC § 1396b (m)(2)(A), the Secretary of the US Department of Health and Human Services (hereinafter referred to as the Secretary) has final authority to approve this Contract. If the Secretary or designee does not approve the Contract entered into under the terms and conditions described herein, it will be considered null and void.

2.1.5 Notices

Whenever a notice is required to be given to the other party, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if a signed receipt is obtained, either when delivered by hand or return receipt requested. Delivery shall also be deemed to have occurred three days after mailing by certified or registered mail. Notices shall be addressed as presented below.

2.1.5.1 Notices to the OHCA

Sheila Killingsworth
Senior Contracts Coordinator
Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, Oklahoma 73105

2.1.5.2 Notices to the Contractor

Name
Address

2.1.6 Notification of Material Changes

The Contractor shall notify the OHCA of all changes materially affecting the delivery of care or the administration of its program. Material changes include but are not limited to those that affect the Contractor's ability to meet Contract requirements delineated in section 2.22, "Contractor Performance Standards."

2.1.7 Contract Term

The Contract shall begin upon Contract award and terminate on June 30, 2019.

There shall be options to renew for four additional one-year periods (July 1 – June 30), with an additional six-month term at the end of the Contract (July 1 – December 31). The option to renew shall be contingent upon the needs of the OHCA and funding availability and is at the sole discretion of the OHCA.

Payment terms for any renewal period shall be administered in accordance with section 2.21, "Payments to Contractor."

The Contractor shall have certain obligations that will survive Contract expiration. These obligations are described in the relevant sections of the Contract.

2.1.8 Consideration of New Contracts during Contract Period

2.1.8.1 SoonerHealth+ Program

The OHCA reserves the right to enter into new Contracts with outside organizations during this Contract term, if determined necessary to meet program capacity needs beyond what existing Contractors are able or willing to provide and/or to remain in compliance with State or federal standards governing service accessibility and member choice. Changes to the composition of Contractors shall be effective at the start of a Contract year, unless otherwise necessary to ensure a continued choice of Contractors.

2.1.8.2 Dual Eligible Financial Alignment Demonstration

In April 2011, the Secretary announced several initiatives that offer states more flexibility to adopt innovative practices in order to provide better and more coordinated care for the dual eligible population. Oklahoma was one of 15 states awarded a Contract to support the design of projects that aimed to improve the coordination of care for people with Medicare and Medicaid coverage.

The OHCA reserves the right to introduce a financial alignment demonstration/Medicare shared savings initiative for SoonerCare dual eligible members, subject to federal approval. Such an initiative would not take effect mid-year, except with the mutual agreement of the OHCA and the Contractor.

2.1.9 Amendments or Modifications

This Contract contains all of the agreements of the parties and no verbal 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 the OHCA and the Contractor. At all times, all parties shall adhere to the overall intent of the Contract.

2.1.10 Early Termination

This Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this section.

2.1.10.1 Mutual Consent

The OHCA and the Contractor may terminate the Contract by mutual written agreement.

2.1.10.2 Termination for Default

The OHCA may terminate this Contract, in whole or in part, whenever it determines that the Contractor or its Subcontractor has failed to satisfactorily perform its contracted duties and responsibilities and is unable or unwilling to cure such failure within a reasonable period of time as specified in writing by the OHCA, taking into consideration the gravity and nature of the default.

The Contractor also shall be in default, and the provisions in this section shall apply, if it terminates early without the mutual consent of the OHCA.

Upon determination by the 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 to cure such failure. If the Contractor is unable or unwilling to cure the failure within the specified time period, the 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, the 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, the OHCA shall give members enrolled with the Contractor notice of termination and information, consistent with 42 CFR § 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, the OHCA may procure, upon such terms and in such manner as is deemed appropriate by the OHCA, supplies or services similar to those terminated and the Contractor shall be liable for any costs associated for such similar supplies or services and all other damages allowed by law. In addition, the Contractor shall be liable to the 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 members from the Contractor's health plan.

In the event of a termination for default, the Contractor shall be paid for any outstanding monies due less any assessed damages. If damages exceed monies due from invoices, collection will be made from the Contractor's performance bond, cash deposit, letter of credit or substitute security, as described in section 2.1.34, "Performance Bond or Substitutes".

The rights and remedies of the 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.

2.1.10.3 Termination for Unavailability of Funds

In the event funding from federal, State or other sources is withdrawn, reduced or limited in any way after the effective date of the Contract, or the 1115 waiver, or specified provisions therein, is not extended as of the effective date of the Contract and prior to the expiration date, the OHCA may terminate this Contract.

In the event the OHCA elects to terminate the Contract pursuant to this provision, the Contractor shall be notified in writing of the basis and extent of termination, either 30 days prior to, or such other reasonable time prior to, the effective date. Upon receipt of notice of termination for unavailability of funds, Contractor shall be paid any outstanding monies due.

2.1.10.4 Termination for Financial Instability

In the event that the Contractor becomes financially unstable to the point of threatening the ability of the 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, the OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

In the event the 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 the OHCA. The Contractor shall ensure that all tasks related to the subcontract are performed in accordance with the terms of the Contract.

2.1.10.5 Termination for Debarment

Section 1932(d)(1) of the Social Security Act prohibits affiliations with individuals debarred by federal agencies. The Contractor may not knowingly have an individual or affiliate, as defined in the Federal Acquisition Regulation at 42 CFR § 2.101, who has been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The prohibited relationships include:

- A director, officer or partner of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A Subcontractor of the Contractor who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A person with beneficial ownership of five percent or more of the Contractor's equity who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- A network provider or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its contract with the State who is (or is affiliated, as defined in the Federal Acquisition Regulation, with a person/entity that is) debarred, suspended or excluded from participation in federal health care programs;
- An individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act;
- Any individual or entity excluded for cause from participation in any state Medicaid program or the Medicare program; or
- Any individual or entity listed on the state or federal excluded provider lists.

The Contractor shall not have a relationship with an individual that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act.

The 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 CFR § 438.610 if directed by CMS, and the OHCA cannot renew or otherwise extend the existing Contract for such an organization unless CMS determines that compelling reasons exist for doing so.

2.1.11 Termination Procedures

Upon delivery to the Contractor of a notice of termination, the Contractor shall work in good faith with the OHCA to carry out termination provisions in a manner that minimizes disruption for members. The Contractor also shall:

- Stop work under the Contract on the date and to the extent specified in the notice;
- Complete the performance of such part of the work that has not been terminated by the notice;
- With the approval of the OHCA, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts;
- Provide all necessary assistance to the OHCA in transitioning members out of the Contractor's health plan to the extent specified in the notice. Such assistance shall include but not be limited to the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized and pregnant members in their last four weeks of pregnancy; and
- Comply with procedures for return of PHI data, as outlined in section 2.1.18, "Confidentiality."

The Contractor shall be liable for all medical claims incurred up to the date of termination. This shall include the relevant portion of hospital inpatient claims incurred for members hospitalized at the time of termination.

The Contractor shall return within 30 days of receipt any funds advanced for coverage of members for periods after the date of termination.

After receipt of a notice of termination, the Contractor shall submit any termination claims in the form and with the certifications prescribed by the OHCA. Such claims shall be submitted promptly, but in no event later than six months from the effective date of termination, unless one or more extensions are granted by the OHCA within such six months or authorized extension thereof.

In the event of a failure to agree in whole or in part as to the amounts to be paid to the Contractor in connection with total or partial termination of work pursuant to this section, the OHCA shall determine on the basis of available information the amount due, if any, by reason of termination. The Contractor shall have the right to appeal, as stated under section 2.1.16, "Disputes."

In no case shall the Contractor's termination claims include any claim for unrealized anticipatory profits.

2.1.12 Termination Reports

The Contractor shall provide to the OHCA on a monthly basis, until instructed otherwise, a monthly claims aging report by provider/creditor that includes incurred but not received claim amounts, a monthly summary of cash disbursements and copies of all bank statements received by the Contractor in the preceding month. Such reports shall be due on the fifth business day of each month for the prior month as specified in section 2.17, "Reporting."

2.1.13 Assignment

The Contractor shall not assign or transfer any rights or obligations under this Contract without prior written consent of the 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.

2.1.14 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 by the parties hereto.

2.1.15 Policy Determinations

In the event that the Contractor may, from time to time, request the OHCA to make policy determinations or to issue operating guidelines required for proper performance of the

Contract, the 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 may only be made by the OHCA's Senior Contracts Coordinator.

2.1.16 Disputes

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

Prior to the institution of arbitration or litigation concerning any dispute arising under the Contract, the Senior Contracts Coordinator is authorized to settle, compromise, pay or otherwise adjust the dispute by or against or in controversy with, the Contractor. This authority to settle or resolve disputes is subject to any limitations or conditions imposed by regulations. Such disputes or controversy may include a claim or controversy based on the Contract, mistake, misinterpretation or other cause for Contract modification or rescission, but excludes any claim or controversy involving penalties or forfeitures prescribed by statute or regulation where an official, other than the Senior Contracts Coordinator, is specifically authorized to settle or determine such controversy.

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

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

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

If the Senior Contracts Coordinator does not issue a written decision within 45 days after written request for a final decision, or within such longer period as might be established in

writing by the parties to the Contract, then the Contractor may proceed as if an adverse decision had been received.

Appeal(s) of the Senior Contracts Coordinator's decision may be made pursuant to OAC 317:2-1-1, et seq. If damages awarded on any Contract claim under this section exceed the original amount of the Contract, such excess shall be limited to $100,000. No person, firm or corporation shall be permitted more than one monetary recovery upon a claim for the enforcement or for breach of Contract with the OHCA.

2.1.17 Audit and Inspection

As used in this clause "records" includes books, documents, accounting procedures and practices and other data regardless of type and regardless of whether such items are in written form, in the form of computer data or in any other form. In accepting any Contract with the State, the Contractor agrees that any pertinent State or federal agency has the right to examine and audit, at any time, all records or documents of the Contractor, or its Subcontractors, relevant to execution and performance of the Contract in accordance with 42 CFR § 438.3(h).

The Contractor and its Subcontractors are required to retain records relative to the Contract for the duration of the Contract and for a period of ten years following completion and/or termination of the Contract. If an audit, litigation or other action involving such records is started before the end of the ten-year period, the records are required to be maintained for two years from the date that all issues arising out of the action are resolved, or until the end of the ten-year retention period, whichever is later.

The Contractor shall keep records as are necessary to disclose fully the extent of services provided under this Contract and shall furnish records and information regarding any claim for providing services to the OHCA, the State Auditor and Inspector (SA&I), Office of State Finance – Central Purchasing Division (CPD), Oklahoma Attorney General's Medicaid Fraud Unit (MFCU), United States General Accounting Office (GAO) and the Secretary, for ten years from the date of service, which includes all renewal options. The Contractor shall not destroy or dispose of records which are under audit, review or investigation when the ten-year limit is met. The Contractor shall maintain such records until informed in writing by the auditing, reviewing or investigating agency that the audit, review or investigation is complete.

Authorized representatives of the OHCA, SA&I, CPD, MFCU, GAO and the Secretary shall have the right to make physical inspection of the Contractor's location, facility and equipment and to examine records relating to financial statements or claims submitted by the Contractor under this Contract and to audit the Contractor's financial records.

Pursuant to 74 O.S. § 85.41, the OHCA, SA&I and CPD shall have the right to examine the Contractor's books, records, documents, accounting procedures, practices or any other items relevant to this Contract. The OHCA shall allow for the inspection of public records in accordance with the provisions of the Oklahoma Open Records Act, 51 O.S. §§ 24A.1 – 29.

2.1.18 Confidentiality

2.1.18.1 Definitions

The following terms in this section 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, Unsecured Protected Health Information and Use.

HIPAA Rules shall mean the Privacy, Security, Breach, Notification and Enforcement Rules at 45 CFR Parts 160 and 164.

HITECH Act shall mean the Privacy, Security, Breach, Notification and Enforcement Rules at 45 CFR Part 160.

2.1.18.2 Obligations of the OHCA

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

The 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.

The OHCA shall notify the Contractor of any restriction to the use or disclosure of PHI that the OHCA has agreed to or is required to abide by in accordance with 42 CFR § 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.

The OHCA agrees to disclose to the Contractor only the minimum amount of PHI necessary to accomplish the services covered under this Contract.

2.1.18.3 Obligations of Contractor

The Contractor agrees that SoonerHealth+ member information is confidential and not to be released pursuant to 42 USC § 1396a (a)(7), 42 CFR §§ 431.300 – 431.306 and 63 O.S. §

5018. The Contractor agrees not to release the information governed by these member requirements to any other person or entity without the approval of the OHCA, or as required by law or court order.

Medical records and any other health and enrollment information that identifies a particular member shall be used and disclosed by the Contractor in accordance with the privacy requirements of Subpart A of 45 CFR parts 160 and Subpart E of 45 CFR Part 164, to the extent that these requirements are applicable.

The Contractor agrees that SoonerHealth+ member and provider information cannot be re-marketed, summarized, distributed or sold to any other organization without the express written approval of the OHCA.

The Contractor agrees to comply with the HIPAA rules that are applicable to such party as mandated by HIPAA and 42 USC § 1320d et. seq.

The Contractor agrees to report potential known violations of 21 O.S. § 1953 to the OHCA Legal Division within 48 hours of knowledge of an unauthorized act. In general, this criminal statute makes it a crime to willfully and without authorization gain access to, alter, modify, disrupt or threaten a computer system.

The Contractor shall, following the discovery of a breach of unsecured PHI as defined in the HITECH or accompanying regulations, notify the OHCA of such breach pursuant to the terms of 45 CFR § 164.410 and cooperate, if requested, with the OHCA's breach analysis procedures, including risk assessment. The Contractor must report a known breach to the OHCA Privacy and Confidentiality Officer within 48 hours of knowledge of an unauthorized act. A breach shall be treated as discovered by the Contractor as of the first day on which such breach is known to the Contractor or, by exercising reasonable diligence, would have been known to the Contractor.

The Contractor shall report to the OHCA any Security Incident of which it becomes aware within 48 hours of knowledge of the incident. 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. In addition, the Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the Contractor of a use or disclosure of PHI by the Contractor in violation of the requirements of this Contract.

The Contractor shall provide encrypted e-mail communication when PHI is transmitted to the OHCA. No direct connection or Virtual Private Network (VPN) to the OHCA will be used for this purpose, nor will the OHCA use individual e-mail certificates for its staff. Such

encrypted e-mail will require a X.509 certificate that can be collected by the existing OHCA e-mail encryption system, so that e-mails can be decrypted automatically by the OHCA. The OHCA shall provide no additional hardware/software to the Contractor for this purpose, or accept any Contractor-provided hardware/software.

In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, the Contractor will ensure that any Subcontractors that create, receive, maintain or transmit 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 from the Subcontractor in its written agreement with the Subcontractor.

The Contractor shall make PHI available to the OHCA in a designated record set as necessary to satisfy the OHCA's obligations under 45 CFR § 164.524.

The Contractor shall make any amendment(s) to PHI in a designated record set as directed or agreed to by the OHCA pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy the OHCA's obligations under 45 CFR § 164.526.

The Contractor shall maintain and make available the information necessary to provide an accounting of disclosures to the OHCA as necessary to satisfy the OHCA's obligations under 45 CFR § 164.528.

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

The Contractor shall make its internal practices, books and records available to the Secretary for purposes of determining compliance with HIPAA rules.

2.1.18.4 Obligations of Contractor upon Termination

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

- Retain only that PHI which is necessary for the Contractor to continue its proper management and administration or to carry out its legal responsibilities;
- Return to the OHCA or, if agreed to by the OHCA, destroy the remaining PHI that the Contractor still maintains in any form;
- Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this section, for as long as the Contractor retains the PHI; and

- Return to the OHCA or, if agreed to by the 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 of the OHCA at termination and the Contractor is obligated to obtain or ensure the destruction of PHI created, received or maintained by Subcontractors.

The obligations of the Contractor under this Contract shall survive the termination of the underlying Contract.

2.1.18.5 Permitted Uses and Disclosures by Contractor

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

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

The Contractor may not use or disclose PHI in a manner that would violate 45 CFR § 164.522, or as mandated pursuant to Section 13405(c) of the HITECH Act.

The Contractor may use or disclose only the minimum amount of PHI necessary to accomplish the services covered in the Contract.

2.1.18.6 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.

2.1.19 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.

2.1.20 Contract Compliance and Penalties

Substantial elements of this Contract are performance-based and require the Contractor to meet specific standards or metrics. The Contractor's performance may be assessed by such means as evaluation of readiness reviews, onsite visits, audits and standardized reports.

Section 2.22, "Contractor Performance Standards," describes performance-based elements of the Contract and potential penalties associated with the Contractor's failure to meet one or more of these standards. In addition to these penalties, the Contractor may be directed to prepare a corrective action plan for the OHCA's review and approval. The OHCA will specify the required content and submission date of the corrective action plan at the time the directive is issued.

Failure to resolve an issue may result in additional action by the OHCA, including withholding or reduction of the Contractor's reimbursement or Contract action, up to and including early termination of the Contract, as described in section 2.1.10, "Early Termination."

2.1.21 Hold Harmless

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

- Any claims for damages or losses arising from services rendered by any Subcontractor, person or firm performing or supplying services, materials or supplies in connection with the performance of the Contract;
- Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of federal or State Medicaid regulations or legal statutes, by the Contractor, its officers, employees or Subcontractors in performance of the Contract;
- Any claims for damages or losses resulting to any person or firm injured or damaged by the Contractor, its officers, employees or Subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Contract in a manner not authorized by the Contract or by federal or State regulations or statutes;
- Any failure of the Contractor, its officers, employees or Subcontractors to observe federal or State laws, including but not limited to labor laws and minimum wage laws; and
- Any claims for damages, losses or costs associated with legal expenses, including but not limited to those incurred by or on behalf of the 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 the OHCA that insurance protections necessary to address each of these risk areas are in place. Minimum requirements for coverage are defined in section 2.1.22, "Insurance."

2.1.22 Insurance

Before commencement of any work in connection with the Contract, the Contractor shall obtain and retain insurance as applicable, or as required by State and federal law, including:

- Automobile insurance;
- Comprehensive liability insurance;
- Errors and omissions insurance;
- General liability insurance;
- Medical malpractice insurance;
- Professional liability insurance;
- Property damage insurance; and
- Worker's compensation.

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

"The State of Oklahoma and the Oklahoma Health Care Authority are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies, boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be cancelled or materially changed without 10 days' written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company."

The Contractor's Certificates of Insurance shall constitute an attachment to the Contract. Each certificate will state the policy, the insured and the insurance period. Each insurance policy shall contain a clause that requires the OHCA to be notified at least 10 days prior to cancellation and shall name the State of Oklahoma and the OHCA as additional named insureds. Such Certificates of Insurance must be submitted to the OHCA within 30 days of notification of Contract award and prior to commencement of services under this Contract.

The Contractor shall require that each of its Subcontractors maintain insurance coverage as specified in this section or provide coverage for each Subcontractor's 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 Contractor shall obtain reinsurance coverage or self-reinsure subject to the provisions of section 2.1.22.4, "Reinsurance," below.

The Contractor shall be in compliance with all applicable insurance laws of the State and federal government throughout the duration of the Contract.

2.1.22.1 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 million for each occurrence.

No later than 30 days prior to July 1 of each Contract year, the Contractor shall advise the OHCA if any of its Subcontractors are covered by the Oklahoma Tort Claims Act and thus, in the Contractor's opinion, do not require professional liability insurance. Such proposed coverage of the Subcontractors by the Oklahoma Tort Claims Act as a substitute for professional liability insurance is subject to the OHCA's approval.

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

2.1.22.2 Minimum Liability and Property Damage Insurance

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

- General liability insurance (including automobile and broad form contractual coverage) against bodily injury or death of any person in the amount of $1 million for any one occurrence;
- 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; and
- Such insurance coverage that will protect the OHCA against liability from other types of damages, for up to $500,000 for each occurrence.

2.1.22.3 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 $1 million.

2.1.22.4 Reinsurance

The Contractor shall purchase reinsurance from a commercial reinsurer in accordance with State insurance requirements and be sufficient to address the level of risk associated with the enrolled population. Alternatively, the Contractor may elect to self-insure based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse financial events.

The Contractor shall provide documentation to the OHCA of its reinsurance arrangements and the underlying assumptions supporting its level of coverage and funding mechanism. The OHCA reserves the right to require the Contractor to modify its coverage arrangements

and level of coverage, including reinsurance attachment point and coinsurance percentage, if the Contractor's proposed coverage is deemed insufficient.

2.1.23 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.

2.1.24 Patent or Copyright Infringement

The Contractor shall represent that, to the best of its knowledge, none of the software to be used, developed or provided pursuant to the Contract violates or infringes upon any patent, copyright or any other right of a third party.

If any claim or suit is brought against the OHCA for the infringement of such patents or copyrights arising from the Contractor's or the OHCA's use of any equipment, materials, computer software and products, or information prepared for, or developed in connection with performance of the Contract, then the Contractor shall, at its expense, defend such use. The Contractor shall satisfy any final award for such infringement, whether it is resolved by settlement or judgment involving such a claim or suit.

2.1.25 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 the OHCA. In circumstances where time is of the essence, the OHCA will make a good faith effort to review and respond within one business day.

2.1.26 Employment Relationship

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

2.1.27 Force Majeure

Neither the Contractor nor the 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 or the OHCA. Such causes may include, but are not limited to, catastrophic events 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.

The Contractor shall have in place a disaster recovery plan that has been reviewed and approved by the OHCA. Within 24 hours of the occurrence of such event, the Contractor shall initiate disaster recovery and/or back-up procedures to provide alternate services, in accordance with the disaster recovery plan and with requirements described in sections 2.2, "Licensure, Administration and Staffing" and 2.15, "Information Technology and Data Management." The Contractor shall notify the OHCA prior to initiation of alternate services as to the extent of the disaster and/or emergency and the expected duration of alternate services within 24 hours of onset of the problem.

2.1.28 Laws Applicable

The parties to this Contract acknowledge and expect that changes may occur over the term of this Contract regarding Federal Medicaid statutes and regulations, State Medicaid statutes and rules and State statutes and rules governing health insurers and the practice of health care professions. The parties shall be mutually bound by such changes in effect at any given time following execution of the Contract.

The Contractor shall comply and certifies compliance with:

- Age Discrimination in Employment Act, 29 USC § 621 et seq.;
- Age Discrimination in Federally Assisted Programs, 42 USC § 6101 et seq.;
- Anti– Kickback Act, 41 USC §§ 8701 – 8707, which prohibits any person from providing or attempting to provide or offering to provide any kickback;
- Drug-Free Workplace Act, 41 USC § 701 et seq.;
- Equal Opportunity for Individuals with Disabilities, 42 USC § 12101 et seq.;
- Equal Pay Act, 29 USC § 201 et seq.;
- Fair Labor Standards Act, 29 USC § 201 et seq.;
- False Claims Act, 31 USC §§ 3729– 3733 and the Administrative Remedies for False Claims Statements, 31 USC § 3801;
- Health Insurance Portability and Accountability Act (HIPAA);
- Health Information Technology for Economic & Clinical Health (HITECH) Act of 2009;
- Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability [Final Rule published May 6, 2016];
- The Patient Protection and Affordable Care Act ("PPACA"), including Section 1557 of the PPACA prohibiting discrimination on the basis of disability in certain health programs and activities;
- Presidential Executive Orders 11141, 11246 and 11375, together requiring certain federal contractors and subcontractors to institute affirmative action plans to

ensure absence of discrimination for employment because of age, race, color, religion, sex or national origin;

- Rehabilitation Act, 29 USC § 701 et seq.;
- Subchapters XIX and XXI of the Social Security Act, 42 USC § 1396 et seq.;
- Titles VI and VII of the Civil Rights Act, 42 USC § 2000(d) et seq.;
- Title IX of the Education Amendments of 1972 (regarding education programs and activities);
- Vietnam Era Veterans Readjustment Act, 38 USC § 4212;
- 31 USC §1 352 and 45 CFR § 93.100 et seq., (1) Prohibiting use of federal funds paid under this Contract to lobby Congress or any federal official to enhance or protect the monies paid under this Contract and (2) Requiring disclosures to be made if other monies are used for such lobbying;
- 45 CFR §§ 76.105 and 76.110 concerning debarment, suspension and other responsibility matters;
- Oklahoma Electronic Information Technology Accessibility (EITA) Act (Oklahoma 2004 HB 2197) regarding information technology accessibility standards for persons with disabilities;
- Oklahoma Medicaid False Claims Act, 63 O.S. §§ 5053 – 5053.7;
- Oklahoma Worker's Compensation Act, 85 O.S. §1 et seq.;
- 74 O.S. § 85.44(B) and (C) and 45 CFR § 74.34 with regard to equipment (as defined by 2 CFR Parts 220, 225 or 230 as applicable to the Contractor's entity) purchased with monies received from the OHCA pursuant to this Contract;
- Title 317 of the Oklahoma Administrative Code ("OAC"); and
- 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.

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.

2.1.29 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.

2.1.30 Counterparts

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

2.1.31 Administrative Procedures Not Covered

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

2.1.32 Days Terminology

Unless otherwise specified, "days" as used in this Contract shall mean calendar days.

2.1.33 Policies, Procedures and Related Materials

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 OHCA, at its discretion, may require the Contractor and any Subcontractor(s) to submit policies and procedures for the OHCA's review and approval prior to their adoption and implementation. The Contractor and any Subcontractor(s) shall furnish policies and procedures to the OHCA upon request. The OHCA will examine policies and procedures as part of readiness review activities described in section 3.11, "Readiness Review," and may require modifications or additions as part of readiness review findings.

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

If the OHCA identifies necessary revisions to the Contractor's and any Subcontractor(s) policies and procedures to conform to Contract standards, the 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 the OHCA has given approval to the revisions.

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

2.1.34 Performance Bond or Substitutes

Contractor shall furnish a performance bond, cash deposit, US Treasury Bill or an irrevocable letter of credit. The performance bond shall be in a form acceptable to the OHCA.

If a cash deposit is used, it must be placed in different financial institutions to a maximum of $250,000 per deposit.

If a letter of credit is used, it must be issued by a bank or savings and loan institution doing business in the State of Oklahoma and insured by the Federal Deposit Insurance Corporation or a credit union doing business in the State of Oklahoma and insured by the National Credit Union Administration.

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

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

The 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 the OHCA may, after supplying written notice, withdraw its permission for substitute security, in which case the Contractor shall provide the OHCA with a form of security as described above.

In the event of termination for default, as described in section 2.1.10.2, "Termination for Default", the performance bond, cash deposit, US Treasury bill, letter of credit or substitute security shall become payable to the OHCA for any outstanding damage assessments against the Contractor. Up to the full amount also may be applied to the Contractor's liability for

any administrative costs and/or excess medical or other costs incurred by the OHCA in obtaining similar services to replace those terminated as a result of the default. The OHCA may seek other remedies under law or equity in addition to this stated liability.

2.2 Licensure, Administration and Staffing

2.2.1 Licensure

The Contractor shall be a licensed 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 the OHCA upon Contract award and must include all counties in awarded region(s). If at any time during the term of the Contract, the Contractor incurs 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 the OHCA. Such loss may be grounds for termination of the Contract under the provisions of section 2.1.10, "Early Termination."

2.2.2 Administration

2.2.2.1 General

The OHCA agrees to purchase, and the Contractor agrees to fulfill all requirements and to furnish and arrange for the delivery of the scope of services as specified in this Contract. The Contractor shall maintain the necessary licenses and furnish the personnel, facilities, equipment, supplies, pharmaceuticals and expertise necessary for, or incidental to, the provision of covered services to SoonerHealth+ members enrolled in its health plan.

2.2.2.2 Subcontractors

The Contractor may enter into written subcontract(s) for performance of certain responsibilities listed in this Contract. All subcontracts must be in writing and fulfill the requirements of 42 CFR § 438.230 that are appropriate to the service or activity being delegated. The Contractor shall make available all subcontracts in electronic format for inspection by the OHCA.

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

- Administrative – Entity anticipated being paid $2 million or more for member- or provider-facing administrative activities, including but not limited to operation of call centers, claims processing and member/provider education;
- Health Service – Entity anticipated being paid $5 million or more for health services under a payment arrangement other than fee-for-service that includes a downside financial risk during the year one Contract period.

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

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

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

The Contractor shall provide the OHCA written notice at least 30 days in advance of any contractual changes in subcontracted services. Notice of these changes shall include a written transition plan describing how the Contractor will notify members of the change and how the Contractor will maintain continuity of care for those affected members. At its discretion, the 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 the 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 the OHCA.

The 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.

2.2.2.3 Advisory Board

The Contractor shall establish a standing Advisory Board that includes members, member representatives (e.g., family members and caregivers), advocates and providers. Members and member representatives shall constitute a majority of the Board, which shall include at least ten persons in total. The Board, in its composition, shall reflect the Contractor's total membership in terms of geography, aid category, race and ethnicity and shall specifically include members who receive HCBS, or other individuals representing the members.

The Contractor shall submit the proposed Board membership to the OHCA for review and approval, prior to convening the first meeting. The Contractor shall keep the 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 member and provider experience, including but not limited to:

- Member outreach and educational activities and materials;

- Provider outreach and educational activities and materials;
- Quality improvement plan, including;
    - Selection of performance improvement plan topics and sharing of results,
    - Identification of measures to be evaluated for the purpose of documenting the Contractor's performance in both the short- and long-term; and
- Strategies for addressing operational deficiencies, as identified through complaint and appeal trends, member satisfaction data, in-home support service gaps, member appointment wait times, ER utilization trends and other quality data.

The Advisory Board shall meet at least quarterly, with the first meeting to be held no later than 90 days after commencement of services. The Contractor shall inform the OHCA at least 30 days in advance of each meeting and shall permit the OHCA to send representative(s) to observe the meeting, if the OHCA so requests.

The Contractor shall make the necessary arrangements, including payment of travel costs for the member and the family member or other person assisting the member to each meeting, to facilitate attendance by board members and their representatives. The Contractor may offer nominal incentives to encourage meeting participation (e.g., refreshments in meetings).

The Contractor shall keep a written record of Advisory Board meetings and shall submit the record to the OHCA upon request.

The OHCA shall collaborate with all program Contractors to develop a uniform performance monitoring data set, as described in section 2.22, "Contractor Performance Standards." The Contractor shall submit recommended measures for monitoring the Contractor and program performance to the OHCA no later than 180 days after commencement of services. The Contractor shall document the Advisory Board's role in formulating the final recommended measures.

2.2.2.4 OHCA Committees and Workgroups

The OHCA may establish standing committees and ad hoc workgroups to address implementation and ongoing short- and long-term operational and quality improvement matters. The Contractor shall send qualified representatives to attend these meetings, as instructed by the OHCA. At the OHCA's discretion, the Contractor may be permitted to have representatives attend remotely, rather than in person.

2.2.3 Staffing

The Contractor shall have sufficient operating staff to meet all Contract standards. This includes, at a minimum, all of the following:

- Executive management with clear oversight authority for all other functions;
- Medical Director's office, with a full time Medical Director;
- Medical management function, with a full time Medical Management Director or equivalent;
- Care management function, with a full time Care Management Director or equivalent;
- Quality improvement function, with a full time Quality Improvement Director or equivalent;
- Member enrollment and services functions, with a full time Member Service Director or equivalent;
- Provider contracting and services functions, with a full time Provider Network Director or equivalent;
- Pharmacy Director, to serve as single-point-of-contact for the OHCA Pharmacy Director (cannot be an employee of a PBM Subcontractor, if one is utilized);
- Full Time Native American liaison;
- Complaint and Appeals function;
- Claims processing function;
- Information technology function;
- Compliance and reporting function; and
- Accounting and finance function.

The Contractor may combine functions as long as it is able to demonstrate that all tasks are being performed. The Contractor also may use administrative service organizations to perform some or all of the above functions, subject to the conditions specified in section 2.2.2.2, "Subcontractors."

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

2.2.3.1 Board of Directors and Executive Management

The Contractor must have a Board of Directors specifically constituted for the health plan entering into a Contract with the OHCA.

The Contractor's executive management, defined to include the president or chief executive officer and chief operating officer or equivalent, if applicable, shall reside in Oklahoma. If the president, chief executive officer or chief operating officer, or equivalent, is not dedicated full time to the SoonerHealth+ program, the Contractor shall designate a full time

program manager, or equivalent, who must reside in Oklahoma. The program manager shall report directly to an executive manager as defined in this section.

The Contract officer specified in section 2.1.2.2, "Contractor," must be one of the individuals described above.

If an administrative service organization serves as executive management for the Contractor, this entity must report directly to Contractor's governing board and the Contractor must demonstrate through such means as policies and procedures and board minutes that its governing board actively participates in setting health plan policies and monitoring health plan performance.

2.2.3.2 Medical Director

The Contractor's medical director shall be board-certified and currently licensed in Oklahoma as a medical doctor or doctor of osteopathy. The medical director shall be a full time employee of the Contractor and shall reside in Oklahoma.

2.2.3.3 Care Management

The Contractor's care management function shall include sufficient management, supervisory level, direct care and support staff to support timely assessment, care plan development and implementation and active monitoring of members in accordance with standards described in section 2.11, "Care and Disease Management."

Staff shall have demonstrated experience in, and responsibility for, directing care and supporting management activities across all member types, including:

- Frail elders receiving in-home support services;
- Children and non-elderly adults with physical disabilities, including but not limited to members receiving in-home support services;
- Medically fragile children and adults;
- Children and adults with intellectual/developmental delays or disabilities;
- Children and adults with behavioral health conditions; and
- Persons dually eligible for Medicare and Medicaid.

2.2.3.4 Member Care Support Staff

The Contractor shall include within Care Management, Member Services or both, dedicated Member Care Support Staff with responsibility for assisting members by:

- Advocating on behalf of a member and his or her preferences with respect to receiving member- and family-centered care;
- Assisting the member to access community-based resources to address non-medical needs and to support the member's care plan objectives and independence;

- Obtaining information about available services in and outside of the health plan; and
- Filing complaints and appeals.

2.2.3.5 Native American Liaison

The Contractor shall employ a full-time liaison to the Native American community, with responsibility for outreach to members, Indian Health Care Providers (IHCPs) and tribal representatives. The liaison shall serve as a resource to, and advocate for, Native American ABD members and IHCPs in their interactions with the health plan.

2.2.3.6 Staffing Plan and Implementation Plan

The Contractor shall organize an implementation team and shall identify the members of the team for the OHCA's review and approval no later than 30 days after Contract execution.

The Contractor shall provide the names of the members of the board of directors, along with current resumes, no later than 30 days after Contract execution.

The Contractor shall submit an implementation plan for the OHCA's review and approval no later than 60 days after Contract execution and shall provide monthly implementation plans and updates to the OHCA.

The Contractor shall submit a hiring and staffing plan for the OHCA's review and approval no later than 60 days after Contract execution and shall provide monthly written updates to the OHCA of hiring activities.

2.2.3.7 Changes in Board of Directors and Management

The Contractor shall notify the OHCA of all changes in board composition and staffing at the department (functional area) manager level and above. The Contractor shall notify the OHCA at least five days in advance of the change, whenever practical. The Contractor shall submit a current resume and job description for the new board or staff member for the OHCA's review.

2.2.4 Prohibition on Off-Shoring

The Contractor shall not enter into any subcontract which uses any public funds within its control to purchase services which will be provided outside the United States. This reflects prohibition on the purchase of offshore services. As requested by the OHCA, the Contractor shall:

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

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

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

The State of Oklahoma will determine when the purchase of offshore services does not apply in regard to:

- Situations in which it is deemed an emergency; and
- The OHCA deems necessary to waive some or all of the requirements herein.

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.

2.2.5 Licensure, Administration and Staffing Reports

The Contractor shall submit licensure, administration and staffing reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Licensure, administration and staffing reports shall include at least the following:

- Advisory board meeting record;
- Implementation plan;
- Hiring and staffing plan;
- Changes in board of directors and management; and
- Known or anticipated value of contracted or subcontracted services.

2.3 Mandatory, Voluntary and Excluded Populations

2.3.1 Eligibility Determination

The State has sole authority for determining eligibility for SoonerCare (Medicaid) and for determining whether a SoonerCare member is eligible for enrollment in the SoonerHealth+ Program. The eligibility and enrollment process is described in section 2.5, "Enrollment and Disenrollment."

2.3.2 Mandatory Enrollment Populations

The SoonerHealth+ Program covers the SoonerCare Aged, Blind and Disabled population on a mandatory basis, except as noted in section 2.3.3, "Voluntary Enrollment Population – Native Americans and section 2.3.4, "Excluded Populations".

2.3.2.1 ABD Members who do not meet Criteria for NF/ICF-ID Level of Care

The mandatory enrollment population includes the following members who do not meet nursing facility or ICF-ID level of care criteria:

- ABD members eligible for Medicaid but not Medicare;
- ABD members dually-eligible for Medicaid (Medical Assistance) and Medicare, with incomes at or below 100 percent of the Federal Poverty Level (FPL) and receiving full Medicaid benefits (secondary to Medicare); and
- Children under age 19 receiving services under provision of the Tax Equity and Financial Responsibility Act (TEFRA Children).

2.3.2.2 ABD Members Who Meet Criteria for NF Level of Care and Receive HCBS

The mandatory enrollment population in year one includes members who meet both financial and clinical eligibility criteria for nursing facility level of care and receive services through one of the following two Section 1915c Home- and Community-Based waivers:

- ADvantage waiver. To be eligible for the ADvantage waiver program, a member must: qualify financially for SoonerCare; be 65 years of age or be a disabled adult as determined by the Social Security Administration; be determined to meet the nursing facility institutional level of care; not have a diagnosis of mental retardation or have a cognitive impairment; reside in his or her own home or family member's home; and have needs that can be safely met with waiver services and family or community supports; and
- Medically Fragile waiver. To be eligible for the Medically Fragile waiver program, a member must: qualify financially for SoonerCare; be at least 19 years of age; meet hospital and/or skilled nursing facility level of care; have a medically fragile condition as defined by the OHCA; and be living at home or a residential setting.

2.3.2.3 Change in Covered Populations

In the event that additional population(s) are identified as eligible for enrollment or other changes in covered populations occur during a Contract year, the OHCA shall implement such changes through the Contract amendment process described in section 2.1.9, "Amendments or Modifications."

2.3.3 Voluntary Enrollment Population – Native Americans

Notwithstanding the requirements outlined in section 2.3.2, "Mandatory Enrollment Populations," Native American ABD members who otherwise meet program eligibility criteria will have the option to enroll in the SoonerHealth+ Program during the annual open enrollment period described in section 2.5, "Enrollment and Disenrollment." Enrolled Native American ABD members may elect to disenroll during any subsequent open enrollment period.

2.3.4 Excluded Populations

Non-ABD SoonerCare members are excluded from the SoonerHealth+ Program. SoonerCare ABD members falling into one of the categories described below also are excluded as long as they remain in that category.

2.3.4.1 Members whose Benefit is Limited to Payment of Medicare Premiums

Members whose Medical Assistance benefit is limited to payment of Medicare premiums are excluded from the program. The affected groups are:

- Qualified Disabled and Working Individuals (QDWI), whose Medical Assistance benefit is limited to payment of Medicare Part A premiums; and
- Specified Low-Income Medicare Beneficiaries (SLMB) and Qualified Individuals, whose Medical Assistance benefit is limited to payment of Medicare Part B premiums.

2.3.4.2 Members Enrolled in a Behavioral Health Home

SoonerCare members assessed to have SMI or SED prior to enrollment in a health plan will be given the option to instead enroll in a Behavioral Health Home, unless the member is currently receiving outpatient services from a designated Health Home provider, in which case the member will be automatically attributed to that Health Home and given the option to opt-out. Members who either choose or are attributed to a Behavioral Health Home will be excluded from the SoonerHealth+ Program for the duration of their Behavioral Health Home enrollment.

Members enrolled in the Contractor's health plan who are found to meet the Behavioral Health Home eligibility criteria described in section 2.11, "Care and Disease Management," will be disenrolled in accordance with the procedures outlined in section 2.5, "Enrollment and Disenrollment" unless the member wishes to remain in the Contractor's health plan.

2.3.4.3 Program of All-Inclusive Care for the Elderly (PACE)

SoonerCare members ages 55 and older who meet SoonerHealth+ Program eligibility criteria will be offered the alternative of enrolling in a Program of All-Inclusive Care for the Elderly (PACE) site, if they also meet PACE eligibility criteria and if there is capacity at a site in their community.

Members who elect to enroll in PACE will be excluded from the SoonerHealth+ Program for the duration of their PACE enrollment. At the time of their disenrollment from PACE, these members will be enrolled in the SoonerHealth+ Program in accordance with the provisions of 2.5.2, "Enrollment Process," if they still meet eligibility criteria.

2.3.4.4 Homeward Bound Waiver

SoonerCare members enrolled in the Homeward Bound waiver are excluded from enrollment in the SoonerHealth+ Program.

2.3.4.5 Living Choice/Money Follows the Person

SoonerCare members transitioning from a nursing facility to the community under the Living Choice/Money Follows the Person Program are excluded from enrollment into the SoonerHealth+ Program during their initial 365-day transition period in the community. Upon reaching 365 days, members who continue to meet eligibility criteria for nursing facility level of care are enrolled in the ADvantage waiver program, at which time they will qualify for mandatory enrollment in the SoonerHealth+ Program.

2.3.4.6 Individuals with ID Who Receive Services through an HCBS Waiver

Individuals with ID who meet both financial and eligibility criteria for ICF-ID level of care and receive services through one of the three IID Section 1915c Home- and Community-Based waivers are excluded from enrollment during the program's first twelve months. These waivers are:

- Community waiver. To be eligible for the Community waiver, members must qualify financially for SoonerCare; have a disability with a diagnosis of mental retardation or a related condition, determined by the Social Security Administration or the OHCA Level of Care Evaluation Unit; be three years of age or older; be determined to meet ICF-ID institutional level of care requirements by the OHCA Level of Care Evaluation Unit; and have critical support needs that cannot be met by the In-Home Supports waivers or other service alternatives;
- In-Home Supports for Adults waiver. To be eligible for the In-Home Supports for Adults waiver, members must qualify financially for SoonerCare; have a disability with a diagnosis of mental retardation, determined by the Social Security Administration or the OHCA Level of Care Evaluation Unit; be 18 years of age or older; be determined to meet ICF-ID institutional level of care requirements by the OHCA Level of Care Evaluation Unit; reside in the home of a family member or

friend, in his or her own home or an Oklahoma DHS foster home; and have critical support needs which can be met within the annual waiver cap; and

- In-Home Supports for Children waiver. To be eligible for the In-Home Supports for Children waiver, members must qualify financially for SoonerCare; have a disability with a diagnosis of mental retardation, determined by the Social Security Administration or the OHCA Level of Care Evaluation Unit; be ages three to 17; be determined to meet ICF-ID institutional level of care requirements by the OHCA Level of Care Evaluation Unit; reside in the home of a family member or friend, in his or her own home or an Oklahoma DHS foster home or group home operated through the Children and Family Services Division; and have critical support needs which can be met within the annual waiver cap.

Beginning in month thirteen, these members will be mandatorily enrolled in the SoonerHealth+ Program in accordance with the procedures for new members outlined in Section 2.5.2, "Enrollment Process". Prior to their enrollment, the OHCA will issue a Contract amendment in accordance with the procedures described in section 2.1.9, "Amendments or Modifications," specifying the Contract standards and payment rates for these members.

The Contractor shall be subject to a readiness review prior to enrollment of these members, in accordance with procedures described in section 3.12, "Readiness Review." The Contractor's continued participation in the program may be contingent on passing the readiness review.

Individuals with ID who receive State Plan benefits but are not enrolled in one of the above HCBS waivers are covered under section 2.3.2, "Mandatory Enrollment Populations", and will be enrolled in SoonerHealth+ at the beginning of the program.

2.3.4.7 ABD Members Who Reside in an Institution

ABD members who meet eligibility criteria for nursing facility or ICF-ID level of care and whose place of residence is either a nursing facility or ICF-ID are excluded from enrollment during the program's first twenty-four months. Members enrolled in the Contractor's health plan whose place of residence transitions to one of these settings will be disenrolled in accordance with the procedures outlined in section 2.5, "Enrollment and Disenrollment."

Beginning in month twenty-five, these members will be mandatorily enrolled in the SoonerHealth+ Program. Prior to their enrollment, the OHCA will issue a Contract amendment in accordance with the procedures described in section 2.1.9, "Amendments or Modifications," specifying the Contract standards and payment rates for these members.

The Contractor shall be subject to a readiness review prior to enrollment of these members, in accordance with procedures described in section 3.11, "Readiness Review." The

Contractor's continued participation in the program may be contingent on passing the readiness review.

2.3.4.8 Children in the Custody of DHS or in Tribal Custody

ABD members who are children in the custody of DHS or in Tribal custody are excluded from enrollment during the program's first twenty-four months. Children enrolled in the Contractor's health plan who come into the custody of DHS or Tribal custody will be disenrolled in accordance with the procedures outlined in section 2.5, "Enrollment and Disenrollment."

Beginning in month twenty-five, these members will be mandatorily enrolled in the SoonerHealth+ Program. Prior to their enrollment, the OHCA will issue a Contract amendment in accordance with the procedures described in section 2.1.9, "Amendments or Modifications," specifying the Contract standards and payment rates for these members.

The Contractor shall be subject to a readiness review prior to enrollment of these members, in accordance with procedures described in section 3.11, "Readiness Review". The Contractor's continued participation in the program may be contingent on passing the readiness review.

2.3.5 Enrollment Phase-in

The OHCA does not anticipate phasing-in enrollment beyond what is described in section 2.3.4, "Excluded Populations". However, the 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 program. The Contractor shall cooperate in the implementation of a phase-in schedule, if one is implemented.

2.4 Capitated and Non-Capitated Benefits

2.4.1 General

The Contractor shall be responsible for furnishing the capitated benefits described in this section, which include both basic and supplemental health care services as classified by the Oklahoma Insurance Department. The Contractor shall ensure that members receive capitated benefits in accordance with:

- Medical necessity and member care plans, as outlined in section 2.11, "Care and Disease Management";
- Program timeliness standards, as outlined in section 2.8, "Provider Network and Service Accessibility";
- Prior authorization standards, as outlined in this section and in section 2.10, "Medical Management," and the OHCA's policies and rules; and
- Member share-of-cost and liability requirements, as outlined in this section and in section 2.16.5, "Member Cost Sharing Limitations."

The Contractor also shall be responsible for coordinating with providers of benefits outside of the SoonerHealth+ capitation to promote service integration and the delivery of holistic, person- and family-centered care. This includes:

- SoonerHealth+-covered non-capitated benefits, as outlined in section 2.4.3, "Non-Capitated SoonerHealth+ Benefits";
- Medicare-covered benefits provided to members dually eligible for Medicare and Medicaid, as outlined in section 2.18, "Financial Standards, Coordination of Benefits and Third Party Liability"; and
- Other benefits a member receives, regardless of payer, including volunteered services.

2.4.2 Capitated SoonerHealth+ Benefits

2.4.2.1 <u>General</u>

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 2.1.9, "Amendments or Modifications."

The Contractor shall adhere to the point of service cost sharing requirements and coverage limitations as specified in the OHCA's policies and rules.

The Contractor may require prior authorization of benefits to the extent these are required under the OHCA's policies and rules.

The Contractor may propose to impose additional prior authorization requirements, subject to the OHCA's review and approval, except for those benefits identified as exempt from prior authorization, as delineated in this section.

2.4.2.2 General Medical and Related Benefits

The following medical and related services are included in the capitated benefit package for children and adults. Annual benefit limits are tracked on a calendar year basis. Copayments do not apply to children under the age of 21. HCBS waiver members have no copayments, other than for prescription drugs.

Service	Children	Adults
Advanced Practice Nurse (APN) (317:30-5-375 – 317:30-5-377)	Covered (APN also can serve as a Patient-Centered Medical Home in accordance with section 2.8.3.1, "PCMH Providers")	Covered (APN also can serve as a Patient-Centered Medical Home in accordance with section 2.8.3.1, "PCMH Providers") $4.00 copayment
Ambulance or emergency transportation (317:30-5-335 – 317:30-5-343)	Covered – emergency only	Covered – emergency only
Ambulatory surgical center (317:30-5-565 – 317:30-5-568)	Covered	Covered $4.00 copayment
Bariatric surgery (317:30-5-137 – 317:30-5-141)	Covered, upon meeting pre-surgical evaluation and weight loss requirements	Covered, upon meeting pre-surgical evaluation and weight loss requirements $4.00 copayment
Birthing centers (317:30-5-890 – 317:30-5-893)	Covered, for low risk pregnancies to be delivered vaginally	Covered, for low risk pregnancies to be delivered vaginally $4.00 copayment
Care/case management	Covered in accordance with section 2.11, "Care and Disease Management"	Covered in accordance with section 2.11, "Care and Disease Management" $4.00 copayment

Service	Children	Adults
Certified Registered Nurse Anesthetist and Anesthesiologist Assistants (317:30-5-605 – 317:30-5-611 and 317:30-5-612 – 317:30-5-615)	Covered	Covered $4.00 copayment
Clinic services (317:30-5-575 – 317:30-5-579)	Covered	Covered $4.00 copayment
Dental services (317:30-5-695. – 317:30-5-705)	Cleaning twice a year, X-rays, fillings and crowns	Emergency extractions and services related to extraction. Limited services related to clearance for organ transplant approval (transplant-related services require prior authorization)
Diagnostic testing entities (317:30-5-907 – 317:30-5-907.3)	Covered	Covered $4.00 copayment
Durable medical equipment (317:30-5-210 – 317:30-5-218)	Covered when prescribed by a medical provider and may require prior authorization	Covered when prescribed by a medical provider and may require prior authorization $4.00 copayment per claim
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Early intervention services, including health and immunization history; physical exams, health assessments and counseling; lab and screening tests; and necessary follow-up care (317:30-3-65. – 317:30-3-65.11)	Covered	No coverage

Service	Children	Adults
Emergency department (317:30-5-42.7)	Covered, under prudent layperson definition	Covered, under prudent layperson definition
Family planning services (317:30-5-12)	Birth control information, contraceptives and permanent sterilization, PAP smears and pregnancy tests	Birth control information, contraceptives and permanent sterilization, PAP smears, pregnancy tests, tubal ligations and vasectomies
Federally Qualified Health Center and Rural Health Clinic services (317:30-5-660 – 317:30-5-664.15 and 317:30-5-355 –317:30-5-363)	Covered	Covered $4.00 copayment
Genetic Counseling and Testing (317:30-5-219 – 317:30-5-223)	Covered for pregnant members and members meeting medical necessity criteria	Covered for pregnant members and members meeting medical necessity criteria
Hearing services (317:30-5-675 – 317:30-5-680)	Evaluations, hearing aids and supplies	Evaluation only $4.00 copayment
Home health care services (317:30-5-545 – 317:30-5-549)	Thirty-six visits annually without prior authorization when prescribed by a physician	Thirty-six visits annually $4.00 copayment per visit
Hospice (non-hospital based) (317:30-5-530 – 317:30-5-538)	Covered for members with a life expectancy of six months or less	No coverage outside of ADvantage and Medically Fragile waiver services
Immunizations, as recommended by the Advisory Committee of Immunization Practices	Covered	Covered, as recommended for adults $4.00 copayment per date of service

Service	Children	Adults
Incontinence supplies (OHCA Incontinence supply guidelines)	Covered for children ages 4-20 with prior authorization	Covered only for adults enrolled in HCBS waivers
Inpatient hospital services (317:30-5-40 – 317:30-5-58 and 317:30-5-110 – 317:30-5-114)	Covered	Covered $10.00 per day copayment for first seven days; $5.00 copayment on eighth day ($75.00 maximum out-of-pocket)
Laboratory and X-ray (317:30-5-100 – 317:30-5-107)	Covered	Covered $4.00 copayment per visit
Lactation consultant (317:30-5-230 – 317:30-5-235)	Covered for pregnant and postpartum members	Covered for pregnant and postpartum members
Lodging and meals for the member and/or one approved medical escort (317:30-3-64)	Covered at the state per diem amounts if prior approved	Covered at the state per diem amounts if prior approved
Long-term care hospital for children (317:30-5-60 – 317:30-5-67)	Covered	No coverage
Mammograms (317:30-5-900 – 317:30-5-905)	Covered	Covered
Maternal and Infant LCSW services (317:30-5-204 – 317:30-5-209)	Covered for pregnant and postpartum members	Covered for pregnant and postpartum members
Medical supplies (317:30-5-210 – 317:30-5-218)	Covered	Covered $4.00 copayment
Nurse midwives (317:30-5-225 – 317:30-5-229)	Not covered	Covered, including care of normal newborn in first 28 days of life

Service	Children	Adults
Nursing Facility and ICF-ID services (317:30-3-42)	Covered	Covered
Nutrition services (dietician) (317:30-5-1075 – 317:30-5-1077)	Covered	Covered up to six hours per year $4.00 copayment
Orthodontic services (317:30-5-700)	Covered when prior authorized	No coverage
OTC contraceptives (317:30-5-12)	Covered	Covered
Outpatient hospital and surgery services (317:30-5-42.1 and 317:30-5-42.14)	Covered	Covered $4.00 copayment per visit
Parenteral/enteral nutrition (317:30-5-210.2 and 317:30-5-211.14)	Enteral and parenteral covered when prior authorized	Parenteral covered when prior authorized $4.00 copayment
Personal care and related services (317:30-5-950 – 317:30-5-953)	Covered, as authorized in a member's care plan, as described in section 2.11, "Care and Disease Management"	Covered, as authorized in a member's care plan, as described in section 2.11, "Care and Disease Management"
Physician and physician assistant services (317:30-5-1 – 317:30-5-25 and 317:30-5-30 –317:30-5-34)	Covered	Unlimited primary care provider visits, including to an APN furnishing primary care, except as noted below; up to four specialist provider visits per month (not all visit types count toward the monthly limit) Note: PCP visits occurring in an FQHC or RHC count toward the adult four visit limit $4.00 copayment per visit

Service	Children	Adults
Podiatry (317:30-5-260 – 317:30-5-279)	Covered	Covered $4.00 copayment per visit
Post-stabilization care services (in accordance with 42 CFR §438.114 and 422.113(c))	Covered	Covered
Pregnancy and maternity services, including prenatal, delivery and postpartum (317:30-5-175 – 317:30-5-180.5)	Covered	Covered
Prescription drugs (317:30-5 Part 5; see also section 2.4.2.4, "Pharmacy Program")	Covered	Covered, up to six prescriptions per month, including up to two brand name drugs without prior authorization and up to three brand name drugs with prior authorization (within the six prescription limit) Includes diabetic supplies $4.00 copayment per prescription Members enrolled in certain HCBS waivers are subject to higher limits and different copayment requirements, as described beginning in section 2.4.2.6, "ADvantage Waiver Services"
Private duty nursing (317:30-5-555 – 317:30-5-560.2)	Covered, as authorized in a member's care plan, as described in section 2.11,	Covered only for adults eligible for Medicare Part B, as authorized in a

Service	Children	Adults
	"Care and Disease Management." Covered for up to 16 hours per day, with exceptions made to the 16-hour limit made for up to 30 days immediately following hospitalization or the temporary incapacitation of the primary caregiver	member's care plan, as described in section 2.11, "Care and Disease Management"
Prosthetic devices (317:30-5-211.13)	Covered when prior authorized, including orthotics for children only (ages 0 – 20)	Limited coverage with prior authorization; orthotics are not covered for adults (ages 21 and older) $4.00 copayment
Public Health Clinic services (317:30-5-1150 – 317:30-5-1161)	Covered	Covered $4.00 copayment
Renal dialysis facility services (317:30-5 Part 29)	Covered	Covered $4.00 copayment
School-based health related services (317:30-5-305 – 317:30-5-307)	Covered	No coverage
Telemedicine (317:30-3-27)	Covered as specified in rules	Covered as specified in rules

Service	Children	Adults
Therapy services – physical therapy (PT), occupational therapy (OT) and speech therapy (ST) (317:30-5-290 – 317:30-5-293, 317:30-5-295 – 317:30-5-299, 317:30-5-675 – 317:30-5-680)	OT and PT – initial evaluation covered without prior authorization; treatment requires prior authorization ST – evaluation and treatment require prior authorization	OT, PT and ST – no prior authorization required; 15 visits per year in hospital outpatient setting (visit limit is per service type) $4.00 copayment per visit
Tobacco cessation products (317:30-5 Part 5 and 317:30-5-72.1. Drug benefit)	Nicotine replacement products and Zyban® are covered without prior authorization. Chantix® is covered up to 180 days per year	Nicotine replacement products and Zyban® are covered without prior authorization. Chantix® is covered up to 180 days per year. Tobacco cessation products do not require a copayment and do not count against the monthly prescription limit
Transplant services (317:30-3-57) Hospitals/organ transplants 317:30-5-41.2	Covered when prior authorized (cornea and kidney transplants do not require prior authorization)	Covered when prior authorized (cornea and kidney transplants do not require prior authorization)
Vision services EPSDT Vision services 317:30-3-65.7 Coverage by category 317:30-5-641	Covered, with a limit of two pairs of eyeglass frames per year	Coverage for eye diseases or eye injuries

2.4.2.3 Behavioral Health Benefits

The following behavioral health services, which are included in the capitated benefit package as described below, must be delivered in compliance with State and federal parity standards, including the Mental Health Parity and Addiction Equity Act.

Service	Children	Adults
Care/case management	Covered in accordance with section 2.11, "Care and Disease Management"	Covered in accordance with section 2.11, "Care and Disease Management" $3.00 copayment
Day Treatment Services (317:30-5-241.2 (f))	Covered when prior authorized for children for a minimum of three hours per day for four days per week	Not Covered
Inpatient hospital – freestanding psychiatric (317:30-5 Part 3 Hospitals and 317:30-5 Part 6 Inpatient Psychiatric Hospitals)	Covered when prior authorized	Covered for adults age 65 and older
Inpatient hospital – general acute (317:30-5 Part 3 Hospitals) 317:30-5-41.1. Acute inpatient psychiatric services 317:30-5 Part 6 Inpatient Psychiatric Hospitals (317:30-5-95 – 317:30-5-97)	Covered when prior authorized	Covered for adults age 21 and older
Independently Contracted Licensed Behavioral Health Provider (317:30-5-280 – 317:30-5-283)	Covered when prior authorized	No coverage

Service	Children	Adults
Outpatient behavioral health agency services (317:30-5-240 – 317:30-5-249)	Covered when prior authorized	Covered when prior authorized $3.00 copayment
Partial Hospitalization (317:30-5-241.2 (e))	Covered when prior authorized for children for a minimum of three hours per day for five days per week with a maximum of four billable hours per day	No coverage
Program of Assertive Community Treatment (PACT) services (317:30-5-241.5 (a) – Therapeutic behavioral services, family support and training and peer recovery support services (317:30-5-241.5 (b-d)	Covered for ages 18 and older in accordance with OAC 450:55	Covered in accordance with OAC 450:55 $3.00 copayment
Psychiatric residential treatment facility (317:30-5-95.29 – 317:30-5-98)	Covered when prior authorized	No coverage
Psychiatrist (Chapter 30-5-1) Part 1 Physicians: 317:30-5-11 Psychiatric services	Covered	Covered $3.00 copayment

Service	Children	Adults
Independently contracted Psychologist (317:30-5-275 – 317:30-5-278.1)	Covered	No coverage
Inpatient/residential substance use disorder treatment (SUD) (317:30-5-95.27 – 317:30-5-95.28)	Covered when prior authorized for detox only	Prior authorization not required for detox

2.4.2.4 Pharmacy Program

The Contractor must provide coverage of covered outpatient drugs, as defined in Section 1927(k)(2) of the Social Security 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 Social Security Act.

All SoonerHealth+ Program health plans, including the Contractor's health plan, shall be required to use the same list of covered drugs, which shall be developed by the OHCA. This common list of covered drugs includes preferred brands as indicated by their placement in lower tiers of tiered therapeutic categories.
The Contractor must post the list of covered drugs on its website and post coverage information with a formulary listing service or electronic prescribing service.

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

The Contractor may substitute generic equivalent drugs whenever such a substitution is considered both bio-equivalent and clinically efficacious. The Contractor must provide a brand name exception process whereby a member may seek brand name coverage. In some cases, the OHCA will prefer the branded product over the generic due to significant net cost savings. In these cases, the Contractor shall follow the 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 the OHCA prior to its initial use and prior to any subsequent revisions.

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

Although diabetic supplies are a DME benefit, the following supplies must be covered under the pharmacy point of sale system: blood glucose test strips, ketone test strips, lancets, lancet devices, meters, syringes, pen needles and control solution.

The Contractor shall provide utilization and other data necessary for the OHCA to bill manufacturers for rebates in accordance with Section 1927(b)(1)(A) of the Act. The data will be submitted in weekly batches, on a delivery schedule and in a format to be defined by the OHCA.

For pharmacy claims, the required data will include at least a claims level report showing member ID, provider pharmacy NPI, prescriber NPI, the NDC of the drug, prescription number, date dispensed, quantity, days' supply and reimbursed amount. For outpatient medical claims such as physician office visits, outpatient procedure or emergency room visits where drugs are administered, the required data will include at least a claims level report showing member ID, rendering provider NPI, ordering provider NPI, the HCPCS codes of drugs administered, the NDC of the product administered, date of service, HCPCS quantity and reimbursed amount of each covered outpatient drug dispensed or covered by the Contractor.

The Contractor shall provide the information in a format defined by the OHCA. The Contractor or their PBM shall designate a specific individual to work with the OHCA Drug Rebate Unit to resolve disputes that arise from Contractor's pharmacy and medical claims files, including Medicare crossover claims.

The Contractor also shall work with the OHCA pharmacy and drug rebate departments to determine the best course of action to handle drugs purchased through the 340B drug discount program and to establish protocols for claims processing and rebate collections.

2.4.2.5 Medicare Crossover Claims

The Contractor shall be responsible for payment of crossover claims for dually eligible members and for coordination of benefits with Medicare payers, Medicare Advantage plans and providers as described in section 2.18, "Financial Standards, Coordination of Benefits and Third Party Liability." The Contractor shall enter into a Coordination of Benefits

agreement with Medicare and participate in the automated claims crossover process for these members.

The Contractor shall provide utilization and other data necessary for the OHCA to bill manufacturers for rebates in accordance with Section 1927(b)(1)(A) of the Act in weekly batches not more than five days after the last date of the week reported. Such information must include, at a minimum, a claims level report showing member ID, rendering provider NPI, ordering provider NPI, the HCPCS and NDC codes of drugs administered, date of service, HCPCS quantity and reimbursed amount of each covered outpatient drug dispensed or covered by the Contractor on Medicare crossover claims.

The Contractor shall establish procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from its utilization reports. The Contractor shall provide the information in a format defined by the OHCA.

2.4.2.6 ADvantage Waiver Benefits

The following services are included in the capitated benefit package for ADvantage waiver members, in the duration and scope defined in the approved 1915c waiver:

- Adult day health care with personal care and therapy enhancements;
- Advanced supportive/restorative assistance;
- Assisted living services;
- Case management services;
- Consumer-directed personal assistance services and supports (CD-PASS);
- Environmental modifications;
- Home-delivered meals;
- Hospice care;
- Institutional transition services;
- Nursing;
- Personal care;
- Personal emergency response system (PERS);
- Prescription drugs – standard Medicaid benefit plus seven additional generic drugs and one extra brand name drug, for a total of 13 prescriptions per month, including three brand name drugs. Additional prescriptions subject to prior authorization, including medication therapy review by a qualified medical professional. Copayments in accordance with the schedule presented in the ADvantage waiver;
- Respite care;
- Specialized medical equipment and supplies;
- Skilled nursing services; and
- Therapy services: occupational, physical, speech and language (speech and language as an enhancement to adult day health care).

Procedures for delivery of goods and services eligible for self-direction are described in section 2.11, "Care and Disease Management."

2.4.2.7 Medically Fragile Waiver Benefits

The following services are included in the capitated benefit package for Medically Fragile waiver members, in the duration and scope defined in the approved 1915c waiver:

- Advanced supportive/restorative assistance;
- Case management;
- Environmental modifications;
- Home delivered meals;
- Hospice;
- Institutional Transition Services;
- Personal care;
- Personal emergency response system (PERS);
- Prescription drugs – standard Medicaid benefit plus seven additional generic drugs and one extra brand name drug, for a total of 13 prescriptions per month, including three brand name drugs. Additional prescriptions subject to prior authorization, including medication therapy review by a qualified medical professional. Copayments in accordance with the schedule presented in the Medically Fragile waiver;
- Respite care;
- Skilled nursing/private duty nursing;
- Specialized medical equipment and supplies; and
- Therapy services: physical, occupational and respiratory.

Procedures for delivery of goods and services eligible for self-direction are described in section 2.11, "Care and Disease Management."

2.4.2.8 Services or Settings in Lieu of Services or Settings Covered under the State Plan

The Contractor may cover services or settings that are in lieu of services or settings covered under the State Plan in accordance with 42 CFR § 438.3(e).

This includes provision of inpatient treatment in an Institution for Mental Diseases (IMD) to members ages 21 to 64, as long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment.

2.4.3 Non-Capitated SoonerHealth+ Benefits

2.4.3.1 Non-Emergency Transportation (NEMT)

NEMT, other than transportation covered through an HCBS waiver, is provided through a separate OHCA contract with a transportation vendor. The Contractor shall coordinate with the vendor when assisting members to schedule services.

2.4.3.2 Services Furnished at Indian Health Services/Tribal/Urban Indian Clinic Settings

Services furnished at Indian Health Services (IHS), Tribal and Urban Indian Clinic settings to the Contractor's members will be reimbursed by the OHCA outside of the Contractor's capitation. The OHCA has accounted for this policy when establishing capitation rates for Native American SoonerHealth+ members.

2.4.3.3 Other Benefits Not Specified

Covered benefits not otherwise identified as part of the capitation benefit package will be reimbursed by the OHCA outside of the capitation rate.

2.4.4 Value-Added Benefits and Services

The Contractor may offer value-added benefits and services in addition to the capitated benefit package to support the health, wellness and independence of members and the State's objectives for the SoonerHealth+ program. This may include, but is not limited to:

- Dental, vision, DME, pharmacy and physician services for adults in excess of fee-for-service program limits;
- HCBS waiver benefits to members not enrolled in one of the waivers; and
- HCBS waiver benefits in excess of fee-for-service program limits for persons enrolled in one of the waivers.

Value-added benefits and services, if offered, cannot be included in determining the Contractor's payment rate.

If the Contractor has proposed any value-added benefits or services in its response to the Solicitation, and the OHCA and CMS have 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 the OHCA's review and approval prior to the start of a Contract year, to take effect in the upcoming Contract year.

2.4.5 Capitated and Non-Capitated Benefits Reports

The Contractor shall submit capitated and non-capitated benefits reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Capitated and non-capitated benefits reports shall include at least the following:

- Pharmacy utilization and other data necessary for the OHCA to bill manufacturers for rebates; and
- Value-added benefits.

2.5 Enrollment and Disenrollment

2.5.1 Program Eligibility

2.5.1.1 Eligibility Determination

The State has sole authority and responsibility for determining eligibility for SoonerCare and the SoonerHealth+ Program.

2.5.1.2 Non-Discrimination

The Contractor may not refuse an assignment or seek to disenroll a member or otherwise discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity or disability. The Contractor also may not discriminate against the member on the basis of expectations that the member 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 member's health.

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 member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment in the Contractor's health plan seriously impairs the entity's ability to furnish services to either this particular member or other members. The Contractor may only request disenrollment of the member in accordance with the provisions outlined in section 2.5.7.2, "At Request of Contractor."

2.5.1.3 Nursing Facility Level of Care and Special Health Care Needs

During enrollment, the OHCA shall provide the Contractor with information about members who are nursing facility level of care and residing in the community, and members who have special health care needs, via the 834 enrollment file and the transfer of existing care plans to the Contractor.

The Contractor shall identify members enrolled in its health plan who may be nursing facility or ICF/ID level of care eligible as part of its assessment activities. The Contractor shall advise these members of their potential eligibility and educate them about the application process. The Contractor's Member Care Support Staff shall be available to assist these members in completing the application process, when requested. The Contractor also shall inform the Oklahoma DHS of a member's potential eligibility, if agreed to by the member.

2.5.2 Enrollment Process

2.5.2.1 Enrollment Choice Counseling

The OHCA will contract with a third-party Enrollment Choice Counselor, responsible for educating eligible persons about the SoonerHealth+ Program and providing unbiased counseling concerning enrollment options. Choice counseling will be available at the time of initial enrollment, during the annual open enrollment period described in section 2.5.2.8, “Annual and Special Open Enrollment Periods” and under the provisions described in section 2.5.7 "Disenrollment Process."

The OHCA will provide notice to prospective members regarding the health plan and PCMH provider selection process and the importance of making a selection in accordance with informational and timing requirements as specified in 42 CFR § 438.54.

The OHCA also will provide information to potential members regarding their right to disenroll consistent with the requirements of 42 CFR § 438.56, the process to exercise their disenrollment right and any other alternatives available to them based on their specific circumstance.

2.5.2.2 Materials for Enrollment Choice Counselor

The Contractor shall furnish materials regarding its health plan and up-to-date provider network rosters in a manner and on a schedule to be defined by the OHCA. The provider network rosters shall include up-to-date information on whether each PCMH provider has an open or closed panel with respect to accepting new patients. Inaccurate provider network information shall be grounds for performance penalties, as described in section 2.22, “Contractor Performance Standards.”

The Contractor also shall supply provider network rosters via website services to the State of Oklahoma HIE vendors in a manner and on a schedule to be defined by the OHCA. Currently these vendors are MyHealth and Coordinated Care of Oklahoma (CCO).

2.5.2.3 Initial Health Plan Selection

The OHCA, at its discretion, may allow up to 90 days for members to select a health plan prior to the start of the program. Subsequent to program start, the OHCA initially will establish a 30-day health plan selection period for members who are newly-eligible to enroll in the SoonerHealth+ Program. The OHCA reserves the right to reduce the selection period to a period of not less than 14 days, if deemed appropriate based on member selection patterns. Members who do not make an election within the allowed timeframe will be assigned to a health plan in accordance with the rules outlined in section 2.5.2.5, “Auto-Assignment.”

2.5.2.4 Re-Enrollment Following Loss of Eligibility

Members who lose and regain eligibility for the SoonerHealth+ Program within a period of two months or less will be re-enrolled automatically with their prior health plan. Re-enrolled members will have the right to change health plans in accordance with section 2.5.2.7, "Enrollment Lock-In Period."

2.5.2.5 Auto-Assignment

Members who are eligible to choose a health plan and fail to make an election will be assigned to one on the following basis:

- If the OHCA is aware of any existing relationship between a member and a PCMH provider, or another provider if the member does not have a relationship with a PCMH provider, it will assign the member to a health plan that has that provider in its network, to the extent practicable. If multiple plans contract with the provider and one is a CPC+ payer partner, the member will be assigned to that plan. Otherwise, the random assignment method described below will be used to select from the eligible health plans, including between two CPC+ payer partner plans, if applicable;
- If the member does not meet the first condition, and it is known to the OHCA that the member is enrolled in a Medicare Advantage health plan operated by one of the SoonerHealth+ program health plans, he or she will be enrolled into that health plan; or
- If the member cannot be assigned through either of the above steps, he or she will be assigned to the health plan that is next due to receive an auto-assigned member. This will be the health plan that has received the fewest number of auto-assignments to that point in time. For purposes of this calculation, members of a family enrolled together will be treated as a single auto-assignment.

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

- The Contractor's maximum enrollment has been capped under the terms outlined in section 2.5.8, "Enrollment Caps," and actual enrollment has reached 95 percent of the cap;
- The Contractor has been excluded from receiving new enrollment due to failure to perform, as outlined in section 2.22, "Contractor Performance Standards," with the exception of newborns; or
- The Contractor's enrollment exceeds 45,000 members or 60 percent of total enrollment, whichever is greater, in which case the Contractor shall be excluded from auto-assignments for a period of not less than 30 days. The OHCA, at its sole discretion, may waive this auto-assignment exclusion if deemed in the best interest of the program.

It is the OHCA's intent to modify the assignment algorithm in Contract renewal periods to take into consideration the Contractor's performance. The revised algorithm will be included as part of Contract renewal terms and conditions.

2.5.2.6 Enrollment Effective Date

Except as provided below, it is the OHCA's intent that members who select or are assigned to a health plan on or before the fifteenth day of the month shall be enrolled effective 12:01 am on the first day of the following month. Members who select or are assigned to a health plan on the sixteenth day of the month or later will be enrolled effective 12:01 am on the first day of the second following month.

Newborns eligible for the SoonerHealth+ Program shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerHealth+ Program.

Members enrolling in a plan at time of discharge from a nursing facility, if known to the OHCA, shall be enrolled effective as the date of discharge, in accordance with the process described in section 2.6.5.2, "Nursing Facility to Home".

Notwithstanding the above language, the effective date of enrollment into the Contractor's health plan shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by the OHCA.

2.5.2.7 Enrollment Lock-In Period

Members will be permitted to change health plans once, without showing cause, during their first 90 days of enrollment in the SoonerHealth+ Program or during the 90 days following the date the OHCA sends the member notice of that enrollment, whichever is later. After the member's period for disenrollment from the SoonerHealth+ Program has lapsed, members will be locked into their health plans until the next annual open enrollment period, unless: disenrolled due to loss of eligibility; for cause; upon re-enrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period; if the OHCA imposes intermediate sanctions on the Contractor and allows members to disenroll without cause; or if the State imposes suspension of all new enrollment on behalf of the Contractor as specified in 42 CFR § 438.702(a)(4).

2.5.2.8 Annual and Special Open Enrollment Periods

The OHCA will conduct an open enrollment period prior to the start of each Contract renewal year. During open enrollment, the OHCA and its Enrollment Choice Counselor will provide members information on their health plan options for the coming year.

Written notice of open enrollment and member disenrollment rights will be provided to members at least 60 days prior to the start of the next Contract year. The Contractor shall

cooperate with the OHCA in furnishing requested materials to current and prospective members, either directly or through the Enrollment Choice Counselor, as part of the open enrollment process.

Members will be informed that if they do not request a new health plan, they will remain in their current health plan, subject to it being offered in the renewal year. All members, including those who do not make a change, will be permitted to change health plans during the first 90 days of the renewal period in accordance with the process outlined in section 2.5.2.7, "Enrollment Lock-in Period."

In the event of the early termination of a health plan under the process described in section 2.1.10, "Early Termination," or the loss of a major network provider whose departure places the Contractor at risk of failing to meet service accessibility standards and for which the Contractor does not have an acceptable plan for mitigating the loss or a finding of non-compliance as delineated in section 2.22, "Contractor Performance Standards," the OHCA at its sole discretion may schedule a special open enrollment period for affected members. The Contractor shall cooperate as directed by the OHCA in facilitating the special open enrollment.

2.5.3 Outreach to New Members

2.5.3.1 Initial Contact

The Contractor shall make all reasonable efforts to contact new members in person, by telephone or through the use of other mechanisms (e.g., email, mail, text messaging) within 10 days of the enrollment effective date. Reasonable efforts are defined to mean at least three attempts, with more than one method of contact being employed (e.g., telephone and mail).

Upon contacting a new member, the Contractor shall:

- Inquire about any urgent health needs or previously scheduled services or advise the member how to contact the health plan to provide this information;
- Conduct a health risk screening, in accordance with the requirements outlined in section 2.11, "Care and Disease Management," or inform the member that he or she will be contacted at a later time for this purpose;
- Inform the member about his or her right to continue certain existing services, as applicable, in accordance with section 2.6, "Transition of Care";
- Review with the member what to do in an emergency;
- Inform the member about the Contractor's policies with respect to obtaining covered services;
- Assist the member in selecting a PCMH provider, if applicable, in accordance with section 2.5.4, "PCMH Selection and Assignment";

- Provide the member with health plan telephone numbers and website address;
- Advise the member about opportunities available for learning about health plan policies and benefits in greater detail; and
- Confirm the member has access to a complete and up-to-date list of network providers who may be accessed directly, without referral or inform the member how to obtain or access such a list. This list must include addresses and telephone numbers of such providers.

2.5.3.2 Member Materials

The Contractor shall distribute member handbooks and identification cards in accordance with the requirements and timelines specified in section 2.7, "Member Services."

2.5.3.3 Failure to Contact

The Contractor shall report to the OHCA on a monthly basis all members that it has failed to contact during the first 30 days of enrollment and the nature and disposition of its contact attempts. The OHCA will specify the reporting format prior to the start of enrollment.

2.5.4 PCMH Selection and Assignment

2.5.4.1 PCMH Covered and Excluded Members

The Contractor shall provide a PCMH provider to all members who are not eligible for Medicare.

The Contractor, at its option, may provide a PCMH provider to members who are dually eligible for Medicaid and Medicare.

2.5.4.2 Eligible Providers

The Contractor shall limit PCMH provider types to those specified in section 2.8, "Provider Network and Service Accessibility." A member whose PCMH site is a multi-provider clinic can be assigned either to the clinic or a specific practitioner within the clinic to serve as his or her PCMH provider.

2.5.4.3 Initial PCMH Selection or Assignment Process

The Contractor must align newly-enrolled members, other than dual eligibles, with an age, gender and culturally-appropriate PCMH provider within 10 days of the member's enrollment effective date. The Contractor, at its option, may allow members a window of opportunity to select a PCMH provider before making an assignment, as long as members are aligned within the 10-day standard. If the Contractor makes an assignment, the PCMH provider must meet the travel time and distance standards specified in section 2.8, "Provider Network and Service Accessibility."

2.5.4.4 Member-Initiated PCMH Changes

The Contractor must permit members to change PCMH providers, without cause. If the Contractor has made an initial assignment, the Contractor must permit the member to change during the first month, effective no later than 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 members have at least two age- and gender-appropriate PCMH providers within the travel time and distance standards specified in section 2.8, "Provider Network and Service Accessibility," from which to select.

2.5.4.5 Contractor-Initiated PCMH Changes

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

- Member requires specialized care for an acute or chronic condition and the member and the Contractor agree that reassignment to a different provider is in the member's interest;
- Member's place of residence has changed such that he or she has moved beyond the PCMH provider travel time distance standard;
- Member's PCMH provider ceases to participate in the Contractor's network;
- Member's behavior toward his or her PCMH provider is disruptive and the provider has made all reasonable efforts to accommodate the member; or
- Member has taken legal action against the provider.

Whenever initiating a change, the Contractor must offer affected members the opportunity to select a new PCMH provider.

2.5.5 Primary Care Dentist (PCD) Selection and Assignment

2.5.5.1 PCD Covered and Excluded Members

The Contractor shall provide a PCD to all members who are under the age of 21. The Contractor shall, as appropriate, seek to align members with PCD's who specialize in treating children with special health care needs, including children with intellectual disabilities.

The Contractor, as its option, may provide a PCD to members ages 21 and older.

2.5.5.2 Initial PCD Selection or Assignment Process

The Contractor must align newly-enrolled members under age 21 with a PCD within 10 days of a member's enrollment effective date. The Contractor, at its option, may allow members or the parents/guardians a window of opportunity to select a PCD before making an assignment, as long as members are aligned within the 10-day standard. If the Contractor

makes an assignment, the PCD must meet the travel time and distance standards specified in section 2.8, "Provider Network and Service Accessibility."

2.5.5.3 Member-Initiated PCD Changes

The Contractor must permit members to change PCDs without cause. If the Contractor has made an initial assignment, the Contractor must permit a member 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.

2.5.5.4 Contractor-Initiated PCD Changes

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

- Member's place of residence has changed such that he or she has moved beyond the PCD's travel time distance standard;
- Member's PCD ceases to participate in the Contractor's network;
- Member's behavior toward his or her PCD is disruptive and the PCD has made all reasonable efforts to accommodate the member; or
- Member has taken legal action against the PCD.

Whenever initiating a change, the Contractor must offer affected members the opportunity to select a new PCD.

2.5.6 Member Status Changes

The Contractor shall notify the OHCA within five business days of learning of any change in a member's status or circumstances that could affect the member's eligibility for the program. The OHCA will specify the manner in which status changes must be reported prior to the start of enrollment.

2.5.7 Disenrollment Process

2.5.7.1 At Request of Member

Members shall be permitted to disenroll from the Contractor's health plan without cause, in accordance with the provisions of section 2.5.2.7, "Enrollment Lock-in Period." During the lock-in period, members may be disenrolled for cause, at any time, under the following conditions:

- The member moves out of the Contractor's region (if serving only one region);
- Member requires specialized care for a chronic condition and the member or member's representative, the Contractor, the OHCA and receiving health plan agree that assignment to the receiving health plan is in the member's best interest;
- Member seeks capitated benefits that the Contractor does not cover for moral or religious reasons;

- Member 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 network; and the member's PCMH provider or another provider determines that receiving the services separately would subject the member to unnecessary risk;
- Member uses a residential, institutional or employment supports provider that exits the Contractor's network;
- Member has filed and prevailed in a complaint or appeal 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 member's health care needs or other matters deemed sufficient to warrant disenrollment; or
- Member has been enrolled in error, as determined by the OHCA.

Members may request disenrollment through the Enrollment Choices Counselor. The Contractor shall refer members requesting disenrollment to the Counselor. Disenrollment requests will be adjudicated by the OHCA and, if approved, will become effective on a date established by the OHCA consistent with section 2.5.7.4, "Disenrollment Effective Date".

2.5.7.2 At Request of Contractor

The Contractor must comply with section 2.5.1.2, "Non-Discrimination," and seek to disenroll a member only for good cause. The following actions, if found by the OHCA, comprise good cause:

- Member requires specialized care for a chronic condition and the member or member's representative, the Contractor, the OHCA and receiving health plan agree that assignment to the receiving health plan is in the member's best interest;
- Member has been enrolled in error, as determined by the OHCA;
- Member is disruptive and the Contractor has made all reasonable efforts to accommodate the member; or
- Member has committed fraud (e.g., loaning ID card for use by another person).

The Contractor must make a written request to the OHCA for disenrollment, in a format to be specified by the OHCA. The Contractor also must communicate its request to the member in writing, in a format to be specified by the OHCA. The OHCA shall have sole authority to grant or deny the disenrollment request.

2.5.7.3 At OHCA's Initiation

The OHCA will initiate disenrollment of members under the following circumstances:

- Loss of eligibility for Medicaid;
- Transition to SoonerCare aid category excluded from the SoonerHealth+ Program;
- Transition from community placement to resident of a nursing facility or ICF/ID, as communicated through disenrollment updates provided by the OHCA on the ANSI ASC X 12 834 electronic transaction;
- Death;

- Member becomes inmate of a public institution;
- Member commits fraud or provides fraudulent information; or
- Disenrollment is ordered by a hearing officer or court of law.

2.5.7.4 Disenrollment Effective Date

Except as provided for below, and unless the OHCA determines that a delay would have an adverse effect on a member's health, it is the OHCA's intent that a disenrollment shall be effective 12:01 am on the first day of the following month. Appeal 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 member's health care needs or other matters deemed sufficient to warrant disenrollment under section 2.5.1.7, "At Request of Member," must be completed within this timeframe. If the Contractor fails to complete the complaint process in time to permit disenrollment by the 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 member's SoonerHealth+ eligibility status changes:

- Loss of eligibility for Medicaid;
- Transition to a SoonerCare aid category excluded from the SoonerHealth+ Program;
- Transition to a Behavioral Health Home;
- Transition from community placement to resident of a nursing facility or ICF/ID, as communicated through disenrollment updates provided by means of disenrollment updates through receipt of outbound ANSI ASC X 12 834 electronic transactions;
- Death;
- Member becomes inmate of a public institution;
- Member commits fraud or provides fraudulent information; or
- Disenrollment is ordered by a hearing officer or court of law.

Notwithstanding the above language, the effective date of disenrollment from the Contractor's health plan shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by the OHCA.

2.5.8 Enrollment Caps

The 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 2.22, "Contractor Performance Standards."

2.5.9 Enrollment and Disenrollment Transaction Data

The Contractor shall be notified of enrollments and disenrollments through receipt of outbound ANSI ASC X 12 834 electronic transactions, as specified in section 2.21, "Payments to Contractor." The Contractor shall be responsible for reconciliation of enrollment data to

capitation payments and subject to recoupments for partial month and retroactive disenrollments, as also specified in section 2.21, “Payments to Contractor.”

2.5.10 Enrollment and Disenrollment Reports

The Contractor shall submit enrollment and disenrollment reports to the OHCA at the frequencies specified in section 2.17, “Reporting.” Enrollment and disenrollment reports shall include at least the following:

- Failure to contact member;
- PCMH provider selection or assignment;
- PCMH provider change;
- PCD selection or assignment;
- PCD change; and
- Member status change.

2.6 Transition of Care

2.6.1 Transition of Care General Provisions

The Contractor shall take all necessary steps to ensure continuity of care when transitioning members into the Contractor's health plan or to another SoonerHealth+ Program health plan. The Contractor shall ensure that established member/provider relationships, current services and existing prior authorizations and care plans will remain in place during the transition period in accordance with the requirements outlined in this section. Transition to the Contractor's health plan shall be as seamless as possible for members and their providers.

The Contractor shall take special care to provide continuity of care for newly enrolled members 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 develop and implement an outreach process, including mailings, emails, text messages, website postings, telephone calls and home visits, as appropriate, to explain the Contractor's transition process to new members. Language used in all forms of communication shall conform with requirements specified in section 2.7, "Member Services."

The Contractor shall ensure that all members are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the transition period.

The Contractor shall complete an Initial Health Risk Screening within 30 days of enrollment for all members transitioning to the Contractor's health plan, in accordance with the requirements specified in section 2.11, "Care and Disease Management." The purpose of the Health Risk Screening will be to obtain basic health and demographic information, identify any immediate needs a member may have and to assist the Contractor in assigning a risk level to the member in order to determine the level of care management needed.

The Contractor shall develop and implement transition of care procedures and standards unique and appropriate for each of the following member populations:

<u>Year 1</u>

- SoonerCare Choice Medicaid-only;
- Members who are dually eligible for Medicare and Medicaid;
- Medically Fragile waiver;

- ADvantage waiver;
- Individuals with ID who are not enrolled in an HCBS waiver and therefore receiving State Plan services; and
- Members opting in from another program (e.g., transition from a Behavioral Heath Home, Native Americans) or who have a special election period.

Year 2

- Individuals with ID who are receiving long-term care services through:
  - Community waiver,
  - In-home Supports for Adults waiver,
  - In-home Supports for Children waiver; and
- Members opting in from another program (e.g., transition from a Behavioral Heath Home, Native Americans) or who have a special election period.

Year 3

- Children in custody of DHS or in Tribal custody;
- Members residing in nursing facilities;
- Members residing in Intermediate Care Facilities for persons with Intellectual/Developmental Disabilities; and
- Members opting in from another program (e.g., transition from a Behavioral Heath Home, Native Americans) or who have a special election period.

2.6.2 Transition of Care Policies and Procedures

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

- A schedule that ensures that the transition does not create a lapse in service;
- A process for timely information exchange (including transfer of a member record, including the member's care plan);
- A process for assuring confidentiality;
- A process for allowing members to request and be granted a change of provider;
- An appropriate schedule for transitioning members from one provider to another when it is medically necessary for ongoing care;
- A process for transitioning members from one care setting to another; and
- A process for transitioning members from or to another health plan.

2.6.3 Transition of Care Period

For all members, prior authorizations for covered services, including physical health, behavioral health, HCBS, medications and other specialty referrals, in place on the day prior to the date of enrollment to the Contractor's health plan shall remain in place for 90 days

following a member's enrollment or until a comprehensive assessment and care plan have been developed, approved and implemented (if applicable), whichever comes sooner.
During the 90-day period, prior authorizations may not be denied on the basis that the authorizing provider is not a network provider and payment to providers, whether contract or non-contract, shall be made at the current Medicaid fee schedule and in accordance with the OHCA's payment timeliness standards, as outlined in section 2.16, "Claims Processing."

The transition of care period shall include the following activities and timeframes:

- The Initial Health Risk Screening shall be completed within 30 days of enrollment;
- Written correspondence shall be sent to the member identifying their assigned care manager within 10 days of completion of the Health Risk Screening, unless the member is at risk level 1 and care management is being performed solely within a CPC+ practice;
- The care manager shall schedule the comprehensive assessment (if applicable) within 30 days of completion of the Health Risk Screening;
- The care manager shall complete the comprehensive assessment (if applicable) within 45 days of completion of the Health Risk Screening; and
- The care manager shall develop and the Contractor shall authorize a care plan within 15 days of completion of a comprehensive assessment (if applicable).

2.6.3.1 Transitioning Members with No Care Plan

As required in section 2.11.6, "Assigning Care Management Risk Levels," the Contractor shall assign a care management risk level to all members based on the Health Risk Screening, existing care or treatment plans, if applicable, and utilization, claims and other data. The Contractor shall develop an appropriate care plan based on a member's risk level.

2.6.3.2 Transitioning Members with an Existing Care or Treatment Plan

For members with an existing care or treatment plan in place on the day prior to the date of enrollment in the Contractor's health plan, the Contractor shall accept the existing care plan for a period of 90 days or until a comprehensive assessment and care plan have been developed, approved and implemented, whichever comes sooner.

Notwithstanding the 90-day period described above, the Contractor shall have procedures in place that specifically address the needs of special groups, including at least the following:

- The Contractor shall be responsible for the costs of pregnant women for continuation of medically necessary prenatal care services, delivery and post-natal care, through follow-up checkup within six weeks of delivery, without any form of prior approval and without regard to whether such services are being provided by a contract or non-network provider;
- The Contractor shall honor the existing treatment plan until such plan has been completed for members receiving chemotherapy or radiation treatment, dialysis,

major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for Hepatitis C treatment or who are terminally ill;

- Children receiving private duty nursing services will continue to receive these services until such time as the Contractor has performed a comprehensive assessment and determined the appropriate level of private duty nursing services as a component of the member's overall care plan. Children receiving private duty nursing services also will receive specific transition notification and assistance in accordance with section 2.6.5.7, "Age Transitions";
- The Contractor shall honor the OHCA's negotiated payment rate for members who are receiving out-of-state services and/or meals and lodging assistance;
- Members who are receiving services for hemophilia shall continue to receive services by their current hemophilia providers for up to 90 days;
- Members with a treatment plan that contains behavioral health services shall be allowed to remain with the current behavioral health treatment provider(s) for up to 90 days; and
- If durable medical equipment (DME) or supplies were authorized and ordered prior to enrollment but not received by the time of enrollment, the Contractor shall coordinate and follow through to ensure that members receive the necessary supportive equipment and supplies without undue delay.

For members receiving HCBS, the Contractor shall:

- Provide continuation of HCBS until a new face-to-face comprehensive assessment and care plan have been developed, approved and implemented, which shall be no more than 90 days following a member's enrollment; and
- Make reasonable efforts to contract with existing vendors to enable members to retain their existing in-home support services, if so desired by the member.

2.6.4 Assignment of Members to Providers

Members with an existing relationship with a network provider shall be allowed to retain that provider during and after transition to the Contractor's health plan.

The Contractor shall continue to pay a member's existing providers until such time as the Contractor can reasonably transfer the member to network providers without impeding service delivery necessary to the member's health or to prevent hospitalization or institutionalization. In the event there is no network provider available who meets the member's needs, the Contractor shall allow the member to retain his/her current provider until either the current provider becomes a network provider or a network provider who meets the member's needs becomes available.

Notwithstanding the above language, members shall be permitted to receive care from an out-of-network provider if:

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

2.6.5 Transitioning Members between Settings, Health Plans or Services

2.6.5.1 Acute Care Hospital or Residential Treatment Facility to Home or Nursing Facility

The Contractor shall have in place discharge planning techniques, policies and procedures to effectively and appropriately manage the transition of care for members being discharged from inpatient care. Such techniques shall be designed to control hospital readmissions within 30 days of discharge.

For dual eligible members or for any members for whom the Contractor's health plan is not the primary payer, the Contractor's care manager shall work cooperatively with a member's Medicare plan's discharge team to ensure the member's smooth transition.

For members for whom the Contractor's health plan is the primary payer, within 24 hours of admission, the Contractor's care manager shall work with the member's PCMH provider, the Interdisciplinary Team (IDT), the hospital discharge planner(s), the attending physician, the member and the member's family to assess and plan for the member's discharge. The Contractor's care manager shall monitor the member's inpatient stay and shall visit the member face-to-face during the inpatient stay, as necessary, to facilitate timely and appropriate discharge planning.

The discharge plan shall address, as needed:

- In-home supports;
- Language or cultural needs;
- Medications;
- Home health care needs;
- DME needs;
- Outpatient service needs, such as chemotherapy, dialysis, mental health or rehabilitation;
- Personal care service needs;
- Mental health and cognitive function;
- Safety factors in the home, such as stairs and the location of bedroom and bathroom;
- Assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs);

- Transportation needs;
- Meals;
- Appointments with PCMH providers or other specialists; and
- Behavioral health appointments.

The Contractor shall ensure that the discharge plan includes arrangements for receiving community-based care, rather than institutional care, whenever possible. The Contractor shall ensure that the IDT and the member's family are well informed of all service options available to meet the member's needs in the community.

For members transitioning from a hospital or behavioral health institution to a nursing facility, the Contractor shall ensure that each member is placed in the least restrictive setting that will meet the member's needs. The Contractor shall update the member's care plan. The Contractor shall be responsible for coordinating care while the member is in the nursing facility until the member's place of residence is changed and the member is disenrolled from the Contractor's health plan on a date specified by the OHCA on the 834 enrollment file.

For members being discharged from a behavioral health inpatient/residential facility, the Contractor's care manager shall perform an evaluation prior to discharge to determine what mental health or substance use disorder treatment services are medically necessary post-discharge. The member's outpatient provider(s) and IDT shall be involved in the discharge planning and appropriate outpatient visit(s) shall be scheduled before discharge to ensure access to proper provider/medication follow-up. The Contractor also shall address the member's placement/housing needs as part of discharge planning activities.

For all of the above instances, the care manager shall make contact with the member within 72 hours of discharge. Within seven days of discharge, the care manager shall perform a reassessment, update the member's care plan and ensure that the discharge plan and any corresponding services are being executed as directed. For members receiving HCBS, the assessment shall be performed face-to-face. The care manager, in collaboration with the member's IDT, shall modify the care plan as appropriate and inform the member, member's family and the member's caregiver(s) of any changes to the plan.

2.6.5.2 Nursing Facility to Home

Members residing in a nursing facility shall choose by written consent to transition to a community setting and receive HCBS. The estimated cost of the HCBS shall not exceed the limit established by the OHCA. The Oklahoma DHS shall be responsible for determining a member's change in status from nursing facility to community.

Upon notification from DHS, the OHCA will assign an enrollment choice counselor to the member while in the nursing facility to assist the member to either select or be auto-assigned to a SoonerHealth+ Program health plan according to the procedures specified in section 2.5, "Enrollment and Disenrollment." The selected SoonerHealth+ Program health plan shall be notified by the OHCA via the 834 enrollment file and be responsible for participating in discharge planning activities while the member is in the nursing facility and prior to enrollment in the SoonerHealth+ Program health plan.

Upon notification, the Contractor shall assign a care manager who will contact the member while the member is in the nursing facility. The Contractor's care manager shall work with the member's IDT and the discharge planning staff at the nursing facility to ensure that a comprehensive assessment has been completed, a care plan developed and all necessary services and supports, including home modifications, are in place prior to the member's return home.

The comprehensive assessment shall include a risk assessment signed by the member or the member's representative. The purpose of the risk assessment is to identify any risk factors a member may have and to develop interventions to eliminate or mitigate the risks.

The member's care plan shall identify all available services and resources to address any risk factors. The care plan also shall include the provision of Institutional Transition Services to members eligible under the ADvantage or Medically Fragile waiver. If a member is being discharged to a private residence, the Contractor's care manager shall complete an onsite evaluation of the residence prior to the member's discharge from the nursing facility to ensure that the setting will meet the member's needs.

The member shall be enrolled in a SoonerHealth+ Program health plan immediately upon disenrollment from the nursing facility. The care manager shall make contact with the member within 72 hours of discharge from the nursing facility to follow-up on the member's status post-transition. The care manager shall perform a face-to-face reassessment and update the member's care plan within seven days of the transition from nursing facility to home in order to evaluate whether all services and supports required by the care plan are being provided.

The care manager, in collaboration with the member's IDT, shall make any necessary changes to the care plan based on the reassessment of the member's needs and shall arrange for any additional services needed. The care manager shall communicate any changes to the care plan to all appropriate parties, including the member, member's representative, family and IDT.

2.6.5.3 Home to Nursing Facility or ICF-ID

The care manager shall be responsible for detecting significant changes in status with members. A significant change can include, but is not limited to, an acute illness or deterioration in the member's health, a change in status of a caregiver such as illness or death or a change in living arrangements. A significant change for a member residing at home could trigger a transition to a nursing facility or ICF-ID.

If a care manager detects a significant change that necessitates a transition to a nursing facility or ICF-ID, the care manager shall complete an updated face-to-face comprehensive assessment and care plan within seven days of the change. The results of the comprehensive assessment shall be communicated to the OHCA so that the transition to the nursing facility or ICF-ID can be implemented. The care manager shall be responsible for managing the member through the transition.

For members placed in a nursing facility or ICF-ID, the Contractor shall complete a face-to-face assessment of the member in order to develop a care plan to transition the member back to the community, if such a transition is deemed possible.

If the comprehensive assessment does not support a return to the community, the Contractor shall be responsible for coordinating care while the member is in the nursing facility until the member’s place of residence is changed and the member is disenrolled from the Contractor’s plan.

2.6.5.4 Transition between Contracted Health Plans

Once a disenrollment transaction has been executed, the transition of care for a member who is moving from one contracted health plan to another contracted health plan will be initiated by the receiving plan care manager. The receiving care manager will make a request to the surrendering health plan care manager for any data that will facilitate a seamless transition, including but not limited to, assessments, care plans, service plans and provider information. Upon request from the receiving health plan, the surrendering health plan will have a maximum of five days to provide data which is available electronically, and a maximum of 30 days to provide data which is not stored electronically.

The care manager at the surrending health plan shall contact the member’s current PCMH provider and other service providers to inform them of the pending transition, advise them of the transition date and inform them to contact the new health plan regarding services furnished after the transition effective date.

The care manager at the surrendering health plan will meet with the member to review his or her rights for continuation of services and to stress the importance of contacting the receiving health plan as soon as possible to arrange for a new assessment and care plan. The

care manager will offer any other assistance the member or member's family needs to ensure the transition occurs safely and to the member's satisfaction.

If the member is hospitalized at the time of enrollment or disenrollment from one contracted health plan to another, the surrendering health plan shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the OHCA until the date of discharge. Upon discharge, the member becomes the financial responsibility of the receiving health plan.

2.6.5.5 Terminated Provider to New Provider

The Contractor shall actively assist members in transitioning to another provider when a current provider has terminated participation with the Contractor. For members who have a care plan in place, this assistance shall be provided by a member's care manager/care management team.

2.6.5.6 Care Manager to New Care Manager

The Contractor shall have strategies in place to minimize the number of situations in which a member must be assigned a new care manager. However, when the Contractor must assign a new care manager to the member, the incoming care manager shall have a case conference with the outgoing care manager to review the member's care plan and transition the member to the new care manager and IDT. For members in risk level 2 or 3, the new care manager shall conduct a face-to-face visit with the member within 30 days and shall include the prior care manager in the visit, if possible, and if agreed to by the member.

2.6.5.7 Age Transitions

The Contractor shall monitor the age status of members and offer assistance to members approaching age thresholds that will affect the SoonerCare coverage or eligibility for Medicare. The Contractor shall educate these members 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.

2.6.6 Transition of Care Reports

The Contractor shall submit transition of care reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Transition of care reports shall include at least the following:

- Acute care hospital or residential treatment facility to home or nursing facility;
- Nursing facility to home;
- Home to nursing facility or ICF-ID;
- Transitions between health plans; and
- Age transitions.

2.7 Member Services

The Contractor shall develop and operate a Member Services department with adequate resources and qualified staff to deliver responsive, person-centered customer care to health plan members, including those with visual, hearing, functional or cognitive impairments.

The Contractor shall ensure that, through its written materials, call center and other Member Service activities, it provides timely and accurate information to members and has appropriate mechanisms for helping members and potential members to understand the benefits and requirements of the health plan.

The Contractor shall have written policies regarding the member rights as specified in 42 CFR § 438.100. The Contractor shall comply with any applicable State and federal laws that pertain to member rights, and ensure that its employees and participating providers observe and protect these rights.

2.7.1 Member Materials

Materials developed by the Contractor that will qualify as member materials include at least the following:

- Member handbooks;
- Member identification cards;
- Member newsletters;
- Provider directories;
- Brochures;
- Social media platforms;
- Notices;
- Mass mailings;
- Form letters; and
- Any other materials provided to members by the Contractor or an affiliated Subcontractor.

As part of its communications, the Contractor shall ensure that it furnishes each member the information required by State and federal laws and regulations.

The Contractor shall ensure that copies (either electronic or paper) of all member materials or other publications are deposited with the Oklahoma Department of Libraries. The Contractor shall be held responsible for delivering these materials both to the OHCA and the Department of Libraries.

2.7.1.1 Prior Approval Process for Member Materials

The Contractor shall submit to the OHCA for review and prior written approval templates of all materials that will be distributed to members. Should the Contractor contract with either a Subcontractor or its providers to create and/or distribute member materials, the materials shall not be distributed to members unless the materials have been submitted to the OHCA by the Contractor for review and prior written approval.

The OHCA will review the submitted member materials and either approve or deny them within 15 days from the date of submission. In the event the OHCA does not approve the materials, the OHCA may provide written comments, and the Contractor shall resubmit the member materials for review. The OHCA will either approve or deny the resubmission within 15 days.

2.7.1.2 Modifications to Approved Member Materials

The Contractor shall not make substantive changes to materials developed for use by or distribution to members without the OHCA's review and prior approval.

Member materials developed by a Subcontractor or network provider operating on the Contractor's behalf, shall not be substantively changed without the OHCA's review and prior written approval.

The OHCA will review the modified member materials and either approve or deny them within 15 days from the date of submission. In the event the OHCA does not approve the materials, the OHCA may provide written comments, and the Contractor shall resubmit the member materials for review.

2.7.1.3 Discontinuation of Use/Modifications to Member Materials After Approval

The OHCA reserves the right to notify the Contractor to discontinue or modify member materials after approval.

2.7.1.4 Language/Accessibility

The Contractor shall make its member materials available in the prevalent non-English languages as specified by the OHCA.

The Contractor shall develop and submit to the OHCA a plan to assist members with limited English proficiency (LEP) and visually impaired members to understand all member materials. The plan shall be due at least 60 days prior to the Contractor's readiness review.

All members shall be notified of the free oral interpretation services and sign language and Telecommunications Device for the Deaf (TDD) services. These services shall be made available to all members along with information on how to access them.

Oral interpreters shall be available to speakers of all languages, regardless of the prevalence of the language. Interpreters shall be made available both in-person and through the telephone. For telephonic assistance, the caller may not be made to disconnect and call a different number. Interpreters shall also be made available for home visits.

The provider shall not suggest or require that members with LEP, or who communicate through sign language, utilize friends or family as interpreters.

When the Contractor learns that the member requires information in a non-English language, all essential member materials shall be sent to the member in that non-English language within three days if the language is considered by the OHCA to be prevalent or 15 days if the language is considered non-prevalent.

When the Contractor learns the member requires a non-English language, a note shall be made in the member 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 also must notify the OHCA in a manner to be specified by the OHCA.

All accommodations for the member's special needs or reading proficiency must be provided to the member free of cost.

2.7.2 Written Material Guidelines

Section 2.7.2 applies, at a minimum, to the following member materials:

- Member handbook;
- Provider directories;
- Complaints and appeals notices (see also 2.14, "Member Complaints and Appeals");
- Service authorization decisions, including denials; and
- Other notices that are critical to obtaining services.

2.7.2.1 Defined Terms

For consistency in the information provided to members, the OHCA will develop and require the Contractor to use standardized definitions for managed care terminology, including:

- Appeal;
- Complaint;
- Copayment;
- Durable medical equipment, prosthetics/orthotics and supplies;
- Emergency medical condition;
- Emergency medical transportation;
- Emergency room care;
- Emergency services;

- Excluded services;
- Habilitation services and devices;
- Health insurance;
- Home health care;
- Hospice services;
- Hospitalization;
- Hospital outpatient care;
- Medically necessary;
- Network;
- Non-participating provider;
- Participating provider;
- Physician services;
- Health plan;
- Preauthorization;
- Premium;
- Prescription drug coverage;
- Prescription drugs;
- Primary Care Provider (i.e. PCMH provider);
- Rehabilitation services and devices;
- Skilled nursing care;
- Specialist; and
- Urgent care.

2.7.2.2 Model Written Member Materials

The OHCA shall develop model member materials including, at least, a member handbook and member notices for use by the Contractor. The OHCA anticipates that the process for development of model member materials will include the participation and input of the Contractor. The model materials developed by the OHCA will include translations of member materials into prevalent non-English languages.

2.7.2.3 Format of Written Member Materials

The Contractor shall provide all written materials for members consistent with the following:

- Use easily understood language and format;
- Use a font size no smaller than 12 point;
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency;
- Be written at a reading level no higher than sixth grade using the Flesch-Kincaid readability test; and

- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats free of cost. Large print means printed in a font size no smaller than 18 point.

2.7.2.4 Mechanism

The Contractor shall have in place a mechanism to help members understand the requirements and benefits of the health plan.

2.7.2.5 Translated Member Materials

The Contractor shall make its written member materials available in the prevalent non-English languages in the State. The OHCA will specify prevalent non-English languages.

2.7.2.6 Alternative Formats and Auxiliary Aids and Services

The Contractor shall make its written member materials available in alternative formats and auxiliary aids and services available upon request of a member at no cost.

2.7.2.7 Taglines

The Contractor shall include in its written materials taglines in each prevalent non-English language in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free numbers for the member services call center, Relay Oklahoma (which provides TDD/TTY services) and the entity providing choice counseling services. Large print means printed in a font size no smaller than 18 point.

2.7.2.8 Interpretation Services

The Contractor shall make interpretation services available to members at no cost. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that that the OHCA identifies as prevalent.

2.7.2.9 Notification of Interpretation Services

The Contractor shall notify members of the following:

- That oral interpretation is available for any language and written information is available in prevalent languages;
- That auxiliary aids and services are available upon request and at no cost for members with disabilities; and
- How to access those services.

2.7.3 Distribution Guidelines

2.7.3.1 Guidelines for Mailing Member Materials

The Contractor shall mail all member materials to a member's address as provided in the OHCA's enrollment file.

The Contractor shall use and regularly update a record of the modalities used to reach the member:

- Updating the file based on changes in the OHCA's registered addresses and recording returned mail and re-mail attempts;
- Calling any telephone number maintained in the OHCA's records or any publicly available phone book or directory; and
- Checking the address and telephone number recorded at the provider's office, if the member has received services recently.

If the Contractor learns of a new address for the member, the Contractor shall notify the OHCA through a method to be specified by the OHCA.

The name of the Contractor and the health plan logo shall be prominently featured on each piece of member mail (once per item). It should solicit updates to any information, including address.

2.7.3.2 Guidelines for Electronic Distribution

The Contractor may distribute member materials in an electronic format instead of a paper copy with a member's express consent. Member materials shall not be provided electronically by the Contractor unless all the following are met:

- The format is readily accessible;
- The information is placed in a location on the Contractor's website that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements specified in section 2.7.1.4, "Language/Accessibility"; and
- The Contractor informs the member that the information is available in paper form without charge upon request and shall be provided to the member upon request within five days.

2.7.3.3 Guidelines for Email

The Contractor shall attempt to contact members through email unless the member 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 members through email addresses obtained by referrals and shall provide an opt-out process for members to no longer be contacted via email. If the email address provided for the member is non-existent, invalid or becomes invalid, or otherwise undeliverable, the Contractor shall switch back to paper correspondence and notify the OHCA of this change in a manner to be specified by the OHCA.

2.7.4 Member Handbook

2.7.4.1 Distribution Timeframe

The Contractor shall provide each member a member handbook within 15 days after receiving notice of a member's enrollment and within seven days of the member's request for a new member handbook. The Contractor must distribute to members any updates or changes to the member handbook that the OHCA deems substantive.

2.7.4.2 Distribution Methods

The Contractor shall be considered to have provided a member handbook to the member if one of the following distribution methods is used:

- Mail a printed copy of the member handbook to the member's mailing address;
- Provide the information by email after obtaining the member's agreement to receive the handbook by email; or
- With the member's express written consent, post the information on the Contractor's website and advise the member in paper or electronic form that the information is available on the Contractor's website. The Contractor shall include the applicable URL address provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

The Contractor shall develop strategies and policies to ensure that member handbooks may be delivered to homeless members and submit these policies to the OHCA for review and approval.

2.7.4.3 Number of Copies

The Contractor must provide to each individual member one written copy of the member handbook, except for situations in which two or more related members are registered to the same address. In this situation, the Contractor may instead send one written copy to that address. The Contractor shall provide information to the member about how to request additional copies of the handbook. This language just pertains to paper copies. Every member that opts to receive information via email shall receive an electronic version of the handbook.

2.7.4.4 Member Handbook Content

The Contractor shall use the OHCA's model handbook content in developing a health plan-specific handbook for the OHCA's review and approval. The content of the member handbook shall include information that enables the member to understand the health plan and SoonerHealth+ program. This information shall include at a minimum:

- A table of contents;
- Information about how to update any personal information;
- Information about what managed care is, with emphasis placed on in-network versus out-of-network providers;
- The amount, duration and scope of benefits available by the Contractor in sufficient detail to ensure that members understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any policies, procedures and requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's PCMH provider;
- Limitations or exclusions to benefits;
    - In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor must inform members that the service is not covered,
    - The Contractor must inform members how they can obtain information from the State about how to access those services,
    - During the term of the Contract, whenever the Contractor adopts a policy to limit or exclude a service under moral or religious objections, to furnish the information to members at least 30 days before the effective date of such policy;
- Information on how to access all services, including but not limited to EPSDT, dental, transportation (both emergency and non-emergency), behavioral health, HCBS and pharmacy;
- Information on how to access services when out-of-state;
- How and where to access any benefits provided by the OHCA, including any cost sharing and how transportation is provided;
- The toll-free telephone number for:
    - Member Services call center,
    - Medical management,
    - Care manager/care management team,
    - Any other unit providing services directly to members;
- Information about the Member Services call center and hours of operation, including services available after-hours;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
    - What constitutes an emergency medical condition and emergency services,
    - The fact that prior authorization is not required for emergency services,

  - The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care,
  - Identifying how to determine emergency status if the member is unsure;
- Any restrictions on the member's freedom of choice among network providers;
- The extent to which, and how, members may obtain benefits, including family planning services and supplies, from out-of-network providers. This includes an explanation that the Contractor shall not require a member to obtain a referral before choosing a family planning provider;
- An assurance of non-discrimination of services;
- Member rights, including the following elements specified in federal regulation:
  - Receive information,
  - Be treated with respect and with due consideration for dignity and privacy,
  - Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,
  - Participate in decisions regarding the member's health care, including the right to refuse treatment,
  - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion,
  - Request and receive a copy of the member's own medical records,
  - Right to be furnished with health care services;
- Complaint, appeal and fair hearing procedures and timeframes, including:
  - The right to file complaints and request appeals,
  - Requirements and timeframes for filing a complaint or requesting an appeal,
  - The availability of assistance in the filing process,
  - The right to request a state fair hearing after the Contractor has made a determination on the member's appeal which is adverse to the member,
  - The fact that, when requested by the member, benefits that the Contractor seeks to reduce or terminate will continue if the member requests an appeal or requests a state fair hearing within the timeframes specified for filing. The member 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 member;
- How to exercise an advance directive;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- Information on how to report suspected fraud or abuse;
- The process of selecting and changing the member's PCMH provider;
- Explanation of the role of the PCMH provider;

- An explanation of how patient age (if applicable, care needs, conditions and geographic location will factor into the assignment of a PCMH provider;
- An explanation on PCMH provider lock-in procedures and timeframes;
- Explanation of the role of the PCD for children and how assignment works;
- The role of the care manager/care management department and how to contact this individual or department;
- Explanation of circumstances in which the member may be billed for services or fees;
- General health and wellness literacy information;
- Explanation about how to disenroll from the Contractor's plan; and
- Any other content required by the OHCA.

The handbook shall also explicitly outline the following member responsibilities:

- Checking the OHCA/Contractor's information; correcting inaccuracies; and allowing government agencies, employers and medical providers to release records to the OHCA/Contractor;
- Assisting the OHCA/Contractor in locating absent parents who may be responsible for bearing some costs of care;
- Notifying the OHCA/Contractor within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes or health insurance changes;
- Transferring, assigning and authorizing to the OHCA all claims the member may have against health insurance, liability insurance companies or other third parties. This includes payments for medical services made by the OHCA for the member's dependents;
- Cooperating with the local child support office to receive medical support for children whose other parent is not in the home;
- Cooperating in establishing medical support, unless the member has requested and received good cause consideration for not cooperating. Also, understanding that the member may file a request with the local child support office to ask that the member's home address or location not be released due to fear of family violence;
- Allowing SoonerCare to collect payments from anyone who is required to pay for medical care;
- Sharing necessary medical information with any insurance company, person or entity who is responsible for paying the bill;
- Inspecting any medical records to see if claims for services can be paid;
- Obtaining permission for Oklahoma DHS or the OHCA to make payment or overpayment decisions;
- Storing his or her identification card and know his or her Social Security number to receive health care services or prescriptions;

- Confirming that any care received is covered;
- Understanding member responsibility as it pertains to securing NEMT and the timeframes required to receive NEMT services;
- Cost sharing; and
- Ensuring all information provided to the OHCA/Contractor is complete and true upon penalty of fraud or perjury.

2.7.4.5 Changes to Member Handbook Content

The Contractor shall give each member notice of any change that the OHCA defines as significant in the information provided in the member handbook. The notice shall be provided at least 30 days before the intended effective date of the change.

2.7.5 Quarterly Member Newsletter

The Contractor shall produce and distribute a member newsletter at least quarterly. Each member newsletter distributed shall be printed with an assurance of non-discrimination in accordance with the provisions of this Contract.

This member newsletter shall remind members of the translation and interpretation services available to them for free, as well as other formats for the visually impaired.

The member newsletter shall include language encouraging members to receive regular preventive care (e.g., screenings), especially for conditions or diseases for which the ABD population is at high-risk.

The text of the member newsletter shall include:

- Any articles, announcements or information requested by the OHCA;
- Notifications regarding SoonerCare and its programs (e.g., ADvantage);
- Information on how to update or change any personal information;
- Notice of how to file complaints, appeals and discrimination complaints; and
- The phone number for the SoonerCare Helpline and the Members Services call center.

The Contractor shall send out each member newsletter within 30 days of the start of each calendar quarter. One copy (either paper or electronic) shall be sent to each member and 25 paper copies shall be sent to the OHCA. The Contractor shall also distribute the member newsletter electronically, in PDF format, to the OHCA.

2.7.6 Member Identification Card

The Contractor shall distribute member identification cards to members within seven days of enrollment.

If the member loses his or her card, or the member's information changes, the identification card must be updated and reissued within seven days of the Contractor receiving notification.

The identification card must be made out of durable material suitable for everyday use, such as durable plastic or laminated paper.

Each identification card must include:

- Member name;
- Member date of birth;
- Benefit plan;
- Identification number;
- Health plan and company logo;
- Effective dates of service;
- PCMH provider name;
- Pharmacy benefit manager number, if applicable;
- Pharmacy BIN and PCN to file claims;
- Cost sharing information; and
- Contractor phone number.

The Contractor must send a sample version of the identification card, with generic information, for the OHCA's review and approval no later than 90 days prior to the commencement of services.

2.7.7 Member Website

2.7.7.1 General Website Requirements

The Contractor shall develop a member website. The Contractor shall:

- Maintain a separate and distinct section on its website for SoonerHealth+ program information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each webpage with the date the page was last updated;
- Clearly label any links;
- Notify individuals that they will leave the Contractor's Medicaid information website if there is a link that will take individuals to non-SoonerHealth+ program information or to a different website;
- Comply with HIPAA when providing member eligibility or member identification on the website, including the provider portal(s); and

- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

2.7.7.2 Website Content

As part of readiness review activities, the Contractor must submit all pages and content related to the SoonerHealth+ program to the OHCA for review and approval before making the content public. At a minimum, the Contractor shall include the following information on its website:

- Contractor's contact information, including address, toll-free customer service number and TTY/TDD number;
- An online version of the quarterly newsletter, posted as it is published;
- Contractor's office hours/days, including availability of customer service;
- Provider directory and information on how to find a network provider near the member's residence;
- Description of any restrictions on the member's freedom of choice among network providers, as well as the extent to which members may obtain benefits from out-of-network providers;
- Preferred drug list;
- Link to the OHCA website and/or other pages within the website, as specified by the OHCA;
- The amount, duration and scope of benefits available by the Contractor in sufficient detail to ensure that members are informed of the services to which they are entitled, including service authorization requirements;
- Procedures for obtaining benefits, including authorization requirements;
- Member handbook; and
- Complaint, appeals and state fair hearing processes.

The Contractor may include the following information on its website:

- Marketing materials specific to the OHCA-approved value-added benefits and services and/or quality rating reports; and
- Materials intended to be read by members or potential members, such as newspaper articles and news releases, with prior approval from the OHCA.

Following program implementation, the Contractor shall notify the OHCA of updates to website content in a manner to be specified by the OHCA. The OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

2.7.7.3 508 Compliance

The Contractor shall ensure that all electronic information and services will be compliant with all language, formatting and accessibility standards such as Section 508 guidelines or

guidelines that provide greater accessibility to individuals with disabilities. The Contractor shall notify members that materials are available in paper form and through auxiliary aids and services upon request and at no cost.

2.7.7.4 Website Translation

The Contractor shall ensure that website content will also be available in the prevalent non-English language as determined by the OHCA. The Contractor shall receive approval of the translation from the OHCA before publishing it online.

2.7.7.5 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 HHS Secretary.

2.7.7.6 Social Media and Mobile Applications

The Contractor shall utilize social media platforms and mobile applications to provide members with health topic information and health plan-related information. The OHCA will work with Contractors on any proposed initiatives. Social media shall be used to maximize Contractor's communication with members.

The Contractor shall receive approval from the OHCA before utilizing a new social media platform. The OHCA reserves the right to require changes to any content deemed to be inaccurate or otherwise in conflict with Contract standards.

2.7.8 Member Services Call Center

2.7.8.1 Member Services Call Center Availability

The Contractor shall operate a toll-free Member Services call center within the borders of the State of Oklahoma aimed at addressing questions about member services from members and their representatives.

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 call center.

The Contractor shall ensure the call center is staffed and operational at least from 8:00 am Central Time (CT) to 5:00 pm CT on Monday through Friday, except for State holidays.

The Contractor shall submit a plan for identifying members with LEP and providing these members with the translation or interpretation services necessary to have their question or issue resolved in a timely manner.

The Contractor shall record all calls received and store them in a searchable database. The Contractor shall have the ability to retrieve these calls within one business day. The Contractor shall also maintain a remote monitoring system that the OHCA may be able to use to survey the Contractor/member interaction.

The Contractor shall operate an after-hours system for fielding calls outside of call center operating hours. This system shall record any message the member leaves, his or her name and telephone number. The Contractor shall ensure that all calls are returned during the next business day.

This line may be operated through Subcontractors.

2.7.8.2 Member Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor Member Services call center activities and performance.

The Contractor shall have the capability to track call center metrics, as described below, and issue a quarterly report to the OHCA breaking down the performance:

- Call abandonment rate shall be less than five percent;
- Eighty-five percent of calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed two minutes;
- Blocked call rate shall not exceed one percent; and
- The overflow call center must not receive more than five percent of all incoming calls to the call center.

The Contractor's quarterly call center report should break down performance by main call center, overflow center if applicable and be broken out by Subcontractors.

The Contractor shall have the capability to track complaints received in the call center by volume and type. The Contractor shall have the capability to compare and report its Oklahoma call center's performance to the performance of its affiliate health plans in other states, if it has affiliate health plans, and if similar performance standards are tracked.
At end of the calendar year, the Contractor shall issue to the OHCA an annual report detailing performance of the call center and mapping out improvement strategies for the following year.

2.7.8.3 Call Center Training

The Contractor shall develop a program to train newly hired staff and retrain current call center operators. This training program shall address topics that include, at least:

- The populations covered under the program;

- Covered and non-covered services;
- Enrollment and disenrollment;
- Accessing services in- and out-of-network;
- Care management;
- Services for Native American members;
- Out-of-state services; and
- Filing a complaint or appeal.

The training program shall teach operators to interact with members efficiently, patiently and respectfully. The staff shall be trained so that they are equipped to recognize situations where a member has LEP or is hearing impaired and to direct them to the appropriate resources.

Call center staff shall receive training quarterly or more frequently through instructor-led training or staff meetings. The staff shall also be retrained immediately upon a major change in service delivery or covered services.

The Contractor shall submit its call center training program to the OHCA annually for review and approval.

2.7.8.4 Bilingual Representatives

The Contractor shall have bilingual representatives able to field calls for every prevalent non-English language identified by the OHCA.

2.7.9 Provider Directory

2.7.9.1 Format and Distribution

The Contractor shall have a provider directory available in electronic or paper formats. The directory shall be distributed to members at least annually in paper format or through a reminder notification to members of its availability on the Contractor's website. If the Contractor does not routinely distribute paper copies, the Contractor shall distribute a paper copy if requested by a member.

2.7.9.2 Content

The provider directory shall contain the following information about the Contractor's network providers:

- Provider's name as well as any group affiliation, including the following provider types:
  - Physicians, including specialists,
  - Hospitals,
  - Pharmacies,

  - Behavioral health providers,
  - HCBS providers,
  - Other providers required under this Contract;
- Street address(es);
- Telephone number(s);
- Website URL, as appropriate;
- Specialty, if appropriate;
- Gender;
- Whether the provider will accept new members (necessary only in the online version);
- Provider's cultural and linguistic capabilities, including languages spoken by the provider or by skilled medical interpreter at the provider's office and whether the provider has completed cultural competence training; and
- Whether the provider's office/facility is accessible for persons with disabilities, including offices, exam room(s) and equipment.

2.7.9.3 Submission Process

The Contractor shall submit its provider directory to the OHCA for review and approval at least 30 days prior to distribution. The open panel status of the provider should be updated online as it changes. Review from the OHCA is not necessary to change the open panel status.

2.7.9.4 Updates

The Contractor shall update its provider directory at the following timeframes:

- At least monthly for the paper directory; and
- No later than three business days after the Contractor receives updated provider information for the online version of the directory.

2.7.9.5 Website Publication

The Contractor shall make the provider directory available on its website without a login requirement.

2.7.10 List of Covered Drugs

2.7.10.1 Format

The Contractor shall make a list of covered drugs available in electronic format.

2.7.10.2 Content

The list shall contain the following information:

- Which medications are covered (both generic and name brand);
- Whether the drug requires prior authorization; and
- What tier each medication is in.

2.7.10.3 Website Publication

The Contractor shall make a list of covered drugs available on its website and in paper copy, upon request.

2.7.11 In-Office Interpretation Services

Interpretation services must be offered in provider offices, in a member's home and all other appropriate venues. The offer of interpretation services to members shall be documented regardless of whether the member expressed an ability to provide his or her own interpreter.

The Contractor shall provide language and cultural competence training to Subcontractors, including how to access interpreter services. Access to interpretation services shall be explained to members through the text in the member handbook.

2.7.12 Cultural Competency

2.7.12.1 General Cultural Outreach

The Contractor shall participate in the OHCA's efforts to promote the delivery of services in a culturally competent manner to all members, including those with LEP and diverse cultural backgrounds and disabilities, regardless of gender, sexual orientation or gender identity.

The Contractor shall develop a cultural competency and sensitivity plan for review and approval by the OHCA at the time of readiness review. The plan shall include guidelines for evaluating and monitoring disparities in membership and service quality, especially with regard to minority groups. Elements of this plan shall address how the Contractor will:

- Identify organizations and advocates that could work with LEP communities and Individuals in a culturally competent way;
- Incorporate cultural competence into the Contractor's medical and care management programs, including outreach and referral methods;
- Recruit and train culturally diverse staff that will be able to operate fluently with all member communities throughout the State;
- Ensure member assessments inquire about language preference;
- Conduct self-assessments of cultural and linguistic competence before services commence and with annual frequency thereafter;

- Ensure cultural competence outcomes through internal audits and performance improvement targets;
- Develop a set of cultural competency standards designed to help all parts of the care management process deliver culturally sensitive care;
- Identify and develop intervention strategies for high-risk health conditions found in certain cultural groups; and
- Provide annual training to care managers, network providers and member facing staff (e.g., Member Services) to ensure the delivery of culturally and linguistically appropriate care.

2.7.13 Member Advocacy

The Contractor shall hire Member Care Support Staff as specified in section 2.2.3.4, "Member Care Support Staff." The Contractor shall educate members at enrollment regarding the nature of the assistance available from the Member Care Support Staff:

- Advocating on behalf of a member and his or her preferences with respect to receiving member- and family-centered care;
- Assisting the member to access community-based resources to address non-medical needs and to support the member's care plan objectives and independence;
- Obtaining information about available services in and outside of the health plan; and
- Filing complaints and appeals.

Member Care Support Staff can be located within the Member Services function, the Care Management function, or both.

2.7.14 Member Services Reports

The Contractor shall submit member services reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Member services reports shall include at least the following:

- Member newsletter;
- Call center performance;
- Call center evaluation; and
- Call center training program.

2.8 Provider Network and Service Accessibility

2.8.1 Provider Network Development General Requirements

2.8.1.1 Adequate Network

The Contractor shall develop, maintain and monitor a network of appropriate providers that is sufficient to provide adequate access and availability to all services covered under this Contract for all members, including those with LEP or physical or mental disabilities.

The Contractor shall have sufficient network providers to ensure all access and appointment wait times developed by the OHCA in accordance with 42 CFR § 438.68, and as defined in sections 2.8.3.1 through 2.8.3.9 of this Contract, will be met.

If the Contractor is unable to provide necessary medical services covered under the Contract to a particular member, the Contractor shall adequately and timely cover the services out-of-network, for as long as the Contractor is unable to provide them within the network. The Contractor shall coordinate payment with out-of-network providers and ensure that the cost to the member is no greater than it would be if the services were furnished within the network.

2.8.1.2 Non-Discrimination in Provider Development

The Contractor may not discriminate in the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

If the Contractor declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.

Notwithstanding other language in this Contract, the Contractor shall not be:

- Required to contract with providers beyond the number necessary to meet the needs of its members;
- Precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- Precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2.8.1.3 Providers Prohibited from Network Participation

The Contractor shall conduct background checks and similar activities as required under State and federal law on all providers before contracting with such providers.

In accordance with 42 CFR § 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 2.1.10.5, "Termination for Debarment."

2.8.1.4 Provider Network Development and Management Plan

The Contractor shall provide assurances and a Provider Network Development and Management Plan, in a manner and format to be specified by the OHCA, that demonstrates that it has the capacity to serve the expected enrollment in its region(s) in accordance with the OHCA's standards for access to care, including the standards in 42 CFR § 438.68 and 438.206.

As part of this, the Contractor shall demonstrate that it (1) offers an appropriate range of preventive, primary care, specialty services and HCBS that is adequate for the anticipated number of enrollees for the region(s); (2) maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the region(s); and (3) requires its network providers to meet the OHCA-defined standards for timely access to care and services, taking into account the urgency of the need for services. The plan shall contain, at a minimum, information on the following:

- Summary of network providers, by provider type and geographical location in the State;
- An attestation that the Contractor's network is sufficient to provide adequate access to all services covered under the Contract for all members, including but not limited to those with LEP or physical or mental disabilities;
- Demonstration of monitoring activities to ensure that the OHCA-defined network access standards, including time and distance, are met;
- Summary of network provider capacity and network adequacy issues by provider, service and county and efforts to address those issues; and
- Ongoing activities for provider development and expansion considerations.

At a minimum, the Provider Network Development and Management Plan shall be submitted to the OHCA at the following timeframes:

- At the time the Contractor enters into a Contract with the OHCA;
- On an annual basis; and
- At any time there has been a significant change, as defined by the OHCA, in the Contractor's operations that would affect adequacy of capacity of services, including changes in the Contractor's services, benefits, region(s), composition of or payments to its provider network or enrollment of a new population in the Contractor's health plan.

The OHCA shall review and approve the Contractor's Provider Network Development and Management Plan. Once approved, the OHCA shall submit an assurance of compliance to

CMS that the Contractor meets the OHCA's requirements for availability of services, as set forth in 42 CFR § 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 provider network. The OHCA shall make available to CMS, upon request, all documentation collected by the OHCA from the Contractor.

2.8.1.5 Monthly Network Provider Listing

The Contractor shall supply to the OHCA, no later than five business days before the end of each month, an up-to-date listing of all network providers. The Contractor's up-to-date listing must include open capacity for PCMH providers and PCDs accepting new members. The listing shall be provided in a format specified by the OHCA. The OHCA reserves the right to request provider listing data on a basis more frequently than monthly.

2.8.1.6 Provider Network Development Policies and Procedures

The Contractor shall maintain written policies and procedures on provider selection, retention and termination of network provider participation with the Contractor and responding to changes in the network that affect access and ability to deliver services in a timely manner. Policies and procedures shall also address access standards.

The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.8.2 Provider Network Changes and Contract Termination

2.8.2.1 Provider Network Contract Termination

The Contractor and its network providers shall have the right to terminate contracts with each other. The Contractor and its network providers may terminate the contract for cause with 30 days' advance written notice to the other party and without cause with 60 days' advance written notice to the other party.

The Contractor shall terminate its contract with the provider immediately under the following circumstances:

- To protect the health and safety of members;
- Upon credible allegation of fraud;
- When the provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the provider to provide services; or
- Upon request of the OHCA.

If the OHCA terminates a provider, the OHCA shall notify the Contractor. The Contractor shall be responsible for monitoring the relevant State registries to review any providers that are terminated by the OHCA and subsequently excluded from participation.

The Contractor shall follow a process to be defined by the OHCA for notification, facilitation of member records and other assistance necessary for an orderly transition of health care.

2.8.2.2 Notification to the OHCA of Provider Network Changes

The Contractor shall notify the OHCA when a provider contract is terminated with:

- A hospital, federally qualified health center (FQHC), IHCP facility or any practitioner who is actively serving 100 or more of the Contractor's SoonerHealth+ Program members; or
- Any provider whose termination has the potential to compromise the Contractor's ability to meet one or more network access standards.

In such an event, the Contractor shall provide the OHCA with a corrective action plan in accordance with the procedures outlined in section 2.22.4.5, "Corrective Action Plan." The OHCA reserves the right to allow for affected members to disenroll from the Contractor's health plan in accordance with the provisions of section 2.22.4.7, "Disenrollment of Members without Cause."

The Contractor shall work with the provider to ensure that any member records and information are provided to the Contractor to facilitate an orderly transition of care.

2.8.2.3 Member Notification of Provider Network Changes

The Contractor shall comply with requirements associated with PCMH provider changes, as described in section 2.5.4, "PCMH Selection and Assignment."

The Contractor shall make a good faith effort to give written notice of termination of any contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The Contractor shall provide notice to a member no more than 30 days after receipt or issuance of the termination notice and earlier if appropriate to ensure quality of care.

"Regular basis", at a minimum, shall be construed to mean any provider delivering care on a routine basis as defined in the member's care plan. When clinically appropriate, the Contractor shall conduct immediate outreach and support for members to select alternative service providers. For members who are receiving treatment for a chronic or ongoing medical condition or HCBS, the Contractor shall ensure that there is no disruption in services.

2.8.2.4 Provider Appeal Rights for Contract Termination

The Contractor shall follow substantially the same process of handling provider appeals of contract terminations as those found in OAC 317:2-1-12. The Contractor shall develop, implement and maintain a system for tracking provider appeals related to 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 appeal. Such documentation shall be made available to the OHCA upon request.

The OHCA reserves the right to include an independent review process established by the OHCA for final determination on these disputes.

If the Contractor believes a suspension of payment to a provider is necessary, the Contractor shall refer the issue to the OHCA to handle.

2.8.2.5 Reporting to Appropriate Authorities

If the Contractor terminates a provider, the Contractor must report the termination to the appropriate authorities, including the National Practitioner Data Bank (NPDB), State licensing agencies and any other entity designated by the OHCA.

2.8.3 Network Access Standards

The Contractor shall ensure compliance with the following:

- Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensure that its network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to other SoonerCare populations, if the provider serves only SoonerCare members;
- Make services included in the Contract available 24 hours a day, 7 days a week, when medically necessary;
- Establish mechanisms (e.g., notices or training materials) to ensure compliance with timely access requirements by network providers;
- Monitor network providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply by a network provider.

The Contractor shall be able to demonstrate the Contractor's ongoing activities and efforts to comply with these standards. The OHCA shall monitor and review the Contractor's compliance with these standards as part of its ongoing oversight activities.

Sections 2.8.3.1 through 2.8.3.9 are 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 network. The Contractor's network for other service providers must

be adequate to ensure that care is available timely and geographically accessible. In addition, the Contractor shall add providers based on the needs of members or due to changes in State or federal requirements.

All travel distances are maximums for the distance it takes a member, using usual travel means in a direct route, to travel from his or her home to the provider. The Contractor may submit to the OHCA a formal written request for a waiver of these requirements for areas where there are no providers within the required driving distance or if it is unable to enter into an agreement with a particular provider type. In such situations, the OHCA may waive the requirement entirely or expand the driving distance by considering community standards for accessing care and the availability of telemedicine.

Nothing in this section shall prevent the Contractor from allowing the member to choose a provider outside of the defined radius, if the member so requests.

2.8.3.1 PCMH Providers

The Contractor shall provide and maintain an adequate network of PCMH providers to ensure that members have access to all primary care services in the capitated benefit package. The Contractor shall ensure that each non-Medicare/Medicaid dually-eligible member has a PCMH provider.

PCMH providers include the following provider types:

- Physicians licensed in the state where they practice and who are engaged in a general practice or in family medicine, general internal medicine or general pediatrics;
- Advance practice nurses licensed in the state where they practice and have prescriptive authority;
- Physician assistants licensed in the state where they practice; and
- FQHC and rural health clinic (RHC) provider groups, physicians, advance 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 members to select a specialist or subspecialist as the members' PCMH provider, where medically appropriate, subject to the provider's willingness to perform all responsibilities of a PCMH provider.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	Within 45 miles of a member's residence.
Appointment Times	• Not to exceed 30 days from date of the member's request for routine appointment. • Within 72 hours for non-urgent sick visits. • Within 24 hours for urgent care.

2.8.3.2 Specialty Providers

The Contractor's network shall include a sufficient number and type of adult and pediatric specialty providers to ensure that members have access to all specialty care services in the benefit package and to meet program access standards for adequate capacity. The Contractor shall provide members with access to network care for at least the following specialty provider types:

- Physician (MD/DO) specialists and subspecialists to provide specialty care services as required in the benefit package;
- Anesthesiologist assistants;
- Audiologists;
- Nutritionists;
- Opticians;
- Optometrists;
- Podiatrists; and
- Therapists to provide specialty care services as required in the benefit package.

This is not intended to be an all-inclusive list. The Contractor shall analyze the clinical needs of the enrolled membership to identify additional specialty provider types to include as part of the Contractor's network.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	Within 60 miles of a member's residence.
Appointment Times	• Not to exceed 60 days from date of the member's request for routine appointment. • Within 24 hours for urgent care.

2.8.3.3 Behavioral Health Providers

The Contractor's network shall include a sufficient number and type of behavioral health providers to ensure that members have access to all behavioral health services in the benefit package outlined in section 2.4.2.3, "Behavioral Health Benefits" and to meet program access standards. The Contractor also shall provide for the delivery of behavioral health services via telemedicine for the OHCA-defined services that are reimbursable through telemedicine.

The Contractor's network shall include all of the following Medicaid behavioral health provider types:

- Acute and Residential Treatment;
- Case Management Psychosocial Rehabilitation Services;
- Community Mental Health Centers (CMHCs);
- Inpatient Psychiatric Hospitals;
- Licensed Behavioral Health Practitioners;
- Crisis Intervention and Crisis Stabilization Facilities;
- Outpatient Behavioral Health Agencies, Clinics and Facilities;
- Programs for Assertive Case Management (PACT);
- Psychiatrists and Psychologists;
- Substance Use Disorder Treatment; and
- Therapeutic Behavioral Services, Family Support and Training and Peer Recovery Support.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	• Within 30 miles of a member's residence for outpatient office visits. • Within 60 miles of the member's residence for all other treatment settings.
Appointment Times	• Not to exceed 60 days from date of the member's request for routine appointment. • Within 24 hours for urgent care.

2.8.3.4 Dental Providers

The Contractor's network shall include a sufficient number and type of dental providers, including primary care dentists for members under age 21, to ensure that members have access to dental services in the benefit package and to meet program access standards. The Contractor shall include adequate numbers of dental providers with experience in treating persons with disabilities.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	Within 40 miles of a member's residence.
Appointment Times	• Not to exceed 30 days from date of the member's request for routine appointment. • Within 24 hours for urgent care.

2.8.3.5 HCBS Providers

The Contractor's network shall include a sufficient number and type of HCBS providers to demonstrate capacity to provide covered services in the member's choice of care setting and in accordance with the members' care plan as approved by the care manager and the member.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	Within 75 miles of a member's residence for HCBS provider types in which the member must travel to the provider and receive services, such as a provider's office, various community locations (employment or recreation) or institution/facility. The OHCA encourages the Contractor to use existing community providers and available community services. In the event a county has an insufficient number of providers licensed, certified or available, the access standard shall be based on the community standard and must be justified and documented to the OHCA. For HCBS providers that travel to the member to deliver services, there shall be a provider of each required type in every county. In the absence of demonstrating this, the Contractor shall submit a plan to the OHCA for review and approval that addresses how a particular county will be covered to ensure appropriate access to HCBS providers in the home setting.
Appointment Times	In accordance with members' care plans, including the amount, frequency, duration and scope of each service, as delineated in the service plan portion of the care plan. Provider shall ensure the availability of back-up providers in accordance with the back-up plan.

The OHCA or its designee may authorize a spouse or legal guardian of a family member as a service provider for HCBS waiver members except as a provider of CD-PASS or self-directed services. Authorization of a spouse or legal guardian as a provider shall only occur under certain conditions whereby the member is offered a choice of providers and documentation demonstrates that:

- No provider is available;
- Available providers are unable to provide necessary care to the member; or
- The needs of the member are so extensive that the spouse or legal guardian who provides the care is prohibited from working outside the home due to the member's need for care.

HCBS waiver members shall have an exception process in place whereby the Contractor shall fulfill the exception requests and submit them to the OHCA or its designee for review and approval.

The service(s) shall:

- Meet the definition of a service or support as outlined in section 2.4, “Capitated and Non-Capitated Benefits”;
- Be necessary to avoid institutionalization;
- Be a service/support that is specified in the member’s service plan;
- Be provided by a person who meets the provider qualifications and training standards for that service;
- Be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the OHCA for payment; and
- Not duplicate or replace assistance and/or care that the spouse or legal guardian would ordinarily perform or is responsible to perform.

If any of the following criteria are met, assistance or care provided by the spouse or legal guardian will be determined to exceed the extent and/or nature of the assistance they would be expected to ordinarily provide in their role as spouse or legal guardian:

- The spouse or legal guardian has resigned from full-time/part-time employment to provide care for the client;
- The spouse or legal guardian has reduced employment from full-time to part-time to provide care for the client;
- The spouse or legal guardian has taken a leave of absence without pay to provide care for the client; or

- The spouse or legal guardian provides assistance/care for the client thirty-five or more hours per week without pay and the client has remaining unmet needs because no other provider is available due to the nature of the assistance/care, special language or communication or intermittent hours of care requirements of the client.

The spouse or legal guardian must be documented as the member's provider in the member's service plan and shall comply with the following:

- Continue non-reimbursed family responsibilities of primary caregiver and emergency back-up caregiver;
- Not provide more than 40 hours of reimbursed services in a seven-day period;
- Make planned work schedules available two weeks in advance to the member's care manager and variations to the schedule must be noted and supplied two weeks in advance to the care manager unless the change is due to an emergency; and
- Maintain and submit time sheets and other required documentation for hours worked.

In addition to care management, monitoring and reporting activities required for all HCBS waiver services, the Contractor shall perform additional monitoring when members elect to use a spouse or legal guardian as a paid service provider. The Contractor shall monitor through documentation submitted by the care manager the following:

- At least quarterly reviews by the care manager of expenditures and the health, safety and welfare status of the individual member;
- Face-to-face visits with the member by the care manager on at least a semi-annual basis; and
- Monthly reviews of hours billed for spouse and legal guardian provided care.

2.8.3.6 Pharmacies

The Contractor's network shall include a sufficient number of pharmacies to ensure that members have access to all prescription drug and pharmacy-based medical supplies in the benefit package and to meet program access standards.

The Contractor shall not require as a condition for participation in its pharmacy network any limitations on provider size or volume that would exclude independent retail pharmacists.

The Contractor may contract with specialty pharmacies to the extent the Contractor determines this is necessary to ensure the adequate availability of specialty drugs. The Contractor may limit distribution of specialty drugs to network pharmacies that meet reasonable requirements to distribute specialty drugs. 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 network but shall not require or incentivize members to use a mail-order pharmacy, including through different member cost shares. Members who elect to use this service must not be charged fees, including postage and handling fees.

The Contractor shall meet the following access standards:

Measure	Standard
Distance	• Within 15 miles of a member's residence. • For 24-hour pharmacy within 45 miles or 45 minutes of the member's residence. • If no pharmacies are located within the defined access standards outlined above, the Contractor shall offer alternative delivery methods for furnishing pharmacy services to its members.

2.8.3.7 Indian Health Care Providers

See Section 2.12, "**Native American (American Indian) Population and Indian Health Care Providers**," for information on network adequacy requirements.

2.8.3.8 Hospitals and Essential Community Providers

The Contractor's network shall include a sufficient number and type of hospitals and essential community providers to ensure that members may access a range of covered physical and mental health services in the setting most appropriate for a member's treatment needs.

Hospitals include the following provider types:

- Disproportionate share hospital (DSH) and DSH-eligible hospitals;
- Children's hospitals;
- Sole community hospitals;
- Critical access hospitals (CAH); and
- Free-standing ERs.

The Contractor shall demonstrate sufficient access to essential hospital services to serve the expected enrollment and to meet, at minimum, the access and availability requirements set forth below:

Measure	Standard
Distance	Within 30 miles of a member's residence, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care and exceptions must be justified and documented to the OHCA on the basis of community standards.

Essential community providers include the following provider types:

- FQHCs and RHCs;
- Family planning providers (Title X family planning clinics and Title X "look-alike" family planning clinics);
- IHCPs;
- Government-funded community health centers;
- Community mental health agencies;
- Local health departments; and
- Other entities certified by CMS as an essential community provider.

The Contractor shall contract with essential community providers in the Contractor's region(s) to the extent possible and practical. Where essential community providers are not utilized, the Contractor shall demonstrate to the OHCA that both adequate capacity and an appropriate range of services for vulnerable populations exist to serve the expected enrollment in the Contractor's region(s) absent these providers. The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

2.8.3.9 Centers of Excellence and Specialty Service Providers

Centers of excellence and specialty service providers offer services tailored to the unique needs and preferences of members. Services are provided using an interdisciplinary process comprised of medical, therapeutic and support staff that are highly trained with extensive experience in care for persons with complex disabilities or conditions. Services may be provided in an inpatient or outpatient setting and promote family unity, community participation, independence and quality of life.

The OHCA has designated the following as SoonerHealth+ centers of excellence/specialty service providers:

- The Children's Center Rehabilitation Hospital (Bethany); and
- The Children's Hospital of Oklahoma University Medical Center (Oklahoma City).

The Contractor shall contract with centers of excellence and specialty service providers regardless of the regions in which the Contractor operates.

2.8.4 Provider Network and Service Availability Reports

The Contractor shall submit provider network and service accessibility reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Provider network and service accessibility reports shall include at least the following:

- Provider network development and management plan;
- Network provider listings; and
- Provider terminations.

2.9 Provider Contracting and Services

2.9.1 Provider Contracting

The Contractor shall develop and utilize a standardized approach to contracting with providers for participation in the Contractor's network. This approach shall incorporate, at a minimum, the following elements:

- A written application for network participation, as described in section 2.9.2, "Provider Network Participation Application";
- Credentialing and recredentialing process, as described in section 2.9.3, "Credentialing";
- A written provider agreement that lists the contractual obligations between the Contractor and the provider, as described in section 2.9.4, "Network Provider Agreements"; and
- Payment to providers, as described in section 2.9.5, "Provider Payment."

2.9.1.1 Provider Contracting Policies and Procedures

The Contractor shall develop and follow written policies and procedures for provider contracting, including at least:

- Provider selection and retention;
- Provider network participation outreach activities;
- Provider network participation application and processing;
- Credentialing and recredentialing processes;
- Nondiscrimination of providers;
- Excluded providers;
- Provider agreements; and
- Payment to providers.

2.9.2 Provider Network Participation Application

2.9.2.1 Application for SoonerCare Participation

The Contractor shall require providers seeking to participate in the Contractor's network to apply for participation in the SoonerCare program and be enrolled as a contracted provider with SoonerCare. A provider will have the option of executing either:

- A standard Medicaid agreement; or
- An agreement specific to the SoonerHealth+ Program. Under this option, the provider's participation in Medicaid will be limited to serving SoonerHealth+ Program members enrolled in health plans for which it is a network provider.

It is the provider's responsibility to maintain active status as a Medicaid provider when periodic re-contracting is conducted by the OHCA.

2.9.2.2 Application for Contractor's Network Participation

The Contractor shall require providers to complete a written application (hardcopy or electronic) for network participation. The application shall address the following:

- Reasons, if any, for the provider's inability to perform the essential functions of the position, with or without accommodation;
- Lack of present illegal drug use;
- History of loss of license and felony conviction and consent to criminal background checks, in accordance with 42 CFR § 455.434(a);
- History of loss or limitation of clinical privileges or disciplinary actions at all facilities and organizations with which the provider has had privileges; and
- Current malpractice insurance coverage that meets OHCA minimum requirements for Medicaid participation.

The application for network participation shall include the following attestations that shall be signed by the applying provider:

- Adherence to the ethics of the appropriate professional organization (e.g., American Medical Association); and
- Correctness and completeness of the application.

The Contractor shall report to the OHCA criminal conviction information disclosed by providers and report provider application denials pursuant to 42 CFR § 455.106.

2.9.3 Credentialing

The Contractor shall require that any provider seeking to participate in the Contractor's provider network undergo credentialing. The Contractor shall comply with any credentialing and recredentialing requirements established by the OHCA, including provider use of the State's uniform credentialing application.

2.9.3.1 Credentialing and Recredentialing Timeframes

The Contractor shall ensure that credentialing of all providers applying for network provider status shall be completed as follows:

- 90 percent within 30 days from the time a complete application has been received by the provider; and
- 100 percent within 45 days from the time a complete application has been received by the provider.

2.9.3.2 Credentialing Committee

The Contractor shall designate a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The credentialing committee shall include a medical director (physician) to oversee the

committee. The credentialing committee shall document its steps in the decision process and maintain individual provider files.

2.9.3.3 Delegation of Credentialing/Recredentialing Activities

The Contractor may delegate credentialing and recredentialing activities to a Subcontractor. If the Contractor delegates such activities to a Subcontractor, the Contractor shall comply with the requirements described in section 2.2.2.2, "Subcontractors."

2.9.3.4 Credentialing and Recredentialing Verification

The Contractor shall conduct timely verification of information to ensure that providers have the legal authority and relevant training and experience to provide quality care to members. The Contractor shall verify credentialing information through primary sources, including:

- Present in the National Provider/Practitioner Databank. (In lieu of this, verification of any disciplinary action with regulatory board, state sanctions or disciplinary claims resulting in a judgment or settlement.);
- Valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable;
- Education and training, including:
    - Current license,
    - Certifications (or practitioner number),
    - Degrees,
    - Residency or specialty training;
- Work history;
- Pending lawsuits or litigation and history of professional liability claims that resulted in settlements or judgments paid on behalf of the provider;
- Sanctions or limitations from state agencies or licensing boards;
- Evidence of malpractice/liability insurance that meets OHCA minimum requirements for Medicaid participation;
- Evidence of contract with the OHCA as a SoonerCare provider; and
- For applicable provider types, provision of national provider identifier (NPI) in accordance with 45 CFR § 162.410.

2.9.3.5 Onsite Review

Onsite reviews shall be performed during initial credentialing to assess the quality, safety and accessibility of all facilities and service delivery sites to be utilized by the Contractor's providers in fulfilling services under this Contract. The Contractor shall have trained and qualified staff to conduct onsite reviews. During the onsite review, the Contractor shall, at a minimum, evaluate:

- Physical accessibility and appearance of the office site in conformance with ADA requirements and the accessibility considerations specified in 42 CFR §438.206(c)(3); and
- Medical records and confidentiality practices.

The Contractor shall have standards and a process for conducting onsite reviews pursuant to ongoing monitoring activities, including but not limited to, investigating complaints from members and evaluating effectiveness of actions to correct deficiencies.

2.9.3.6 Database Checks/Screenings and Criminal Background Checks

The Contractor shall conduct screening of all network providers in accordance with State and federal laws and ensure that all network providers are screened against the State and federal provider exclusion registries. Screenings shall be conducted at the time of initial credentialing and conducted no less than monthly thereafter. The Contractor shall notify the OHCA if a provider is terminated from the Contractor's network in accordance with section 2.8.2.2, "Notification to the OHCA of Provider Network Changes."

The OHCA shall waive the criminal background checks, including fingerprinting, for providers who are confirmed as approved Medicaid providers and who are not listed on any of the State's registries as being excluded from participation in Medicaid. The Contractor shall have access to all State registries to perform screening for this purpose.

The Contractor shall participate in and require that its network providers, including any applicable agency employees, comply with State and federal criminal background check and fingerprinting requirements, including Oklahoma House Bill 2582 (2012) and 42 CFR Part 455, Subpart E. The OHCA reserves the right to deny enrollment or terminate a contract with a provider as provided under State and/or federal law. The Contractor shall not include in its network any individuals or entities denied or terminated from enrollment with the OHCA.

2.9.3.7 Recredentialing Review

The Contractor shall complete recredentialing of its network providers at least every 36 months. The Contractor shall identify changes that have occurred since the last credentialing. The recredentialing process shall involve verifying and updating information obtained during the initial credentialing process.

In addition, the Contractor shall use provider performance data during recredentialing (e.g., complaints, quality of care issues, pay-for-performance data and compliance with timeliness standards) and results of medical review records (e.g., utilization management information, such as ER use and hospital length of stay).

2.9.3.8 Ongoing Monitoring

The Contractor shall complete ongoing monitoring of provider sanctions, complaints 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.

2.9.3.9 Non-Licensed Providers

When individuals providing covered 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 agencies that employ or hire non-licensed staff.

2.9.4 Network Provider Agreements

The Contractor shall establish written agreements with all network providers.

2.9.4.1 General Requirements for Provider Agreements

In all provider agreements, the Contractor shall comply with the requirements specified in 42 CFR §§ 438.12 and 438.214. 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 RFP. Under the terms of the provider agreement, the provider shall agree that all applicable terms and conditions set out in this Contract, any incorporated documents, the RFP and all applicable State and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members.

If any requirement in the provider agreement is determined by the OHCA to conflict with this Contract, such requirement shall be null and void and all other provisions shall remain in full force and effect.

2.9.4.2 Minimum Requirements for Network Provider Agreements

Network provider agreements shall contain at least the following provisions:

- Parties to the Agreement. Identify the parties of the agreement and their legal basis of operation in the State of Oklahoma;
- Agreement Term. Include provisions describing when the provider agreement shall become effective and expire;
- Termination of Provider Agreement. Include the procedures and specific criteria for:
    - Situations for termination,
    - The Contractor's ability to deny, refuse to renew or terminate any provider agreement in accordance with the terms of this Contract and applicable statutes and regulations,
    - Written notice requirements,
    - In the event of termination of the provider agreement, the provider shall immediately make available to the OHCA or its designated representative in a usable form any or all records whether medically or financially related to the provider's activities undertaken pursuant to the provider agreement and that the provision of such records shall be at no expense to the OHCA,
    - The OHCA reserves the right to direct the Contractor to terminate any provider if the OHCA determines the termination is in the best interest of the State;
- Independent Contractor. Specify that the provider is not a third party beneficiary to the Contract between the Contractor and the State and that the provider is an independent contractor performing services as outlined in this Contract between the Contractor and the State;
- Scope of Work. Identify the services, activities and reporting responsibilities to be performed by the provider;
- NPI. Require that any provider, including providers ordering or referring a covered service, have an NPI, to the extent such provider is not an atypical provider as defined by CMS;
- Credentialing and Recredentialing. The Contractor shall maintain all provider agreements in accordance with the requirements specified in 42 CFR § 438.214;
- Member Rights and Responsibilities. Require all providers to abide by member rights and responsibilities denoted in this Contract;
- Display Notices of Member Rights to Complaints, Appeals and Fair Hearings. Require that the provider display notices in public areas of the provider's facility/facilities in accordance with State requirements and subsequent amendments;
- Physical Accessibility. Require providers to provide physical access, accommodations and accessible equipment for Medicaid members with physical or mental disabilities;
- Interpreter Presence. Require providers to accommodate the presence of interpreters;

- Emergency Services. Provide that emergency services be rendered without the requirement of prior authorization;
- Confidentiality. Require that member information be kept confidential, as defined by State and federal laws, regulations and policy;
- Record Keeping. Require 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. Members and their representatives shall be given access to and can request copies of the members' medical records to the extent and in the manner provided under State or federal law;
- Record Availability. Require providers to maintain all records related to services provided to members for a six-year period. In addition, require providers to make all member medical records or other service records available for any quality reviews that may be conducted by the Contractor, the OHCA or its designated agent(s) during and after the term of the provider agreement;
- Vaccines for Children. If the 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 the OHCA;
- Facility and Record Access for Evaluation, Inspection or Auditing Purposes. Include a provision that authorized representatives of the OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the provider agreement;
- Release of Information for Monitoring Purposes. Include a provision that the provider shall release to the Contractor any information necessary to monitor provider performance on an ongoing and periodic basis;
- Member Cost Sharing. Specify the provider's responsibilities and prohibited activities regarding cost sharing. When the covered service provided has a copayment, as allowed by the Contractor, the provider may charge the member only the amount of the allowed copayment, which cannot exceed the copayment amount allowed by the OHCA. The provider shall accept payment made by the Contractor as payment in full for covered services, and the provider shall not solicit or accept any surety or guarantee of payment from the member, the OHCA or the State;
- Third Party Liability. Include a provision for provider responsibility with respect to third party liability, including:
    - The provider's obligation to identify member third party liability coverage, including Medicare and long term care insurance as applicable,
    - Except as otherwise required, the provider shall seek such third party liability payment before submitting claims to the Contractor;

- Reimbursement Rates and Risk Assumptions. Include the reimbursement rates and risk assumptions, if applicable;
- Claims Submission and Payment. Provide for prompt submission of claims information needed to make payment;
- Performance-Based Provider Payments/Incentive Plans. Describe, as applicable, any performance-based provider payment(s)/incentive plan(s) to which the provider is subject;
- QM/QI Participation. The Contractor shall monitor the quality of services delivered under the provider agreement and require the provider's participation and cooperation in any internal and external QM/QI monitoring, utilization review, peer review and/or appeal procedures established by the OHCA and/or the Contractor. Also require the provider's participation in any corrective action processes that will be taken where necessary to improve quality of care;
- Data and Reporting. Provide for the timely submission of all reports, clinical information and encounter data required by the Contractor and the OHCA;
- Indemnify and Hold Harmless. Specify that all times during the term of the provider agreement the provider shall indemnify and hold the OHCA harmless from all claims, losses or suits relating to activities undertaken by the provider pursuant to the provider agreement;
- Non-discrimination. Require providers to:
    - Agree that no person, on the grounds of disability, age, race, color, religion, sex 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 provider,
    - Identify members in a manner which will not result in discrimination against the member in order to provide or coordinate the provision of covered services,
    - Not use discriminatory practices with regard to members such as separate waiting rooms, separate appointment days or preference to private pay patients;
- Access and Cultural Competency. Require providers to take adequate steps to promote the delivery of services in a culturally competent manner to members, including those with LEP and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity; and
- Database Screening and Criminal Background Check of Employees. Require providers to comply with State and federal law/requirements for database screening and criminal background checks of new hires and current employees/staff who have direct contact with members and/or access to members' protected health information. 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. The Contractor shall require 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 provider shall be required to immediately report to the Contractor any exclusion information discovered. The OHCA reserves the right to deny enrollment or terminate a contract with a provider as provided under State and/or federal law.

2.9.4.3 Network Provider Agreement Limitations/Restrictions

The Contractor shall not include any of the following limitations or restrictions in its provider agreements:

- Non-Compete Clause. Prohibit a provider from entering into a contractual relationship with another managed care entity (i.e., no covenant-not-to-compete) or include any compensation terms (i.e., incentive or disincentive) that encourages a provider not to enter into a contractual relationship with another managed care entity;
- Interference with Provider-Patient Relationship. Contain any provisions that prohibit or otherwise restrict providers from advising or advocating on behalf of members for the following:
    - Member health status, medical care or treatment options, including any alternative treatment that may be self-administered,
    - Any information a member needs to decide among all relevant treatment options,
    - The risks, benefits and consequences of treatment or non-treatment,
    - The member's right to participate in decisions regarding the member's health care, including the right to refuse treatment and to express preferences about future treatment decisions, or
    - Request resolution or support to file a complaint or appeal on behalf of the member if authorized by the member.

2.9.4.4 Requirements for Specific Provider Types

The Contractor shall include the following provisions in its network provider agreements, as applicable to the provider type:

Specific Requirements for PCMH Providers

In its provider agreements with PCMH providers, the Contractor shall also discuss the responsibilities of these providers. At a minimum, PCMH responsibilities shall include:

- Delivering primary care services and follow-up care;
- Utilizing and practicing evidence-based medicine and clinical decision supports;

- Making referrals for specialty care and other covered services and, when applicable, working with the Contractor to allow members to directly access a specialist as appropriate for a member's condition and identified needs;
- Maintaining a current medical record for the member;
- Using health information technology to support care delivery;
- Participating as appropriate on the member's IDT, if the member has such a team, and otherwise providing care coordination in accordance with the member's care plan and in cooperation with the member's care manager;
- Ensuring coordination and continuity of care with providers, including but not limited to specialists, HCBS and behavioral health providers;
- Engaging active participation by the member and the member's family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and care plan development;
- Providing access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other providers, clinics and/or local hospitals;
- Providing enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible;
- Participating in continuous quality improvement and voluntary performance measures established by the Contractor and/or the OHCA; and
- For PCMH providers also participating in the CPC+ program, complying with all CPC+ PCMH care management, quality and other plan-related functions.

Specific Requirements for PCD's

The Contractor shall provide each member under age 21 with access to a PCD in accordance with the process described in section 2.5.5, "Primary Care Dentist (PCD) Selection and Assignment." In its provider agreements with PCD's, the Contractor shall delineate PCD responsibilities.

Specific Requirements for HCBS Providers

In its provider agreements with HCBS Providers, the Contractor shall also delineate the responsibilities of HCBS Providers. At a minimum, the Contractor shall require the HCBS provider to:

- Provide at least 30 days' advance notice to Contractor when the HCBS provider is no longer willing or able to provide services to the member and to cooperate with the member's care manager and IDT to facilitate a seamless transition to alternate providers;
- In the event that a HCBS provider change is initiated for the member, the transferring HCBS provider shall continue to provide services to the member in accordance with the member's care plan until the member has been transitioned to

a new provider, as determined by the Contractor, or as otherwise directed by the Contractor, which may exceed 30 days from the date of notice to the Contractor;

- Immediately report any deviations from the member's service schedule to the member's care manager;
- Provide approved services to the member as indicated in the member's care plan and ensure that provider has staff sufficient to provide service(s) authorized by the Contractor in accordance with the member's care plan, including the amount, frequency, duration and scope of each service in accordance with the member's service plan;
- Provide back-up resources if the provider's own staff is unable to fulfill the assignment for any reason and ensure that back-up staff meet the qualifications for authorized service; and
- Prohibit petitioning the member to change providers or other health care entities to refer members to the provider.

Specific Requirements for Laboratory Testing Sites

The Contractor shall require that all 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.

2.9.4.5 Single Case Agreements

The Contractor may enter into single case agreements with providers performing covered services who are not willing to become a part of the Contractor's provider network. The Contractor must ensure that the provider contracts with the OHCA to allow for acceptance of encounter data.

2.9.5 Provider Payment

2.9.5.1 Rate Setting

The Contractor shall ensure that rates for providers are reasonable to ensure member access to services and that they comply with State and federal provisions regarding rate setting. The Contractor may adopt the current SoonerCare fee schedule in the absence of a separate payment rate and methodology negotiated with a provider.

The Contractor shall adhere to State and federal requirements pertaining to payments of specific provider types as described in sections 2.9.5.4 through 2.9.5.8.

The Contractor shall implement any CMS-approved directed payments to OHCA-defined classes of providers, in accordance with 42 CFR 438.6. This includes, but is not necessarily limited, to pharmacies, as described in section 2.9.5.8, "Payments to Pharmacy Providers." The Contractor shall support OHCA activities related to integrating directed payments into

the OHCA quality strategy and evaluation plan. The OHCA's capitation rate methodology will identify and account for any such directed payments, as appropriate.

The Contractor also shall facilitate any CMS-approved pass-through payments to specific provider types as specified by the OHCA. The OHCA's capitation rate methodology will identify and account for any such pass-through payments, as appropriate.

The Contractor's provider rate setting in the aggregate must align with the provisions of section 2.9.5.9, "Performance-Based Provider Payments".

2.9.5.2 Timely Claims Submission and Payment

The Contractor shall conform to claims filing and timely payment provisions, as outlined in section 2.16, "Claims Processing."

2.9.5.3 Balance Billing

The Contractor shall ensure that a member is held harmless by the provider for the costs of covered services except for applicable copayment amount allowed by the OHCA. The Contractor shall ensure that the provider shall not solicit or accept any surety or guarantee of payment from the member, the OHCA or the State.

2.9.5.4 Payments to Out-of-Network Providers

If the Contractor is unable to provide covered services to a member within the Contractor's network, the Contractor must adequately and timely arrange for the provision of these services out-of-network. The Contractor shall ensure that, if applicable, the cost to the member is no greater than it would have been if the services were furnished with the Contractor's network. Except as otherwise precluded by law and/or specified for IHCPs and FQHCs/RHCs, the Contractor shall reimburse out-of-network providers at 100 percent of the current Medicaid fee schedule/payment rate, unless the parties agree to a different reimbursement amount.

2.9.5.5 Payment for Emergency Services

The Contractor shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. The Contractor shall pay out-of-network providers for emergency services no more than the amount that would have been paid by the OHCA under fee-for-service.

2.9.5.6 Payments to IHCPs (Non-FQHC)

See section 2.12.4.3, "Payments to IHCPs," for information on payments to IHCPs.

2.9.5.7 Payments to FQHCs and RHCs

Notwithstanding the provisions of section 2.9.5.1, "Rate Setting", the Contractor shall provide payment for the provision of covered services at the same Prospective Payment System (PPS) Rate and methodology as employed by the OHCA for members not enrolled in SoonerHealth+, unless a separate payment rate and methodology is negotiated with the provider and approved by the OHCA.

2.9.5.8 Payments to Pharmacy Providers

Notwithstanding the provisions of section 2.9.5.1, "Rate Setting", the rate paid to the pharmacy providers should be no less than the fee for service payment rate employed by the OHCA for the SoonerCare program.

2.9.5.9 Performance-Based Provider Payments

The OHCA and the Contractor agree that performance-based payment arrangements between the Contractor and its network are essential to advancing program quality and outcome objectives. The Contractor shall implement performance-based payments that:

- Include mechanisms to advance and encourage both high quality care and cost savings and that are appropriate to the different components of its network; and
- Include but are not limited to PCMH providers, other medical providers, behavioral health providers, dentists and HCBS providers.

The Contractor's performance-based payments may be made using any combination of the following models:

- Bundled payments, in which the Contractor reimburses providers for a set of services related to a procedure or health condition rather than for each service separately;
- Pay-for-Performance, in which providers are rewarded for meeting quality or outcome goals, including with respect to service accessibility, service utilization, clinical outcomes, member/patient satisfaction and/or cost of care;
- Payment penalties, for failure to meet quality or outcomes goals, provider deviation from evidence-based practice standards or when provider care is connected to sub-standard outcomes such as certain health care acquired conditions;
- Shared savings, in which the Contractor sets a cost target and providers share in savings of avoided costs if they meet or exceed the targets;
- Shared savings and shared risk, in which the provider also is put at financial risk if costs exceed the defined target threshold;
- Global capitation in which the Contractor gives a provider, provider group or health system a single per-patient payment with the intention that the provider or health system will provide all necessary services to that patient during the Contract period; and/or
- Other models that conform to the objectives and standards of this section.

Such payment arrangements, as applicable, must meet the physician incentive plan requirements of 42 CFR §§ 422.208 and 422.210. The Contractor shall not make a payment, directly or indirectly, to a provider as an inducement to reduce or limit covered services furnished to a member.

In the contract year commencing in 2020, at least 80 percent of the Contractor's payments to network providers, shall be to providers whose provider agreements include a performance-based component. The 80 percent threshold will be calculated using a numerator consisting of total payments to these providers (performance-based and other) and a denominator consisting of all network provider payments. Providers whose payment methodology is prescribed by the OHCA will be excluded from the calculation.

The Contractor shall submit an annual Performance-Based Payments Plan to the OHCA in a format and on a schedule to be defined by the OHCA. The plan must meet the requirements of 42 CFR § 438.6(c) and shall detail the Contractor's strategy and good faith efforts for reaching the 80 percent target in 2020, including specifying the Contractor's intermediate targets for 2018 and 2019. The plan also shall describe the Contractor's methodology or methodologies by provider type. The plan must be submitted to the OHCA for review and approval by the OHCA prior to implementation. The Contractor shall submit performance-based payment reports on a quarterly basis to the OHCA that detail the specific payments for that quarter.

2.9.5.10 Overpayments to Providers

The Contractor shall report improper payments to the OHCA and recover overpayments the Contractor identifies from its network providers as specified in section 2.20.11, "Overpayments to Providers." The State shall take such recoveries into account when developing capitation rates. Capitation rates that include the amount of improper payments recovered by the Contractor as projected costs would not be considered actuarially sound.

2.9.5.11 Suspension of Payments

The Contractor shall suspend payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23.

2.9.5.12 Providers Ineligible for Payment

The Contractor is prohibited from using Medicaid program funds to pay for an item or service (other than an emergency item or service, not including items or services furnished in an ER of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician, individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to Section 1128, 1128A, 1156, 1842(j)(2), 1903(i) or 1932(d)(1) 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).

2.9.5.13 Other Prohibited Payments

The Contractor shall not make payments:

- To a provider for provider-preventable conditions that meet the following criteria:
  - Is identified in the State Plan,
  - Has been found by the State, based upon review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines,
  - Has a negative consequence for the member,
  - Is auditable, and
  - Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, on the wrong body part or on the wrong patient;
- For an item or service (other than an emergency item or service, not including items or services furnished in an ER of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
- For an item or service (other than an emergency item or service, not including items or services furnished in an ER of a hospital) with respect to any amount expended for roads, bridges, stadiums or any other item or service not covered under the Medicaid State Plan; or
- For an item or service (other than an emergency item or service, not including items or services furnished in an ER of a hospital) for home health care services provided by an agency or organization, unless the agency provides the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

2.9.6 Provider Services

The Contractor shall develop and implement a comprehensive provider services (relations) function that will include, at a minimum, the communication requirements outlined in this section.

2.9.6.1 Provider Services Policies and Procedures

The Contractor shall develop and maintain written policies and procedures on provider services, including at least the following:

- Provider services call center policies and procedures that address, at a minimum, staffing, training, hours of operation, access and response standards, monitoring of calls and compliance with standards;
- Provider website policies and procedures that address, at a minimum, website content, frequency of updates and ongoing monitoring of accuracy;
- Provider manual content, review and distribution;

- Provider training and education; and
- Provider complaint system.

2.9.6.2 Provider Services Call Center

The Contractor shall maintain a provider services call center within the borders of the State of Oklahoma with a separate toll-free telephone line to respond to provider questions, comments and inquiries and requests for prior authorizations.

The Contractor may operate an overflow call center within the United States for the purposes of meeting the performance requirements listed in this Contract for the provider services call center.

Hours of Operation and Staffing

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 CT to 5:00 pm CT, Monday through Friday, except for State holidays.

A pharmacy call center shall be available at a minimum from 8:00 am CT to 7:00 pm CT, Monday through Friday, 9:00 am CT to 5:00 pm CT Saturday and 11:00 am CT to 4:00 pm CT Sunday, except the following holidays: New Year's Day, Martin Luther King Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. The call center must be able to connect providers with qualified, licensed medical professionals (e.g., pharmacists, nurses, physicians) to discuss medication therapy options.

The Contractor shall have an automated system available during business and non-business hours. The automated system shall include, at a minimum, information on how to obtain after hours' prior authorization and a voice mailbox for callers to leave messages. In addition, the Contractor shall return messages on the next business day.

Provider Services Call Center Training

The Contractor shall develop a program to train newly hired staff and retrain current call center operators. This training program shall address topics that include, at least:

- The populations covered under the program;
- Covered and non-covered services;
- Prior authorization requirements and processes;
- Claims submission requirements and processes;
- Care management;
- Services for Native American members;
- Out-of-state services; and
- Filing a complaint.

Pharmacy call center staff shall also be trained on the following topics:

- How to resolve and approve denied claims in real time;
- Distinguishing between Medicare Part D, Part B or Medicaid drug coverage for dually eligible members; and
- How to determine if a given product is eligible for coverage based on Medicaid Drug Rebate status.

Provider Services Call Center Performance Standards

The Contractor shall have a quality control plan to monitor call center activities and performance.

The Contractor shall have the capability to track call center metrics as described below and issue a quarterly report to the OHCA breaking down the performance:

- Call abandonment rate shall be less than five percent;
- Eighty-five percent of calls shall be answered by a live voice within 30 seconds of the first ring;
- Average wait time shall not exceed two minutes;
- Blocked call rate shall not exceed one percent; and
- The overflow call center must not receive more than five percent of all incoming calls to the call center.

The Contractor quarterly call center report shall break down performance by main call center, overflow center if applicable, and pharmacy help desk and be broken out by Subcontractors.

At end of the calendar year the Contractor shall issue to the OHCA an annual report detailing performance of the call center and mapping out improvement strategies for the next year.

Combined Member and Provider Services Call Center

The Contractor may operate a single call center to serve both members and providers, subject to the requirements specified in section 2.9.6.2, “Provider Services Call Center”. This call center may be operated through Subcontractors.

2.9.6.3 Provider Website

The Contractor shall maintain a website that is accessible to providers. The Contractor shall:

- Maintain a separate and distinct section on its website for its SoonerHealth+ program information if the Contractor markets other lines of business;
- Ensure posted information is current and accurate;
- Review and update website content at least monthly;
- Include a date stamp on each webpage with the date the page was last updated;

- Clearly label any links;
- Comply with HIPAA when providing member eligibility or member identification on the website, including provider portal(s); and
- Minimize download and wait times and avoid tools or techniques that require significant memory or special intervention.

Website Content

The website shall include all pertinent information including, at least, the:

- Provider manual;
- Sample provider agreements;
- Information about how to contact the Contractor and its provider services department;
- Functionality to allow providers to make inquiries and receive responses from the Contractor regarding care for members, including real-time eligibility information and electronic prior authorization request and approval;
- Prior authorization forms and criteria for medications;
- How to track the status of claims online;
- Complaints, appeals and fair hearing processes; and
- How to file provider complaints.

2.9.6.4 Provider Manual

The Contractor shall provide and maintain a written provider manual for use by the Contractor's provider network. The Contractor shall issue a provider manual at least 60 days before the provider's effective date with the Contractor or upon executing a provider agreement, whichever occurs later. The provider manual shall be made available electronically, and in hard copy (upon provider request), to all network providers, without cost.

Provider Manual Content

The provider manual shall include, at a minimum, the following topics:

- Requirements for updating provider demographic data and the OHCA-defined network access and availability standards, the process for updating and the timeframes;
- Requirements for tracking and following-up on referrals for other services (e.g., specialist referrals);
- Benefits provided by the Contractor;
- Coordination of benefits with other providers, Subcontractors and the OHCA's contractors;
- How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections:

what benefits are not covered and how members can obtain information and access those services;

- Prior authorization, utilization management, second opinion and referral processes. This shall include the Contractor's mechanism to allow members to directly access a specialist as appropriate for a member's condition and identified needs;
- For female members, direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist;
- The extent to which, and how, members may obtain benefits, including family planning services and supplies, from out-of-network providers;
- Medical necessity standards and clinical practice guidelines;
- The extent to which, and how, after-hours and emergency coverage are provided;
- Any restrictions on the member's freedom of choice among network providers;
- Information about HCBS provider access;
- Cost sharing and the Contractor's tracking systems for aggregate limits;
- Member rights and responsibilities;
- Confidentiality and HIPAA requirements with which the provider must comply;
- Provider rights for advising and advocating on behalf of patients;
- Provider non-discrimination information;
- The process of selecting and changing the member's PCMH provider;
- Complaint, appeal and fair hearing procedures and timeframes;
- How to file provider complaints;
- Advance directives;
- How to access auxiliary aids and services, including additional information in alternative formats or languages for patients;
- The Contractor and State contact information such as addresses and phone numbers;
- Information on how to report any potential fraud, waste and abuse;
- Information on how to report any potential cases of neglect, abuse and exploitation of members;
- Critical incident reporting;
- Policies and procedures for third party liability and other collections;
- Protocols for encounter data reporting and records;
- Claims submission/filing protocols and standards;
- Payment policies;
- Credentialing/recredentialing information;
- Performance standards;
- Information about the Contractor's care management model;
- Self-direction programs;

- Disease management programs;
- The Contractor's Quality Assessment and Performance Improvement (QAPI) program; and
- Requirements regarding provider's responsibility in monitoring and immediately addressing service gaps, including the use of back-up staff.

2.9.6.5 Provider Education, Training and Technical Assistance

The Contractor shall establish and maintain a provider training, education and technical assistance plan. The Contractor shall update the plan annually. The Contractor shall submit the plan and updates to the OHCA.

Provider Education and Training Frequency

The Contractor shall provide initial and ongoing, at a minimum annual, education and training to its provider network.

Provider Education and Training Content

The Contractor shall provide the following information, at a minimum, in provider trainings and educational materials and upon request of a provider:

- Conditions of participation with the Contractor;
- Provider responsibilities to the Contractor and to members;
- HCBS provider access;
- Prior authorization, utilization management, second opinion and referral processes. This shall include the Contractor's mechanism to allow members to directly access a specialist as appropriate for a member's condition and identified needs;
- For female members, direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist;
- The extent to which, and how, members may obtain benefits, including family planning services and supplies, from out-of-network providers;
- How to update demographic or facility information with the Contractor and under what timeline;
- Billing requirements, rate structures and amounts;
- Claims submission and dispute resolution processes;
- Encounter submission and encounter rejection remediation process;
- Cultural and linguistic competency and resources;
- Credentialing and recredentialing processes;
- Complaint, appeals and state fair hearing processes;
- How to file provider complaints;
- Information on how to report any potential cases of abuse, neglect and exploitation of members;

- Critical incident reporting;
- Advance directives;
- Information about the Contractor's care management model;
- Information, as applicable, about the CPC+ program and CPC+ provider responsibilities, including but not limited to care management responsibilities;
- Self-direction programs;
- Disease management programs;
- The Contractor's Quality Assessment and Performance Improvement (QAPI) program; and
- Other training and education as required/requested by the OHCA or any other State or federal agency.

Provider Technical Assistance

The Contractor shall provide technical assistance to network providers when determined necessary by the Contractor or the OHCA or as requested by providers. Technical assistance includes but is not limited to in-person and telephonic one-on-one meetings. Technical assistance shall be provided in a culturally competent manner.

Record Keeping

The Contractor shall maintain a record of its training, education and technical assistance activities. The Contractor shall make this information available to the OHCA upon request.

2.9.6.6 State Sponsored Provider Outreach Activities

The OHCA reserves the right to mandate that the Contractor coordinate with the OHCA for State sponsored provider outreach activities.

2.9.6.7 Provider Complaint System

A provider complaint is any verbal or written expression by a provider involving dissatisfaction with the Contractor's policies, procedures or action/communication by the Contractor. A network or out-of-network provider may file a provider complaint with the Contractor. The Contractor shall establish a provider complaint system to track the receipt and resolution of provider complaints. The Contractor shall:

- Be able to receive provider complaints by telephone, in writing or in person;
- Have staff designated to receive, process and resolve provider complaints;
- Thoroughly investigate each provider complaint;
- Have an escalation process in place;
- Furnish the provider timely written notification of resolution/results; and
- Maintain a tracking system capable of generating reports to the OHCA on complaint volume and resolution, in accordance with reporting requirements specified in section 2.17, "Reporting."

2.9.7 Provider Contracting and Services Reports

The Contractor shall submit, at a minimum, the following provider contracting and services reports to the OHCA at the frequencies specified in section 2.17, "Reporting."

- Provider criminal convictions report;
- Provider application denials;
- Performance-based payments plan;
- Performance-based payments activity;
- Improper payments to providers;
- Provider services call center performance;
- Provider services call center evaluation;
- Provider training, education and technical assistance plan; and
- Provider complaints.

2.10 Medical Management

The Contractor and the OHCA agree that the purpose of medical (utilization) management is to ensure members 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:

- Is no more restrictive than that used in the Oklahoma Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan and other State policies and procedures; and
- Addresses the Contractor's responsibility for covering services that address:
    - The prevention, diagnosis and treatment of a member's disease, condition and/or disorder that results in health impairments and/or disability,
    - The ability for the member to achieve age-appropriate growth and development,
    - The ability for the member to attain, maintain or regain functional capacity,
    - The opportunity for the member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

The components of medical management, as delineated in this section, include:

- Prior authorization, concurrent review and retrospective review;
- Emergency services utilization management;
- Pharmacy benefit management; and
- Referral protocols.

2.10.1 Structure

The Contractor shall develop a medical management structure for the SoonerHealth+ Program that is integrated with and complementary to the Contractor's quality improvement 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 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 the OHCA.

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

2.10.2 Qualified Staff

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

All decisions either denying service or authorizing services that fall short of the request in amount, duration or scope shall be made by an individual who has appropriate clinical expertise in treating a member's condition or disease.

If the Contractor uses a third party to perform medical management activities, it shall ensure these activities are not structured in such a way to incentivize denial, limiting or discontinuing medically necessary services to any member.

2.10.3 Medical Management Criteria

The Contractor shall ensure that the covered services identified in section 2.4, "Capitated and Non-Capitated Benefits," are furnished in an amount, duration and scope that is no less than the amount, duration or scope for the same services furnished to the programs in existence (SoonerCare Choice and SoonerCare Traditional, including 1915(c) waiver programs) prior to this procurement.

The Contractor shall ensure that the services are sufficient in amount, duration or scope to reasonably achieve the purpose for which they are furnished. Services may not be arbitrarily denied or reduced in amount, scope or duration solely because of diagnosis, type of illness or condition of a member.

The Contractor may place appropriate limits on a service on the basis of criteria applied under the State Plan (i.e., medical necessity) or for the purpose of utilization control, provided the services furnished can reasonably achieve their purpose.

Should there be a dispute between the Contractor and a provider, the Contractor shall attempt to resolve the dispute using the procedures for dispute resolution specified in section 2.16.2.4, "Timely Payment Requirements." Should the dispute persist beyond the second level of resolution within the Contractor's organization, the Contractor shall refer the dispute to the OHCA for final determination in accordance with a process defined by the OHCA.

Initial and ongoing authorization decisions for services shall be made according to the Contractor's written policies and procedures. The Contractor must have mechanisms to ensure the consistent application of review criteria for authorization decisions and for consultation with the requesting provider, as appropriate.

The services supporting individuals with ongoing or chronic conditions or who require HCBS shall be authorized in a manner that reflects the member's ongoing need for such services.

Family planning services shall be provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20.

2.10.4 Prior Authorization Process

The Contractor shall develop a prior authorization process as part of the medical management program that comports with all State and federal requirements. The process shall be equipped to receive and evaluate both initial and continuing prior authorization requests.

The Contractor shall conduct its prior authorization process in a manner that complies with the requirements of Section 1927(d)(5) of the Social Security Act, as if such requirements applied to the Contractor instead of the State.

Providers shall be able to request prior authorization by fax, toll free phone call or online. Phone requests shall be handled by the Contractor's toll free provider services call center or a dedicated toll free authorization line. The line shall be equipped to respond to urgent care prior authorization requests on a 24-hour, seven-day per week basis. If an urgent care prior authorization request must be recorded by a voice mail system due to capacity issues, that phone call must be returned within 30 minutes and a decision rendered within one hour.

The line shall be equipped after regular business hours to field calls from in-network providers treating members with urgent care needs. Should a provider determine that a member needs a prompt referral to a specialist, call center policies and procedures shall be able to allow that prompt referral if necessary. All calls regarding urgent care situations shall be returned within 30 minutes.

Online requests shall be submitted through the provider portal on the Contractor's website.

2.10.5 Prior Authorization Timelines

The Contractor shall decide standard prior authorization requests within 10 days of receipt of the request or as expeditiously as a member's health requires. If the provider indicates, or the Contractor is aware, that adhering to the standard timeframe could jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an authorization decision within 72 hours. Prior authorization decisions involving transplants and pregnancies may require a longer timeframe than this if specified by the OHCA.

The Contractor may extend the timeframe by up to 10 additional days if the member, or provider on behalf of the member in the case of standard authorizations, requests the extension or if the Contractor can justify to the OHCA the need for additional information and show that the extension is in the member's best interest, in accordance with a process to be defined by the OHCA. If an extension is granted that is not requested by the member, the Contractor shall provide the member with a written explanation and information on how an appeal may be filed in response to the extension.

The prior authorization of pharmaceuticals is excluded from these restrictions and is described in further detail in section 2.10.9, "Pharmacy Benefit Management.

2.10.6 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.

2.10.7 Retrospective Review

The Contractor shall develop retrospective review policies and procedures as part of its medical management program. The retrospective review component of the medical management program shall evaluate the appropriateness of care previously received by a member.

The Contractor shall ensure the retrospective review process evaluates claims as expediently as is feasible and shall deliver the decision on coverage to the provider no later than the next business day after a decision is reached.

2.10.8 ER Utilization

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

The Contractor shall work with a member in concert with his or her care manager, provider and the member's IDT to reduce ER utilization. The Contractor shall ensure that appropriate and timely updates are made to the member's care plan as part of the ER utilization process.

2.10.9 Pharmacy Benefit Management

2.10.9.1 General

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 2.4.2.4, "Pharmacy Program."

The Contractor shall only require prior authorization for prescription drugs that are required to be prior authorized by the OHCA, including new drugs added to the OHCA list of covered drugs in accordance with the provisions in section 2.4.2.4, "Pharmacy Program." The Contractor or their PBM shall utilize the criteria established by the OHCA DUR Board for medication prior authorization determinations.

The Contractor shall approve or deny prior authorization requests for prescription drugs within 24 hours of receipt of the request. If the Contractor is unable to provide authorization within 24 hours, there shall be procedures in place to ensure that a member does not run out of the medication before a decision is made. Prior authorization requests shall not be denied by non-licensed medical personnel.

If the pharmacist is unable to refill the member's prescription due to a prior authorization requirement and the prescribing provider is unreachable, the Contractor must require the pharmacist to dispense a 72-hour supply of the prescribed medicine. This requirement does not apply if the dispensing pharmacist establishes that dispensing this dosage would jeopardize the health or safety of the member, in which case the pharmacist should contact the prescribing provider. The Contractor shall compensate the pharmacist at the ordinary rate for dispensing this dosage. The 72-hour supply shall not count against the monthly prescription limitation.

2.10.9.2 Drug Utilization Review

The Contractor shall have policies and procedures that subject the utilization of prescription drugs to prospective, concurrent and retrospective review. Both the prospective and concurrent review should happen at the point of sale.

Prospective review shall analyze, at a minimum: drug-disease contraindications, generic or preferred brand substitution, dosage appropriateness, drug-allergy interactions, inappropriate duration of treatment and clinical abuse indicators.

Concurrent review shall analyze, at a minimum: drug-to-drug interactions, drug-pregnancy precautions, over or underutilization, drug-age precautions, duplicative prescriptions or therapies, drug-disease interactions and excessive or low dosages.

Retrospective review shall analyze, at a minimum: appropriateness of doses and duration, drug-to-drug interaction, drug-disease contraindications, duplicative prescriptions or therapies, appropriate use of generics and clinical abuse. Pharmacies and prescribing providers shall be contacted about aberrant drug use patterns.

The Contractor shall operate a drug utilization program that complies with the requirements described in Section 1927(g) of the Social Security Act and Subpart K of 42 CFR Part 456, as if such requirement applied to the Contractor.

The Contractor shall provide a detailed description of its drug utilization review program activities to the OHCA on an annual basis, in a manner to be defined by the OHCA.

2.10.9.3 Pharmacy Benefit Manager

If the Contractor utilizes a pharmacy benefit manager, the Contractor shall develop policies and procedures to independently audit payments, eliminate conflicts of interest with any affiliated pharmacy providers, monitor pharmacy benefit manager performance and ensure the confidentiality of member information and State information that is not public. These policies shall be submitted to the OHCA for review and approval.

The pharmacy benefit manager shall employ a State liaison with whom the 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 the OHCA to resolve drug rebate disputes that arise from Contractor's claim files.

2.10.9.4 Pharmacy Benefit Financial Disclosures

The Contractor shall disclose to the OHCA all financial arrangements between the Contractor or Subcontractor and all drug-related companies, including manufacturers, labelers, compounders and benefit managers. The OHCA retains the right to request this information at any time and will treat it as confidential as required under State and federal law.

If the PBM is owned wholly or in part by a 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 member and OHCA proprietary information. The proposed PBM subcontract shall meet the requirements specified in 42 CFR § 438.230.

2.10.9.5 Rebates and Financial Reports

All rebates for pharmaceutical products and diabetic testing supplies shall accrue to the OHCA and shall not be kept or shared by or with the Contractor or its PBM.

The PBM shall report quarterly to OHCA their payments to the pharmacy providers and their charge to the Contractor. The rate paid to the pharmacy providers should be no less than the fee for service payment by the SoonerCare program. The PBM drug pricing file should be updated to reflect current pricing at least every seven days.

2.10.10 Referrals

2.10.10.1 General

The Contractor shall develop referral policies and procedures to ensure that members have access to in-network specialty providers for medically necessary care for their covered conditions. All members and providers shall be educated on the referral policy and procedures, including which services require referrals. The referral form that providers must complete to direct members to specialty care shall be separate from the prior authorization form.

Members shall be educated on the possible consequences of self-referrals, including receiving a bill for the service. If a member attempts to receive services through a self-referral or a non-covered service, the member shall be made aware at the point of service that he or she may be billed for the service and how much he or she will be billed.

If a medically necessary service is unavailable within the State, the Contractor shall provide for these services through out-of-state providers. The Contractor shall facilitate such referrals as appropriate.

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

A referral shall not be required for a female member to receive prenatal care.

2.10.10.2 Direct Access to Specialists

The Contractor must have a process, such as standing referrals or approved number of visits, to allow members to directly access a specialist as appropriate for a member's condition and identified needs, when members are determined through an assessment by

an appropriate health care professional to need a course of treatment or regular care monitoring.

2.10.11 Medical Management Reports

The Contractor shall submit medical management reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Medical management reports shall include at least the following:

- Medical management program description;
- Medical management work plan;
- Medical management program evaluation;
- ER utilization management activities and findings;
- Drug utilization review program activities;
- Pharmacy benefit financial arrangements;
- Rebates and financial reports;
- Referral requests and disposition;
- Over- and under-utilization of services;
- Over- and under-utilization of drugs; and
- HCBS utilization.

2.11 Care and Disease Management

The Contractor shall develop and operate a comprehensive care management program that is person-centered, holistic and identifies the unique physical health, behavioral health, HCBS and community and social support needs of members across the continuum of care. The Contractor shall ensure that its care management program complies with 42 CFR § 438.208.

The Contractor shall ensure that all members enrolled in the SoonerHealth+ Program receive care management in accordance with the requirements of this section. If the Contractor has executed an MOU with CMS to participate in the CPC+ program, the Contractor shall follow the procedures specific to members aligned with a CPC+ provider as outlined in section 2.11.10, "CPC+ Care Management Procedures".

Care management activities shall consist of varying degrees of care management and disease management based on assessment of member needs and personal preferences. The Contractor shall ensure timely access to and provision, coordination and monitoring of physical health, behavioral health, HCBS and community and social support services necessary to maintain or improve health status and maximize independence and autonomy as outlined in a member's care plan.

The Contractor shall be responsible for all aspects of care management and establish a set of person-centered, goal-oriented and culturally appropriate steps to ensure that the member receives services that are high-quality, cost-effective and delivered in the least restrictive setting. Care management, disease management, discharge planning and transition planning are elements of care management for members across all providers, health plans and settings.

The Contractor shall develop and maintain policies and procedures for care management that comply with the requirements of this Contract.

2.11.1 Care Manager Responsibilities and Qualifications

Care managers shall be the Contractor's primary point of contact for members. The Contractor shall utilize care managers with specialized skills, knowledge and personal competencies.

2.11.1.1 Care Manager Responsibilities

Care managers shall perform specific duties to meet SoonerHealth+ Program standards. This includes, at a minimum, all of the following:

- Outreaching to engage a member;

- Completing or arranging for necessary assessments to identify the member's physical health, behavioral health, HCBS and community and social support needs;
- Overseeing the creation of an IDT in collaboration with the member and/or the member's representative;
- Arranging for options counseling or otherwise describing service options in sufficient detail to assure that the member, or parent or guardian if applicable, is able to make an informed choice regarding the type of provider;
- Assuming overall responsibility for the development, implementation and updating of a care plan;
- For HCBS waiver members, developing a service plan that defines the types of services needed, regardless of funding source, and the amount, frequency and duration of services required to meet the assessed needs;
- Authorizing or facilitating authorization of services in accordance with the member's care plan;
- Arranging for all services outlined in the care plan;
- Performing monitoring activities to ensure that services are provided in accordance with the care plan and to ascertain whether these services continue to meet the member's needs;
- Offering care management support for self-direction;
- Coordinating services in collaboration with the member's PCMH provider, other providers, health plans, programs and payers (e.g., Medicare) to ensure continuity of care;
- Assisting members in transitioning between service settings and health plans in accordance with requirements delineated in section 2.6, "Transition of Care";
- Providing assistance in resolving any concerns about service delivery or providers;
- Reporting critical incidents in a timely manner and in accordance with the Contractor's critical incident reporting system as described in section 2.13.12, "Critical Incident Reporting System";
- Conducting reassessments at specified intervals, as described in section 2.11.7.4, "Reassessment Timeframes," to identify changes that occurred since the initial or most recent assessment and to measure progress toward goals and outcomes in the care plan; and
- Documenting findings in the member's case record.

2.11.1.2 Care Manager Qualifications

Care managers shall, at a minimum, have the following qualifications:

- Bachelor's degree in social work, psychology, gerontology or a related social services field and at least one year of related professional experience with a similar population as those in the SoonerHealth+ 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;

- Registered or licensed practical nurse, licensed to practice in the State of Oklahoma, with at least one year of professional experience; or
- Bachelor's degree in a human services field and one year of related professional experience with a similar population as those in SoonerHealth+ Program. Related professional experience includes acting as a care manager, rehabilitation specialist, health specialist or social services coordinator in the State of Oklahoma.

The Contractor shall complete a criminal history and background investigation on all care managers prior to their employment or use on a contracted basis.

2.11.1.3 Care Management Supervisor Responsibilities and Qualifications

Care management supervisors shall be responsible for: training and reviewing the work of newly hired care managers; monitoring the day-to-day activities of care managers; overseeing staffing and scheduling; reviewing care management reports; performing case file audits; evaluating the consistency of member assessments, care plans and service authorizations; and developing quality improvement strategies to address areas of improvement.

A supervisor shall be a registered nurse, licensed social worker or hold a Bachelor's degree in social work, psychology, gerontology or a related social services field and have a minimum of two years' experience serving in a supervisory or care management capacity. At least one of the two years of required experience must be related to working with a similar population as those in the SoonerHealth+ Program.

The Contractor shall establish and adhere to a supervisor-to-care manager ratio to ensure the necessary support is in place for care managers.

2.11.2 Care Manager Training

The Contractor shall provide care managers with initial and ongoing training on topics related to the populations served. The Contractor shall develop a curriculum and training plan to ensure all care managers attend initial and ongoing training sessions. The Contractor shall obtain and review training curriculum for the existing HCBS waiver programs to ensure the Contractor's care management training factors in relevant waiver training topics. 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.

2.11.2.1 Initial Care Manager Training

The Contractor shall provide initial training to newly hired and/or contracted care managers. Initial training topics shall include, at a minimum, all of the following:

- Orientation to Medicare and Medicaid programs;
- Overview of SoonerHealth+ Program population categories;
- Oklahoma HCBS waiver requirements;
- Coordination of care for dually eligible members;
- CPC+ program overview;
- SoonerHealth+ Program benefits and services;
- Behavioral health;
- Disease management;
- Instruction on conducting a home visit;
- Member outreach and interviewing techniques;
- Completion of a Health Risk Screening and comprehensive assessment;
- Reassessment procedures;
- Creation, implementation and monitoring of person-centered care plans and understanding HCBS setting requirements;
- Service planning;
- Development and implementation of back-up plans;
- Instruction on updating care plans;
- IDT procedures;
- Independent living philosophy;
- Identification of risk and risk mitigation techniques;
- Abuse, neglect and exploitation – how to recognize and report;
- Self-direction program;
- EVV system and procedures;
- Critical incident reporting;
- Service authorization;
- Service delivery monitoring;
- Care management functions;
- Instruction on locating and arranging community-based services;
- Management of care transitions (e.g., hospital discharge planning);
- Cultural competency;
- Advance directives;
- HIPAA;
- Disaster planning;
- Care management information system; and
- Documentation of findings in a member's case record.

2.11.2.2 Ongoing Care Manager Training

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 or the Contractor's-specific priority areas identified by the OHCA.

2.11.3 Care Manager Staffing

Except where noted in this section, every member shall be assigned to a care manager who has the required qualifications as specified in section 2.11.1.2, "Care Manager Qualifications." The care manager shall serve as a member's single point of contact for coordination of all physical health, behavioral health, HCBS and social support services. Care managers shall be based in Oklahoma.

The Contractor shall offer a contract to the existing ADvantage waiver and Medically Fragile waiver case management agencies for the provision of care management services for at least the initial program Contract year. Members who are currently assigned to an existing care manager shall be given the opportunity to continue using that care manager if the case management agency contracts with the Contractor, the member chooses to use the existing care manager and if the care manager has the capacity within his or her assigned caseload.

As a condition of contracting, the Contractor may:

- Require contracted case management agencies to be accountable for meeting all relevant performance standards delineated in this Contract;
- Require agency staff to participate in the Contractor's care management training as specified in section 2.11.2, "Care Manager Training"; and
- Require agency care managers to be co-located with the Contractor's employed care management staff as deemed appropriate.

At all times, the Contractor shall have the ability to modify the care plan and/or service plan that the agency care manager has implemented if deemed appropriate, including the frequency, duration and scope of services, in accordance with Contract provisions for modification of care plans.

2.11.3.1 Care Manager Ratios and Staffing Plans

The Contractor shall ensure an adequate number of care managers are available and that sufficient staffing ratios are maintained to address the needs of the diverse SoonerHealth+ Program population groups and the requirements specified in this Contract.

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

- Number of care managers, supervisors/managers and support staff;

- Ratio of care managers to members for each of the SoonerHealth+ Program populations;
- Methodology by which the Contractor arrived at its ratios; and
- Process by which the Contractor will ensure the ratios are sufficient to fulfill the requirements specified in this Contract.

2.11.3.2 Care Manager Assignment

The Contractor shall establish procedures for assigning a care manager to a member, including procedures for maintaining existing care manager to member relationships in accordance with section 2.11.3, "Care Manager Staffing." The Contractor shall assign an appropriate care manager based on the primary need(s) identified in the member's Initial Health Risk Screening. Within 10 days of the completion of a Health Risk Screening, the Contractor shall notify the member of the following:

- The assigned care manager's name and contact information;
- Procedures to contact the assigned care manager if any issues or needs arise;
- The member's assigned risk level in accordance with the requirements outlined in section 2.11.6, "Assigning Care Management Risk Levels"; and
- When the member can expect to be contacted by the care manager based on the risk level assigned to the member. This communication shall be in writing to the member.

The Contractor may assign mixed caseloads (e.g., HCBS and non-HCBS) to care managers as long as the required minimum initial and ongoing training are performed as outlined in section 2.11.2, "Care Manager Training."

2.11.3.3 Member-Initiated Care Manager Changes

The Contractor shall allow a member to change a care manager if the member 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 member by making an appropriate initial assignment and working to resolve issues before they result in a request for a change.

2.11.3.4 Contractor-Initiated Care Manager Changes

The Contractor may initiate a change in care managers in the following circumstances:

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

The Contractor shall provide advance notice to a member to the extent practicable and shall minimize disruption through adherence to the process described in section 2.6.5.6, "Care Manager to New Care Manager."

2.11.3.5 Member Access to Care Managers

The Contractor shall ensure that members 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. If the call requires immediate attention from a care manager, the staff member answering the call shall immediately transfer the call to the member's care manager.

A back-up system shall be in place for members when their care manager is unavailable, including after hours and holidays. Members shall be given an emergency telephone number to call 24 hours per day, 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 member's need(s) are addressed as soon as possible. Procedures shall be in place to ensure members, representatives and providers receive timely communication for calls placed on this line.

2.11.4 Electronic Care Management System

The Contractor shall have an electronic care management system that includes a unique case file for each member. Case files shall be retained for a minimum of ten years using a phased-in approach. Member case files shall include, at a minimum, all of the following:

- Member demographics;
- Health Risk Screening;
- Comprehensive assessment (if applicable);
- Care plan (including a service plan and back-up plan, if applicable);
- Reassessments;
- Referrals and authorizations; and
- Member case notes.

The Contractor's care management system shall have interfaces with the State's clinical information systems to facilitate exchange of relevant member data. Likewise, the Contractor may require a contracted HCBS waiver case management agency to utilize the Contractor's electronic care management system as a condition of contracting with the agency.

2.11.5 Initial Member Outreach for Health Risk Screenings

The Contractor shall demonstrate good faith efforts to perform a Health Risk Screening on all new members within the recommended timeframes. The purpose of the Health Risk Screening will be to obtain basic health and demographic information, identify any

immediate needs a member may have and assist the Contractor to assign a risk level needed for the member in order to determine the level of care management needed.

The Contractor shall use a Health Risk Screening questionnaire that has been previously reviewed and approved by the OHCA. The Health Risk Screening shall be conducted by telephone. The Health Risk Screening questionnaire shall be brief. The information from the Health Risk Screening should enable the Contractor to develop a basic care plan for members who do not require a comprehensive assessment (i.e., Level 1 (Low Risk) member).

2.11.5.1 Health Risk Screening Content

At a minimum, the Health Risk Screening shall include questions about the following:

- Demographic information for verification purposes;
- Current or past physical health and behavioral health conditions;
- Pending physical health and behavioral health procedures;
- Most recent ER visit, hospitalization, physical exam and medical appointments;
- Current medications; and
- Current HCBS.

In addition to the above screening questions, the Contractor shall determine if a member has behavioral health needs that require further assessment by ODMHSAS in order to see if the member qualifies for enrollment in a Behavioral Health Home. To do so, the Contractor shall utilize the ODMHSAS mandated screening tools (e.g., Texas Christian University Drug Screen, Patient Health Questionnaire-9) on all members as components of the Contractor's Health Risk Screening.

2.11.5.2 Referral to ODMHSAS for Behavioral Health Assessment

Members who are identified as having behavioral health needs shall be referred to the ODMHSAS within two days of performing the Health Risk Screening, if the member consents. An ODMHSAS independent assessor will then secure an appointment with the member for a behavioral health assessment within two days of the Contractor's referral to ODMHSAS, to be performed using the ODMHSAS-mandated behavioral health and substance use disorder assessment instruments.

The ODMHSAS independent assessor shall perform a behavioral health assessment and notify the Contractor and the OHCA of the outcome within 14 days of scheduling the assessment appointment. During this time period, the Contractor shall not be required to perform a comprehensive assessment pending the disposition of the ODMHSAS assessment.

Members with behavioral health needs who are assessed using the ODMHSAS instruments are placed into one of four tiers, with tier 1 being the lowest behavioral health service level

need and tier 4 being the highest behavioral health service level need. Members who are assessed at tier 1 are primarily children with incidental/episodic needs; tier 2 is reserved for members with a mild or moderate depression level; and tiers 3 and 4 are reserved for members with SMI and SED that qualify the member for Behavioral Health Home placement, subject to the member's consent.

Members with substance use disorder are assessed using the Addiction Severity Index. Members scoring above 35 and meeting the required thresholds qualify for Behavioral Health Home placement, subject to the member's consent.

2.11.5.3 Behavioral Health Home Enrollment Procedures

The ODMHSAS shall provide the results of the behavioral health assessment to the Contractor and the OHCA. If the Contractor receives notification from ODMHSAS that the member qualifies for a Behavioral Health Home, the Enrollment Choice Counselor shall inform the member of such and offer the member a choice to remain in the Contractor's health plan or to enroll in a Behavioral Health Home. The Enrollment Choice Counselor shall notify the OHCA, the ODMHSAS and the Contractor within one day of the member's decision.

If the member is agreeable to enrollment in a Behavioral Health Home, the member shall be disenrolled from the Contractor's health plan. Disenrollment requests shall be adjudicated by the OHCA and become effective on a date consistent with section 2.5.7.4, "Disenrollment Effective Date." If upon the annual reassessment by the ODMHSAS the member's condition has improved, the member opts out of the Behavioral Health Home or no longer qualifies for Behavioral Health Home services, the member shall be placed out of the Behavioral Health Home and enrolled with a health plan based on the member's choice.

If the member elects to remain in the Contractor's health plan, the Enrollment Choice Counselor shall inform the OHCA of the member's choice. The Contractor shall then proceed to assign the member to a care manager as outlined in section 2.11.3.2, "Care Manager Assignment" who will assign the member to a care management risk level and perform a comprehensive assessment.

2.11.5.4 Health Risk Screening Timeframes

During the transition period described in section 2.6, "Transition of Care," the Contractor shall perform the Health Risk Screening within 30 days of a member's enrollment effective date. Following the transition period ("steady state"), the Contractor shall perform the Health Risk Screening within 10 days following the member's enrollment effective date.

Notwithstanding the above timelines, if the member 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, the Contractor shall assign a care manager, if one has not already been assigned, and perform a face-to-face comprehensive assessment within seven days of notification of the event.

The Contractor shall make at least three call attempts to contact the member by telephone. If call attempts are unsuccessful, follow-up correspondence shall be sent to the members. The correspondence shall provide information about the SoonerHealth+ Program, the Contractor's care management program and how to obtain a Health Risk Screening. The Contractor also may use other methods (e.g., email and text messaging) to attempt to contact the member. The Contractor shall document all outreach attempts and make the documentation available to the OHCA upon request.

2.11.6 Assigning Care Management Risk Levels

The Contractor shall assign every member to a risk level based on the criteria outlined below. The Contractor shall use the Health Risk Screening, in combination with any existing care plans, utilization data and/or claims data and other relevant data, to assign a risk level to a member in order to determine the level of care management needed.

2.11.6.1 Level 1 (Low Risk) Description and Care Management Requirements

Level 1 shall consist of members dually eligible for Medicare and Medicaid who are not receiving HCBS or who do not have unstable chronic conditions. The Contractor is not required to perform a comprehensive assessment on Level 1 members.

Level 1 members shall receive, at a minimum, the following care management services:

- Development of a basic care plan that identifies any disease management and/or health education needs as noted during the Health Risk Screening;
- Quarterly or semi-annual written correspondence of disease management and other health education materials, with a frequency based on member need;
- Quarterly review of claims and utilization data to determine if a member may need a comprehensive assessment and placement in a higher risk level;
- Semi-annual or more frequent member telephonic or alternative means of contact to perform disease management education; and
- Annual completion of a Health Risk Screening to identify whether the member may need a comprehensive assessment and placement in a higher risk level.

2.11.6.2 Level 2 (Moderate Risk) Description and Care Management Requirements

Level 2 shall consist of:

- Members who are eligible for Medicaid but not Medicare and do not meet the criteria for inclusion in Level 3;
- Members dually eligible for Medicare and Medicaid who have unstable chronic conditions;

- Individuals on the waiting list for IID waiver services; and
- Members who meet the criteria for Level 1 but for whom the Contractor determines Level 2 would be more appropriate based on findings from a member's Health Risk Screening, existing care plans (if any), utilization data and/or claims data and other relevant data available to the Contractor.

Level 2 members shall receive, at a minimum, the following care management services:

- Annual comprehensive assessment to determine if a lower or higher risk level is needed;
- Development, implementation and updating of a person-centered care plan that addresses the member's physical health, behavioral health, HCBS and community and social support needs;
- Evaluation of the care plan to determine if it is meeting the member's needs;
- Quarterly or more frequent telephonic contact with the member to perform disease management and other health promotion activities; and
- Semi-annual, face-to-face visits with the member.

2.11.6.3 Level 3 (High Risk) Description and Care Management Requirements

Level 3 shall consist of:

- Members receiving HCBS;
- Children who are receiving private duty nursing services;
- Members receiving care management at the time of their enrollment into the Contractor's plan through the SoonerCare Health Management Program, Chronic Care Unit, or a Health Access Network, as communicated by the OHCA to the Contractor. These members shall remain in Level 3 for the first year until they receive an annual reassessment; and
- Members who meet the criteria for Level 1 or Level 2 but for whom the Contractor determines Level 3 would be more appropriate based on findings from a member's Health Risk Screening, comprehensive assessment (once performed), existing care plans (if any), utilization data and/or claims data and other relevant data available to the Contractor.

Level 3 members shall receive, at a minimum, the following care management services:

- Annual comprehensive assessment to determine if a lower risk level is needed;
- Development, implementation and updating of a person-centered care plan that addresses the member's physical health, behavioral health, HCBS and community and social support needs;
- Evaluation of the care plan, including HCBS care setting to determine if it is meeting the member's needs and adhering to HCBS requirements;
- Self-direction monitoring and program implementation services, if applicable;

- Monthly or quarterly face-to-face visits with the member based on the member's acuity; and
- Monthly telephone contact with the member and/or their guardian.

2.11.7 Comprehensive Assessment for Risk Levels 2 and 3

The Contractor shall perform a face-to-face comprehensive assessment on all members assigned to Levels 2 and 3. The Contractor shall use an assessment instrument that has been previously reviewed and approved by the OHCA. The instrument must assess a member's physical health, behavioral health, HCBS and community and social support needs. Any changes to the Contractor's assessment instrument must be submitted to the OHCA for review and approval at least 45 days prior to its use.

The Contractor shall ensure that all assessments are conducted in a culturally competent manner and that information and instructions are accessible to individuals with disabilities and persons who have limited English proficiency.

The care manager shall contact the member's PCMH provider, if applicable, or Medicare PCMH provider, the behavioral health, HCBS and/or other providers as identified by the member during the comprehensive assessment process in order to provide his or her contact information to the provider and office staff.

The care manager will provide updates to all providers concerning any changes in the member's health and will assist in scheduling member appointments. The PCMH provider, if one is assigned, shall be an integral part of the member's IDT.

2.11.7.1 Comprehensive Assessment Domains

At a minimum, the comprehensive assessment shall include questions from the following domains:

- Demographic intake;
- Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content and memory;
- Functional or adaptive deficits/needs (e.g., Activities of Daily Living, Instrumental Activities of Daily Living);
- Behavioral health, including previous psychiatric, addictions and/or substance use disorder history, and a behavioral health, depression and substance use disorder screen. The Contractor shall use the OHCA's behavioral health adult and pediatric screening instruments to fulfill this domain;
- Medical conditions, complications and disease management needs;
- Trauma, abuse, neglect, violence and/or sexual assault history of self and/or others, including Department of Human Services involvement;
- Disability history;

- Educational attainment, skills training, certificates, difficulties and history;
- Family/caregiver and social history;
- Medication history and current medications, including name, strength, dosage and length of time on medication;
- Social profile, community and social supports (e.g., transportation, employment, living arrangements, financial, community resources) and support system, including peer and other recovery supports;
- Advance directives;
- Present living arrangements;
- Member strengths, needs and abilities;
- Home environment; and
- Member cultural, religious, self-direction, if applicable, and other preferences.

2.11.7.2 Assessment for Personal Care Services

Members who are not enrolled in one of the HCBS waiver programs may qualify for personal care services based on the findings of a comprehensive assessment. In these instances, the Contractor shall refer the member to the Oklahoma DHS to perform an assessment utilizing the Uniform Comprehensive Assessment Tool (UCAT) to identify whether the member meets the nursing facility level of care criteria for enrollment in an HCBS waiver or if the member meets medical eligibility standards for personal care services in accordance with OAC 317:35-15-4.

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

The Oklahoma DHS shall determine medical eligibility for personal care services based on the UCAT and the determination that the member has unmet care needs that require personal care services. To be eligible for personal care services, the member must meet the following conditions:

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

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

If it is determined that the member meets criteria for personal care services, based on the UCAT, the Contractor shall authorize these services and include them in the care plan.

2.11.7.3 Comprehensive Assessment Timeframes

During the transition period, the Contractor shall call a member to schedule the comprehensive assessment within 30 days of the Health Risk Screening. Written correspondence shall be sent to the member immediately following the call, listing the date, time and location of the assessment. The Contractor shall complete the comprehensive assessment within 45 days of the Health Risk Screening.

During the steady state period, the Contractor shall schedule the comprehensive assessment within 14 days of the Health Risk Screening and complete the comprehensive assessment within 30 days of the Health Risk Screening.

2.11.7.4 Reassessment Timeframes

The comprehensive assessment shall be conducted face to face on an annual basis for all members assigned to Levels 2 and 3. The annual reassessment shall be completed within one year of the member's last assessment date.

If there is a significant change in status prior to a member's reassessment, the care manager will make contact with the member and family, if applicable, within 72 hours of notification of the significant change and then perform a follow-up visit for a reassessment and care plan review within seven days of the change in status. Significant changes can include, but are not limited to, an acute illness or deterioration in the member's health, change in the status of a caregiver (e.g., death or illness), transition from one setting to another (e.g., hospital to home) and change in living arrangements.

2.11.8 Care Planning

The Contractor shall develop and implement care plans for all members. The Contractor shall use a care planning instrument that has been previously reviewed and approved by the OHCA. Any changes to the Contractor's care planning instrument shall be approved 45 days prior to use by the Contractor.

The Contractor shall ensure that all care planning processes are accessible to individuals with disabilities and persons who have limited English proficiency.

The Contractor shall obtain existing care plans for waiver members and review these plans prior to finalizing the Contractor's care plan. The Contractor shall store all existing care plans in its care management system.

The Contractor shall continue providing members access to all capitated benefits through the transition period outlined in section 2.6, "Transition of Care." For members with an existing care plan, the Contractor shall accept the existing care plan for a period of 90 days or until a comprehensive assessment and new care plan have been completed and implemented, whichever comes sooner.

The Contractor shall have policies and procedures for resolving conflict or disagreement within the process, including clear conflict of interest guidelines to ensure conflict-free care management and accessible alternative dispute resolution processes for all planning participants.

2.11.8.1 IDT

The Contractor shall ensure that all members assigned to risk levels 2 and 3 have an IDT. The assigned care manager shall work with a member to formulate an IDT for the purpose of developing a comprehensive care plan. The care manager shall establish personal contact and begin building relationships with the member, the member's family, representative, PCMH provider and other providers during the assessment and care planning process.

Participants on the IDT shall be selected by the member, legal guardian or representative and may include, but are not limited to, the member, family members, legal guardian or representative, Member Care Support Staff, PCMH provider, specialty providers, behavioral health providers, HCBS providers and Medicare care managers (for dually eligible members). The member or the member's legal guardian, Member Care Support Staff, PCMH provider and the care manager shall comprise a minimum IDT.

The care manager will provide the necessary information and support to ensure that the member directs the care planning process to the maximum extent practical and is able to make informed choices and decisions.

The care manager shall ensure all participants of the IDT receive a copy of the care plan and convene at regular intervals to review the member's goals to ensure progress is being made. Care plan reviews shall be at times and locations that are convenient for the member and/or representative/guardian.

There shall be continuous communication between members of the IDT regarding care plan reviews. This interaction may range from individual phone calls or visits to a provider's office to an IDT conference or teleconference call for more complex members or situations. All IDT meetings and communications shall be documented in the Contractor's electronic care management system.

2.11.8.2 Care Plan Requirements

The care plan for members in Level 1 shall include any disease management and/or health education needs as noted during a member's Health Risk Screening call or from findings in the member's claims history and/or utilization data.

At a minimum, the care plan for members in Level 2 or 3 shall include the following:

- Demographic information;
- Member goals and desired outcomes;
- Caregiver supports (paid and unpaid);
- Current medical, behavioral health and functional needs and conditions;
- Disease management needs including strategies, interventions and related tasks to be performed by the care manager and member;
- Medications and medication management;
- Self-direction services and providers;
- Back-up plan for when regularly scheduled providers are unavailable or do not arrive as scheduled. This may include both informal and formal supports;
- Medical equipment;
- Special communication needs or devices used by the member;
- Physical environment and any modifications needed to ensure the member's health and safety;
- Advance directives;
- Risk factors and measures in place to minimize them, including individualized crisis and/or negotiated risk contracts, as applicable;
- Care manager's signature and date; and
- Member's signature and date.

For members utilizing a HCBS setting for residential or day supports, the plan will document the options considered by the member and that the setting outlined in the care plan was chosen by the member based on an informed decision-making process.

2.11.8.3 Service Plans

The Contractor shall ensure that all members that are assigned to a Level 3 have a service plan. The service plan is a component of the care plan and contains all services (paid and unpaid) to be provided, including services paid by Medicare for dually eligible members, physical health, behavioral health/substance use disorder, HCBS and community and social supports. All needs, including unmet needs for non-covered services, shall be identified in the care plan and service plan.

The comprehensive service plan shall include the amount, frequency, duration, name and type of provider for each service, regardless of funding source, including those services that a member chooses to self-direct, if applicable, State Plan services and informal supports and community services that complement waiver services in meeting the needs of the member.

The Contractor shall have HCBS authorization criteria in place to determine the amount, frequency and duration of each service based on the member's comprehensive assessment and consistent with the person-centered service plan.

Service plans shall be reviewed and updated throughout the care management process, including during telephone contact with the member, during face-to-face visits and in collaboration with the IDT, including the PCMH provider. Care managers shall update the plans based on any identified changes in the member's condition or circumstances, including but not limited to hospitalizations, ER visits, crisis center visits or a change in setting or at the request of the member.

Member Care Support Staff shall be part of the Contractor's care management staff to assist members in accessing community-based resources, addressing non-medical needs and supporting the member's care plan objectives and independence. They shall also assist members to obtain information about available services inside and outside of the health plan.

After completing the comprehensive in-home assessment, as part of the care planning process, the care manager shall discuss service options to best meet the member's needs. A provider directory shall be provided to and reviewed with the member. The member shall then select a provider to deliver each service. If the member declines to make a provider choice, the care manager shall notify the Contractor's care management department to auto-assign a provider for the member based on a list of available providers in the Contractor's network.

All service plans shall be finalized and agreed to, with the informed consent of the member obtained in writing and signed by all providers responsible for implementation and as specified in section 2.11.8.4, "Care Plan Approval." Any changes in the service plan shall be

documented and agreed to by the member and/or the member's legal guardian or representative.

2.11.8.4 Care Plan Approval

The care manager shall submit the care plan and service plan to a care management supervisor for review and approval. The Contractor shall have procedures in place for the timely review and approval of care plans by supervisory staff. The approval shall ensure that care plan services meet a member's assessed needs and that the HCBS service units are appropriate to meet assessed needs.

The care manager shall review the approved care plan with the member and obtain the member's or parent/guardian's signature, if applicable, and date. The care manager shall provide a copy of the completed care plan to the member and to each of the member's IDT participants within five days of approval.

2.11.8.5 Care Plan Timeframes

During both the transition period and steady state period, the Contractor shall develop care plans within 15 days of completion of a comprehensive assessment.

2.11.8.6 Care Plan Reviews

Care plans for members who are assigned to Level 1 shall be reviewed at least on a semi-annual basis. Care plans for members that are assigned to Level 2 or 3 shall be reviewed at least on a quarterly basis or upon request by a member.

If there is a significant change in status prior to the member's care plan review, the care manager will make contact with the member and family, if applicable, within 72 hours of notification of the significant change and perform a follow-up visit for a reassessment and care plan review within seven days of the change in status. Significant changes can include, but are not limited to, an acute illness or deterioration in the member's health, change in the status of a caregiver (e.g., death or illness), transition from one setting to another (e.g. hospital to home) and change in living arrangements.

2.11.9 Ongoing Care Management

The Contractor shall provide ongoing care management and shall make care management contacts as specified in section 2.11.6, "Assigning Care Management Risk Levels.**"** Ongoing care management activities shall include, at a minimum, the following:

- Authorize services within timeframes specified in the care plan;
- Contact members within five days of service initiation to confirm that services are being rendered and that a member's needs are being met;
- Update the care plan as needed;
- Perform disease management interventions, if applicable;

- Coordinate member updates and progress with the IDT;
- Identify, address and evaluate service gaps;
- Schedule appointments and arrange for transportation and other supports;
- Remind the member about upcoming appointments;
- Perform reassessments;
- Oversee self-direction services, if applicable;
- Document ongoing updates in the member's case file;
- Update consent forms as necessary;
- Address complaints or concerns regarding quality of care rendered by providers, self-direction providers or care management staff;
- Assess member satisfaction with services and care;
- Monitor the safety of the member's home environment;
- Coordinate care transitions between settings, health plans and providers;
- Perform a review of claims and utilization activity between annual assessments;
- Educate the member about advance directives and document the member's decision in the case file, in accordance with 63 O.S. §§3101.1-3101.4 of the Oklahoma Advance Directive Act;
- Monitor treatment and compliance with services; and
- Evaluate whether the member met the goals as outlined in the care plan.

2.11.10 CPC+ Care Management Procedures

Under CPC+, participating primary care providers are classified by CMS into one of two tracks and must perform a variety of activities as components of the CPC+ advanced primary care medical home model. These include, but are not limited to:

- Track 1
    - Empanelment of patients;
    - Twenty-four hour/seven-day patient access;
    - Assignment to care teams;
    - Risk stratification;
    - Short-term and targeted, proactive, relationship-based care management; and
    - Emergency room visit and hospital follow-up.
- Track 2
    - All Track 1 activities, including two-step stratification process for empaneled patients;
    - Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits and/or expanded hours; and
    - Care plans for high risk chronic disease patients.

If Contractor has executed an MOU with CMS to participate as a payer in CPC+, Contractor shall follow the procedures outlined in this section for its members aligned with a network CPC+ primary care provider. Contractor also shall collaborate with the OHCA and other CPC+ participating plans to evaluate and update procedures as appropriate to facilitate the integration of the SoonerHealth+ and CPC+ programs.

2.11.10.1 Assignment of Contractor Care Manager

The Contractor shall assign a plan care manager to members in risk levels 2 and 3 who are aligned with a CPC+ provider. The care manager's role shall be to act as a resource in supporting the CPC+ practice in fulfilling its care management responsibilities as defined by CPC+ and to perform care management functions required by SoonerHealth+ that fall outside the scope of the CPC+ program, as applicable.

2.11.10.2 Health Risk Screenings and Risk Stratification

The Contractor shall perform health risk screenings and risk stratification for members aligned with a CPC+ provider in the same manner as for other SoonerHealth+ members. The Contractor shall provide the results of the screening and stratification to CPC+ providers for their use in fulfilling CPC+ risk stratification requirements.

2.11.10.3 Members Assigned to Risk Level 1

Upon completion of the Health Risk Screening and the assignment of a care management risk level, all Level 1 members who are aligned with a CPC+ provider will be referred to their assigned CPC+ provider, who will be responsible for performing all care management activities described in section 2.11.6.1, "Level 1 (Low Risk) Description and Care Management Requirements", except for the annual Health Risk Screening, which shall be performed by the Contractor. The Contractor is not required to assign these members a plan-level care manager but must make member care support staff available to assist members and CPC+ practice staff as appropriate.

2.11.10.4 Members Assigned to Risk Level 2

Upon completion of the Health Risk Screening, the assignment of a care management risk level and completion of a comprehensive assessment, all Level 2 members who are aligned with a CPC+ provider will be referred to their assigned CPC+ provider, who will perform all care management activities as described in section 2.11.6.2, "Level 2 (Moderate Risk) Description and Care Management Requirements", except for the annual comprehensive assessment, which shall be performed either by the Contractor or CPC+ provider, in accordance with the Contractor's policies and procedures.

2.11.10.5 Members Assigned to Risk Level 3

Upon completion of the Health Risk Screening, the assignment of a care management risk level and completion of a comprehensive assessment, all Level 3 members who are aligned

with a CPC+ provider will be referred to their assigned CPC+ PCMH provider, who will be responsible for development of a person-centered care plan. The CPC+ provider will be responsible for performing all care management activities described in section 2.11.6.3, “Level 3 (High Risk) Description and Care Management Requirements”, except for the development of service plans; management of HCBS waiver activities; and management of self-direction program activities as described in section 2.11.12, "Self-Direction”. The annual comprehensive assessment shall be performed either by the Contractor or CPC+ provider, in accordance with the Contractor’s policies and procedures.

2.11.10.6 Ongoing Care Management

The Contractor shall perform the following tasks for members aligned with a CPC+ provider:

- Authorize services within timeframes specified in the care plan;
- Contact members within five days of service initiation to confirm that services are being rendered and that a member’s needs are being met;
- Perform reassessments;
- Oversee self-direction services, if applicable;
- Document ongoing updates in the member’s case file;
- Update consent forms as necessary;
- Address complaints or concerns regarding quality of care rendered by providers, self-direction providers or care management staff;
- Assess member satisfaction with services and care; and
- Monitor the safety of the member’s home environment.

The Contractor shall monitor and support CPC+ providers in their performance of care management tasks. It will be the responsibility of the CPC+ provider to:

- Update the care plan as needed;
- Perform disease management interventions, if applicable;
- Coordinate member updates and progress with the IDT;
- Identify, address and evaluate service gaps;
- Schedule appointments and arrange for transportation and other supports;
- Remind the member about upcoming appointments;
- Coordinate care transitions between settings, health plans and providers;
- Perform a review of claims and utilization activity between annual assessments;
- Educate the member about advance directives and document the member’s decision in the case file;
- Monitor treatment and compliance with services; and
- Evaluate whether the member met the goals as outlined in the care plan.

2.11.11 Monitoring Service Delivery

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

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

- Care management tools and procedures are consistently and objectively applied and outcomes are continuously measured;
- Health Risk Screenings, comprehensive assessments and reassessments occur within the required timeframes and are submitted to the OHCA in accordance with the requirements in sections 2.11.5, "Initial Member Outreach for Health Risk Screenings," and 2.11.7, "Comprehensive Assessment for Risk Levels 2 and 3";
- Care plans, service plans and back-up plans, if applicable, are developed and updated on schedule and in compliance with this Contract;
- Services are delivered in a timely manner and are provided as authorized by the Contractor;
- Care plans address needs identified in the comprehensive assessment and are appropriate and adequate to address a member's needs;
- Service utilization is appropriate;
- Service gaps are identified and addressed in a timely manner;
- Minimum care management contacts are performed;
- Care manager ratios are in compliance with the approved Annual Care Management Staffing Plan submitted to the OHCA;
- Care manager assigned risk levels are accurate;
- Care manager assignments are performed in a timely and accurate manner;
- Service plans are monitored and appropriate action is taken if the member is nearing or exceeding a service limit, if applicable; and
- Self-direction program training and service delivery are being performed in a timely and effective manner.

2.11.12 Additional Care Management Program Requirements

2.11.12.1 Pharmacy Lock-in

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's pharmacy lock-in program and associated policies and procedures shall be reviewed and approved by the OHCA prior to adoption and implementation. 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 and reporting.

Members 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. When warranted, a member shall be "locked-in," and therefore required to fill all prescriptions for which Medicaid is the primary payer at a single designated pharmacy and by a single designated prescriber or group in order to better manage medication utilization.

The Contractor shall perform an in-depth analysis to determine if a SoonerHealth+ Program member's pharmacy utilization is inappropriate and meets lock-in program criteria. If lock-in program criteria are met, the Contractor shall lock eligible members into one pharmacy, monitor and conduct reviews of pharmacy utilization by locked-in members and other members who merit concern, perform case closure activities and manage all lock-in program correspondence with members.

For members who are referred for the lock-in program, the Contractor shall review pharmacy utilization reports to see if the member potentially qualifies for the lock-in program. If the pharmacy utilization reports indicate that any of the program criteria have been met, the Contractor shall ensure the member is locked-in. The Contractor shall track all lock-in program data and activity in its electronic care management system.

For any member who was in a lock-in program within fee-for-service Medicaid or another SoonerHealth+ plan at time of enrollment into the Contractor's plan, the Contractor shall place the member in its lock-in program upon enrollment.

2.11.12.2 Advance Directives

The Contractor shall develop and maintain written policies and procedures for advance directives. These policies and procedures shall comply with all State and federal requirements concerning advance directives, including 42 CFR §§ 422.128, 438.3(j)(1) - (j)(4), 42 CFR Part 489, Subpart I and 63 O.S. §§3101.1 through 3101.15, 3102.1 through 3102.3 and 3102A.

Any and all changes in State law as they pertain to advance directives must be incorporated into the written policies and procedures within 30 days of the change and must then subsequently be submitted to the OHCA for approval.

The Contractor shall supply all adult members with its advance directive policies and procedures. A member shall be notified of his or her right under State law to accept or refuse medical treatment and the right of formulation of advance directives. The Contractor shall be responsible for educating the member on all aspects of care that they are entitled to under advance directives. Advance directives shall be incorporated into the member's case file within the care management system as well as the member's medical records, as applicable.

The Contractor shall not administer care conditionally based on whether the member has executed an advance directive or not.

The Contractor shall ensure that the relevant Subcontractors and staff are educated about its advance directive policies and procedures, situations in which advance directives could be applicable and the Contractor's legal obligation to ensure members are informed of their rights as they relate to advance directives. These staff and Subcontractors shall be informed about how to assist members to best utilize the advance directive mechanism. The Contractor shall specifically designate staff members or Subcontractors to provide this education.

The Contractor shall not be required to provide care that conflicts with an advance directive.

2.11.12.3 Disease Management

The Contractor shall employ disease management (DM) strategies to members with identified chronic conditions as part of its care management processes and activities. The Contractor's DM strategies may include but are not limited to population identification/stratification, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement projects.

The Contractor shall develop DM programs that include the array of physical health and behavioral health conditions that impact the SoonerHealth+ Program membership. As part of this, the Contractor shall develop DM policies and procedures that are integrated with its care management program.

The Contractor shall submit an annual DM Program Plan to the OHCA for review and approval, which shall include a description of the DM strategies and interventions, goals and

measurable objectives and expected outcomes. In addition, the Contractor shall submit an annual DM Program Evaluation to the OHCA, which shall include a quantitative and qualitative evaluation of the efficacy of the prior year's DM strategies, document the degree to which goals were addressed and report outcomes in the area of cost, utilization and quality.

2.11.12.4 Home- and Community-Based Settings Requirements

The care manager, in conjunction with Contractor's network representatives, shall monitor HCBS settings for members in Level 3 to ensure network providers of home, employment and/or center-based day supports maintain adherence to all federal HCBS settings requirements at 42 CFR 441.710.

2.11.13 Self-Direction

The Contractor shall provide all members the opportunity to self-direct select services outlined in this section if they are determined through an assessment to need such service(s) and a member chooses self-direction and meets State standards to self-direct their care.

The Contractor shall develop and maintain policies and procedures for self-direction that comply with the requirements of this Contract. The OHCA will review the Contractor's self-direction policies and procedures as part of readiness review activities.

2.11.13.1 Self-Directed Services – ADvantage Waiver

The ADvantage waiver self-direction program is referred to as, "Consumer-Directed Personal Assistance Services and Supports (CD-PASS)." The following services may be self-directed for members who meet the criteria for the ADvantage waiver, in the duration and scope defined in the approved 1915c waiver:

- Personal services assistance;
- Advanced personal services assistance; and
- Self-directed goods and services.

2.11.13.2 Self-Directed Services – Medically Fragile

The following services may be self-directed for members who meet the criteria for the Medically Fragile waiver, in the duration and scope defined in the approved 1915c waiver:

- Advanced supportive restorative assistance;
- Personal care;
- Respite services; and
- Self-directed goods and services.

2.11.13.3 Methods of Self-Direction

Self-direction in the SoonerHealth+ Program affords members the opportunity to have choice and control over how services are delivered. Members shall have employer authority, whereby they make the decisions to recruit, hire, train and supervise the individuals who furnish their services. Members shall also have budget authority, whereby they determine how the funds in their budget are spent.

2.11.13.4 Authorized Representatives

A member may choose to designate an authorized representative to assist in executing the employer functions. Services may be directed by:

- An adult member, if the member has the ability to self-direct;
- A legal representative of the member, including a parent, spouse, or legal guardian who is at least 18 years of age; or
- A non-legal representative freely chosen by the member or the member's legal representative.

The provider(s) of self-directed services shall:

- Comply with the Oklahoma DHS and the OHCA's rules and regulations;
- Complete required training for self-direction provided by the Contractor in collaboration with the FMS;
- Sign an agreement with the health plan consenting to self-direct one or more of their services;
- Be approved by the member or the member's representative to act in the capacity of a representative; and
- Demonstrate knowledge and understanding of the member's needs and preferences.

The authorized representative shall advise and assist the member regarding any and all self-direction activities and decisions for which the member is responsible and take actions on behalf of the member when directed by the member. An authorized representative shall not make decisions for or on behalf of the member unless he or she has the legal authority to make decisions on behalf of the member. In order to be an authorized legal representative, the person must be the legal guardian of the member or have a durable power of attorney for the member.

If the member chooses to designate an authorized representative, the designation identifying the individual to assume this role and the responsibilities shall be documented with dated signatures of the member, the designee and the member's care manager via a consent form. The Contractor shall use a consent form that has been previously reviewed and approved by the OHCA or designee.

The authorized representative's name and contact information and the consent form shall be part of the member's case file in the Contractor's electronic care management system.

The member who chooses a non-legal representative as a surrogate can change the authorized representative at any time. A new consent form shall be completed with dated signatures of the member, the designee and the member's care manager. Information on the authorized representative, as well as the consent form, shall be part of the member's case file in the Contractor's electronic care management system.

2.11.13.5 Contractor Responsibilities

The Contractor shall ensure that a member and/or the member's authorized representative have access to resources and supports in order to fully participate in the self-direction program. At a minimum, the Contractor shall perform the following functions related to self-direction:

- Comply with the Oklahoma DHS and the OHCA's rules and regulations;
- Subcontract with the existing FMS entity that is currently under contract with Oklahoma DHS to perform payroll and other employment related functions;
- Cooperate with the FMS in administering self-direction services;
- Reimburse the FMS for authorized self-directed services provided by self-direction providers based on paid claims, which include applicable payroll taxes;
- Provide freedom of choice to members;
- Understand the roles and responsibilities of members and/or authorized representatives, the FMS, care managers and self-direction providers;
- Secure provider contracts with all self-direction providers;
- Verify that all self-direction providers hired by the member meet provider network credentialing standards as established by the OHCA prior to service delivery;
- Obtain a service agreement from the member delineating the roles and responsibilities of the member and self-direction provider and include the service agreement in the member's case file in the Contractor's electronic care management system;
- Develop and provide self-direction training to members and/or authorized representatives, self-direction providers, care managers and key staff;
- Understand the array of self-direction services and procedures to be followed to administer self-direction;
- Identify and resolve any issues related to implementation of self-direction;
- Monitor and report on all aspects of the Contractor's self-direction program;
- Provide oversight of the Individualized Budget Allocation (IBA) process and review IBA on a regular basis;
- Monitor the quality of services provided by self-direction providers;
- Monitor late or missed visits and the implementation of back-up plans;
- Address any issues or complaints related to the health and welfare of the member;

- Recognize and report any critical incidents; and
- Facilitate resolution of any disputes regarding payment to self-direction providers for services rendered.

2.11.13.6 Care Manager Responsibilities

At a minimum, the care manager shall perform the following functions related to self-direction:

- Comply with the Oklahoma DHS and the OHCA's rules and regulations;
- Assist a member and/or authorized representative in facilitating self-direction and in accessing available resources and supports;
- Inform the member of the services that may be self-directed;
- Ensure that person-centered planning for all self-directed services complies with State and federal standards;
- Educate members about the roles and responsibilities of the member and/or authorized representative, the health plan, care manager and FMS;
- Provide required training and other resources to members who choose self-direction in collaboration with the FMS;
- Oversee the service planning process and work with the member and/or authorized representative to determine the individual services needed, the budgeted amounts for each service and the total IBA;
- Facilitate the development and ongoing review of the status of the member's IBA;
- Submit the care plan, including the service plan, for approval to the care management supervisor, in accordance with sections 2.11.8.4, "Care Plan Approval";
- Provide the member with information about qualified self-direction providers and assist the member and/or authorized representative with selecting providers;
- Assist the member with emergency back-up planning;
- Arrange alternative emergency back-up services, as necessary, in the event that the emergency back-up plan provided in the care plan cannot be employed;
- Arrange for the delivery of self-direction services;
- Ensure that services are initiated within the required time frames;
- Monitor the member's service plan to ensure the member's well-being and the overall quality of self-direction supports and services;
- Assess the adequacy and appropriateness of the services provided to determine the extent to which adjustments to the service plan and IBA are necessary;
- Update the member's service plan and IBA as needed;
- Inform members about their appeal rights and processes, complaint registration/resolution process and risk management initiation and process; and
- Provide information to the member about the option to terminate self-direction or change to the agency-directed model of service delivery.

2.11.13.7 Member Responsibilities

A member who chooses self-direction shall be responsible for the following functions:

- Comply with the Oklahoma DHS and the OHCA's rules and regulations;
- Complete a self-assessment in collaboration with the care manager;
- Participate in required self-direction training;
- Develop interview questions;
- Screen and interview applicants in collaboration with the FMS;
- Recruit, hire and train self-direction providers;
- Determine self-direction provider duties;
- Instruct and train self-direction providers on duties in collaboration with the assigned care manager;
- Schedule self-direction providers;
- Assist with the development of a back-up plan;
- Be the employer of record and maintain budget authority;
- Supervise self-direction providers;
- Evaluate self-direction providers;
- Terminate self-direction providers, as necessary;
- Verify time worked by self-direction providers and approve time sheets; and
- Work with the FMS to ensure that the employment complies with State and federal labor law requirements.

2.11.13.8 Fiscal Management Services (FMS) Responsibilities

At a minimum, the FMS shall perform the following functions related to self-direction:

- Comply with the Oklahoma DHS and the OHCA's rules and regulations;
- Provide an employee and employer orientation packet to each member and/or authorized representative who elects the self-direction option;
- Perform an orientation and ongoing training and support to a member and/or the member's representative on how to perform employer-related functions;
- Perform an orientation and ongoing training and support to self-direction providers on how to perform employee-related functions;
- Provide training to the Contractor's care managers regarding self-direction and the role and responsibilities of the FMS;
- Assist with individual budgeting, managing budget expenditures and budget revisions;
- Prepare, equip and assist the member to recruit, train, manage and supervise self-direction providers;
- Verify provider citizenship status;
- Obtain criminal and abuse registry background checks and provide this information to the Contractor;
- Collect and process self-direction provider timesheets;

- Process payroll, withholding, filing and payment of applicable federal, State and local employment-related taxes and insurance;
- Process and pay invoices for goods and services approved in the service plan;
- Maintain a separate account for each member's self-direction budget;
- Provide the Contractor, Oklahoma DHS and the OHCA representatives access to individual member accounts through a web-based program;
- Track and report member funds, disbursements and the balance of member funds;
- Provide members and the Contractor with periodic reports of expenditures and the status of their self-direction budget; and
- Execute and maintain a contractual agreement with the Contractor.

2.11.13.9 Self-Direction Outreach

The care manager shall provide all new and existing members assigned to Level 3 with a self-direction handbook, which contains basic information about the self-direction option including at least the following:

- Description of the self-direction service option;
- The services that may be self-directed;
- A list of the responsibilities of a member choosing the self-directed option;
- Resources available to members who choose self-direction;
- How to request the self-direction option; and
- A telephone number to contact the care manager or a member of the care management team to obtain additional information about the self-direction option.

Members may request self-direction services at any time through a care manager or by contacting the Contractor.

2.11.13.10 Self-Assessment for Self-Direction

As part of the service planning process, outlined in section 2.11.8.2, “Care Plan Requirements,” members who are assessed as needing any of the services listed in sections 2.11.13.1 - 2.11.13.2 shall be informed by their care manager of the option to self-direct the service(s). Members interested in self-direction shall be required to make a voluntary informed choice to participate by providing a signed statement regarding their decision to participate, as well as completing a self-assessment form.

The self-assessment form is intended to determine a member’s ability to make decisions regarding health and services, as well as assess the member’s knowledge and skills to be an employer of record.

The care manager shall provide the member with the self-direction consent form and self-assessment form, as well as assist in completing them. Both the self-direction consent form

and self-assessment form shall be reviewed and approved by the OHCA or designee prior to use by the Contractor.

If, based on the results of the self-assessment, the care manager determines that the member requires assistance to self-direct services, the care manager shall inform the member that he or she will need to designate an authorized representative to assume the self-direction functions on the member's behalf.

Members who are unable to complete a self-assessment form due to a physical or cognitive limitation, or choose not to complete the form but are interested in self-direction, may do so if they elect an authorized representative to assume the responsibilities on their behalf.

Refer to section 2.11.13.4, "Authorized Representatives," for more information about authorized representatives.

The member's consent form to self-direct and self-assessment form shall be part of the member's case file in the Contractor's electronic care management system.

2.11.13.11 Contractor Denial of Self-Direction

Based on a review of the self-assessment and in combination with any existing care plans, utilization data and/or claims data and other relevant data, and after collaboration with a member's IDT, the following shall be the basis for the Contractor's denial of a request for self-direction:

- Inability to assure member health and safety;
- The member is not willing to assume responsibility or to enlist an authorized representative to assume responsibility in one or more areas;
- The member has a history of self-neglect or self-abuse within the past twelve months that is confirmed by Adult Protective Services and does not have an authorized representative with capacity to assist with self-direction responsibilities; or
- The member's UCAT or comprehensive assessment document that the member is high risk (i.e., UCAT Mental Status Questionnaire score of 12 or greater) and is unable to obtain an authorized representative who is willing to assist with employer responsibilities.

If the member does not meet self-direction participation criteria, the Contractor shall send the member written correspondence detailing the reason(s) for the denial and give the member the right to appeal the decision and a right to a fair hearing as specified in section 2.14, "Member Complaints and Appeals."

The Contractor shall arrange agency providers of the member's choice to render services to meet the needs of the member. The Contractor shall ensure that the same quality of self-directed services is available to the member as through the use of agency providers.

The Contractor shall communicate this information to both the member and the OHCA in writing in a format to be specified by the OHCA.

2.11.13.12 Self-Direction Training

Care managers shall be trained on self-direction, as specified in section 2.11.2, "Care Manager Training." Care managers shall be provided training regarding all elements of the self-direction program including, at least, person-centered planning, their roles and responsibilities in facilitating the development and review of the self-directed budget, arranging back-up services and the roles and responsibilities of the care manager, a member and/or authorized representative, FMS and self-directed providers.

The FMS shall be responsible for providing a portion of this training. The Contractor shall obtain and review training curriculum for the ADvantage CD-PASS self-direction program to ensure the Contractor's self-direction training factors in CD-PASS training topics.

The Contractor shall require that all members and/or authorized representatives participate in an initial self-direction training program prior to receiving self-direction services and ongoing training upon request and as necessary. At a minimum, the Contractor's self-direction training program for members shall include the following:

- Philosophy of self-direction;
- Policies and procedures on self-direction;
- Member rights, risks and responsibilities as they relate to self-direction;
- An understanding of the roles and responsibilities of the care manager and the FMS;
- Cultural diversity;
- Person-centered planning;
- Self-direction provider recruitment;
- The hiring of self-direction providers as employer of record;
- Orientation and instruction of self-direction providers in required duties;
- Supervision of self-direction providers including scheduling and service provisions;
- Approval of timesheets;
- The scheduling of self-direction providers and back-up planning;
- Evaluation of self-direction providers;
- Critical incident reporting;
- Fraud and abuse prevention and reporting;
- Abuse and neglect reporting;
- Termination of self-direction providers;

- Individual budgeting; and
- Development of a care plan, service plan and back-up plan.

The Contractor shall require that all self-direction providers participate in a self-direction training program prior to rendering self-direction services and ongoing training upon request and as necessary. At a minimum, the Contractor's self-direction training program for providers shall include the following:

- Overview of the Contractor's self-direction program and self-directed services;
- Instruction on caring for elderly and disabled populations;
- Person-centered planning;
- Member rights, risks and responsibilities as they relate to self-direction;
- The roles and responsibilities of the care manager and the FMS;
- The responsibilities of assuming the role of self-direction provider, including criteria for job termination;
- Understanding the member's IBA and service plan;
- Instruction on submitting appropriate documentation and withholdings;
- Completion of timesheets;
- Payment schedules;
- Process for notifying the member if they are unable to perform the assigned duties;
- Skills, competencies and required training to become a self-direction provider;
- Credentialing requirements;
- Self-direction provider agreements;
- Critical incident reporting;
- Fraud and abuse prevention and reporting; and
- Abuse and neglect reporting.

The initial self-direction training programs for members and providers shall be performed face to face. The Contractor shall maintain attendance records and verify successful completion of training for all individuals. The Contractor shall develop training materials in alternative formats upon request of members and/or providers or at the recommendation of the care manager.

The Contractor's self-direction training program materials for members and providers shall be reviewed and approved by the OHCA or designee prior to use by the Contractor. Any changes to programs and materials shall be submitted to the OHCA or designee for review and approval at least 45 days prior to its use.

2.11.13.13 Individualized Budget Allocation (IBA)

As part of the care planning process outlined in section 2.11.8.2, “Care Plan Requirements,” the care manager shall develop a service plan and budget for each member electing self-direction. The member’s service plan determines the intensity, frequency and duration of needed services. The IBA shall be based on the member’s assessed needs, the units of service the member requires for each allowable service and the payment rates for each service as specified by the OHCA or designee.

The amount of the IBA shall be based on the amount authorized in the care plan for the services the member has elected to direct and cannot exceed the cost limits contained in each of the program waivers. The Contractor shall comply with the IBA rules in place for the current HCBS waiver programs, including the IBA Expenditure Accounts Determination process as described in Oklahoma Administrative Code (OAC) 317:30-5-764.

The care manager shall work with the member to determine the individual services needed, the budgeted amounts for each service and the total IBA. The care manager shall submit the care plan, along with the service plan, for review and approval to the care management supervisor and as specified in section 2.11.8.4, “Care Plan Approval.” The care manager shall work with the member to understand that the IBA is intended to last for one year.

The care manager shall confirm the member understands the established budget amounts included in the service plan, ensure the member reviews the care plan and obtain the member's signature on the approved care plan. The care manager shall provide a copy of the approved care plan, including the service plan with the approved budget, to the member, IDT and to the FMS. The FMS shall establish a budget account for each self-directed member and his or her service(s).

The care manager shall ensure the IBA is updated on an annual or more frequent basis. The care manager shall closely monitor the adequacy and appropriateness of self-directed services to determine the extent to which adjustments to the care plan will necessitate adjustments to the budget and that the member does not exceed the annual IBA limit. Any changes to the budget must be reviewed by the Contractor and submitted to the FMS.

The member may request an adjustment in the services and budget amount at any time through the care manager.

If the member's need for services changes due to a change in health status and/or a change in the level of support available from other sources to meet the member’s needs, the care manager shall perform an updated assessment and revise the care plan, including the service plan, to meet any additional member needs.

2.11.13.14 Back-up Plans

During care plan development, a member's care manager shall assess the member's risks and develop a service plan that addresses the risks as well as develop back-up plans for management of risks. Every member in Level 2 and 3, as well as any member who self-directs a service, will be required to have a back-up plan in the event a provider of services and supports who is essential to the member's health and welfare is unavailable.

The back-up plan shall identify who is responsible for ensuring back-up services are available and who is responsible for responding to emergencies. Care managers shall work with the member and IDT to ensure that an effective back-up plan is in place. Such back-up plans may utilize various combinations of paid providers and unpaid caregiver supports from multiple providers to ensure continuity of services. The back-up plan shall address services and supports needed to prevent or reduce risk.

Care managers shall be responsible for ongoing monitoring and oversight of the member's care plan, including back-up plans. Care managers shall make revisions and modifications, as appropriate, to the member's back-up plan to ensure the health and safety of the member. The back-up plan must be reviewed and updated as changes occur or as needed. At a minimum, the back-up plan shall be reviewed during the required care plan update timeframes as specified in section 2.11.8.6, "Care Plan Reviews."

As part of the care planning process, the care manager shall provide a copy of the back-up plan to the member, each of the member's IDT participants and FMS within the timeframe specified in sections 2.11.8.5 and 2.11.8.6.

2.11.13.15 Self-Direction Providers

Self-direction providers shall meet all applicable provider requirements as established by the OHCA or designee. The Contractor shall secure provider agreements with all self-direction providers and ensure they satisfactorily pass all credentialing requirements prior to hire, including all criminal and abuse registry background checks.

Provider agreements shall specify the roles and responsibilities of self-direction providers and the Contractor. The Contractor shall have the ability to terminate a self-direction provider on behalf of a member for health and welfare issues.

The provider agreement between the self-direction provider and the Contractor shall outline the terms and conditions for terminating a self-direction provider.

The Contractor shall coordinate with the member in choosing a self-direction provider. As part of the interview and hiring process, members shall develop an employment agreement in collaboration with the care manager with each of their self-direction providers. The

employment agreement shall detail the roles and responsibilities of both the member and the self-direction provider.

The employment agreement shall be included in the Contractor's agreement with the self-direction provider. A copy of the employment agreement shall be provided to the member and/or authorized representative and the self-direction provider. The employment agreement template shall be reviewed and approved by the OHCA or designee as part of readiness review and prior to use by the Contractor.

A member may terminate a self-direction provider at any time. The Contractor shall terminate a self-direction provider under any of the following circumstances:

- Member abuse or exploitation;
- Fraud; or
- Inferior quality of services provided by the member's employee jeopardizes the member's health, safety and/or welfare.

Terminations of self-direction providers shall be documented in the member's case file in the Contractor's electronic care management system, as well as referred to the Contractor's quality department if the termination is the result of any quality issues or concerns.

2.11.13.16 Voluntary Termination of Self-Direction

A member may choose to terminate self-direction at any time. Terminations of self-direction shall be documented by the member and/or authorized representative and stored in the member's case file in the Contractor's electronic care management system.

The Contractor shall arrange agency providers of the member's choice to render services of the same quality as the self-directed services. The member's back-up plan shall be implemented, as necessary, until agency provider services start.

2.11.13.17 Involuntary Termination of Self-Direction

The Contractor shall involuntarily terminate a member from self-direction under any of the following circumstances:

- Member is abused, neglected or exploited by an employee;
- Member falsifies a timesheet or other work record;
- Member, even with FMS assistance, is unable to operate within the IBA;
- Member is unable to follow the employer guidelines and/or processes established by the Contractor;
- Member's UCAT or comprehensive assessment document that the member is high risk (i.e., UCAT Mental Status Questionnaire score of 12 or greater) and would need assistance in performing employer responsibilities and the member is unable or unwilling to obtain an authorized representative to assist; or

- An employee provides inferior quality of services that jeopardizes the member's health and/or safety and the member is unwilling or unable to make changes to an alternative self-direction provider.

If termination of self-direction occurs, the care manager shall work to ensure continuity of services and the member's health and welfare during the transition period. The care manager shall assist the member in replacing self-direction services with comparable services from one or more qualified provider agencies selected by the member.

2.11.13.18 Self-Direction Monitoring

As part of its care management model, the Contractor shall ensure there is ongoing monitoring in place for all components of its self-direction program. Care managers shall monitor service delivery, member satisfaction with self-direction and the health, safety and welfare of members as required in section 2.11.11, "Monitoring Service Delivery."

The Contractor shall review reports that track and summarize the performance of the FMS in meeting Contract performance standards under this Contract as specified in section 2.17, "Reporting." The Contractor shall adhere to all State requirements for critical incident identification, reporting and investigation.

The care manager shall monitor implementation of a member's back-up plan.

The care manager shall track the member's budget and expenditures and provide assistance to the member in making any needed adjustments to stay within the IBA.

2.11.14 EVV System

DHS contracts with an EVV vendor to monitor ADvantage waiver member utilization of HCBS and generate claims for payment of covered services. The Contractor shall utilize the EVV vendor to perform the same functions for ADvantage members enrolled in the Contractor's plan and the Contractor shall be responsible for any additional costs necessary to support Contractor's operations and/or reporting responsibilities. The EVV vendor will transmit an electronic claims submission file in the 837 format to the Contractor on at least a daily basis.

The Contractor also may independently contract with the EVV for other SoonerHealth+ populations receiving HCBS, including Medically Fragile waiver members.

The OHCA, DHS, Contractor and other health plans will collaborate to ensure that EVV functions uniformly and efficiently support the SoonerHealth+ program. Information about the capabilities of the Oklahoma DHS EVV system shall be made available in the Bidder's Library.

2.11.15 Care Management Reports

The Contractor shall submit care management reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Care management reports shall include at least the following:

- *Care management staffing plan* - addresses care management staffing;
- *Care manager assignment change* - number and percentage of care manager assignment changes, reason for the change, care manager name, date of change and any action taken on behalf of the Contractor as a result of the change;
- *Health Risk Screening* - compliance rates regarding completion of Health Risk Screenings, number and percentage of Health Risk Screenings performed within 30 days of enrollment during the initial transition period and the number and percentage of Health Risk Screenings performed within 10 days following a member's enrollment effective date during the steady state period;
- *Health Risk Screening unreachable members* - member name, number of outreach attempts, type of attempt (e.g., phone, letter, email, visit to residence) and the member's contact information including phone number and address on file;
- *Care manager risk levels* - number and percentage of the Contractor's total membership that had a risk level assigned within the timeframes associated with risk level assignment, the Contractor membership by risk level, movement between risk levels (i.e., higher or lower risk levels); and compliance with face-to-face and telephonic visit standards for each risk level;
- *Comprehensive assessment and reassessment* - compliance rates regarding completion of comprehensive assessments for members in Levels 2 and 3 within 45 days of the Health Risk Screening during the initial transition period, within 30 days of the Health Risk Screening during the steady state period and annual reassessment compliance rates;
- *Care plan* - number of care plans developed within 15 days of the comprehensive assessment for members in Levels 2 and 3, number and percentage of care plans approved within five days and number and percentage of Level 3 members who required implementation of a back-up plan;
- *Pharmacy Lock-in* - lock-in members, program data and activity;
- *Advance directives* - number and percent of case files that include evidence that advance directives were discussed with the member;
- *DM program plan* - DM strategies and interventions, goal and measurable objective and expected outcomes;
- *DM program evaluation* - quantitative and qualitative evaluation of the efficacy of the prior year's DM strategies;
- *Self-direction* - enrollment and activity report, including: program membership, compliance rates with self-assessments, program denials, number and percent who remained within the IBA amount, number and percent who exceeded IBA amount,

self-direction provider terminations, program terminations (i.e., voluntary and involuntary) and FMS reports; and

- *EVV System* – activity reports, including late or missed visits, service schedules and service authorizations.

2.12 Native American (American Indian) Population and Indian Health Care Providers

The OHCA is committed to preserving the protections afforded to Native American (American Indian) members under federal law, while expanding access to person/family-centered care coordination. The OHCA also is committed to preventing disruption in payments to Indian Health Care Providers (IHCPs), while encouraging opportunities for creative partnerships between the Contractor and IHCP community.

The OHCA and the Contractor will pursue these objectives and maintain open communication with Native American stakeholders through the processes outlined in this section.

2.12.1 Native American Liaison

The Contractor shall employ a full-time Native American Liaison to conduct outreach to the Native American community and to serve as a resource for members and providers with questions or issues. The Contractor shall develop an outreach plan for the OHCA's review and approval for submission during the Contractor's readiness review.

2.12.2 OHCA Tribal Government Relations Unit

The OHCA Tribal Government Relations Unit performs Native American liaison services between the OHCA and CMS, Indian Health Service and the tribes of Oklahoma for State and national level issues, including Native American work groups, policy development and compliance, tribal consultation, payment issues and elimination of health disparities. The Contractor's Native American Liaison shall serve as a single point-of-contact for the OHCA Tribal Government Relations Unit and shall attend tribal consultative meetings held by the OHCA.

2.12.3 Native American Members

2.12.3.1 Enrollment and Disenrollment

The OHCA Enrollment Choice Counselor and the OHCA's enrollment materials will advise eligible Native American members that they have the option to enroll in the SoonerHealth+ Program. Members who elect to enroll will be subject to the enrollment provisions specified in section 2.5, "Enrollment and Disenrollment," except that Native American members may disenroll from the SoonerHealth+ Program without cause, in accordance with the provisions of section 2.5.7, "Disenrollment Process." If a Native American member elects not to enroll, or enrolls and then chooses to disenroll from the program, he or she shall have a new opportunity to enroll at the next open enrollment period.

2.12.3.2 IHCP as Primary Care Provider

Unless the Contractor is an Indian managed care entity, the Contractor shall permit its members who are Native American to receive services from an IHCP primary care provider participating as a network provider and to choose that IHCP as the member's primary care provider, as long as that provider has capacity to provide the services.

2.12.3.3 Access to Out-of-Network IHCPs and Referrals under Contract Health Services

The Contractor shall permit its members who are Native American to obtain services covered under the Contract between the OHCA and the Contractor from providers that a member is otherwise eligible to use. This includes services furnished by an out-of-network IHCP or through referral under contract health services. The Contractor also shall permit out-of-network IHCPs to refer Native American members to network providers.

2.12.3.4 Member Cost Sharing

Native American members are exempt from program cost sharing requirements for services furnished at an IHCP or through referral under contract health services. Native American members who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under contract health services are exempt from all cost sharing.

2.12.3.5 Care Management

The Contractor shall include Native American care managers within its care management staffing. The Contractor shall inquire of Native American members as to their preference, if any, and shall offer Native American members the option of receiving care management from a Native American care manager, to the extent practicable.

2.12.4 IHCPs

2.12.4.1 Sufficient IHCP Participation

The Contractor shall demonstrate that there are sufficient IHCPs participating in the Contractor's network to ensure timely access to services available under the Contract from such providers for Native American members who are eligible to receive services. The Contractor shall provide the OHCA with network accessibility reports that are specific to its Native American membership and IHCP network, when requested by the OHCA as specified in section 2.17, "Reporting."

2.12.4.2 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 members who are Native American are permitted by the Contractor to access out-of-state IHCPs.

This circumstance also shall be deemed to be good cause for disenrollment from both the Contractor and the State's managed care program in accordance with 42 CFR § 438.56(c).

2.12.4.3 Payments to IHCPs

The Contractor is not responsible for paying any claims for services furnished directly by IHCPs to Native American members, or furnished by an IHCP-contracted provider upon referral from an IHCP. The Contractor shall notify IHCPs that submit claims to the Contractor that the claims were submitted in error and must be submitted to the OHCA's fiscal agent for payment.

The Contractor is responsible for paying IHCP claims for services furnished to non-Native American members. Payment shall be made at the OMB all-inclusive rate.

The Contractor may enter into arrangements with IHCPs to make performance-based payments related to IHCP achievement of access- or quality-related benchmarks. The Contractor shall submit any such methodology to the OHCA for review and approval prior to its implementation.

2.12.5 Enrollment in an Indian Managed Care Entity (IMCE)

An IMCE may restrict its enrollment to Native Americans in the same manner as Indian Health Programs may restrict the delivery of services to Native Americans, without being in violation of the requirements in 42 CFR § 438.3(d).

2.13 Quality Improvement

The OHCA is responsible for ensuring that all members receive high-quality services in the most efficient and effective manner possible. Accordingly, the Contractor shall deliver quality care that is accessible and efficient and is provided in the least restrictive setting for a member, according to professionally accepted standards, and in a coordinated and continuous manner.

The Contractor shall comply with the OHCA's requirements regarding quality oversight, monitoring and evaluation. The Contractor shall comply with the OHCA's comprehensive quality strategy and with all State and federal regulations, including 42 CFR § 438.340.

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

- Adequate capacity and service to ensure member choice and timely access to appropriate services and care;
- Effective coordination and continuity of care;
- Protection of member rights and the provision of services in a manner that is sensitive to the cultural needs of members;
- Encouragement and assistance to members in participating in decisions regarding their care;
- Emphasis on health promotion and prevention, as well as early diagnosis, treatment and health maintenance;
- Appropriate utilization of medically necessary services; and
- A continuous quality improvement approach.

2.13.1 Quality Rating System

The OHCA shall develop and implement a Medicaid managed care quality rating system to evaluate the annual performance of managed care organizations (MCOs) that participate in the SoonerHealth+ Program. The OHCA shall adopt the Medicaid managed care quality rating system developed by CMS.

The OHCA shall issue an annual quality rating to the Contractor based on the performance measures collected. The OHCA shall prominently display the quality rating given by the OHCA to the Contractor on the OHCA's website in a manner that complies with the standards in 42 CFR § 438.10(d).

2.13.2 External Quality Review Organization (EQRO)

The OHCA will retain the services of a qualified EQRO in accordance with the qualifications for competence and independence laid out in 42 CFR § 438.354. The SoonerHealth+ Program EQRO shall conduct all necessary audits, as well as any additional optional audits, that further the management of the SoonerHealth+ Program. All EQRO-related quality

activities performed by the SoonerHealth+ Program EQRO must comply with all State and federal regulations, including 42 CFR § 438.358. The Contractor shall cooperate fully with the EQRO and demonstrate to the SoonerHealth+ Program EQRO the Contractor's compliance with managed care regulations and quality standards as set forth in federal regulation and the OHCA's policy.

The SoonerHealth+ EQRO will produce an annual report on quality outcomes, including timeliness of services and access to services covered by the SoonerHealth+ Program. The report will detail, analyze and aggregate the data from all activities conducted in accordance with 42 CFR § 438.358. The report will include the following for each activity conducted: objectives, technical methods of data collection and analysis, descriptions of data obtained and conclusions drawn from the data. The information obtained by the SoonerHealth+ Program EQRO must be obtained consistent with protocols established in 42 CFR § 438.352 and the results made available as specified in 42 CFR § 438.364.

The Contractor shall participate with the SoonerHealth+ Program EQRO in various other tasks and projects identified by the OHCA to gauge performance in a variety of areas, including care management and management and treatment of special populations. The Contractor shall ensure that the SoonerHealth+ Program EQRO has sufficient information to carry out this review and that the information used to carry out the review is obtained from the SoonerHealth+ Program EQRO-related activities described in 42 CFR § 438.358 or from a Medicare or private accreditation review as described in 42 CFR § 438.360.

The OHCA may elect to have the SoonerHealth+ Program EQRO perform optional review activities including validation of the Contractor's encounter data, administer or validate consumer or provider surveys of quality of care, calculate performance measures in addition to those reported by the Contractor, conduct performance improvement projects in addition to those conducted by the Contractor, conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time, and assist with the quality ratings of the Contractor. The OHCA may also request that the SoonerHealth+ Program EQRO provide technical assistance to the Contractor in conducting activities relating to the mandatory and optional activities described in this section.

The OHCA reserves the right to exempt the Contractor from the external quality review if all conditions of all relevant State and federal regulations, including 42 CFR § 438.362, are met and the OHCA feels it is the appropriate course of action.

2.13.3 Quality Assessment and Performance Improvement (QAPI) Program

2.13.3.1 QAPI Program

The Contractor shall have a documented QAPI program based on a model of continuous quality improvement. The program shall evaluate all SoonerHealth+ Program population

groups, care settings and types of services, including physical health services, behavioral health services and HCBS. The Contractor's QAPI program shall comply with every aspect of State and federal law, including final rule 42 CFR § 438.330 in its entirety.

The OHCA or its designee shall perform oversight and monitoring functions for the Contractor's QAPI programs, reporting and all SoonerHealth+ Program contractual obligations. The Contractor shall be responsible for the day-to-day performance and operational requirements contained in SoonerHealth+ Program Contract. The Contractor shall report to the OHCA Quality Committee.

The Contractor's QAPI program shall be in compliance with all State and federal laws, regulations and standards for quality management, quality improvement and quality assessment and performance improvement programs and shall use standards and guidelines from one of the CMS-recognized accrediting entities.

Any changes to the QAPI program structure shall require prior written approval from the OHCA.

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

The Contractor shall use the results of QAPI activities to improve the quality of physical health, behavioral health and HCBS delivery, with appropriate input from providers and members. 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 members. The Contractor shall provide technical assistance, corrective action plans and follow-up activities as necessary to providers to assist them in improving their performance.

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

2.13.3.2 QAPI Program Oversight

The Contractor shall have a Quality Department within its organizational structure that is separate and distinct from any other units or departments, such as Medical Management or Care Management. The Quality Department shall be accountable to the Contractor's board of directors and executive management team, who set strategic direction for the QAPI

program and ensure that the QAPI plan is incorporated into operations throughout the Contractor's organization.

The Contractor shall have a Quality Improvement Committee (QIC) that oversees all QAPI functions. The Contractor's medical director shall chair the committee. Other committee representatives shall be selected to meet the needs of the Contractor but must include representation from the following functional areas:

- Quality Improvement;
- Complaints and Appeals;
- Care Management;
- Medical Management;
- Credentialing;
- Compliance;
- Member Care Support Staff (at least one staff member); and
- Providers, including physical health, behavioral health and HCBS providers.

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

The QIC shall:

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

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

2.13.3.3 QAPI Program Documentation

The Contractor shall submit an annual QAPI program description and work plan to the 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 the OHCA. The Contractor's QAPI program description, work plan and program evaluation shall be exclusive to Oklahoma Medicaid and shall not contain documentation from other state Medicaid programs. The annual QAPI program description, associated work plan and program evaluation shall be submitted in a format specified by the OHCA.

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

- Guiding philosophy and strategic direction for the QAPI program;
- Communication mechanism between the executive management team and the QIC;
- QAPI program committee structure, including specific committees, their representatives and why they were chosen;
- Roles of member and provider representatives on the QIC;
- Process for selecting and directing task forces or subcommittees;
- Types of training, including quality protocols developed by CMS, provided to quality staff and QIC members;
- Specific components of the QAPI plan, including HCBS and behavioral health;
- Process the QAPI program will use to review and suggest new and/or improved quality activities;
- Process to report findings to appropriate executive authority, staff and departments within the Contractor's organization, as well as relevant stakeholders, such as participating providers;
- Methodology for which and how many providers to profile and how measures for profiling will be selected;
- Process for selecting evaluation and study design procedures;
- How data will be collected and used;
- How the Contractor will ensure that QAPI program activities take place throughout the organization and the procedures to document results for reviewers;
- The health management information systems that will support the QAPI program;
- Process for reporting findings to the OHCA, providers and members; and
- Process for annual program evaluation.

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

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

- A description of ongoing and completed QAPI activities;

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

In accordance with 42 CFR 438.330(e), the OHCA or its designees shall annually review the impact and effectiveness of the Contractor's QAPI program using a variety of methods, including at least:

- Reviewing, evaluating and reporting all QAPI Program documents, HCBS waiver performance measures for submission to CMS, the Contractor's performance measures and MCO reports regularly required by the OHCA or its designees;
- Reviewing, evaluating, or validating implementation of specific policies and procedures or special reports relating to areas such as member choice, rights and protections, services provided to members with special health care needs, utilization management, care management, network access standards, measurement and improvement standards, clinical practice guidelines and continuity and coordination of care;
- Performing medical records reviews;
- Analyzing the results of any efforts by the Contractor to support community integration for members using HCBS; and
- Conducting on-site reviews to interview the Contractor's staff for clarification, to review records, or to validate implementation of processes and procedures.

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

2.13.4 Accreditation

The Contractor shall be accredited by one of the CMS-recognized accrediting entities within 18 months of Contract award. If the Contractor is undergoing accreditation, the Contractor shall submit reports documenting the status of the accreditation process as required by the OHCA.

The Contractor shall undergo reaccreditation not less than once every three years. 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 OHCA and the Contractor shall post information about the Contractor's accreditation status on the OHCA and the Contractor's website, which includes the accreditation level. This information shall be updated at least annually.

2.13.5 Quality Performance Measures

The Contractor shall comply with all of the OHCA's requirements to improve performance for the OHCA-established quality performance measures. Annually, the Contractor shall submit a Quality Performance Measure Report for all quality performance measures listed in Appendix 2, "Quality Performance Measures." Quality performance measures shall be: (1) modified annually by the OHCA or CMS and published in advance; (2) be specific to the SoonerHealth+ population and (3) include target performance rates that will increase annually. Required quality performance measures will include measures for physical health, behavioral health and HCBS.

Annually, the Contractor shall complete the specified HEDIS measures designated by the OHCA as relevant to the members being served in the SoonerHealth+ Program. The Contractor shall contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA requirements. By November 1 of each year, the Contractor shall submit to the OHCA a copy of the signed contract with the NCQA-approved vendor to perform the HEDIS audit. Audited HEDIS results shall be submitted to the OHCA, NCQA and the OHCA's SoonerHealth+ Program EQRO annually as required in section 2.13.13, "Quality Reporting Requirements."

In addition to the 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 the OHCA-specified performance targets for all quality performance measures. The OHCA, the Contractor and other health plans shall collaborate post-award to establish performance targets for each of the required measures.

Although quality performance targets will be updated annually, the OHCA, at its discretion, may change these targets and/or change the timelines associated with meeting the targets. The quality performance targets will be incorporated into the comprehensive Uniform Performance Monitoring Data Set described in section 2.22.2, "Performance-Based Contracting."

The OHCA shall post information about quality measures and performance outcomes on the OHCA's website. This information shall be updated at least annually.

If the OHCA determines that the Contractor's performance relative to any of the quality performance targets is not acceptable, the OHCA may require the Contractor to submit a corrective action plan in accordance with section 2.22.4.5, "Corrective Action Plan." The OHCA also may impose penalties for failure to meet quality performance targets or demonstrate improvement in a measure rate in accordance with section 2.22.4.11, "Schedule of Actions." When considering whether to impose penalties, the 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 the 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 administrative penalties as described in section 2.22.4.11, "Schedule of Actions."

A report or certification is "false" if done 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 administrative penalties.

In addition to quality requirements (e.g., surveys, HEDIS, performance measures), the Contractor shall be responsible for collecting and reporting, to the OHCA or its designee, all of the CMS-approved HCBS waiver performance measures plus any additional reports and/or performance measures to be finalized prior to go-live by the OHCA or its designee in collaboration with the SoonerHealth+ Program MCOs.

2.13.6 Member Satisfaction and Experience Surveys

2.13.6.1 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The Contractor shall conduct an annual CAHPS survey, beginning in 2019. Annual CAHPS survey reports will be due to the OHCA no later than June 15 of each year. The Contractor shall enter into an agreement with a vendor that is certified by NCQA to perform annual CAHPS surveys. The Contractor's vendor shall perform the CAHPS adult survey, the CAHPS children with chronic conditions survey, and the Experience of Care and Health Outcomes (ECHO) Survey using the most current CAHPS versions specified by NCQA.

The Contractor shall submit to the OHCA by November 1 of each year a proposal for survey administration and reporting that includes identification of the survey administrator and evidence of NCQA certification as a CAHPS survey vendor, sampling methodology, administration protocol, analysis plan and reporting description.

Survey results shall be reported to the OHCA separately for each required CAHPS survey listed above. Survey results shall be submitted to OHCA, NCQA and the OHCA's SoonerHealth+ Program EQRO annually as required in section 2.13.13, "Quality Reporting Requirements."

The Contractor shall:

- Use the annual CAHPS results in the Contractor's internal QAPI program by using areas of decreased satisfaction as areas for targeted improvement;
- Include additional survey questions in addition to the CAHPS that are specified by the OHCA;
- Make available results of the surveys to providers, the OHCA, members and families/caregivers;
- Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall survey results; and
- Have mechanisms in place to incorporate survey results in the QAPI plan for program and systems improvements.

2.13.6.2 HCBS Member Satisfaction and Experience Survey

Beginning in 2019, the Contractor shall evaluate HCBS members' satisfaction and experience either by conducting a separate annual member survey or by adding specific HCBS questions to the CAHPS surveys. The OHCA shall collaborate with the MCOs post-award to develop a uniform survey instrument or a uniform set of CAHPS questions that capture all measures required by CMS and the OHCA.

The survey questions shall seek members' experience in areas, including perception of general health, residential setting, choice of setting, social life, connection to community,

safety, level of participation and control in developing the care plan, choice of services and providers, timeliness and quality of services and providers, coordination of services and providers and treatment with dignity and respect.

The member satisfaction and experience survey shall fulfill some of the HCBS performance measure requirements noted in section 2.13.5, "Quality Performance Measures."

2.13.6.3 National Core Indicators Aging and Disabilities (NCI-AD) Consumer Survey

For members who are receiving HCBS waiver services, the Contractor shall collaborate with the OHCA on performing the annual NCI-AD Consumer Survey. Results of the survey will be used to evaluate MCO performance for HCBS members.

2.13.7 Provider Satisfaction Survey

The Contractor shall conduct an annual provider satisfaction survey that includes the entire array of contract providers in its network. The OHCA will collaborate with the MCOs post-award to define a uniform set of provider satisfaction measures and a uniform survey instrument. The Contractor shall conduct the survey and compile and analyze its survey results for submission annually.

The survey instrument shall include the following domains:

- Provider relations and communication;
- Clinical management processes;
- Authorization processes, including denials and appeals;
- Timeliness of claims payment and assistance with claims processing;
- Complaint resolution process; and
- Care management support.

The survey report results shall include a summary of the provider survey methods and findings for physical health, behavioral health and HCBS providers separately, with an analysis of opportunities for improvement.

The Contractor shall provide the survey results to the OHCA with an action plan to address the results of the Provider Satisfaction survey in accordance with section 2.13.13, "Quality Reporting Requirements."

2.13.8 Performance Improvement Projects (PIPs)

The Contractor shall conduct at least one PIP per year in each of the three following areas:

- Physical health, defined to include diabetes, hypertension, obesity or tobacco cessation;
- Behavioral health; and
- HCBS.

For Year 1, the Contractor shall propose, subject to the OHCA's approval, PIPs in each of the areas listed above. In subsequent years, PIP study topics may be identified by CMS, the Contractor, or the OHCA.

As required by federal regulations, each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements:

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

The Contractor shall report the status and results of each PIP conducted to the OHCA as requested, but not less than annually. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes shall be evaluated for statistical significance using a 95 percent confidence interval.

PIPs are subject to annual independent validation by the OHCA's SoonerHealth+ Program EQRO to ensure compliance with CMS' protocols and the OHCA's policy, including timeline requirements. The OHCA reserves the right to require the Contractor to have a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Status reports on PIPs may be requested more frequently by the OHCA.

PIPs that have successfully achieved sustained improvement, as approved by the OHCA, shall be considered complete and shall not meet the requirement for one of the number of PIPs required by the 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 the OHCA for approval.

2.13.9 Provider Profiling

The Contractor shall conduct PCMH provider and other provider profiling activities at least quarterly. As part of its QAPI Program, the Contractor must describe the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers.

Provider profiling activities shall include, without limitation:

- Developing PCMH provider and other provider-specific reports that include a multi-dimensional assessment of a PCMH provider or other provider's performance using

clinical, administrative and member satisfaction indicators of care that are accurate, measurable and relevant to the enrolled population;

- Establishing PCMH provider, other provider, group, or regional benchmarks for areas profiled, where applicable; and
- Providing feedback to individual PCMH providers and other providers regarding the results of their performance and the overall performance of the provider network.

2.13.10 Clinical Practice Guidelines

The Contractor shall adopt physical health, behavioral health and HCBS clinical practice guidelines that are comprehensive, addressing both the quality of clinical care and non-clinical services and include availability, accessibility, coordination and continuity of care.

The clinical practice guidelines shall meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of members in each of the population groups;
- Are adopted in consultation with contract providers; and
- Are reviewed and updated as needed or at least every two years.

The Contractor may coordinate the development of clinical practice guidelines with other MCOs serving the Oklahoma Medicaid populations to avoid the possibility that providers would receive conflicting clinical practice guidelines from different MCOs.

The Contractor shall disseminate clinical practice guidelines to all affected contract providers and, upon request, to members or potential members.

The Contractor shall take steps to encourage adoption of the clinical practice guidelines by providers and to measure compliance with the clinical practice guidelines.

2.13.11 Medical Records

2.13.11.1 Medical Record Standards

As part of its QAPI Program, the Contractor shall establish medical records standards, as well as a record review system to assess and ensure conformity with the standards. The standards shall, at a minimum:

- Require that the medical record be maintained by the provider;
- Ensure that the OHCA's personnel or personnel contracted by the OHCA have access to all records, as long as access to the records is needed to perform the duties under this Contract and to administer the Medicaid program;
- Comply with any and all State and federal laws regarding confidentiality;

- Provide the OHCA or its designee(s) with prompt access to members' medical records;
- Provide members with the right to request and receive copies of their medical records and to request they be amended; and
- Allow for paper or electronic record keeping.

The Contractor and its providers shall retain all medical records for a minimum of ten years from the last date of entry in the records. For minors, the Contractor shall retain all medical records during the period of minority plus a minimum of ten years after the age of majority.

2.13.11.2 Medical/Case Record Audits

The Contractor shall furnish specific data requested in order for the OHCA to conduct the medical/case record audit, including audit of member care plans, 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 required to submit a corrective action plan in accordance with section 2.22.4.5, "Corrective Action Plan," and may be subject to penalties in accordance with section 2.22.4.11, "Schedule of Actions."

2.13.12 Critical Incident Reporting System

The Contractor shall develop and implement a critical incident reporting and tracking system for adverse or critical incidents and shall require participating service providers and direct service providers, including self-directed providers, to report adverse or critical incidents to the Contractor. The Contractor shall provide appropriate training and take corrective action as needed to ensure its staff, participating providers and direct service providers comply with critical incident requirements.

During the comprehensive assessment and care plan meeting, the Contractor's care manager shall provide information and education along with written materials to a member and his/her representative regarding member rights, responsibilities, the complaint process and procedures, pertinent phone number(s) and how to report critical incidents. Thereafter, information and materials shall be made available upon request by the member, family and/or representative and routinely provided during annual reevaluation.

The Contractor shall ensure that any serious incident that harms or potentially harms the member's health, safety, or well-being is immediately identified, reported, reviewed, investigated and corrected. As required by State law, the Contractor shall report abuse, neglect and/or exploitation on the appropriate form to the OHCA within one business day

for immediate investigation by the appropriate State authority. If the initial report is not made in writing, the Contractor shall submit a written report within 48 hours.

The Contractor's staff and contract providers shall immediately, but not to exceed 24 hours, take steps to prevent further harm to any and all members and respond to any emergency needs of members. If the allegation is in reference to an HCBS provider or a provider serving an HCBS member, the provider shall be immediately released from his/her duties until the State's investigation is complete.

The Contractor's 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 incident, and, except under extenuating circumstances, no later than 30 days after the date of the incident. The Contractor shall review the provider's report and follow up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable timeframes.

Critical incidents shall include:

- Suspected maltreatment (physical abuse, neglect, sexual abuse, financial exploitation, or sexual exploitation) of the member;
- Threatened or attempted suicide by the member;
- Death of the member;
- Law enforcement involvement in a situation concerning the member;
- Property loss of more than $500;
- Loss of residence due to disaster;
- Fall or injury requiring medical attention;
- Interruption of critical medical equipment supports;
- A member is missing; and
- A highly restrictive procedure is used with the member.

The procedures for reporting incidents considered as "non-critical" are identical to those described for critical incidents except that the time limit for reporting non-critical incidents to the OHCA is within 72 hours of the incident. Incident Reports are required under the following circumstances:

- Injury to the member;
- Unplanned health-related event;
- Physical aggression by the member;
- Fire setting by the member;
- Deliberate harm to an animal by the member;
- Property loss of less than $500;
- Vehicle accident involving the member;

- Suspension, termination, or removal of the member's program; and
- A medication event involving the member.

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, 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 members.

The Contractor shall submit quarterly reports of critical and non-critical incidents 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.

In addition to the above reports, the Contractor shall be responsible for collecting and reporting, to the OHCA or its designee, all of the critical incident performance measures as contained in the CMS-approved HCBS waivers.

2.13.13 Quality Reporting Requirements

The Contractor shall submit quality reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Quality reports shall include at least the following:

- *Annual QAPI program* - The report shall be reviewed and approved by the Contractor's medical director and QIC prior to submission to the OHCA. The report shall address all elements described in section 2.13.3, "Quality Assessment and Performance Improvement (QAPI) Program," including the following:
    - An executive summary outlining any changes from the prior QAPI Program,
    - A detailed set of QAPI Program goals and objectives that are developed annually, including timetables for implementation and accomplishments,
    - A copy of the Contractor's organizational chart, including vacancies of required staff, changes in scope of responsibilities, changes in delegated activities and additions or deletions of positions,
    - A current list of the required staff, including name, title, location, phone number and fax number,
    - A copy of the current approved QAPI program description, the QAPI program work plan, and, if issued as a separate document, the Contractor's current utilization management program description with signatures and dates,
    - The QAPI Program Evaluation Report for the prior year's program,

  - A copy of utilization management program evaluation reports;
- *Accreditation status* - submit reports documenting the status of its accreditation process;
- *Reevaluation of accreditation status* - submit the Contractor's annual reevaluation of accreditation status based on HEDIS scores;
- *Three-year re-accreditation* - provide the final bound copy of the Contractor's required three-year re-accreditation;
- *Quality performance measures* - submit an annual report of the Contractor's audited HEDIS results and a quality performance measures report for all required measures as described in section 2.13.5, "Quality Performance Measures";
- *EPSDT* - submit EPSDT information utilizing encounter data submissions in accordance with specifications for the CMS-416 report on children enrolled in the Contractor's plan;
- *CAHPS adult survey, CAHPS children with chronic conditions and Experience of Care and Health Outcomes (ECHO) survey* - submit annual reports for each of the audited surveys specified in section 2.13.6.1, "Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey";
- *HCBS member satisfaction and experience survey* - submit a report of the results of the annual HCBS member satisfaction and experience survey as described in section 2.13.6.2, "Member Satisfaction and Experience Surveys";
- *NCI-AD Consumer Survey* - submit a report of the results of the annual NCI-AD Consumer Survey as described in section 2.13.6.3, "National Core Indicators Aging and Disability (NCI-AD) Consumer Survey";
- *Provider survey* - The Contractor shall submit a report of the results of the annual provider survey as described in section 2.13.7, "Provider Satisfaction Surveys";
- *Performance improvement projects* - submit a separate report for each of the PIPs as described in section 2.13.8, "Performance Improvement Project (PIPs)";
- *Provider profiling* - submit provider performance monitoring reports that include all elements as described in section 2.13.9, "Provider Profiling"; and
- *Critical incidents* - submit all critical and non-critical incident reports in a timely manner as described in section 2.13.12, "Critical Incident Reporting System."

2.14 Member Complaints and Appeals

2.14.1 General Requirements

2.14.1.1 Member Complaints and Appeals System

The Contractor shall develop, implement and maintain a member complaints and appeals system that complies with the requirements in applicable State and federal laws, regulations and guidance. The Contractor's member complaints and appeals system shall include a complaints and appeals process, access to the State's fair hearing system and processes to collect and track information.

The Contractor shall maintain written policies and procedures on its member complaints and appeals system.

2.14.1.2 Provision of Information About Member Complaints and Appeals System

The Contractor shall provide information about member complaints, appeals and state fair hearing procedures and timeframes to members, providers and Subcontractors. Information shall be consistent with State and federal law, regulation and guidance. Information shall include the:

- Right to file complaints and request appeals;
- Requirements and timeframes for filing a complaint or requesting an appeal;
- Availability of assistance in the filing process;
- Right to request a state fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member;
- Right to request an external medical review; and
- For benefits which the member has requested, and that the Contractor seeks to reduce or terminate, assurance that said benefits will continue if the member requests an appeal or a request for state fair hearing within the timeframes specified for filing. The member 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 member.

At a minimum, the Contractor shall include this information in:

- Applicable member written notifications;
- Provider and Subcontractor contracts with the Contractor;
- The member handbook;
- The provider manual;
- Applicable provider and Subcontractor training materials; and
- Any other materials as required by State or federal law, regulation and guidance.

2.14.1.3 Assistance to Members

The Contractor shall give members any reasonable assistance in completing complaints and appeals forms and taking other procedural steps. This includes, at least, availability of Member Care Support Staff, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.

2.14.1.4 Availability of Alternative Formats

The Contractor shall ensure that all notices related to complaints and appeals are available in the State-established prevalent non-English languages as specified by the OHCA. 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.

2.14.1.5 Receipt of Member Complaints and Appeals

The Contractor shall have a process for acknowledging receipt of each complaint and appeal.

2.14.1.6 Decision Makers of Member Complaints and Appeals

The Contractor shall ensure that its decision makers on complaints and appeals were not involved in previous levels of review or decision-making and not a subordinate of any such individual.

The Contractor shall have health care professionals who have the appropriate clinical expertise, as determined by the State, in treating a member's condition or disease when deciding any of the following:

- Appeal of a denial that is based on lack of medical necessity;
- Complaint regarding denial of expedited resolution of an appeal; or
- Complaint or appeal that involves clinical issues.

The Contractor's decision makers shall take into account all comments, documents, records and other information submitted by the member and his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

2.14.1.7 Oral Inquiries

The Contractor shall provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless a member, authorized representative or provider requests expedited resolution.

2.14.1.8 Present Evidence

The Contractor shall provide a member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for standard and expedited appeals.

2.14.1.9 Member Access to Case Files

The Contractor shall provide a member and his/her representative (free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeals) the member's case file, including medical records, other documents and records and any new or additional evidence considered, relied upon, or generated by the Contractor in connection with the appeal of the adverse benefit determination.

2.14.1.10 Parties to a Member Appeal

The Contractor shall include, as parties to an appeal:

- The member and the member's authorized representative; or
- The legal representative of a deceased member's estate.

2.14.1.11 Record Keeping of Member Complaints and Appeals

The Contractor shall maintain records of complaints and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The Contractor shall accurately maintain the records in a manner accessible to the OHCA and available upon request to CMS. The record of each complaint or appeal shall contain, at a minimum, all of the following information:

- A general description of the reason for the complaint or appeal;
- Date the complaint or appeal request was received;
- Date of each review or, if applicable, review meeting;
- Resolution at each level of the complaint or appeal, if applicable;
- Date of resolution at each level, if applicable; and
- Name of the member for whom the complaint was filed or the appeal requested.

2.14.1.12 Reporting of Member Complaints and Appeals

The Contractor shall submit to the OHCA monthly complaint and appeals data for the first six months of the Contract period and then submit data quarterly thereafter or at a frequency specified by the OHCA as outlined in section 2.17, "Reporting." The OHCA reserves the right to extend the monthly reporting requirement at its sole discretion. The OHCA shall use this information to measure the Contractor's performance.

2.14.2 Member Requests for Disenrollment

Members shall seek redress through the Contractor's member complaints and appeals system before the OHCA will make a determination on a member's request for disenrollment. The Contractor shall complete review of the complaint or appeal in time to permit disenrollment to be effective no later than the first day of the second month following the month in which the member or the Contractor files the request.

2.14.3 Adverse Benefit Determination and Denials of Service Authorizations Processes

An adverse benefit determination means, in the case of the Contractor, any of the following:

- 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;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment of a service;
- Failure to provide services in a timely manner, as defined by the OHCA;
- Failure to process complaints or appeals within State and federal required timeframes;
- For a rural area member with only one Contractor in the region, the denial of a member's request to obtain services outside the network; or
- The denial of the member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

The Contractor shall provide members and requesting providers with timely and adequate written notice of an adverse benefit determination. This includes any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

2.14.3.1 Notice Content

The OHCA intends to work with the Contractor to develop model notices. The written notice shall explain the following:

- The adverse benefit determination the Contractor has made or intends to make;
- The reasons for the adverse benefit determination;
- The member'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 member's claim for benefits and procedures to obtain these documents;
- The member's right to request an appeal of the Contractor's adverse benefit determination and procedures for filing an appeal and the right to request a state fair hearing;
- The circumstances under which an appeal process can be expedited and how to request it; and

- The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances, consistent with the OHCA's policy, under which the member may be required to pay the costs of these services.

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.

2.14.3.2 Timeframes for Notice

The Contractor shall mail the written notice of an adverse benefit determination at least 10 days before the date of the action, when the action is a termination, suspension or reduction of previously authorized Medicaid-covered services. Exceptions to this timing are described as follows:

Cases of Probable Member Fraud

The Contractor shall provide members with written notice of an adverse benefit determination in as few as five days prior to the date of the action if the Contractor has verified information indicating probable member fraud.

Member Voluntary/Involuntary Ineligibility

The Contractor shall provide members with written notice of an adverse benefit determination by the date of the action when any of the following occur:

- Member has died;
- Member submits a signed written statement requesting service termination;
- Member submits a signed written statement including information that requires service termination or reduction and indicates that the member understands that service termination or reduction will result;
- Member has been admitted to an institution in which the member is ineligible for Medicaid services;
- Member has an unknown address based on returned mail with no forwarding address;
- Member is accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth;
- Notice involves an adverse benefit determination with regard to preadmission screening requirements; or
- Transfer or discharge from a facility will occur in an expedited fashion as described in 42 CFR § 483.12(a)(5)(ii).

Denial of Payment

The Contractor shall provide members with written notice of an adverse benefit determination on the date of action when the action is a denial of payment.

Standard Service Authorization Denial

For standard authorization decisions, the Contractor shall provide members with written notice of an adverse benefit determination as expeditiously as the member's health condition requires and not to exceed seven days following receipt of the request for service, for standard authorization decisions that deny or limit services.

The Contractor may extend the seven-day service authorization notice timeframe up to 14 additional calendar days if the:

- Member or provider as authorized representative requests the extension; or
- Contractor justifies (to the OHCA, upon request) a need for additional information and how the extension is in the member's interest.

If the standard authorization decision timeframe is extended, the:

- Contractor shall provide the member with written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a complaint if the member disagrees with that decision; and
- Contractor shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Expedited Service Authorization Denial

For cases in which a provider indicates, or the Contractor determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide oral notice as expeditiously as the member's health condition requires and provide written notice no later than 72 hours after receipt of the request for service.

The Contractor may extend the 72-hour time period by up to 14 days if the:

- Member or provider as authorized representative requests the extension; or
- Contractor justifies (to the OHCA, upon request) a need for additional information and how the extension is in the member's interest.

If the standard authorization decision timeframe is extended, the:

- Contractor shall provide the member with written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a complaint if the member disagrees with that decision; and
- Contractor shall issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

2.14.3.3 Untimely Service Authorization Decisions

The Contractor shall provide a member with written notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus an adverse benefit determination.

2.14.4 Member Complaints Processes

A complaint is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints may include, but are not limited to:

- Quality of care or services provided;
- Aspects of interpersonal relationships such as rudeness of a provider or a Contractor's employee;
- Failure to respect a member's rights regardless of whether remedial action is requested; or
- The member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

2.14.4.1 Authority to File

The Contractor shall allow a member to file a complaint with the Contractor.

The Contractor shall allow a provider or an authorized representative acting on behalf of the member to file a complaint with the Contractor if written consent is obtained from the member.

2.14.4.2 Timeframe for Filing

The Contractor shall allow complaints to be filed with the Contractor at any time.

2.14.4.3 Method for Filing

The Contractor shall accept complaints filed either orally or in writing.

2.14.4.4 Timeframe for Resolution

The Contractor shall make a resolution within 30 days from the date the Contractor receives the complaint. The Contractor shall send written notice of its resolution to the affected parties within 30 days from the date the Contractor receives the complaint.

2.14.4.5 Notice Content

The OHCA intends to work with the Contractor to develop model notices. The notice shall explain the disposition.

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.

2.14.5 Member Appeals Processes

An appeal is a review by the Contractor of an adverse benefit determination. The Contractor shall review each standard and expedited appeal and provide notice of its resolution as outlined below.

2.14.5.1 Authority to Request

The Contractor shall allow a member to request an appeal with the Contractor.

The Contractor shall allow a provider or an authorized representative acting on behalf of the member to request an appeal with the Contractor if written consent is obtained from the member.

2.14.5.2 Timeframe for Requesting

The Contractor shall provide members, their authorized representatives and providers acting on behalf of a member, 60 days from the date of the adverse benefit to request an appeal with the Contractor.

2.14.5.3 Method for Requesting

The Contractor shall accept appeals requested either orally or in writing. Unless an expedited resolution is requested, an oral appeal shall be followed by a written signed appeal.

2.14.5.4 Member Appeal Standard Resolution Timeframe

The Contractor shall make a resolution within 30 days from the date the Contractor receives the appeal. The Contractor shall send written notice of its standard resolution to the affected parties within 30 days from the date the Contractor receives the appeal.

2.14.5.5 Expedited Resolution Timeframe

The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines (for a request from a member/authorized representative) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports the member's appeal.

The Contractor shall make a resolution within 72 hours after the Contractor receives the appeal. The Contractor shall make an expedited resolution and provide oral notice as expeditiously as the member's health condition requires and provide written notice no later than 72 hours after receipt of the appeal.

If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and follow the requirements for standard resolution of an appeal.

2.14.5.6 Extension of Standard and Expedited Resolution Timeframes

The Contractor may extend the resolution timeframes for standard and expedited appeals by up to 14 days if the:

- Member or provider, acting on a member's behalf, requests an extension; or
- Contractor shows (to the satisfaction of the OHCA, upon request) a need for additional information and how the extension is in a member's interest.

For extensions of resolution timeframes not made by the member, the Contractor shall complete all of the following:

- Make reasonable efforts, as determined by the OHCA, to give the member prompt oral notice of the delay;
- Within two days provide written notice to the member of the reason for the decision to extend the timeframe and inform the member of the right to file a complaint if the member disagrees with that decision; and
- Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

If the Contractor fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Contractor's appeals process. In this case, the member may initiate a state fair hearing.

2.14.5.7 Notice Content

The OHCA intends to work with the Contractor to develop model notices. The notice shall include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of a member, the notice shall include the following:

- The right to request a state fair hearing;
- How to request a state fair hearing;
- The right to request and receive benefits while the state fair hearing is pending;
- How to request benefits while the state fair hearing is pending; and
- Notice that the member may, consistent with State policy, be held liable for the cost of those benefits if the state fair hearing decision upholds the Contractor's adverse benefit determination.

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.

2.14.6 Access to State Fair Hearings

A state fair hearing is a State-level administrative review of a decision made by the Contractor.

2.14.6.1 Availability of State Fair Hearings

A member may request a state fair hearing. The member's provider or an authorized representative acting on behalf of the member may request a state fair hearing if written consent is obtained from the member.

The request for a state fair hearing may be requested only after receiving notice that the Contractor is upholding the adverse benefit determination. The request for a state fair hearing shall be made no later than 120 days from the date of the Contractor's notice of resolution.

2.14.6.2 Parties to the State Fair Hearing

Parties to a state fair hearing shall include:

- The Contractor;
- A member and the member's authorized representative; or
- The legal representative of a deceased member's estate.

2.14.7 Continuation of Benefits While Member Appeal and State Fair Hearing Are Pending

2.14.7.1 Continuation of Benefits

The Contractor shall continue a member's benefits if all of the following occur:

- The member requests the appeal timely, meaning on or before the later of the following:
  - 10 days of the Contractor mailing the notice of adverse benefit determination,
  - The intended effective date of the Contractor's proposed adverse benefit determination;
- The appeal involves the termination, suspension or reduction of a previously authorized services;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member timely files for continuation of benefits.

2.14.7.2 Duration of Continued or Reinstated Benefits

If, at a member's request, the Contractor continues or reinstates the member's benefits while the appeal or state fair hearing is pending, the benefits shall continue until one of the following occurs:

- The member withdraws the appeal or request for state fair hearing;
- The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal under 42 CFR § 438.408(d)(2); or
- The state fair hearing office issues a hearing decision adverse to the member.

2.14.7.3 Contractor Recovery/Recoupment

If the final resolution of the appeal or state fair hearing is adverse to a member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements set forth in 42 CFR § 438.420 and in 42 CFR § 431.230(b).

2.14.8 Effectuation of Reversed Member Appeal Resolutions

2.14.8.1 Services Not Furnished While Member Appeal Is Pending

If the Contractor or the state fair hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as a member's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination.

2.14.8.2 Services Furnished While Member Appeal Is Pending

If the Contractor or state fair hearing officer reverses a decision to deny authorization of services, and a member received the disputed services while the appeal was pending, the Contractor must pay for those services, in accordance with the Contract.

2.14.9 External Medical Review

The Contractor may offer and arrange for an external medical review if the following conditions are met:

- The review must be at a member's option and shall not be required before or used as a deterrent to proceeding to the State fair hearing;
- The review must be independent of both the State and the Contractor;
- The review must be offered without any cost to the member; and
- The review must not extend any of the timeframes specified in 42 CFR § 438.408 and must not disrupt the continuation of benefits in 42 CFR § 438.420.

2.15 Information Technology and Data Management

The Contractor shall maintain a health information management system in full compliance with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), requirements set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH) in 42 USC 17931, Section 6504(a) of the Affordable Care Act and other applicable State and federal laws and regulations.

The Contractor shall ensure that its information technology system is compliant with any future State or federal regulations within the timeframe stipulated by the regulatory body.

The definitions used in this section are compliant with 42 CFR § 438.2.

2.15.1 Operations

The Contractor's information system shall integrate information and data components across health plan operations in accordance with 42 CFR § 438.242. Integration of care management shall specifically address data related to health risk screenings, comprehensive assessments, medical history, past and current care plans and authorizations, care management contacts and interventions and reporting and analysis systems for medical management purposes.

This system also shall capture and provide information on other operational areas including, but not limited to, utilization, claims, complaints and appeals, provider data, encounters, disenrollments for other than loss of Medicaid eligibility, data related to calculating quality and performance measures and State and federal monitoring and reporting requirements. The Contractor shall be able to process, receive and send data on these areas in a HIPAA-compliant format where applicable. The Contractor shall ensure all data collection and exchange capabilities comply with 42 CFR § 438.242.

The Contractor's data management and records system shall have protocols for managing duplicative records for individual members or populations.

The Contractor shall ensure the accuracy and completeness of all data submitted to the OHCA, including data from network providers receiving compensation from the Contractor. All data shall be screened for completeness, logic, consistency and be collected from providers in standardized formats to the extent feasible and appropriate.

2.15.2 Communication with the OHCA

The information system shall be capable of utilizing formats specified by the OHCA and shall be capable of sharing information with the OHCA's systems. The Contractor shall be

responsible for ensuring a working interface between the OHCA's and the Contractor's system to facilitate exchange of relevant member data.

The Contractor shall operate a functional email server that is compatible with the systems maintained by the OHCA and its fiscal agent. This server should be capable of sending and receiving confidential encrypted material over a virtual private network specified by the OHCA.

The Contractor shall have the ability to meet the OHCA's security standards in all communication, including encryption of confidential data and materials.

2.15.3 Member Encounter Data

2.15.3.1 Format

The Contractor shall submit HIPAA-compliant encounter data no less than monthly in the detail and format to be specified by the OHCA. Should the OHCA alter the level of detail or format in which the data is to be submitted, the Contractor shall comply with these changes. The member encounter data shall meet all requirements outlined in 42 CFR § 438.818 and shall be submitted to the OHCA in ASC X12N 837, NCPDP formats and the ASC X12N 835 format as appropriate. Collection, maintenance, submission and specifications of member encounter data shall be compliant with 42 CFR § 438.242. The data shall be certified and submitted as described in 42 CFR § 438.606.

2.15.3.2 Timely Submission and Reconciliation

The Contractor shall ensure all providers submit encounter and claims data in sufficient detail to support detailed utilization tracking and financial reporting. The Contractor shall submit encounter data to the OHCA by the tenth day of the month for encounters adjudicated in the previous month. The data submitted by the Contractor shall include the encounter data from all Subcontractors and be sufficient to determine which provider rendered or ordered a service or provided care. Data submitted regarding a provider interaction shall include the appropriate National Provider Identification (NPI) number and service location code.

The Contractor shall submit encounter data for 99 percent of encounters within 30 days of adjudication (whether payment or denial). The data shall be accurate and complete in a HIPAA-compliant format specified by the OHCA. Encounter data shall be certified and submitted in accordance with 42 CFR § 438.606 and section 2.17.1.1, "Certification Requirements."

The OHCA shall review and validate that the encounter data collected, maintained, and submitted to the OHCA by the Contractor meets the requirements of 42 CFR § 438.242. If

the OHCA determines that the Contractor encounter data submission does not meet accuracy and completeness standards or is denied by the OHCA for another reason, it shall require the Contractor to correct the encounter claim and resubmit it to the OHCA within 30 days. The OHCA may audit the data for accuracy at any time. The Contractor is responsible for supporting the OHCA's encounter data validation activities.

The Contractor acknowledges that complete and validated encounter data is critical for the State to meet the CMS reporting and rate setting requirements.

2.15.3.3 Health Information Exchange

If required by the OHCA, the Contractor shall participate in the State's designated health information exchange initiatives for submission of encounter data and exchange of clinical information.

2.15.4 Enrollment Data

The Contractor shall maintain an eligibility and enrollment subsystem that is continuously updated with information both received from the OHCA and received directly from a member. This subsystem shall be able to interface with the care management system and maintain information at a detail level to be specified by the OHCA.

The Contractor's database shall have the capability to identify an individual member across multiple demographic and clinical data sets.

The Contractor shall develop and maintain policies and procedures to ensure the accuracy and completeness of the data submitted to the OHCA. The subsystem shall be continuously updated with data submitted by the OHCA, Oklahoma DHS and the member. The OHCA reserves the right to audit data submitted by the Contractor for validity and completeness at any time. The data shall be screened for completeness, logic and consistency. The Contractor's system shall maintain audit trails for this purpose.

2.15.5 System Security

The Contractor shall ensure access to data systems is restricted. Every point of data receipt and processing shall have security and data integrity protocols in place and access to data shall be tiered based on an individual user's security clearance.

The Contractor shall be responsible for providing physical safeguards to its data processing center and any related information or systems. These safeguards shall remain in place for the duration of the Contractor's relationship with the OHCA. The Contractor shall grant authorized OHCA and CMS personnel and designees access to its facilities upon request.

The Contractor shall provide the OHCA with a list of all staff with access to identifying member data when requested by the OHCA.

The Contractor shall make available identifying member data to authorized and designated State and federal employees and designees.

The Contractor shall immediately notify the OHCA in the event of an information security breach, including unintentional security issues caused by the Contractor's employees. The Contractor shall maintain audit trails on individual member documentation and be able to determine who has accessed or seen the member's personal medical information.

2.15.6 Disaster Preparation and Data Recovery

The Contractor shall submit a plan that addresses disaster recovery and business continuity related to emergency situations to the OHCA for review and approval during readiness review and on an annual basis. The submission deadline date shall be agreed upon by both parties.

The plan must include at least the following aspects of disaster recovery: communications, physical plant security, data security and fire/disaster prevention and recovery procedures. Each aspect included within the disaster recovery plan must describe both the Contractor and the OHCA's responsibilities.

The Contractor may include resources outside Oklahoma but within the United States as part of this plan. If applicable, the plan must satisfy all requirements for federal certification.

The plan shall be maintained and updated by the Contractor throughout the term of the Contract and shall be available for review by State or federal officials on request. The Contractor shall certify to the OHCA that the disaster recovery plan has been tested at least annually and has passed all aspects of testing.

The Contractor shall have a disaster preparation and recovery plan specific to operating information systems in a disaster situation. The Contractor shall have the capability to continue receiving, processing and disseminating data and reports within 24 hours of 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.

2.15.7 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 a failure that incapacitates main systems.

The Contractor shall submit this back-up plan to the OHCA for review. The OHCA retains the right to veto, change and request revisions to the back-up plan.

2.15.8 Accessibility

The Contractor shall maintain a point of contact with the OHCA should the OHCA staff require assistance interfacing/exchanging data with Contractor's system.

The Contractor shall ensure that members and providers have continuous access to information to be designated by the OHCA, through both internet and toll-free telephone. Internet accessibility shall comply with requirements laid out in Section 2.7, "Member Services," Section 508 of the Rehabilitation Act of 1973 and 62 O.S. 2001 §41.5.

This information shall include, but is not limited to, information on member enrollment. This information shall be made available to members and providers 24 hours per day, 7 days per week. The Contractor may suspend service of this system for maintenance or updates during specific time periods approved in advance by the OHCA.

The URL shall be submitted to the OHCA to embed in agency websites. The URL may not be changed without the OHCA's approval.

The Contractor shall ensure that all system functions for members, providers and State staff are accessible between 7 am and 7 pm Central Time.

2.15.9 Information Technology and Data Management Reports

The Contractor shall submit information technology and data management reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Information technology and data management reports shall include at least the following:

- Encounter data;
- Encounter data and financial summary reconciliation;
- Information security breach;
- Disaster preparation and recovery plan; and
- Back-up plan.

2.16 Claims Processing

2.16.1 Claims Processing System

The Contractor shall maintain a claims payment system capable of processing and paying claims in an accurate and timely manner and in full compliance with the HIPAA Implementation Guide. The claim processing system shall comport with all the information exchange provisions outlined in section 2.15, "Information Technology and Data Management."

The Contractor shall ensure that either provider claims submissions or checks/warrants payable be printed, in boldface type, with the language specified in 42 CFR § 455.18 or 42 CFR § 455.19, respectively.

This system shall store information about each claim for a period of time to be specified by the OHCA. At a minimum, these records shall include:

- The identity of the provider submitting the claim;
- Date stamp of day received;
- Type of claim;
- Amount billed;
- All adjustments;
- Dates of all relevant action taken on the claim, including payment and denial;
- Amount paid;
- Service code;
- Provider involved in claim, including ordering, referring and rendering;
- Service location;
- Application of coordination of benefits and subrogation of claims; and
- Information on the units of service used so that the OHCA may collect information for the purposes of utilization management.

The claims processing system used by the Contractor shall be equipped to receive and quickly adjudicate claims submitted electronically and by mail. The Contractor shall ensure that the electronic claims submission process is usable with a standard internet connection.

The Contractor's and subcontractors' payment cycle for newly submitted claims shall run at least weekly.

Providers must be able to track the status of claims online and contact a health plan representative for resolution of claims questions.

The claims processing system shall be equipped to review claims to ensure that the ordering, referring and rendering provider is licensed to do so; is contracted with the program; and that services are appropriate in amount, duration and scope.

The Contractor shall check for eligibility of enrolled member, third party liability, prior approval, duplicate claims and benefit restrictions at the front end of the claims system.

Each financial adjustment to each claims payment shall be recorded, including third party liability adjustments, interest and copayments.

The Contractor shall develop policies prohibiting payment for provider-preventable conditions as set forth in federal requirements, including 42 CFR § 434.6(a)(12) and 42 CFR § 447.26. The Contractor must report provider-preventable conditions in form and frequency as specified by the OHCA, in accordance with provisions outlined in section 2.9.5.13, "Other Prohibited Payments."

The Contractor's claims processing system shall track the error rates in claims and encounter data received from the provider of service or a third party prior to a claim or encounter being adjudicated and submitted to the OHCA.

2.16.2 Filing and Processing Timeframes

2.16.2.1 Provider Timely 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 claims to be submitted within six months from the date of service. The Contractor shall require claims to be resubmitted, when applicable, within 365 days from the date of service. The only exceptions to the 365-day resubmission claim deadline are the following:

- Administrative correction or action by the Contractor taken to resolve a dispute;
- Reversal of the eligibility determination;
- Investigation for fraud or abuse of the provider; or
- Court order or hearing decision.

2.16.2.2 Clean Claim Definition

For this purpose of this section, a clean claim is a claim or encounter which can be adjudicated and submitted to the OHCA without obtaining additional information from the provider of service or a third party. Clean claims do not include claims from a provider that is under investigation for potential fraud and/or abuse or claims that routinely suspend even if not due to billing errors by the provider.

2.16.2.3 Date Definitions

The following definitions shall apply for the purpose of determining timely payment of clean claims:

- The date of receipt, for the purposes of this section, shall be considered to be the date indicated by the date stamp on the claim; and
- Date of payment shall be considered to be the date of the check or other method of payment.

2.16.2.4 Timely Payment Requirements

The Contractor shall observe the following requirements in adjudicating clean claims:

- Ensure that 90 percent of clean claims received from nursing facilities and HCBS providers are paid within 14 days of receipt;
- Ensure that 99 percent of clean claims received from nursing facilities and HCBS providers are paid within 30 days of receipt;
- Ensure that 90 percent of all clean claims received from all other providers are paid within 30 days of receipt; and
- Ensure that 99 percent clean claims received from all other providers are paid within 90 days of receipt.

All claims shall be paid within 365 days of date of receipt, except in the following cases:

- The time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in 42 CFR § 447.272;
- If a claim for payment under Medicare has been filed in a timely manner, the Contractor may pay a SoonerCare claim relating to the same services within six months after the Contractor or the provider receives notice of the disposition of the Medicare claim;
- The time limitation does not apply to claims from providers under investigation for fraud and abuse; and
- The Contractor may make payments at any time in accordance with a court order, to carry out hearing decisions or the OHCA/Contractor corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action or court order to others in the same situation as those directly affected by it.

The Contractor shall develop policies and procedures governing the processing of claims. These policies and procedures should cover the format in which claims are to be submitted, the speed with which the provider or Subcontractor can expect them to be processed and compliance with State and federal law.

The Contractor shall pay its providers and Subcontractors consistent with Section 1902(a)(37)(A) of the Social Security Act.

2.16.2.5 Interest Payments for Untimely Processing

The Contractor shall pay a monthly interest rate of 1.5 percent on all clean claims that are not adjudicated within 45 days of receipt. This interest rate shall be prorated on a daily basis.

2.16.2.6 Treatment of Unclean Claims

If the Contractor receives a claim submission that does not include all the necessary documentation or information to pay the claim, the Contractor shall notify the provider who submitted the claim in writing within seven days and explain what further documentation is needed to adjudicate the claim.

2.16.2.7 Corrections and Resubmissions

Corrections or resubmissions of existing, paid claims shall be submitted as adjustments to the existing claim.

2.16.3 Formats

The Contractor shall require providers to submit claims in a standardized format approved or specified by the OHCA. The Contractor shall require its providers and Subcontractors to use HIPAA-compliant standard codes or another code as specified by the OHCA for services lacking a standard code. The Contractor shall encourage filing of claims in 837 format.

A remittance advice shall be sent with the payment unless payment is executed electronically. If the payment is electronic, the remittance advice shall be sent the same day either electronically in 835 format or via mail.

The Contractor shall incorporate the NPI number of the relevant provider into claim documentation, as well as service location code and any other data element requested by the OHCA.

2.16.4 Inquiries and Disputes

The Contractor shall develop policies and procedures for resolution of claims inquiries and disputes. The policies and procedures shall allow providers to dispute the nature of 'medical necessity' at two levels within the Contractor's MCO. If a dispute persists past the two levels within the Contractor's MCO, the Contractor shall refer the dispute to the OHCA for final adjudication.

2.16.5 Member Cost Sharing Limitations

Medicaid premiums and cost sharing are capped at five percent of family income. Any cost sharing imposed on members shall be in accordance with 42 CFR § 447.50 through 447.82. The Contractor shall report member premiums and cost sharing through a process to be defined by the OHCA. The OHCA will combine the Contractor's data with data on member

cost sharing associated with non-capitated benefit and will notify the Contractor when a member has reached the aggregate limit and cost sharing is to be discontinued. The Contractor shall notify members and network providers when the aggregate limit has been reached; the OHCA will notify providers of non-capitated benefits.

2.16.6 Claims Reports

The Contractor shall submit claims reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Claims reports shall include at least the following:

- *Claims activity* - submit a weekly report on claims activities. This report shall break down the number of claims received, denied, paid, total amount paid and any adjustments or edits to claims;
- *Claims payment accuracy* - submit a quarterly report on accuracy of claims payment 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 quarter. The report shall document the results of the audit, including the number and percentage of claims and dollars that were paid accurately. Denied claims shall be included in this audit, as well;
- *Claims timeliness* - submit a quarterly report on the timeliness of claims paid by claim type and provider type. The report shall include the number and percentage of claims processed for that quarter that were paid within 30 days of service date, within 60 days of service date, within 90 days of service date, those left pending and those that were submitted in previous quarters but paid in the reporting quarter; and
- *Member premium and cost sharing* - report member premiums and cost sharing.

2.17 Reporting

2.17.1 General Reporting Requirements

The Contractor shall comply with all reporting requirements established by the OHCA. The Contractor shall also comply with all current and future State and federal laws and regulations governing reporting and disclosure requirements.

If the Contractor delegates any activities or obligations under this Contract, the Subcontractor, individual or entity accepting delegation shall also perform the Contractor's reporting responsibilities and obligations in compliance with the Contract.

2.17.1.1 Certification Requirements

All data, information and documentation that the Contractor is required to submit under 42 CFR § 438.604 must be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. Such certification shall be provided concurrently with the submission required. The certifying officer must attest that, based on best information, knowledge, and belief, the data, documentation and information submitted is accurate, complete and truthful.

2.17.1.2 Reporting Formats and Submission Procedures

The Contractor shall submit the required reports to the OHCA or its designee in electronic format and in the manner and format prescribed by the OHCA. The OHCA shall provide the Contractor with procedures for submission, instructions and technical specifications as required. The OHCA and contracted health plans will collaborate post-award to establish appropriate report formats, instructions, submission timetables and technical assistance to the extent they are not defined within the Contract already.

2.17.1.3 Changes in Reporting Requirements

The OHCA, in its discretion, reserves the right to alter specified reporting formats, content and reporting frequencies at any time during the term of the Contract.

The OHCA may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring. The OHCA will provide the Contractor with written notice of such changes within at least 30 days prior to the effective date.

2.17.1.4 Timeliness and Accuracy of Submissions

The Contractor shall submit all required reports to the OHCA on or before the due date specified. The Contractor shall also ensure that all submitted reports are accurate and in the proper format identified by written instructions and applicable technical specifications. The submission of an untimely, inaccurate or incomplete report is subject to penalties, in accordance with the provisions outlined in section 2.22, "Contractor Performance Standards."

2.17.1.5 Non-Compliant Report Submissions and Required Revision

At any time that a submitted report is rejected for non-compliance other than timeliness, the Contractor shall revise the report and cure the reason for rejection within five days of notification from the OHCA or as otherwise specified. Any revisions to previously submitted reports must be re-submitted in the format specified by the OHCA.

2.17.2 General Terms and Conditions - Termination Reports

The Contractor shall report and disclose termination reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
GENERAL TERMS AND CONDITIONS – TERMINATIONS		
Monthly claims aging report by provider/creditor	2.1.12	On the fifth business day of each month for the prior month

2.17.3 Licensure, Administration and Staffing Reports

The Contractor shall report and disclose licensure, administration and staffing reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
LICENSURE, ADMINISTRATION AND STAFFING		
Advisory Board meeting records	2.2.2.3	As requested by the OHCA
Implementation plan	2.2.3.6	60 days post-Contract execution and then monthly or as specified by the OHCA

Report Name by Category	Contract Section	Frequency
Hiring and staffing plan	2.2.3.6	60 days post-Contract execution and then monthly or as specified by the OHCA
Changes in board of directors and management	2.2.3.7	When applicable and at least five days in advance of the change whenever practical
Known or anticipated value of contracted or subcontracted services	2.2.4	When applicable

2.17.4 Capitated and Non-Capitated Benefits Reports

The Contractor shall submit capitated and non-capitated benefits reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
CAPITATED AND NON-CAPITATED BENEFITS		
Utilization and other data necessary for the OHCA to bill drug manufacturers for rebates for pharmacy claims and physician administered drugs, including Medicare crossover claims.	2.4.2.4 and 2.4.2.5	Weekly batches submitted on an OHCA-defined schedule.
Value-added benefits	2.4.4	Quarterly

2.17.5 Enrollment and Disenrollment Reports

The Contractor shall submit enrollment and disenrollment reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
ENROLLMENT AND DISENROLLMENT		
Failure to contact member	2.5.3.3	Monthly
PCMH provider	2.5.4	Monthly

Report Name by Category	Contract Section	Frequency
selection or assignment		
PCMH provider change	2.5.4	Monthly
PCD selection or assignment	2.5.5	Monthly
PCD change	2.5.5	Monthly
Member status change	2.5.6	Within five business days of a learning of a member status change

2.17.6 Transition of Care Reports

The Contractor shall submit transition of care reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
TRANSITION OF CARE		
Acute care hospital or residential treatment facility to home or nursing facility	2.6.5.1	Quarterly
Nursing facility to home	2.6.5.2	Quarterly
Home to nursing facility or ICF-ID	2.6.5.3	Quarterly
Transitions between health plans	2.6.5.4	Quarterly
Age transitions	2.6.5.7	Quarterly

2.17.7 Member Services Reports

The Contractor shall submit member services reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
MEMBER SERVICES		
Member newsletter	2.7.5	Quarterly
Call center performance	2.7.8.2	Quarterly

Report Name by Category	Contract Section	Frequency
Call center evaluation	2.7.8.2	Annual
Call center training program	2.7.8.3	Annual

2.17.8 Provider Network and Service Accessibility Reports

The Contractor shall submit to the OHCA reports that demonstrate the Contractor has an appropriate range of physical health, behavior health and HCBS providers adequate for the anticipated number of enrolled members, by region or sub-region service area (as defined by the OHCA) and for the State as a whole. Such reporting shall include, but not be limited to:

Report Name by Category	Contract Section	Frequency
PROVIDER NETWORK AND SERVICE ACCESSIBILITY		
Provider network development and management plan	2.8.1.4	At the time the Contractor enters into a Contract with the OHCA, annual and at any time there has been a significant change
Network provider listings	2.8.1.5	Monthly
Provider terminations	2.8.2.2	When applicable

2.17.9 Provider Contracting and Services Reports

The Contractor shall submit provider contracting and services reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
PROVIDER CONTRACTING AND SERVICES		
Provider criminal convictions report	2.9.2.2	When applicable
Provider application denials	2.9.2.2	When applicable
Performance based provider payments plan	2.9.5.9	Annual

Report Name by Category	Contract Section	Frequency
Performance-based payments activity	2.9.5.9	Quarterly
Improper payments to providers	2.9.5.10	When applicable
Provider services call center performance report	2.9.6.2	Quarterly
Provider services call center evaluation	2.9.6.2	Annual
Provider training, education and technical assistance plan	2.9.6.5	Annual
Provider complaints	2.9.6.7	Monthly

2.17.10 Medical Management Reports

The Contractor shall submit medical management reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
MEDICAL MANAGEMENT		
Medical management program description	2.10.1	Annual
Medical management work plan	2.10.1	Annual
Medical management program evaluation	2.10.1	Annual
ER utilization management activities and findings	2.10.8	Biannual
Drug utilization review program activities	2.10.9.2	Annual
Pharmacy benefit financial arrangements	2.10.9.4	When applicable
Rebates and financial reports	2.10.9.5	Quarterly
Referral requests and disposition	2.10.10	Quarterly

Report Name by Category	Contract Section	Frequency
Over – and under – utilization of services	2.10.11	Quarterly
Over – and under – utilization of drugs	2.10.11	Quarterly
HCBS utilization	2.10.11	Quarterly

2.17.11 Care and Disease Management Reports

The Contractor shall submit care and disease management reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
CARE AND DISEASE MANAGEMENT		
Care management staffing plan	2.11.3.1	Annual
Care manager assignment change	2.11.3.3 and 2.11.3.4	Monthly
Health Risk Screening report	2.11.5	Monthly
Health Risk Screening unreachable members	2.11.5	Monthly
Care manager risk levels	2.11.6	Quarterly
Comprehensive assessment and reassessment	2.11.7	Quarterly
Care plan	2.11.8	Quarterly
Pharmacy lock-in	2.11.12.1	Quarterly
Advance directives	2.11.12.2	Quarterly
DM program plan	2.11.12.3	Annual
DM program evaluation	2.11.12.3	Annual
Self-direction	2.11.13	Quarterly
EVV System	2.11.14	Quarterly

2.17.12 Native American Population and IHCP Reports

The Contractor shall submit Native American population and IHCP reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
NATIVE AMERICAN POPULATION AND IHCP		
Network accessibility for Native American Population and IHCPs	2.12.4.1	As requested by the OHCA

2.17.13 Quality Improvement Reports

The Contractor shall submit quality-related reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
QUALITY IMPROVEMENT		
Annual QAPI Program	2.13.3	Annual – July 1
Accreditation status	2.13.4	Immediately upon receipt but not to exceed 10 days from receipt from accreditation entity
Reevaluation of accreditation status	2.13.4	Immediately upon receipt but not to exceed 10 days from receipt from accreditation entity
Final bound copy of three-year re-accreditation	2.13.4	Immediately upon receipt but not to exceed 10 days from receipt from accreditation entity
Quality Performance measures	2.13.5	Annual – June 15
EPSDT	2.13.5	Annual – January 31
CAHPS Adult Survey	2.13.6.1	Annual – June 15
CAHPS Children with Chronic Conditions	2.13.6.1	Annual – June 15
Experience of Care and Health Outcomes (ECHO) Survey	2.13.6.1	Annual – June 15

Report Name by Category	Contract Section	Frequency
HCBS Member Satisfaction and Experience Survey	2.13.6.2	Annual – June 15
National Core Indicators Aging and Disability (NCI-AD) Consumer Survey	2.13.6.3	Annual – June 15
Provider survey	2.13.7	Annual – July 1
Performance improvement projects	2.13.8	Annual – July 1
Provider profiling	2.13.9	Quarterly within 15 days of end of each quarter
Critical incident	2.13.12	Quarterly – within 15 days of end of each quarter

2.17.14 Complaints and Appeals Reports

The Contractor shall submit complaint and appeals reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
COMPLAINTS AND APPEALS		
Member complaints and appeals	2.14.1.2	Monthly for the first six months and quarterly thereafter or as specified by the OHCA

2.17.15 Information Technology and Data Management Reports

The Contractor shall submit information technology and data management reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
INFORMATION TECHNOLOGY AND DATA MANAGEMENT		
Encounter data	2.15.3	Monthly

Report Name by Category	Contract Section	Frequency
Encounter data and financial summary reconciliation	2.15.3	Quarterly
Information security breach notification	2.15.5	Immediately in the event of an information security breach
Disaster preparation and recovery plan	2.15.6	Annual
Back-up plan	2.15.7	Annual

2.17.16 Claims Processing Reports

The Contractor shall submit claims processing reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
CLAIMS PROCESSING		
Claims activity	2.16.1	Weekly
Claims payment accuracy	2.16.1	Quarterly
Claims timeliness	2.16.2	Quarterly
Member premium and cost sharing	2.16.5	Quarterly

2.17.17 Financial Standards, Coordination of Benefits and Third Party Liability Reports

The Contractor shall submit financial reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
FINANCIAL STANDARDS, COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY		
Audited financial reports	2.18.4.1	Quarterly financial statements Annual financial statements
Change in independent actuary or independent auditor	2.18.4.2	Within 10 days of expiration of Contractor's Contract

Report Name by Category	Contract Section	Frequency
Disclosure of sales and transactions	2.18.4.3	Quarterly
Disclosure of fiduciary relationships and bonding	2.18.4.4	When applicable
Third party payment recovery	2.18.4.5	Quarterly
Third party subrogation and recovery	2.18.4.6	Quarterly
Third party payment resource information	2.18.4.7	Quarterly
Rate cell financial reports	2.18.4.8	Quarterly and year-to-date basis, and submitted to the OHCA within 90 days after the end of the quarter

2.17.18 Marketing Reports

The Contractor shall submit marketing reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
MARKETING		
Marketing staff training curriculum	2.19.1.2	As requested by the OHCA
Marketing plan	2.19.2	As requested by the OHCA

2.17.19 Program Integrity/Compliance Reports

The Contractor shall submit program integrity/compliance reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
PROGRAM INTEGRITY/COMPLIANCE		
Fraud, waste and abuse	2.20.1.2	When applicable
Compliance plan	2.20.2.1	Annual
Compliance education	2.20.2.2	As requested by the

Report Name by Category	Contract Section	Frequency
and training		OHCA
Changes in member circumstances	2.20.3	When applicable
Changes in provider circumstances	2.20.4	When applicable
Verifying delivery of services to members	2.20.5	Quarterly
EOBs	2.20.5.1	Quarterly
Improper payments due to potential fraud	2.20.7	When applicable
Overpayment to providers	2.20.11	Within 60 days of identification
Recoveries of overpayments	2.20.11.3	Annual

2.17.20 Payments to Contractor Reports

The Contractor shall submit payment reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
PAYMENTS TO CONTRACTOR		
Medical and administrative expenses	2.21.2	Quarterly
Final analysis of medical expenses	2.21.2	No later than 180 days after conclusion of a Contract year
Capitation reconciliation	2.21.5	Monthly

2.17.21 Contractor Performance Standards Reports

The Contractor shall submit performance standards reports to the OHCA that include at least the following:

Report Name by Category	Contract Section	Frequency
CONTRACTOR PERFORMANCE STANDARDS		
Compliance monitoring	2.22.3.2	Monthly

2.18 Financial Standards, Coordination of Benefits and Third Party Liability

2.18.1 Financial Stability

The Contractor must maintain a financially stable operation under State and federal laws, and applicable 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 Department of Insurance (OK DOI) requirements for a minimum net worth and risk-based capital including the following requirements:

- Initial and continuing net worth;
- Paid-in capital;
- Determination of liabilities;
- Reinsurance, as addressed here and in section 2.1.22.4, “Reinsurance”;
- Risk-based capital investments; and
- Additional reserve or surplus protections as may be required by the Oklahoma Department of Insurance (OK DOI).

The OHCA and the OK DOI will monitor the Contractor’s financial performance. The OHCA will include OK DOI findings in its monitoring activities. The Contractor shall copy the OHCA on required filings with the OK DOI and shall separate financial information pertaining to this Contract upon submission. Further responsibilities may also be required following the Contract award date.

2.18.1.1 Insolvency Protection

The Contractor shall comply with State and federal requirements for protection against insolvency, including 42 CFR § 438.106 and Section 1932(b)(6) of the Social Security Act. The Contractor shall develop and maintain an Insolvency Plan pursuant to 36 O.S. § 6913(E) and have a process in place to review and authorize contracts established for reinsurance and third party liability, as applicable. Unless the Contractor is a federally qualified HMO (as defined in Section 1310 of the Public Health Service Act), the Contractor shall comply with 42 CFR § 438.116, which requires the Contractor:

- Provide satisfactory assurances showing that its provision against the risk of insolvency is adequate to ensure that its members will not be liable for the Contractor's debts should it become insolvent; and
- Meet the solvency standards established by the HMO Act of 2003, 36 O.S. § 6901, et seq. (OSCN 2016).

2.18.1.2 Eligible Investments

The Contractor shall invest in or loan their funds on the security of, and shall hold as assets, only eligible investments as prescribed in 36 O.S. § 1601, et seq.

2.18.1.3 Modified Current Ratio

The Contractor must maintain current assets, plus long term investments that can be converted to cash within five business days without incurring a penalty of more than 20 percent 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.

2.18.1.4 Prior Approval of Payments to Affiliates

The Contractor may not pay money or transfer any assets to an affiliate without prior approval from the OHCA except for payment of a claim for a medical product or service that was provided to a member and paid in accordance with a written provider contract and this Contract. To obtain authorization, the Contractor must demonstrate to the OHCA that the Contractor:

- Meets specified risk-based capital requirements as of the close of the most recent year for which the due date for filing the annual unaudited OK DOI financial report has passed;
- Is in compliance 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 OK DOI financial reports has passed; and
- Would remain in compliance with the Contract's financial stability and solvency protection requirements following the proposed transaction.

The 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.

2.18.2 Coordination of Benefits

The Contractor will be notified of known member third party resources via the enrollment file. Member third party resource information will be based upon information obtained or made available to the OHCA at the time of a member's eligibility determination or re-determination.

2.18.2.1 Coordination of Benefits for Dual Eligible Members

The Contractor is responsible for providing medically necessary covered services to members who are also eligible for Medicare if the service is not covered by Medicare or another payer taking precedence over Medicaid. The Contractor must ensure that services

covered and provided under this Contract are delivered without charge to members who are dually eligible for Medicare and Medicaid. The Contractor must coordinate with Medicare payers, Medicare Advantage Plans and Medicare providers as appropriate to coordinate the care and benefits of members who are also eligible for Medicare.

The Contractor must sign a Coordination of Benefits Contract and participate in the automated claims crossover process administered by Medicare as required by 42 CFR § 438.3(t).

The Contractor must include in all of its provider agreements provisions to ensure coordination of benefits. In addition, the provider agreement must specify the provider's responsibility regarding third party liability including identifying Medicare and other insurance as applicable and seeking payment through other identified sources before submitting claims to the Contractor.

2.18.3 Third Party Liability

Medicaid shall be the payer of last resort for all covered services in accordance with federal regulations, including 42 CFR 433 Subpart D and 42 CFR § 447.20. The Contractor shall make every reasonable effort to:

- Determine the liability of third parties to pay for services rendered to members;
- Avoid costs which may be the responsibility of third parties; and
- Recover any liability from responsible third party sources.

2.18.3.1 Third Party Liability Procedures

The Contractor shall develop and implement policies and procedures to meet its obligations regarding third party liability cost avoidance and recovery when the third party pays a benefit to a member.

2.18.3.2 Third Party Payment to Subcontractors

If third party liability exists for part or all of the services provided to a member by a Subcontractor or a provider, and the third party will make payment within a reasonable time, the Contractor may pay the Subcontractor or provider only the amount, if any, by which the Subcontractor's or provider's allowable claim exceeds the amount of third party liability.

2.18.3.3 Determination of Third Party Payment

If probable existence of third party liability has been established at the time a claim is filed, the Contractor may reject the claim and return it to the provider for a determination of the amount of any third party liability. At the time such claims are presented for payment by the provider, the Contractor shall bill the responsible third party. The Contractor shall provide

third party liability data to any provider having a claim denied by the Contractor based upon third party liability.

2.18.3.4 Third Party Payment Denial

The Contractor shall deny payment on a claim that has been denied by a third party payer when the reason for denial is the provider or member's failure to follow claims and payment procedures specified by the third party. The basis for such denials may include the failure to obtain prior authorization and timely submit claims for payment according to submission procedures.

2.18.3.5 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 member.

2.18.3.6 Estate Recovery Activities

The OHCA shall be solely responsible for estate recovery activities and shall retain any funds recovered thorough these activities.

2.18.3.7 Third Party Subrogation and Recovery

The Contractor shall identify potential subrogation cases using a list of the OHCA-approved diagnosis and treatment codes. When subrogation is identified, the OHCA shall be notified by the Contractor. The OHCA will be responsible for pursuing subrogation and will retain all subrogation recoveries.

2.18.3.8 Third Party Payment Exclusions

The Contractor shall not consider allowable member cost sharing and member payment responsibilities as permitted under the Contract as a third party liability source.

2.18.3.9 Third Party Payment Resource Information

The Contractor must cooperate with the OHCA or its cost-recovery vendor, in recovering benefits provided by member's access to other insurance.

The OHCA may require a contracted third party liability vendor to review paid claims that are over 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.

If the Contractor operates or administers any non-Medicaid MCO, health plan or other lines of business, the Contractor shall assist the OHCA in a manner to be specified with identification of members with access to other insurance.

2.18.4 Financial, Coordination of Benefits and Third Party Liability Reports

The Contractor shall report and disclose matters regarding the Contractor's financial viability and compliance with this Contract at the frequencies specified in section 2.17, "Reporting." Financial, coordination of benefits and third party liability reports shall include at least the following:

2.18.4.1 Audited Financial Reports

The Contractor shall submit audited financial reports as specified by the OHCA or required by State and federal laws, regulations, or guidance. Financial audits must be conducted in accordance with generally accepted accounting principles and auditing standards. Audited Financial Reports include, at least, the reports specified below:

- Quarterly Financial Statements; and
- Annual Financial Statements.

2.18.4.2 Change in Independent Actuary or Independent Auditor

The Contractor must provide the OHCA with notice within 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.

2.18.4.3 Disclosure of Sales and Transactions Reports

The Contractor shall report and disclose matters related to sales and transactions with any parties-in-interest regarding the:

- Sale or exchange, or leasing of any property between the organization and such a party;
- Furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party; and
- Lending of money or an extension of credit between the Contractor and any party-in-interest.

2.18.4.4 Disclosure of Fiduciary Relationships & 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 the 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 the OHCA with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

2.18.4.5 Third Party Payment Recovery Reports

The Contractor shall report all cost avoidance values to the OHCA in accordance with State and federal guidelines.

2.18.4.6 Third Party Subrogation and Recovery Reports

The Contractor shall report potential subrogation cases to the OHCA under a process to be defined by the OHCA.

2.18.4.7 Third Party Payment Resource Information Reports

The Contractor shall provide the OHCA with any third party resource information.

2.18.4.8 Rate Cell Financial Reports

The Contractor shall submit certified financial reports as specified by the OHCA reflecting cost experience at the rate cell level. These reports will initially be done on a quarterly and year-to-date basis, and submitted to the OHCA within 90 days after the end of the quarter. At the OHCA's discretion, these reports may later be converted to an annual basis.

2.19 Marketing

2.19.1 General Requirements for Marketing

Marketing is any communication from the Contractor to a SoonerHealth+ member who is not enrolled with the Contractor that can reasonably be interpreted to try to influence the member to:

- Enroll in the Contractor's Medicaid product; or
- Either not enroll in, or disenroll from, another MCO Medicaid product.

Marketing does not include:

- Communication to a SoonerCare member from the issuer of a qualified health plan, as defined in 42 CFR § 155.20, about the qualified health plan; and
- Communication related to educating members about health plan operations or educating members as part of care and disease 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 the OHCA or its designee as intended to market the Contractor (or its employees, network providers, agents or Subcontractors) to potential members. 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.

2.19.1.1 Policies and Procedures

The Contractor shall develop and maintain written policies and procedures governing the development and implementation/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 members, the OHCA or the State.

2.19.1.2 Training Curriculum

The Contractor shall develop training curriculum and provide training for marketing representatives, including the Contractor's staff and Subcontractors. The Contractor shall maintain documentation of training efforts and provide such documentation upon request to the OHCA.

2.19.1.3 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 member population. All marketing materials shall be in compliance with the information requirements in 42 CFR § 438.10 to ensure that, before enrolling, a member receives accurate oral and written information needed to make an informed decision on whether to enroll.

For further instruction on the requirements for member materials, refer to section 2.7.2, "Written Material Guidelines."

2.19.1.4 OHCA Review and Approval Process

The Contractor shall not distribute marketing materials without first obtaining OHCA approval. In reviewing the marketing materials submitted by the Contractor, the OHCA shall consult with the Member Advisory Task Force.

The Contractor shall submit marketing materials to the OHCA for review and approval at least 60 days prior to expected use and distribution. The Contractor shall not change any approved materials without the consent and approval of the OHCA.

2.19.1.5 Use of State Agency Logos

The Contractor shall not refer to or use the OHCA or other State agency name or logo in its marketing materials without prior written approval. Any approval given for the name or logo is specific to the use requested and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in its marketing materials upon the request of the OHCA.

2.19.1.6 Geographic Distribution

The Contractor shall distribute marketing materials to its entire service area as defined by the Contract.

2.19.1.7 Sanctions

The OHCA may impose financial sanctions, up to the federal limit, on the Contractor for distributing directly, or indirectly through an agent or Subcontractor, marketing materials that have not been approved by the OHCA or that contain false or materially misleading information.

See section 2.22, "Contractor Performance Standards" for more information on penalties.

2.19.2 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 CFR § 438.104 and include, at a minimum, the following information:

- Marketing goals and strategies;
- Details of proposed marketing activities and events, including calendar of planned outreach activities and events from the Contract start date through the end of the first benefit year and distribution methods and schedules. This includes any proposed advertising campaigns, website development and launch, social media

platform development and launch and printed materials development and distribution;

- Process for removing outdated materials;
- How the Contractor shall meet the informational needs, relative to marketing, of the cultural and physical diversity of its membership;
- Summary of value-added benefits, if applicable;
- List of all Subcontractors engaged in marketing activities for the Contractor;
- Copy of training curriculum for marketing representatives, including employees and Subcontractors;
- Procedures for monitoring and enforcing compliance with marketing guidelines;
- Methods for tracking marketing contacts, including (but not limited to) website visits and social media interactions;
- Process for responding to unsolicited direct contact from members or potentially eligible persons; and
- Details regarding the basis the Contractor uses for awarding bonuses or increasing the salary of marketing representatives or any other employees involved in marketing activities.

The Contractor shall submit the plan to the OHCA for review and approval as part of readiness review activities, on a schedule to be defined by the OHCA. The Contractor shall submit any changes to the OHCA for review and approval a minimum of 30 days before intended implementation of the marketing activity.

The plan also shall be updated quarterly and submitted to the OHCA for review.

2.19.3 Marketing Activities

2.19.3.1 Allowable Marketing Activities

The Contractor and its Subcontractors are allowed to perform the following marketing activities (either written or verbal):

- Distributing general information through mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets);
- Responding to verbal or written requests for health plan-specific information made by a member;
- 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 the OHCA;
- Attending events at the request of the OHCA to disseminate or share information about the Contractor, its services and outcomes; and

- Offering potential members tokens or gifts of nominal value, as long as the Contractor acts in compliance with all marketing provisions provided for in 42 CFR § 438.104, which addresses marketing activities and other State and federal laws, regulations and guidance regarding inducements.

2.19.3.2 Prohibited Marketing Activities

The Contractor and its Subcontractors are prohibited from engaging in the following marketing activities (either written or verbal):

- Distributing marketing materials or attending/organizing marketing events that have not received prior approval from the OHCA;
- Engaging in direct or indirect door-to-door, telephone, email, texting or other cold-call marketing (i.e., unsolicited personal contact) techniques or activities;
- Influencing enrollment in conjunction with the sale or offering of any private insurance, except as provided in 42 CFR § 438.104;
- Distributing plans and materials or making any statement that the OHCA determines to be inaccurate, false, misleading or intended to defraud members or the OHCA. This includes statements that mislead or falsely describe covered services, membership or availability of network providers or network providers' qualifications or skills;
- Asserting that a member must enroll in the Contractor to obtain benefits or to not lose benefits;
- Asserting that the Contractor is endorsed by CMS, the State or federal government or similar entity, including any other governmental entity;
- Assisting with enrollment or improperly influencing health plan selection;
- Designing a marketing plan that discourages or encourages health plan selection based on health status or risk (however, this provision does not preclude the Contractor from proclaiming expertise or excellence with a specific subpopulation within the enrolled members covered by this program); and
- Conducting any other marketing activity prohibited by the OHCA during the term of this Contract.

The OHCA reserves the right to prohibit additional marketing activities at its discretion.

2.19.3.3 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 health plans in which the provider/clinic participates have an equal opportunity to be represented.

The Contractor is prohibited from:

- Requiring providers to distribute Contractor-prepared marketing and educational communications to patients;
- Providing incentives or giveaways to providers to distribute them to members or potential members;
- Allowing providers to solicit enrollment or disenrollment with the Contractor or another health plan; and
- Conducting marketing activities or distributing member materials in areas where patients primarily receive health care services or are waiting to receive health care services.

The Contractor shall instruct providers on permissible and prohibited marketing activities and obtain the written consent of the provider when conducting any form of marketing in a provider's office. The Contractor shall maintain records of the instruction and consent.

2.19.4 Media Contacts

The Contractor shall not provide information to the media or participate in media interviews without the prior consent of the OHCA. In circumstances where time is of the essence, the OHCA will make a good faith effort to review the Contractor's request and respond within one business day. The Contractor shall refer to the OHCA any contacts by the media or entity/individual not directly related to the program.

2.19.5 Marketing Reports

The Contractor shall submit marketing reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Marketing reports shall include at least the following:

- Marketing staff training curriculum; and
- Marketing plan.

2.20 Program Integrity/Compliance

2.20.1 General Requirements for Program Integrity/Compliance

The Contractor and its Subcontractors shall comply with all State and federal laws and regulations related to program integrity and disclosure requirements. This includes any future laws and regulations that may be required as well as current laws and regulations.

2.20.1.1 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 the OHCA's Program Integrity and Accountability Unit. The arrangements and procedures must include, at a minimum, the following:

- Prompt referral of any potential fraud, waste or abuse to the OHCA's Program Integrity and Accountability Unit, as described in section 2.20.1.2, "Referral to the OHCA's Program Integrity and Accountability Unit";
- A compliance program, as described in section 2.20.2, "Compliance Program";
- Prompt notification to the OHCA regarding changes in a member's circumstances that may affect program eligibility, as described in section 2.20.3, "Reporting Member Changes in Circumstances";
- Notification to the OHCA regarding changes in a provider's circumstances that may affect program eligibility, as described in section 2.20.4, "Reporting Provider Changes in Circumstances";
- Method to verify member's receipt of covered services, as described in section 2.20.5, "Verifying Delivery of Services to Members";
- Written policies and procedures to prevent fraud, waste and abuse and employee whistleblower protections, as described in section 2.20.6, "Mandatory Reporting under the False Claims Act";
- Prompt reporting of all improper payments, as described in section 2.20.7, "Reporting Improper Payments"; and
- Suspending payments to network providers where there is a credible allegation of fraud, as described in section 2.20.8, "Payment Suspension Due to Credible Allegations of Fraud."

2.20.1.2 Referral to the OHCA's Program Integrity and Accountability Unit

The Contractor shall promptly refer any potential fraud, waste or abuse that the Contractor identifies to the OHCA's Program Integrity and Accountability Unit in a manner and format to be specified by the OHCA.

2.20.1.3 Audit Requirements

The Contractor shall cooperate in any audit activity performed by the OHCA, the OHCA's Program Integrity and Accountability Unit, Medicaid recovery audit contractor, the CMS and/or Payment Error Rate Management and the CMS audit Medicaid integrity contractors. The Contractor, its Subcontractors and network 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.

2.20.2 Compliance Program

The Contractor and its Subcontractors shall have a compliance program that includes, at a minimum, all of the following elements:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract and all applicable State and federal requirements;
- Agreement to report all allegations of fraud, waste and abuse to the OHCA's Program Integrity and Accountability Unit. The policies and procedures shall:
    - Designate the Contractor's staff members responsible for reporting fraud to the OHCA's Program Integrity and Accountability Unit,
    - Process for timely, complete and consistent exchange of information and collaboration with the OHCA's Program Integrity and Accountability Unit, designated agents and contracted external quality review organizations;
- Agreement to and implementation of a process to:
    - Suspend all provider payments when notified by the OHCA's Program Integrity and Accountability Unit and other State/federal agencies to suspend payments because of credible allegation(s) of fraud,
    - Comply with requests from the Program Integrity and Accountability Unit and other State/federal agencies to access and receive copies of any records kept by the Contractor;
- Staff that are qualified and adequate in number and training to effectively monitor the Contract;
- 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 the Contract and who reports directly to the chief executive officer and the board of directors;
- The establishment of a regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with requirements under the Contract;
- A system for training and education for the compliance officer, the organization's senior management and the organization's employees for the State and federal

standards and requirements under the Contract, as described in section 2.20.2.2, "Education and Training";

- Effective lines of communication between the compliance officer and the organization's employees;
- A process for the confidential reporting of health plan violations, including:
    - Hotline and/or electronic method for reporting violations, as described in section 2.20.2.3, "Compliance Hotline",
    - Designate individual to receive reports of violations,
    - Independent reporting paths for the reporting of violations so that such reports cannot be diverted by any supervisors or other personnel;
- The establishment of protections to ensure that:
    - No individual who reports cases or suspected cases of program integrity violation, fraud, waste or abuse is retaliated against by anyone who is employed by or contracted with the Contractor,
    - The identity of the individual(s) reporting violations or suspected violations be kept confidential to the extent possible;
- An internal and external process for conducting investigations and follow-up of any suspected or confirmed fraud, waste and abuse or compliance violations;
- Enforcement of standards through well-publicized disciplinary guidelines;
- The establishment and implementation of procedures for proactive specific controls in place to detect fraud, waste and abuse and erroneous payments, including review of provider records and technology used to identify:
    - Aberrant billing patterns,
    - Pre/post-payment claims edits,
    - Post-processing review of claims,
    - Provider profiling and credentialing used to aid program and payment integrity reviews,
    - Surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of covered services,
    - Provisions in Subcontractor and provider agreements that ensure integrity of provider credentials,
    - Member record reviews;
- Monthly check for exclusions of the Contractor's employees, owners and agents and database to capture identifiable information; and
- The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence and ongoing compliance with the requirements under the Contract.

2.20.2.1 Compliance Plan

The Contractor shall have a written compliance plan that addresses, at a minimum, the items described in section 2.20.2, "Compliance Program." The Contractor shall submit a copy of the compliance plan to the OHCA's Program Integrity and Accountability Unit for review and approval a minimum of 45 days prior to the Contract start date and annually thereafter by December 31st of each year. The initial compliance plan must be approved by the OHCA's Program Integrity and Accountability Unit prior to implementation by the Contractor. The Contractor shall submit any request(s) for revision(s) to the compliance plan for review to the OHCA's Program Integrity and Accountability Unit a minimum of 45 days prior to the requested implementation date of the revision(s). Revisions must be approved by the OHCA's Program Integrity and Accountability Unit prior to implementation by the Contractor.

2.20.2.2 Education and Training

The Contractor shall educate and train employees, including management, and any Subcontractors/agents about:

- Provisions of 42 CFR § 438.610 and all relevant State and federal laws, regulations, policies procedures and guidance, including updates and amendments to these documents or any such standards;
- The Contractor's compliance program, as described in section 2.20.2, "Compliance Program";
- The Contractor's code of conduct; and
- Privacy and security, including but not limited to HIPAA.

The Contractor shall conduct training for new hires within 30 days of employment and annually for all employees. The Contractor shall maintain evidence of completed education and training efforts. The Contractor shall provide such evidence upon request by the OHCA.

2.20.2.3 Compliance Hotline

The Contractor shall maintain a toll-free compliance hotline number. The Contractor's hotline and the OHCA's hotline shall be accessible by employees, Subcontractors/agents, network providers and members to report compliance concerns, including suspected fraud, waste and abuse. The Contractor shall ensure that the Contractor's hotline number and the OHCA's hotline number as well as an explanatory statement are distributed to its employees, Subcontractors/agents, network providers and staff.

2.20.3 Reporting Member Changes in Circumstances

The Contractor shall promptly notify the OHCA when the Contractor receives information about changes in a member's circumstances that may affect the member's eligibility, in accordance with the provisions of section 2.5.6, "Member Status Changes," including all of the following:

- Changes in the member's residence or notification of the member's mail that is returned as undeliverable;
- Change in the member's income; and
- Death of the member.

The Contractor shall provide notification in a manner prescribed by the OHCA.

2.20.4 Reporting Provider Changes in Circumstances

The Contractor shall promptly notify the OHCA when the Contractor receives information about a change in a provider's circumstances that may affect the provider's eligibility to participate in the SoonerHealth+ program, including termination of the provider agreement with the Contractor. The Contractor shall provide notification in a manner prescribed by the OHCA.

2.20.5 Verifying Delivery of Services to Members

The Contractor shall have a method to verify that services from network providers have been actually provided to members. The Contractor may conduct verification by telephone, electronic correspondence or writing. The Contractor shall report the results of this monitoring to the OHCA on a quarterly basis in a manner prescribed by the OHCA.

2.20.5.1 Explanation of Benefits (EOBs)

The Contractor shall develop and distribute EOBs to verify the delivery of services consistent with the requirements of 42 CFR § 438.608(a)(5). The EOBs shall be distributed using a methodology developed or approved by the OHCA that ensures all services and provider types are sampled regularly.

The EOB shall conform to all requirements of 42 CFR §§ 455.20 and 433.116. The EOB should list the services delivered, name of the provider claiming the service, date on which it was claimed to have been delivered, service location and amount of payment. A member shall be instructed to call the phone number if the services are incorrect.

The Contractor shall respond to member notification that a service was not received in accordance with the provisions of section 2.20, "Program Integrity/Compliance."

The Contractor shall oversample if a specific service or class of provider justifies closer oversight.

The Contractor shall submit a quarterly explanation of benefits report. This report shall detail the number of EOBs distributed, member responses and resolution of member response.

2.20.6 Mandatory Reporting under the False Claims Act

The Contractor shall establish and implement written policies for all employees (including management) and any Subcontractor or agent of the Contractor's that provides services to members, detailed information about preventing and detecting fraud, waste and abuse in federal health care programs:

- The False Claims Act;
- Administrative remedies for false claims and statements;
- State laws pertaining to civil or criminal penalties for false claims and statements, including O.S. §§ 63-5053 – 63-5053.7;
- Whistleblower protection under such laws; and
- The Contractor's policies and procedures for detecting and preventing fraud, waste and abuse.

In addition, the Contractor shall include this information in its employee handbook.

2.20.7 Reporting Improper Payments

The Contractor shall promptly report all improper payments identified or recovered, specifying the improper payments due to potential fraud, to the State or law enforcement in a manner and format to be specified by the OHCA.

2.20.8 Payment Suspension Due to Credible Allegations of Fraud

The Contractor shall suspend payments to a network provider for which the OHCA determines there is a credible allegation of fraud in accordance with 42 CFR § 455.23. The OHCA shall determine whether payments should be suspended or if an exception is appropriate. The OHCA shall notify the Contractor of payment suspensions, and the Contractor must then suspend payments. The Contractor must ensure that no Medicaid dollars are received by a provider whose payments have been suspended or that has been terminated by the OHCA.

In cases involving potential or confirmed risk to members, the OHCA may allow the Contractor to engage in actions that would otherwise be prohibited. The OHCA shall provide the Contractor with written notification of the action(s) the Contractor may take. The Contractor may not take any action against the provider at issue that is not specified by the OHCA.

After a credible allegation of fraud, unless prior written approval is obtained from the OHCA, the Contractor may not take any of the following actions:

- Contact the subject of the investigation concerning any matter related to the investigation;
- Institute any interventions, sanctions or remedial procedures towards the subject of the investigation, including but not limited to hearings, suspension or termination;
- Take any actions to recoup or withhold improperly paid funds already paid or potentially due to the provider;
- File any civil action based upon the suspected fraud against the subject of the investigation;
- Enter into or attempt to negotiate any settlement or agreement regarding the suspected fraud; or
- Accept any money or other thing of value offered by the subject of the investigation in connection with suspected fraud.

If the Contractor thinks that it is appropriate to initiate a recoupment or withholding action against a provider under these circumstances, the Contractor shall consult with the OHCA and the OHCA's Program Integrity and Accountability Unit to ensure whether such action is permissible. In the event that the Contractor obtains funds from an action when recoupment or withholding is prohibited, the Contractor shall return the funds to the provider.

2.20.9 Provider Screening and Enrollment Requirements

The Contractor shall work with the OHCA to ensure that all of the Contractor's network providers are screened and enrolled with the State as Medicaid providers and periodically revalidated consistent with the provider disclosure, screening and enrollment requirements of 42 CFR § 438.602.

2.20.10 Written Disclosures

The Contractor and its Subcontractors shall provide to the OHCA written disclosure of any prohibited affiliation under 42 CFR § 438.610 and information on ownership and control required under 42 CFR § 455.104.

2.20.11 Overpayments to Providers

The Contractor shall report to the OHCA within 60 days when capitation payments or other payments in excess of amounts specified in the Contract have been identified. For purposes of sections 2.20.11.1 through 2.20.11.3, an overpayment is any payment made to a network provider by the Contractor to which the network provider is not entitled to under Title XIX of the Social Security Act.

2.20.11.1 Treatment of Recoveries Made by Contractor of Overpayments to Providers

The OHCA shall furnish policies, procedures, timelines and documentation to the Contractor prior to the Contractor's readiness review. The Contractor shall comply with the following:

- The OHCA's retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste or abuse;
- The process, timeframes and documentation required for reporting the recovery of all overpayments;
- The process, timeframes and documentation required for payment of recoveries of overpayments to the OHCA in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments; and
- That this provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

2.20.11.2 Overpayment Reporting Mechanism for Network Providers

The Contractor shall require and have a mechanism for a network provider to report to the Contractor when the provider has received an overpayment, to return the overpayment to the Contractor within 60 days after the date on which the overpayment was identified and to notify the Contractor in writing of the reason for the overpayment.

2.20.11.3 Annual Reporting of Overpayment Recoveries

The Contractor shall report annually to the OHCA on the Contractor's recoveries of overpayments. The Contractor shall use the reporting process designated by the OHCA.

2.20.12 Fraudulent and Abusive Member Conduct

Fraudulent or abusive member behavior may include, but is not limited to:

- Overutilization, such as:
    - Concurrently obtaining services from two or more providers of the same specialty, not in the same group practice, with no referrals,
    - Using two or more emergency facilities for non-emergent diagnosis,
    - Concurrently using two or more prescribing physicians to obtain drugs from the same therapeutic class of medication,
    - Two or more occurrences of having prescriptions for the same therapeutic class of medication filled two or more times on the same or subsequent day by the same or different providers,
    - Concurrently using two or more pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer's maximum recommended dosage as approved by the Food and Drug Administration (FDA);
- Fraud, such as:
    - Purchasing drugs on a forged prescription,

  - Loaning the SoonerCare card to another individual to obtain Medicaid-reimbursed services; or
- Engaging in threatening or abusive conduct to providers.

Members may be identified through utilization management, chart review or by referral from network providers. The Contractor shall notify the OHCA of members who have been identified as participating in fraudulent or abusive activities within 24 hours of identification.

The Contractor shall take additional steps in accordance with the OHCA's guidance. The OHCA shall work with the Contractor and the member based on the specific circumstances of the fraudulent or abusive activity.

The Contractor, with the OHCA's approval, shall provide a member with written notification and supporting documentation of the identified fraudulent and/or abusive behavior. The Contractor shall provide education to the member regarding the member's behavior. The Contractor shall document all efforts.

The Contractor may request initiation of disenrollment of members for fraudulent behavior in accordance with the provisions of section 2.5.7.2, "At Request of Contractor."

2.20.13 Program Integrity/Compliance Reports

The Contractor shall submit program integrity/compliance reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Program integrity/compliance reports shall include at least the following:

- Fraud, waste and abuse;
- Compliance plan;
- Compliance education and training;
- Changes in member circumstances;
- Changes in provider circumstances;
- Verifying delivery of services to members;
- EOBs;
- Improper payments due to potential fraud;
- Overpayments to providers; and
- Recoveries of overpayments.

2.21 Payments to Contractor

2.21.1 General

The Contractor shall be paid a monthly capitation fee for enrolled members through the MMIS, in accordance with the rate schedule provided in Appendix 4 to this Contract. The Contractor and the OHCA agree that capitation payments must be in accordance with 42 CFR § 438.3(c) and approved as actuarially sound by CMS in accordance with 42 CFR § 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.

Capitation shall be net of patient liability, for members with a financial responsibility. Patient liability amounts will be shown as part of enrollment data.

The Contractor agrees that the capitation payment shall represent the OHCA's payment in full for all services furnished under this Contract. Capitation payments may only be made by the OHCA and retained by the Contractor for Medicaid-eligible members.

The OHCA and members shall never be held liable for the Contractor's failure to pay legitimate claims for covered services.

The Contractor shall indemnify and hold harmless the OHCA and any affiliated staff or representatives from liabilities, losses, expenses, claims or settlements resulting from activities addressed in the Contract, except as otherwise specified.

The Contractor acknowledges that payment cannot be made by the OHCA to vendors providing services under federally assisted programs unless services are provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap.

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

2.21.2 Medical and Administrative Expense

The Contractor shall spend a minimum of 85 percent of aggregate capitation revenues (net of premium tax) on medical expenses, as defined in 42 CFR § 438.8. The Contractor's administrative expenses and retained earnings shall not exceed 15 percent of aggregate capitation revenues (net of premium tax). The Contractor's medical expense ratio must be calculated, reported and attested to on an annual basis to the OHCA consistent with 42 CFR § 438.8.

If the Contractor's medical expense percentage is below 85 percent, the Contractor shall refund the amount of paid capitation in excess of the amount associated with an 85 percent medical expense ratio. The refund shall be made in a manner and by a date specified by the OHCA. This provision shall survive expiration of the Contractor's other duties under the program, in the event the Contractor is terminated or not renewed.

The Contractor's failure to maintain an 85 percent medical expense ratio during Contract year may result in issuance of a corrective action plan under the provisions of section 2.22, "Contractor Performance Standards."

2.21.3 Payment Schedule

The Contractor shall be notified of enrollment and disenrollment updates through receipt of outbound ANSI ASC X 12 834 electronic transactions. The Contractor shall receive notification of capitation payment through receipt of an ASC X12N 820 electronic transition. Capitation payment will be made through electronic funds transfer in accordance with a schedule to be published by the OHCA, but no later than the fourteenth day of the month to which the capitation applies.

2.21.4 Recoupment of Capitation Payments

The OHCA shall be the sole determiner of a member's enrollment and disenrollment effective dates, as described in section 2.5, "Enrollment and Disenrollment." For members whose enrollment lapses for any portion of a month in which a capitation payment was made, as described in section 2.5.7.4, "Disenrollment Effective Date," the OHCA shall adjust the capitation payment through a reconciliation process to be defined by the OHCA.

2.21.5 Capitation Reconciliation

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

2.21.6 Capitation Rate Changes

Programmatic changes made during the Contract year that affect capitation rates shall result in an adjustment to the rates, to be calculated by the OHCA's consulting actuary. The rate change(s) shall be included in the Contract amendment issued to the Contractor in accordance with the provisions outlined in section 2.1.9, "Amendments or Modifications."

2.21.7 Payment Reports

The Contractor shall submit payment reports to the OHCA at the frequencies specified in section 2.17, "Reporting." Payment reports shall include at least the following:

- *Medical and administrative expenses* – report medical and administrative expenses;

- *Final analysis of medical expenses* – furnish a final analysis of medical expenses to the OHCA no later than 180 days after conclusion of a Contract year in a format to be specified by the OHCA and in compliance with the reporting requirements specified in 42 CFR § 438.8(k). The format shall specify the maximum incurred but not received claims percentage that Contractor may apply to its analysis; and
- *Capitation reconciliation* – notify the OHCA of discrepancies.

2.22 Contractor Performance Standards

2.22.1 Full Compliance

The performance standards for the Contractor are defined as full compliance with the participation requirements specified in this Contract. The Contractor shall be subject to the penalties described in this section for failure to meet performance standards.

2.22.2 Performance-Based Contracting

The Contractor and the OHCA agree that the program shall be administered in accordance with the tenets of performance-based contracting, including:

- Defining quality of care, quality of life and health outcomes objectives for SoonerHealth+ Program members;
- Measuring the Contractor's progress in meeting performance objectives; and
- Rewarding the Contractor for achievement of performance objectives and penalizing the Contractor for failure to achieve performance objectives, through the methods described in this section.

The OHCA, the Contractor and other health plans shall collaborate in development of a uniform performance monitoring data set starting no later than 180 days after commencement of services. The data set shall incorporate mandatory reports as described in section 2.17, "Reporting," and shall include performance benchmarks related to service accessibility and utilization, care and disease management, quality improvement and non-clinical functions. The OHCA shall have sole authority for establishing final benchmarks.

2.22.3 Monitoring and Evaluation of Contractor Performance

2.22.3.1 <u>OHCA Monitoring Methods</u>

The Contractor shall cooperate fully to support the OHCA's performance of monitoring activities. The OHCA will monitor the Contractor's performance and compliance with Contract participation requirements through multiple methods, including but not limited to:

- Pre-implementation readiness reviews, to be conducted onsite and through desk audits;
- Ongoing operational and financial reviews, to be conducted onsite and through desk audits;
- Review of the Contractor clinical and administrative operational reports and financial reports, as delineated in section 2.17, "Reporting," and throughout this Contract;
- Review of the Contractor quality improvement measures and performance improvement project outcomes, as described in section 2.13, "Quality Improvement";

- Assessment of the Contractor performance against uniform performance monitoring benchmarks; and
- Additional data concerning the Contractor performance gathered directly by the OHCA from members, providers and other program stakeholders.

2.22.3.2 Contractor Internal Monitoring Methods

The Contractor shall have an internal monitoring process for ensuring compliance with program participation requirements.

The Contractor shall report to the OHCA monthly on its compliance monitoring activities, in a format to be specified by the OHCA. The Contractor shall document any self-identified area of non-compliance with participation requirements and shall describe the actions being taken to correct the deficiency. At its discretion, the OHCA may request additional information or require submission of a formal corrective action plan, in accordance with the provisions of section 2.22.4.5, "Corrective Action Plan".

2.22.3.3 Treatment of Self-Reported Deficiencies in Assessment of Damages

In the event that the Contractor identifies and reports an area of non-compliance (deficiency) that falls within a category for which civil monetary damages apply, as described in section 2.22.4.10, "Appointment of Temporary Management," the 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 the OHCA.

The OHCA's standard policy shall be not to waive monetary damages, if applicable, when an area of non-compliance (deficiency) is identified by the OHCA without first being reported by the Contractor.

2.22.3.4 Consideration of Contractor Performance in Auto Assignments

It is the OHCA's intent, starting in year two of the program, to modify the auto assignment algorithm described in section 2.5.2.5, "Auto Assignment," to include data on the Contractor's performance. The revised algorithm will be included as part of a Contract amendment to be issued in accordance with section 2.1.9, "Amendments or Modifications."

2.22.3.5 Consideration of Contractor Performance in Re-Contracting

It is the 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.

2.22.4 Non-Compliance with Participation Requirements

2.22.4.1 Sole Authority

The OHCA shall have sole authority for determining whether the Contractor has failed to comply with Contract participation standards.

2.22.4.2 Potential OHCA Actions for Non-Compliance

The OHCA may take one or more of the following actions in response to the Contractor's non-compliance with participation requirements:

- Require submission of a corrective action plan in accordance with section 2.22.4.5, "Corrective Action Plan";
- Impose intermediate sanctions (penalties) in conformance with requirements of 42 CFR § 438.702, including:
    - Civil monetary penalties in accordance with section 2.22.4.6, "Civil Monetary Penalty",
    - Permitting members to disenroll without cause through a special open enrollment period in accordance with section 2.22.4.7, "Disenrollment of Members without Cause",
    - Suspending all new enrollment, including default enrollment (auto assignments), in accordance with section 2.22.4.8, "Enrollment Suspension",
    - Suspending payment for members enrolled after the effective date of the sanction and until the OHCA or CMS is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to occur, in accordance with section 2.22.4.9, "Payment Suspension for New Members",
    - Appointing temporary management of the Contractor's plan in accordance with section 2.22.4.10, "Appointment of Temporary Management", and/or
- Terminate the Contract in accordance with section 2.1.10, "Early Termination."

2.22.4.3 Notification of Non-Compliance Finding

The OHCA Senior Contracts Coordinator shall notify the Contractor of any finding of non-compliance (deficiency) in writing, in accordance with the provisions of section 2.1.5, "Notices." The notice will:

- Describe the nature of the deficiency, including the specific Contract provision(s) affected;
- Outline required steps to be taken by the Contractor to remedy the deficiency, including the filing of a corrective action plan, if applicable;
- Provide a date by which the deficiency must be remedied;
- Describe the method by which the Contractor shall demonstrate it has remedied the deficiency;
- Identify civil monetary damages to be assessed or other actions to be taken, including appointment of temporary management, suspension of enrollment,

imposition of enrollment caps or scheduling of a special open enrollment period, if applicable; and

- Note whether civil monetary damages, if applicable, are waivable at the OHCA's discretion upon remedying of the deficiency.

2.22.4.4 Appeal of Finding of Non-Compliance

The Contractor may challenge a finding of non-compliance that results in an adverse action, through appeal to the OHCA Administrative Law Judge. Such an appeal must be filed in writing with the Administrative Law Judge Docket Clerk within 20 days of the Contractor's receipt of notice of the adverse action. The appeal will be adjudicated in accordance with the OHCA's administrative rules.

The decision of the Administrative Law Judge may be appealed by either party to the OHCA Chief Executive Officer within 20 days of receipt of the written decision. Appeal to the Chief Executive Officer shall be limited to the record made before the Administrative Law Judge.

2.22.4.5 Corrective Action Plan

As part of a finding of non-compliance (deficiency), the OHCA may direct the Contractor to submit a formal corrective action plan describing how the Contractor will remedy the deficiency. Corrective action plans must be reviewed and approved by the OHCA.

2.22.4.6 Civil Monetary Penalty

The OHCA may impose civil monetary penalties (damages) to recoup actual losses to the program or as liquidated damages. Any civil monetary damages owed by the Contractor will be secured by the OHCA by deducting the amount from the Contractor's capitation payment or via a demand for payment. The deduction, if applicable, will be made from the second capitation payment occurring after issuance of a notice of damages, to allow time for the Contractor to appeal the assessment. Damages may be assessed on a different schedule if requested by the Contractor and agreed to by the OHCA.

2.22.4.7 Disenrollment of Members without Cause

The OHCA, as part of an applicable finding of non-compliance, as identified in section 2.22.4.11, "Schedule of Actions," may permit members to disenroll without cause beyond the time period specified in section 2.5, "Enrollment and Disenrollment." Such members will be permitted to select a new health plan through a special open enrollment.

2.22.4.8 Enrollment Suspension

The OHCA, as part of an applicable finding of non-compliance, as identified in section 2.22.4.11, "Schedule of Actions," may suspend new enrollments into the Contractor's health plan, including auto assignments.

If new enrollments are suspended, the OHCA's Enrollment Choice Counselor will remove the Contractor's health plan from the list of offerings presented to new members. The OHCA, at its discretion, may continue to re-enroll members who lose and regain eligibility within two months, as provided for in section 2.5.2.4, "Re-enrollment Following Loss of Eligibility." The suspension may be for any length of time as specified by the OHCA or may be indefinite.

2.22.4.9 Payment Suspension for New Members

The OHCA, as part of an applicable finding of non-compliance, as identified in section 2.22.4.11, "Schedule of Actions," may suspend payment for members enrolled after the effective date of the sanction until the OHCA or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. The OHCA will define the conditions for lifting of the suspension in writing and will release the suspended funds one business day after notifying the Contractor in writing that the conditions have been satisfied. Release of the funds may be conditioned upon prior approval by CMS.

2.22.4.10 Appointment of Temporary Management

The OHCA, as part of an applicable finding of non-compliance, as identified in section 2.22.4.11, "Schedule of Actions," and subject to the special rules defined in 42 CFR § 438.706, may appoint temporary management of the Contractor's health plan. In such a circumstance, the Contractor shall cooperate fully in the transition process to ensure any disruption to members and providers is minimized.

The 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 members pending the Contractor's termination from the program or remedying of the underlying deficiency. The OHCA shall have the authority to hire staff, execute any instrument in the name of the Contractor and to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party during the temporary management period.

The Contractor shall be responsible for all reasonable expenses related to the direct operation of the health plan, including but not limited to attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor.

2.22.4.11 Schedule of Actions

The OHCA may take action as noted in the table below in response to findings of the Contractor's non-compliance. The OHCA's decision whether to take action shall not relieve the Contractor of its obligation to remedy its non-compliance. The OHCA's decision whether to take action in a previous instance of non-compliance by the Contractor or another health plan shall not restrict the OHCA's freedom to act or not act when adjudicating a new instance of non-compliance.

In addition to the potential actions listed below, the OHCA retains authority to seek other remedies and take other actions as appropriate to ensure compliance, satisfy contractual obligations and/or safeguard members' rights and interests.

Non-Compliance	Potential Actions
Failure to Provide Medically Necessary Services – The Contractor fails to substantially provide medically necessary services to a member that the Contractor is required to provide under law or under the Contract.	• Monetary penalty of up to $25,000 for each failure to provide services • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments
Excess Premiums or Charges – The Contractor imposes premiums or charges that are in excess of those permitted in the program.	• Monetary penalty of up to $25,000, or double the amount of the excess charges (whichever is greater) • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments
Discrimination – The Contractor discriminates among members on the basis of their health status or need for health services.	• Monetary penalty of up to $100,000 for each instance of discrimination • Monetary penalty up to $15,000 for each individual the Contractor did not enroll because of a discriminatory practice, up to the $100,000 maximum • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments

Non-Compliance	Potential Actions
Misrepresentation to State or CMS – The Contractor misrepresents or falsifies information that it furnishes to the State or CMS.	• Monetary penalty of up to $100,000 for each instance of misrepresentation • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments
Misrepresentation to Member Potential Member or Provider – The Contractor misrepresents or falsifies information that it furnishes to a member, potential member or provider or distributes directly, or indirectly through an agent or independent contractor, marketing materials that have not been approved by the OHCA or that contain false or materially misleading information.	• Monetary penalty of up to $25,000 for each instance of misrepresentation • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments
Failure to Comply with Medicare Physician Incentive Plan Requirements – The Contractor fails to comply with Medicare Physician Incentive Plan requirements	• Monetary penalty of up to $25,000 for each failure to comply • Appointment of temporary management • Granting members the right to disenroll without cause • Suspension of new enrollments • Suspension of payments for new enrollments
Failure to Reconcile Enrollment Data – The Contractor fails to perform monthly member reconciliation as described in section 2.21.5, "Capitation Reconciliation."	• 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 • Monetary penalty of up to $5,000 per day that the Contractor remains

Non-Compliance	Potential Actions
	out-of-compliance with reconciliation requirement
Failure to Submit Monthly Encounter Data Timely – The Contractor fails to submit data in accordance with program timeliness standards.	• For failure to submit by the tenth of the month, a monetary penalty equal to 15 percent of capitation paid for the month previous to the month for which the encounter data was due • For submission of any encounter data after the tenth of the month following 120 days after the end of the month in which the encounter occurred, a monetary penalty equal to one dollar per encounter claim per day the encounter is late, not to exceed the capitation paid for the month previous to the month for which the encounter data was due
Failure to Submit Accurate Encounter Data – The Contractor fails to submit data in accordance with program accuracy standards, as determined through bi-annual (every six months) encounter validation studies.	• For error rate of 5.1 to 7.0 percent: 5 percent of capitation paid in validation study period • For error rate of 7.1 to 10 percent: 10 percent of capitation paid in validation study period • For error rate of 10.1 percent or greater: 15 percent of capitation paid in validation study period
Failure to Submit Mandatory Reports – The Contractor fails to submit mandatory report, other than encounter data report, timely and/or accurately. For purpose of this penalty, corrective action plans are considered to be reports.	• Monetary penalty up to $2,500 per business day that any report is delivered after the date it is due, or includes less than the required information or is not in the approved media or format

Non-Compliance	Potential Actions
Failure to Meet Other Participation Requirements – The Contractor fails to meet a program participation requirement delineated in section 2 of the Contract. For purpose of this penalty, failure to complete a corrective action plan timely is considered to be a failure to meet participation requirements.	• Monetary penalty up to $5,000 per day that the Contractor remains out-of-compliance with participation requirement • Granting members the right to disenroll without cause • Suspension of new enrollments and associated payments for new enrollments

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: _____

Section 3 – Solicitation Guidelines

3.1 Overview

This section presents proposal submission requirements for Solicitation Number 8070000933. The submission requirements have been developed to identify organizations with the necessary experience, capacity and processes to deliver high quality, cost effective services to SoonerHealth+ Program members.

In conducting this solicitation, the OHCA reserves the right to:

- Reject any bids that do not comply with the requirements and specifications of the solicitation. A bid may be rejected when the Bidder imposes terms or conditions that would modify the requirements of the solicitation or limit the Bidder's liability to the State. Other possible reasons for rejection are listed in OAC 580:16-7-32.
- Waive minor irregularities in proposals if determined to be in the best interest of the State. If granted, the waivers will in no way modify the requirements of the solicitation or the obligations of Bidders awarded Contracts;
- Award a Contract based on this solicitation and the proposals of selected Bidders;
- Request clarification or correction of proposals;
- Reject any or all proposals received; or
- Cancel this solicitation, if determined to be in the best interest of the State.

3.1.1 One Proposal

Bidders may submit only one proposal in response to this solicitation. Bidders may withdraw and resubmit a proposal at any time prior to the submission deadline.

3.1.2 Strict Due Date and Time

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

3.1.3 Withdrawal from Solicitation

Bidders may withdraw proposals and remove themselves from consideration by providing written notification to the OHCA sole point of contact at any time prior to the submission deadline. The OHCA Sole Point of Contact is provided in section 1.2.2, "OHCA Sole Point of Contact."

3.1.4 Binding Proposals

Bidders whose proposals are accepted for evaluation will be bound by the terms of the solicitation and the contents of the proposals for the duration of the solicitation. Bidders

awarded a Contract will be governed by the terms outlined in section 2.1.3, "Legal Contract."

3.1.5 Property of the State

All material submitted by Bidders becomes the property of the state of Oklahoma and will be a matter of public record, subject to the procedures for treatment of proprietary information, as described in section 3.5.3, "Proprietary Information." The OHCA shall have the right to use all concepts described in proposals, whether or not such proposals are accepted.

3.2 Non-Binding Letter of Intent

Potential Bidders are invited to submit a non-binding letter of intent by the date and time specified in section 1.3, "Solicitation Timeline." Submission of a letter will guarantee receipt of communications regarding the procurement. (Communications also will be posted to the Bidder's Library.) Letters of intent must be submitted to the individual identified in section 1.2.2, "OHCA Sole Point of Contact." Letters of intent may be submitted by mail, fax or email.

The letter of intent must identify a bidder's sole point of contact for receipt of communications related to the solicitation and provide the individual's telephone, fax, mail and email contact information.

3.3 Submission of Questions

Bidders may submit written questions by email only to the OHCA sole point of contact. Questions must be submitted using Form 8070000933-A-Questions included in the Bidder's Library. The form must be submitted in original Excel format.

Questions may be submitted at any time prior to the proposal deadline. The OHCA will provide written answers to all technical proposal and price questions received on or before the dates specified in section 1.3, "Solicitation Timeline." Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library.

The OHCA, at its sole discretion, may answer questions submitted after the deadline for inclusion in the second question and answer round. Such answers, if provided, will again be posted in the form of a solicitation amendment to the Bidder's Library.

3.4 Actuarial Bidders' Conference

The OHCA will hold an actuarial bidder's conference at the OHCA offices on the date and time specified in section 1.3, "Solicitation Timeline." Additional information about the bidder's conference will be provided in advance of the session.

3.5 Proposal Structure & Submission Requirements

3.5.1 Hard Copy Proposals

Bidders must submit ten hard copy proposals. One proposal must be marked as "Original" on the cover and must contain original signatures from an individual with authority to bind the organization to the terms of the solicitation.

Proposals must be submitted in sturdy three-ring binders that are not susceptible to breakage. The OHCA will not be responsible for reassembling and evaluating proposals whose contents were separated from the binders prior to receipt and opening.

Hard copy proposals must include on both the cover and spine:

- Bidder's name and address;
- Solicitation number and SoonerHealth+ Program; and
- The volume number and the sequential page numbers contained within the binder, if multiple volumes are submitted.

3.5.2 Electronic Proposals

Bidders must submit ten virus-free CD-ROMs, each containing a complete proposal. CD-ROMs must be labeled with the solicitation number and Bidder's name.

Bidders must create two folders on each CD-ROM, labeled "Technical Proposal" and "Excel Proposal Forms".

The Technical folder must hold a single PDF file containing the entire technical proposal. The file must be named "Solicitation 807000933 - [Bidder Name] – Technical Proposal".

The Excel Proposal folder must contain the OHCA-furnished Microsoft Excel technical proposal forms in the original file format. Each form must retain its original name as provided by the OHCA, followed by the Bidder's name (e.g., "Form 8070000933-C-Bidder Representations-Bidder Name"). It is not necessary to provide Microsoft Word-format proposal submission forms separate from the technical proposal.

3.5.3 Proprietary Information

Documents and information bidders submit, as part of or in connection with a solicitation, are public records and subject to disclosure, unless otherwise specified in applicable law. Bidders claiming any portion of their bid as proprietary or confidential must specifically identify what documents or portions of documents they consider confidential and submit an additional electronic and hard copy of the bid with this information redacted (marked out to be illegible). The additional copies should be clearly labeled "Redacted Copy". The OHCA shall make the final decision as to whether the documentation or information is confidential.

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

3.5.4 Inconsistencies in Proposals

Bidders are responsible for ensuring all proposals contain the same information. Submission of proposals with inconsistent content may be treated as a failure to submit one proposal and may be grounds for disqualification. In the event of an inconsistency that does not result in disqualification, the "Original" hard copy proposal will be the controlling version.

3.5.5 Proposal Delivery

Proposals must be delivered to the following location on or before the submission deadline specified in section 1.3, "Solicitation Timeline":

Oklahoma Health Care Authority
4345 North Lincoln Boulevard
Oklahoma City, OK 73105
ATTN: Sheila Killingsworth

All containers must be labeled with the Bidder's name and address and the solicitation name and number.

In addition to the hard copy and electronic proposals, Bidders must arrange for submission of completed reference forms directly to the OHCA in accordance with the instructions provided in section 3.6.2, "Technical Proposal Contents." Reference forms must be received prior to the submission deadline to be considered in the evaluation. The Bidder is solely responsible for ensuring delivery of forms. The OHCA is not responsible for forms lost in the mail or otherwise not received by the deadline.

3.5.6 Opening of Proposals

Sealed bids shall be opened by the OHCA located at 4345 North Lincoln Boulevard, Oklahoma City, OK 73105 at the time and date specified in the solicitation as the Response Due Date and Time.

3.6 Technical Proposal Requirements

3.6.1 Format

Technical proposals must conform to the following formatting requirements:

- Proposals must be on standard-sized 8 ½ by 11-inch paper and printed on one side only.
- Proposal header must include the solicitation number and the Bidder's name.
- Proposal footer must include a page number. Pages must be numbered sequentially, beginning with the transmittal letter and continuing to the end of the technical proposal. Pages must run 1, 2, 3 etc., without starting over and with no section or question prefixes. It is not necessary to erase page numbers on pre-printed documents, such as solicitation amendments, as long as the sequential page numbering is visible. The original worksheet files included in electronic format in the CD-ROM Excel Proposal Forms folder do not require page numbers that align with the consolidated hard copy and PDF versions.
- Narrative submission responses must be in 12-point or greater Calibri or Times New Roman font, with a minimum of one-inch margins and 1.15 line spacing.
- Wording in any exhibits included or attached to proposal narrative must be in 8-point or greater font.
- Each hard copy submission response should be separated by a tab denoting the submission item number.
- Narrative submission responses should begin by restating the submission requirement number (i.e., Item Number) and bold-faced title. It is not necessary to restate the question.
- Page limits, where applicable, are noted at the end of a submission requirement. Page limits include headers, footers and titles. Page limits also apply to exhibits and attachments, unless otherwise specified. The OHCA will not review material outside of page limits.

- Handwritten edits in ink are permissible, if initialed by the same individual signing the transmittal letter.

3.6.2 Technical Proposal Contents

The Technical Proposal must contain the elements listed below, in the order shown. Mandated forms/templates are included in Appendix 4.4 of the solicitation and in the Bidder's library.

In preparing technical proposals, Bidders are encouraged to:

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

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

- Address diversity within and (if applicable) across regions when describing challenges to, and strategies for, meeting program requirements, including but not limited to differences between urban and rural areas;

- Discuss innovative programs and best practices implemented in other states or for other Oklahoma populations that also will be offered to the SoonerHealth+ population; and

- 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.

ITEM	INSTRUCTIONS
1	**Bidder Proposal Submission Checklist** Complete and include a copy of **Form 8070000933-B-Bidder Proposal Submission Checklist.** Indicate whether each submission item is included by checking "Yes" or "No". If you check "No" 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 your proposal as non-responsive. (Page Limit: N/A.)
2	**Transmittal Letter** Include a 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: • Solicitation number, Bidder's address and FEIN. • Single point-of-contact for ongoing communication. This can be the same individual identified in the Letter of Intent or a different individual. • A statement attesting to the accuracy and truthfulness of all information contained in the proposal; • A statement that the Bidder is willing to enroll and serve all of the member types described in the solicitation as eligible for inclusion in the program; • A statement indicating whether the Bidder is proposing to serve the West Region only, East Region only or is submitting a statewide bid, and in the event of statewide bid, an acknowledgement that the bidder understands the OHCA will make awards by Region and it is possible the bidder may receive an award for one Region only; • A statement that the entity proposing to contract with the OHCA is located inside the United States; and • A statement that the Bidder has reviewed and accepts the SoonerHealth+ capitation rates and methodology for updating the rates. The letter also must include either: • A statement that the Bidder has read, understands and is able and willing to comply with all standards and participation requirements described in the solicitation; or • A statement specifying any objections the Bidder has to one or more solicitation terms or conditions.

ITEM	INSTRUCTIONS
	The OHCA reserves the right to disqualify a proposal with objections on the grounds of non-responsiveness. Even if the OHCA does not disqualify a proposal, it makes no commitment to modifying terms and conditions based on the Bidder's objections. (Page Limit: N/A.)
3	**Solicitation Amendments** Include a signed cover page from each RFP amendment. (Page Limit: N/A.)
4	**OMES- and OHCA-Mandated Representations and Certifications** Include completed **OMES-CP-004 (Certification for Competitive Bid and/or Contract), OMES-CP-076 (Responding Bidder Information)** and **Form 8070000933-C-Bidder Representations and Certifications**. Note that Form 8070000933-C consists of both a Word document and Excel File ("companion templates"). Include a hard copy of the Excel file content immediately behind Form 8070000933-C. 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. OMES-CP-004, OMES-CP-076 and Form 8070000933-C include signature requirements. The forms should be signed by the same individual signing the Bidder's Transmittal Letter. (Page Limit: N/A.)
5	**Executive Summary** Include an Executive Summary of your proposal to serve SoonerHealth+ members. The Executive Summary should describe your approach to delivering person- and family-centered care and should highlight your strengths with regard to meeting solicitation requirements and advancing the stakeholder principles outlined in section 1.1.2, "SoonerHealth+ Program." Information included in the Executive Summary may be used by the OHCA when preparing public announcements concerning solicitation awards. (Page Limit: 4 pages.)
6	**Regions** Include **Form 8070000933-D- SoonerHealth+ Regions**, identifying the portions of the State you are proposing to serve under a SoonerHealth+ Contract. The regions must match the regions identified in your transmittal letter. Note that the form also requires identification of any counties in which you are not currently licensed. (Page Limit: N/A.)

ITEM	INSTRUCTIONS
7	**Oklahoma Experience** Describe your organization's experience in the State of Oklahoma serving publicly- and privately-funded populations. For purpose of responding to this item, the organization must be the same one identified in Form 80700009330-E. Provide examples (as applicable) of innovative and person-centered programs/initiatives implemented for Oklahoma populations, results achieved and how these programs/initiatives will be integrated into your strategy for serving SoonerHealth+ members who enroll with you. Limit your examples to calendar year 2012 or later. Describe your status with respect to participation as a payer partner in the CPC+ program. Also include **Form 8070000933-E-Oklahoma Experience**. (Page Limit: 5 pages, excluding Form 8070000933-E.)
8	**Oklahoma Medicare Advantage Expansion** Describe your organization's plans for offering Medicare Advantage products in geographic areas of Oklahoma not currently served. Describe both any pending application and any applications you intend to submit in 2017 for the 2018 contract year. In your response: • Specify the product types being offered and/or to be offered; • Current enrollment by product type, including dual eligible enrollment; • Describe status of network development activities for expansion areas; and • Identify subcontractor roles within your plan(s). Also provide examples (as applicable) of innovative and person-centered programs/initiatives implemented in Oklahoma for existing Medicare product(s), results achieved and how these programs/initiatives will be integrated into your strategy for serving SoonerHealth+ members who enroll with you for both Medicare and Medicaid services. Limit your examples to calendar year 2012 or later. (Page Limit: 5 pages.)
9	**Other State Medicaid and Medicare Experience** Describe your organization's experience serving the populations covered under the SoonerHealth+ Program in other states. Address both Medicaid and Medicare experience. For purpose of responding to this item, the organization(s) may include any and all of the entities identified in Form 80700009330-F.

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	As part of your response, provide examples (as applicable) of innovative and person-centered programs/initiatives implemented in other states and results achieved. Describe their relevance to the SoonerHealth+ program, potential barriers to implementation in Oklahoma and how you intend to overcome these barriers when implementing them for the SoonerHealth+ population. Limit your examples to calendar year 2012 or later. Also include **Form 8070000933-F-Other State Medicaid and Medicare Experience**. (Page Limit: 6 pages, excluding Form 8070000933-F.)
10	**Benchmark Contracts (Programs)** Identify up to three contracts from the information presented on proposal submission forms 8070000933-E and 8070000933-F, to serve as benchmark programs for the remainder of your proposal, and describe the basis for their selection. At least one of the benchmark programs should be from Oklahoma, if applicable. For the Commercial-Group and Commercial-Individual categories only, selection of one (or both) as a benchmark means all contracts of that type are to be included together for data reporting purposes. For example, all Commercial-Group contract data would be reported in aggregate and treated as one benchmark program. Select contracts from other states that are most similar to SoonerHealth+, in terms of populations served and capitated benefits, and for which you have performance data that can be shared in your proposal. Do not select any programs for which your contract has ended or in which you have operated for less than two years, unless necessary to reach the three-program benchmark limit. Do not select more than one contract per state, unless necessary to reach the three-program benchmark limit. Note: When you are asked to provide performance data specific to one or more benchmark programs in a proposal submission form, and data either is not available or cannot be shared, enter N/A. Do not include data for a non-benchmark contract unless explicitly permitted in the submission instructions. Since inability to provide data may negatively affect a bidder's evaluation results, bidders are encouraged to select benchmarks for which data is available and can be shared. (Page Limit: 3 pages.)

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11	**References** Include **Form 8070000933-G.1-Identification of Bidder References**, identifying the individual from the contracting agency within each benchmark program who will serve as a reference for your organization. The individual should be provided with a copy of **Form 8070000933-G.2-Oklahoma SoonerHealth+ Program Reference**, to complete and return directly to the OHCA prior to the proposal submission deadline. The form must be returned using one of the methods provided for in the form instructions. If one of your benchmarks is "Oklahoma Commercial", the individual reference must be from one of your three largest commercial customers, in terms of covered lives. If one of your benchmarks is "Oklahoma Individual", do not submit a reference for this benchmark. (Bidders with an Oklahoma Individual benchmark will have a maximum of two references.) (Page Limit: N/A.)
12	**Insurance** Describe how you intend to meet the reinsurance requirements outlined in model Contract section 2.1.22.4, "Reinsurance." (Page Limit: 1 page.)
13	**HMO License** Include a copy of your HMO license (Certificate of Authority), in accordance with the requirements outlined in model Contract section 2.2.1, "Licensure." If you are not currently licensed in all Oklahoma counties within the Region(s) being bid, as denoted on Form 8070000933-D-SoonerHealth+ Regions, describe your plan for obtaining region-wide or statewide licensure and provide the date by which this is anticipated to occur. Note that you must be licensed in all counties of the region(s) you bid at time of Contract awards to receive an award. (Page Limit: 2 pages, excluding HMO license. If licensed statewide, do not submit a narrative.)
14	**Major Subcontractors** Identify the services to be furnished by major Subcontractors, as defined in model Contract section 2.2.2.2, "Subcontractors." As part of your response, discuss: • How you will monitor major Subcontractor activity;

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	• Frequency and nature of communication with major Subcontractors; and • Your process for addressing identified deficiencies. In addition, provide an example from one of your benchmark programs of a performance issue you addressed with one of your Subcontractors, including how the issue was identified, the corrective actions undertaken and the resolution. Limit your example to calendar year 2012 or later. Also include **Form 8070000933-H-Major Subcontractors** for each applicable Subcontracting organization. (Page Limit: 3 pages, excluding Form 8070000933-H.)
15	**Policies and Procedures** Describe your process and timeline for development and internal approval of policies and procedures necessary for operation of the plan in accordance with SoonerHealth+ Program requirements outlined in model Contract section 2.1.33, "Policies, Procedures and Related Materials." (Page Limit: 3 pages.)
16	**Organization Charts** Describe the organizational structure for your SoonerHealth+ plan, including the relationship to other Oklahoma lines of business and to a corporate parent, as applicable. Also provide: - Chart of SoonerHealth+ plan showing functions, staff types and reporting relationships. Identify functions located within and outside of Oklahoma and functions performed by Subcontractors; and - Chart depicting SoonerHealth+ plan's relationship to parent and affiliate plans, as applicable. (Page Limit: 2 pages, excluding charts.)
17	**Board of Directors** Identify the Board of Directors for your SoonerHealth+ plan and provide a biographical description for each board member. (Page Limit: 3 pages.)

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18	**Plan Management** Describe your plan management structure and include a copy of **Form 8070000933-I-Plan Management** identifying the individuals who will serve in the designated positions, if known. Also: - Identify any positions that will be located out-of-state, explain the basis for this decision and describe how you will ensure the individual(s) duties are properly fulfilled; - Include a job description for each position denoted on Form 8070000933-I that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable; and - Include a current resume for each of the individuals identified on Form 8070000933-I-Plan Management. Resumes must include at least the following information: Summary of relevant experience; work history up to the present time; educational history; and licenses/credentials, if applicable. (Page Limit: 3 pages, excluding Form 8070000933-I, job descriptions and resumes.)
19	**Staffing** Describe your staffing plan for the SoonerHealth+ Program and your basis for determining required numbers of staff by position type. Also include a copy of **Form 8070000933-J-Plan Staffing** denoting the estimated number of plan staff, by position, along with a job description for each position denoted on Form 8070000933-J that includes at least the following information: position responsibilities; reporting relationship; educational and experience requirements; and license/credential requirements, if applicable. Note that a final version of the plan will be required in event of Contract award in accordance with model Contract section 2.2.3.6, "Staffing Plan and Implementation Plan." (Page Limit: 3 pages, excluding Form 8070000933-J and job descriptions.)
20	**Location of Staff within Oklahoma** Identify your existing and proposed office locations within the State and the locations of other field-based staff, if applicable (i.e., if staff will be working from virtual offices) and describe your basis for selecting these locations. Include a region- or state-level map denoting the locations. (Page Limit: 3 pages, excluding map.)

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21	**Economic Impact** Describe how your organization will contribute to the Oklahoma economy, in terms of jobs created specifically for this Contract. Also include a copy of **Form 8070000933-K-Economic Impact** documenting the estimated economic impact of your proposed Oklahoma-based staff. (Page Limit: 2 pages, excluding Form 8070000933-K.)
22	**Advisory Boards** Describe your relevant experience establishing member and provider advisory boards in your benchmark programs and the proposed structure and composition of your SoonerHealth+ Member Majority Advisory Board. Discuss the steps you will take to identify, recruit and encourage participation by plan enrollees. Also, provide two examples of issues brought before the member or provider advisory board(s) in benchmark program(s), actions taken based on recommendations from the board(s) and results achieved. Limit your examples to calendar year 2012 or later. In addition, as part of the response, you may include a letter of reference from an advisory board member in a benchmark program. The letter, if included, should discuss the board member's experience in terms of having meaningful input into plan decision making and the board member's opinion of the plan's level of inclusiveness with respect to soliciting and acting on the recommendations of stakeholders. (Page Limit: 4 pages, excluding letter of reference.)
23	**Implementation Plan** Address your plan for implementation through all of the following: • Identify key implementation activities and describe your approach for ensuring these activities will be completed prior to the onsite readiness review scheduled to occur approximately 90 days prior to go live; • Discuss potential barriers to timely implementation and your process for addressing these barriers; • Discuss the results of readiness reviews conducted in benchmark programs, if applicable, including any functions that failed at the time of the review and any corrective action plans issued as a result. If none of the benchmark programs included a readiness review in calendar year 2012 or later, discuss your most recent readiness review (any program); and • Include an implementation work plan created in Microsoft Project or

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	equivalent format that presents major implementation milestones and associated tasks by functional area between proposal submission and 90 days post-go live. (The format specification is for presentation purposes only; the implementation plan should be submitted as part of the larger PDF proposal.) The work plan should be in sufficient detail to serve as a management tool for tracking implementation progress in the event of Contract award. Note that a final version of the plan will be required in event of Contract award in accordance with model Contract section 2.2.3.6, "Staffing Plan and Implementation Plan." (Page Limit: 7 pages, excluding work plan.)
24	**Inclusion of Individuals with ID** Describe your relevant experience serving individuals with intellectual disabilities and the steps you will take to prepare for inclusion of individuals with ID receiving state plan services at the beginning of the SoonerHealth+ program and IID waiver members one year after the start of the program. As part of your response, discuss: • How the needs of individuals with ID differ from other SoonerHealth+ members and how this will inform your activities in areas such as member services, provider network development, care and disease management and quality improvement; • Challenges to serving members who are receiving state plan services and are on the waiver waiting list and how you will address these challenges as part of your care management strategy; and • Major activities associated with transitioning IID waiver members into SoonerHealth+ in program year two, potential barriers to an effective transition and how you will address these barriers. In addition, provide an example from one of your benchmark programs (if applicable) of an innovative approach you took to enhancing person/family-centered care for individuals with ID, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 8 pages.)
25	**Inclusion of Residents of Long Term Care Facilities** Describe your relevant experience serving residents of long term care facilities and the steps you will take to prepare for their inclusion two years after the start of the SoonerHealth+ program. As part of your response, discuss: • How the needs of residents of long term care facilities differ from their counterparts receiving HCBS and how this will inform your activities in areas

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	such as member services, care and disease management and quality improvement; • Challenges to identifying members who may be candidates for placement in the community and your strategy for identifying these members and managing a successful placement; and • Major activities associated with transitioning residents of long term care facilities into SoonerHealth+ in program year three, potential barriers to an effective transition and how you will address these barriers. In addition, provide an example from one of your benchmark programs (if applicable) of an innovative approach you took to enhancing person/family-centered care for residents of long term care facilities, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 6 pages.)
26	**Benefits: Capitated Benefits** Identify any capitated benefits specified in model Contract section 2.4, "Capitated and Non-Capitated Benefits" that you do not have experience offering on a risk basis and describe how you will prepare as an organization to deliver the benefits in accordance with model Contract requirements. (Page Limit: 3 pages.)
27	**Benefits: Value-Added Benefits** Identify any value-added benefits you propose to offer to SoonerHealth+ members and the basis for their selection. Complete **Form 8070000933-L-Value-Added Benefits** specifying expected utilization and cost of each benefit, as well as any limits in terms of eligible populations, service caps and/or prior authorization requirements. Note that Form 8070000933-L must be signed by the actuary attesting to the actuarial value estimate. (Page Limit: 3 pages, excluding Form 8070000933-L.)
28	**Enrollment: New Member Contact Rates** Describe your relevant experience and proposed approaches for conducting outreach to new members and making initial contact in accordance with requirements outlined in model Contract section 2.5.3, "Outreach to New Members." As part of your response discuss:

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	• How you will undertake and track initial contact efforts; • SoonerHealth+ population segments most likely to be "hard-to-contact" and steps you will take to reach hard-to-contact members; • How you will manage distribution of member materials; and • Initial member education activities. In addition, provide an example from one of your benchmark programs of an innovative approach you took to improve contact rates among hard-to-contact member segments, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. Also include a copy of **Form 8070000933-M-New Member Contact Rates**. (Page Limit: 6 pages, excluding Form 8070000933-M.)
29	**Enrollment: PCMH Provider Selection and Assignment** Describe your relevant experience and proposed approach for aligning members with appropriate PCMH providers in accordance with requirements outlined in model Contract section 2.5.4, "PCMH Selection and Assignment." As part of your response discuss: • Whether you will allow members an opportunity to select a PCMH provider prior to making an assignment; • Whether you will align dual-eligible members with a PCMH provider; • How you will educate members about their PCMH options; • Criteria you will apply in making assignments; and • How you will monitor trends with regard to PMCH changes and use the data as part of network management activities. In addition, provide an example (if applicable) from one of your benchmark programs of an innovative approach you took to identify and align members with special needs with an appropriate PCMH provider, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 4 pages.)
30	**Enrollment: Primary Care Dentist (PCD) Selection and Assignment** Describe your relevant experience and proposed approach for aligning members with appropriate PCMH providers in accordance with requirements outlined in model Contract 2.5.5, "Primary Care Dentist (PCD) Selection and Assignment." As

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	part of your response discuss: • Whether you will allow members an opportunity to select a PCD provider prior to making an assignment; • Whether you will align adult members with a PCD provider; • How you will educate members (parents/guardians) about their PCD options; • Criteria you will apply in making assignments; and • How you will monitor trends with regard to PCD changes and use the data as part of network management activities. In addition, provide an example (if applicable) from one of your benchmark programs of an innovative approach you took to identify and align members under the age of 21 with special needs with an appropriate PCD provider, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 4 pages.)
31	**Enrollment: NF or ICF/ID Level-of-Care Eligible Members** Describe your relevant experience and proposed approach for identifying members enrolled in your plan who may be nursing facility or ICF/ID level-of-care eligible and residing in the community, in accordance with requirements outlined in model Contract section 2.5.1.3, "Nursing Facility Level of Care and Special Health Care Needs." As part of your response, discuss: • How assessment data will be used in the identification process; • How network providers will be engaged in the identification process; and • How members and their families will be educated about their potential eligibility and next steps. (Page Limit: 3 pages.)
32	**Enrollment: New Member Case Study (Rebecca)** Rebecca is a 24-year-old SoonerHealth+ member enrolled effective June 1. Rebecca was auto-assigned to your plan. Her enrollment information did not include a phone number and listed an Oklahoma City area homeless shelter as her last place of residence. Rebecca left the shelter on May 25 and the shelter does not know her current whereabouts. Describe how you will attempt to contact Rebecca by July 1. (Page Limit: 3 pages.)

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33	**Transition of Care: Initial Period** Describe your relevant experience and proposed approach for completing initial transition of care activities in accordance with requirements outlined in model Contract section 2.6.3, "Transition of Care Period." As part of your response, discuss: • How you will capture existing service authorizations in your medical management system and ensure they are honored during the transition period; • How you will share data and coordinate with other plans and non-network service providers; • How you will monitor compliance with transition of care screening and assessment timeframes; and • Any differences in your approach, based on population type, as applicable. (Page Limit: 4 pages.)
34	**Transition of Care: Member with Existing Care Plan Case Study (Duane)** Duane is a 20-year-old SoonerHealth+/medically fragile waiver member transitioning into your plan from another SoonerHealth+ plan. He has quadriplegia as the result of a motor vehicle accident one year ago. Duane has an existing care plan that authorizes a number of in-home services, including registered nurse, registered dietician, personal assistance services, physical therapy, occupational therapy and respite care for his mother, with whom he lives. He has an existing case manager who oversees his care plan and arranges for and monitors all of his services. As a result of his condition, Duane has a primary care provider, neurologist, pulmonologist, orthopedist and behavioral health provider who he must see for ongoing follow-up. Duane requires wheelchair transport to and from all of his appointments. His current neurologist and pulmonologist are not in the plan network. Describe the transition of care process you will employ to ensure Duane does not experience any disruption in services. As part of your response, address the transition of care timeline, member outreach activities, care manager-to-care manager interactions and service continuity, including network development/management activities. (Page Limit: 4 pages.)

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35	**Transition of Care: Hospital-to-Home Case Study (Sheila)** Sheila is a 42-year-old Medicaid-only SoonerHealth+ member transitioning from the hospital to home after hip replacement surgery. Approximately one month ago, Sheila was diagnosed with Type 2 diabetes, which has been complicated by the stress of her surgery. Sheila also is obese and has hypertension. She is a single mother of two school-age children who reside at home with her. She has a sister who will be staying with her while she recovers. Sheila will require medication adjustments for her diabetes and hypertension when she returns home. She will need physical therapy and follow-up visits to her orthopedic surgeon and PCMH provider. Describe the transition of care process you will employ for Sheila. As part of your response, address member outreach, discharge planning and post-discharge activities. (Page Limit: 4 pages.)
36	**Member Services: Accessibility** Describe your relevant experience and proposed approach to ensuring that member services are accessible to all plan enrollees, including members with disabilities, in accordance with requirements outlined in model Contract section 2.7, "Member Services." As part of your response, discuss: • How you will ensure distribution of member materials in compliance with timeliness standards; • How you will meet in-office interpreter requirements; • How you will monitor your provider network for compliance with ADA requirements; and • How you will ensure compliance with SoonerHealth+ cultural competency requirements. In addition, provide an example from one of your benchmark programs of an innovative approach you took to make member services accessible to members with disabilities, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)

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37	**Member Services: Call Center** Describe your relevant experience and proposed approach to operating a call center, in accordance with the requirements outlined in model Contract section 2.7.8, "Member Services Call Center." As part of your response, discuss: • Call center location(s) and hours of operation; • How you will train call center staff; • How you will monitor compliance with performance standards and address staffing needs during unanticipated spikes in volume; and • Whether you will operate a combined call center for member and provider services. If not, briefly describe your proposed provider service call center structure. Also include a copy of **Form 8070000933-N-Call Center Performance**. (Page Limit: 5 pages, excluding Form 8070000933-N.)
38	**Member Services: Social Media** Describe your relevant experience and proposed approach to using social media and mobile applications to enhance communications with members. As part of your response, discuss: • The types of social media applications and platforms you will employ; • How social media will be tailored to the different SoonerHealth+ populations; • How you will monitor member use and responsiveness to social media; and • How you will ensure compliance with HIPAA requirements when interacting with members. In addition, provide an example from one of your benchmark programs of an innovative approach you took to improve member health outcomes through social media, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
39	**Member Services: Member Care Support Staff** Describe how you will use Member Care Support Staff to assist members in the areas outlined in model Contract section 2.7.13, "Member Advocacy." (Page Limit: 3 pages.)

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40	**Member Services: Member Service Case Study (Keisha)** Keisha is a 10-year-old member residing in Oklahoma City who acquired Methicillin Resistant Staphylococcus Aureus (MRSA) as a result of an immune deficiency. She has a wound infection on her leg with drainage. Her treatment plan includes dressing changes, around the clock antibiotics, infection control and fever management. Keisha has been on antibiotics for four days and her fevers have started to subside. Unfortunately, when Keisha's mother, Teri, wakes Keisha up Saturday evening at 11:00 pm to give her a dose of the antibiotic, she realizes she forgot to refill the prescription and the bottle is empty. Teri calls the Member Services line for assistance in getting a refill. Describe what will happen when Teri calls Member Services and how Keisha will obtain the medication. (Page Limit: 3 pages.)
41	**Provider Network: Network Development** Describe your relevant experience developing a network to serve the populations covered under SoonerHealth+ and your network development activities to date, including assessment of needs, credentialing and contracting, to ensure compliance with access standards outlined in model Contract section 2.8.3, "Network Access Standards" at time of readiness review. Also discuss: • What you consider to be the most significant challenges to developing a complete provider network throughout the region(s) being bid; • Innovative network development strategies you have employed in other programs and how you will implement these strategies for your SoonerHealth+ network to overcome identified challenges; and • How you will address gaps and barriers to care where there are no providers in a geographic area. Include a copy of **Form 8070000933-O-Network Summary and Rosters** denoting your current provider and case management agency contracts by provider/agency type. Note that Form 8070000933-O is an Excel worksheet with multiple tabs, each of which must be completed. Include Form-8070000933-O-Network Summary tab in your hard copy proposal. Print pages down and then across, so that all provider types for a group of counties are shown before data for the next group of counties is presented.

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	It is not necessary to include other Form 8070000933-O tabs (detail provider listings) in your hard copy proposal. Include these tabs in your electronic proposal only. (Page Limit: 6 pages, excluding Form 8070000933-O network summary tab.)
42	**Provider Network: Network Management** Describe your relevant experience and proposed approach to preparing the network to serve SoonerHealth+ members and for ongoing network management in accordance with model Contract section 2.9.6, "Provider Services." As part of your response, discuss: • Network education and training activities prior to go live; • Assessment of provider readiness prior to go live; • Collaboration with providers to meet performance-based contracting targets; and • Methods for ongoing monitoring of network compliance with program requirements. In addition, provide an example from one of your benchmark programs 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 SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
43	**Provider Network: Monitoring Compliance with Access Standards** Describe your relevant experience and proposed approach for monitoring compliance with access standards and how you will respond to gaps identified through monitoring activities. Also, for each of your benchmark programs, indicate whether you have ever been found to be out-of-compliance with minimum network standards by the contracting entity or regulatory agency. If yes, discuss the most recent example, the steps taken to resolve the deficiency and the current status of the network. In addition, provide an example from one of your benchmark programs of an innovative approach you took to close a network gap, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar

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	year 2012 or later. (Page Limit: 4 pages for experience and process; 1 page for each benchmark program deficiency description, if applicable.)
44	**Provider Network: Updating of Provider Listings** Describe your relevant experience and proposed approach for ensuring the timely and accurate updating of provider listings in accordance with the requirements outlined in model Contract section 2.8.1.5, "Monthly Network Provider Listing." Discuss whether you have received a deficiency or corrective action notice related to provider rosters in any program in calendar year 2012 or later and your response (not limited to benchmark programs). (Page Limit: 2 pages for experience and process; 2 pages for deficiency/corrective action discussion, if applicable.)
45	**Provider Network: HCBS Provider Education** Describe your relevant experience and proposed approach to educating HCBS providers about managed care and assisting these providers to comply with plan requirements concerning prior authorization, claims payment, encounter submissions, EVV usage and quality-related data reporting. (Page Limit: 3 pages.)
46	**Provider Network: Telehealth** Describe your relevant experience and proposed approach for using telehealth to expand access to specialty/referral services. As part of your response, discuss: • Any telehealth initiatives you are undertaking in partnership with network provider(s); • Services to be targeted for telehealth; and • Geographic areas to be targeted for telehealth. In addition, provide an example from one of your benchmark programs of an innovative approach you took to expanding network capacity/access to care through telehealth, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 4 pages.)

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47	**Provider Network: Patient Centered Medical Home Model** Describe your relevant experience and proposed approach for meeting the Patient Centered Medical Home requirements outlined in model Contract section 2.9.4.4, "Requirements for Specific Provider Types." As part of your response, discuss: • Your PCMH payment structure; • How PCMH use of evidence-based practices will be encouraged and monitored; • How you will support the PCMH through use of health information technology; and • How you will encourage PCMH participation on Interdisciplinary Teams. In addition, provide an example from one of your benchmark programs of an innovative approach you took to support PCMH activities and quality of care through use of health information technology, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2014 or later. (Page Limit: 5 pages.)
48	**Provider Network: Performance-Based Provider Contracts** Describe your relevant experience and proposed approach for meeting the performance-based provider payment thresholds outlined in model Contract section 2.9.5.9, "Performance Based Provider Payments." As part of your response: • Separately discuss PCMH, specialist, hospital and HCBS providers; • Outline the specific reimbursement methodology, or methodologies, to be implemented, including payment structure, performance incentives and metrics; • Describe your strategy to move providers along the continuum of alternative payment models as defined in the Health Care Payment Learning and Action Network Framework, from category 2 (fee-for-service with a link of payment to quality) to categories 3 (alternative payment models built on fee-for-service architecture) and 4 (population-based payments); and • Describe how data sharing and reporting will be used to promote transparency, collaboration and accountability with provider partners of all types. Also provide an example of an innovative performance-based purchasing initiative undertaken in one of your benchmark programs, including objectives for the initiative, month/year of implementation, barriers encountered, how these barriers

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	were overcome and the results achieved. Limit your example to calendar year 2012 or later. (Page Limit: 7 pages.)
49	**Provider Network: Partnerships with Provider Systems** For plans that are not provider-sponsored: Describe, as applicable, any subcontracts entered into with local providers and/or regional provider systems, under which these systems will be responsible both for service delivery and care management within their scope of expertise, and for which reimbursement will be at least partially performance based. For provider-sponsored plans: Describe how you will engage downstream providers in advancing performance-based model(s) of care and how you will differentiate between employed and affiliated providers, if applicable. (Page Limit: 4 pages.)
50	**Medical Management: Evidence-Based Guidelines** Describe your relevant experience and approach to developing an evidence-based medical management strategy. As part of your response, describe: • How evidence-based guidelines are developed and employed in medical management decision making; • How providers are educated about guidelines, including updates; • How service utilization and other operational data are used to evaluate the effectiveness of guidelines; and • How guidelines are updated based on outcomes and to remain current with national trends. In addition, provide two examples from your benchmark programs 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 calendar year 2012 or later. (Page Limit: 6 pages.)
51	**Medical Management: Prior Authorization** Describe your relevant experience and proposed approach for performing prior authorizations in accordance with the requirements outlined in model Contract section 2.10, “Medical Management.” As part of your response, discuss:

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	• External guidelines to be used, if applicable; • Where prior authorization staff will be located; • Qualifications of prior authorization personnel; • Who will have authority to deny services; and • How you will ensure consistent application of review criteria. (Page Limit: 5 pages.)
52	**Medical Management: Hospital Utilization** Based on available data, provide your assessment of hospital utilization rates within the SoonerHealth+ population and their potential for being lowered. Describe your strategy for reducing inpatient hospital admission and readmission rates within the SoonerHealth+ population. In addition, provide an example from one of your benchmark programs of an initiative undertaken to reduce hospital utilization. Discuss the identified problem, intervention and results achieved. Limit your example to calendar year 2012 or later. Also include a copy of **Form 8070000933-P-Hospital Utilization**. (Page Limit: 4 pages.)
53	**Medical Management: Emergency Room Utilization** Based on available data, provide your assessment of emergency room utilization rates within the SoonerHealth+ population and their potential for being lowered. Describe your strategy for reducing emergency room visit rates within the SoonerHealth+ population. In addition, provide an example from one of your benchmark programs of an initiative undertaken to reduce emergency room utilization. Discuss the identified problem, intervention and results achieved. Limit your example to calendar year 2012 or later. Also include a copy of **Form 8070000933-Q-Emergency Room Utilization**. (Page Limit: 4 pages.)

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54	**Medical Management: High Utilizers** Describe your strategy for defining, identifying, improving quality of care and outcomes among very high utilizers within the SoonerHealth+ program. In addition, provide an example from one of your benchmark programs of an initiative undertaken to improve quality of care and outcomes for a high utilization population. Discuss the identified problem, intervention and results achieved. Limit your example to calendar year 2012 or later. (Page Limit: 4 pages.)
55	**Medical Management: Pharmacy Benefit Management** Describe your proposed structure for pharmacy benefit management (PBM). 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, including but not limited to timely processing of prior authorization requests by the PBM. Also address the following in your response: • Describe your Drug Utilization Review programs and discuss how you determine over/under utilization and whether you have an adherence program; • Describe any direct and indirect remuneration fees to be charged to pharmacies for SoonerHealth+ member prescriptions, your process and timing for collecting fees, including through reconciliations, and your process for providing detailed disclosure of the fees to pharmacies at time of collection; • Describe how you will administer the pharmacy lock-in program in accordance with the requirements outlined in model Contract section 2.11.12.1, “Pharmacy Lock-in.” • Describe how care managers access prescription claims history and whether they have real-time access to pharmacy claims. If they do not, specify the pharmacy claim data lag and whether any other personnel at the plan have real-time access; • Describe how you will capture and ensure timely and accurate reporting of pharmacy encounters; • Describe how you will identify encounters for drugs eligible for 340b pricing to ensure the OHCA does not claim rebates on these drugs; and • Describe how you will monitor utilization of new drugs to identify trends for consideration by the OHCA DUR.

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	Finally, discuss how you will structure the pharmacy benefit for Medicaid-only adults not enrolled in an HCBS waiver. Specifically, describe whether you will adhere to fee-for-service monthly program benefit limits or if you will raise or eliminate the limits. (Page Limit: 10 pages.)
56	**Care and Disease Management: Care Manager Training** Describe your relevant experience and proposed approach for the initial and ongoing training programs you will undertake in accordance with the requirements in model Contract section 2.11.2, "Care Manager Training." As part of your response, discuss: • Your approach to curriculum development; • Your process to ensure all care managers, contracted and hired, receive adequate training to meet the requirements in section 2.11, "Care and Disease Management." As part of this discussion, provide information on how attendance will be documented and stored as well as how competencies will be evaluated post-training; and • The training modalities to be used for initial and ongoing training. In addition, provide a draft training curriculum to be used or a representative sample from one of your benchmark programs. (Page Limit: 4 pages, excluding curriculum; there is no page limit for the curriculum.)
57	**Care and Disease Management: Care Manager Ratios** Provide your proposed staffing ratios for the care management components specified in model Contract section 2.11.3.1, "Care Manager Ratios and Staffing Plans" and explain the basis for their selection. If you employ care manager staffing ratios in one or more benchmark programs for population(s) served under SoonerHealth+, also provide those ratios by aid category served and explain the rationale for any differences between your proposed SoonerHealth+ ratios and the ratios in other programs. Indicate if the ratios in other program(s) are mandated by the contracting agency. (Page Limit: 4 pages.)
58	**Care and Disease Management: Care Manager Assignments and Caseloads Revised** Describe your relevant experience and proposed approach for performing care manager assignment and caseload management procedures in accordance with the

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	requirements outlined in model Contract section 2.11.3.2, "Care Manager Assignment." Address the following: • The process to be used to assign members to care managers, both contracted and hired; • Whether caseloads will be mixed by member type (e.g., HCBS and non-HCBS); • How you will track, monitor and evaluate the adequacy and appropriateness of care manager caseloads; and • The retention strategies you will employ to manage caseloads and minimize staff turnover. (Page Limit: 5 pages.)
59	**Care and Disease Management: Care Manager Changes** Describe how continuity of care will be maintained for members when a care manager change occurs, whether member- or plan-initiated, in accordance with requirements in model Contract section 2.11.3.3, "Member-Initiated Care Manager Changes" and 2.11.3.4, "Contractor-Initiated Care Manager Changes." (Page Limit: 3 pages.)
60	**Care and Disease Management: Member Access to Care Managers** Describe the back-up system that will be in place for members when their care manager is unavailable, including after hours and holidays, in accordance with requirements in model Contract section 2.11.3.5, "Member Access to Care Managers." (Page Limit: 3 pages.)
61	**Care and Disease Management: Electronic Care Management System** Provide an overview of the care management system you will employ to meet the requirements specified in model Contract section 2.11.4, "Electronic Care Management System." Discuss the system's current functionality in comparison to program requirements. Also discuss whether the system is in use today and, if so, what modifications will be required to meet SoonerHealth+ Program requirements. If the system is not in use today, describe your plan for having an operational system at the time of readiness review. (Page Limit: 5 pages.)

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62	**Care and Disease Management: Health Risk Screening** Describe your relevant experience and proposed approach for performing health risk screens and assigning members to risk levels in accordance with requirements outlined in model Contract sections 2.11.5, "Initial Member Outreach for Health Risk Screenings" and 2.11.6, "Assigning Care Management Risk Levels." As part of your response, discuss: • Methods to be used to maximize the reach and screening rates for new members; and • Your methodology for assigning members to a risk level based on the results of the screening and other information relevant to the assignment. In addition, provide a draft health risk screening instrument to be used or a representative tool from one of your benchmark programs. Also include a copy of **Form 8070000933-R-Health Risk Screening Activity Rates**, documenting health risk screening activity in your benchmark programs. (Page Limit: 5 pages, excluding Health Risk Screening instrument and form 8070000933-R; there is no page limit for the Health Risk Screening instrument and any related instructions.)
63	**Care and Disease Management: Comprehensive Assessment** Describe your relevant experience and proposed approach for performing comprehensive assessments in accordance with requirements outlined in model Contract section 2.11.7, "Comprehensive Assessment for Risk Levels 2 and 3." As part of your response, discuss: • The qualifications of the individuals who will be performing the assessments; and • The circumstances that would trigger an early reassessment of a member. In addition, provide a draft of the comprehensive assessment tool or a representative tool from one of your benchmark programs. Also include a copy of **Form 8070000933-S-Comprehensive Assessment Activity Rates**, documenting comprehensive assessment activity in your benchmark programs. (Page Limit: 5 pages, excluding Comprehensive Assessment instrument and form 8070000933-S; there is no page limit for the Comprehensive Assessment instrument and any related instructions.)

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64	**Care and Disease Management: Care Planning** Describe your relevant experience and proposed approach for developing and implementing care plans in accordance with requirements outlined in model Contract section 2.11.8, "Care Planning." As part of your response, discuss: • Procedures to be used in establishing the Interdisciplinary Team and encouraging participation by the member's PCMH and other providers, as appropriate; • Procedures and timeframes for development, review and approval of the care plan, including service plan and back-up plan; and • Procedures for review of existing care plans. In addition, provide a draft of the proposed care plan template or a representative example from one of your benchmark programs. (Page Limit: 5 pages, excluding care plan; there is no page limit for the care plan.)
65	**Care and Disease Management: Coordination with Medicare** Describe your relevant experience and proposed approach for coordinating service delivery with Medicare plans and service providers, for members who are dually-eligible but not enrolled with your Medicare plan (if applicable) for services. As part of your response, discuss: • How Medicare services will be identified and monitored as part of care management activities; • Steps that will be taken if service gaps are identified; and • How your efforts will mitigate against redundant care management activity and operational processes that could otherwise create confusion for members and/or service providers. In addition, provide an example from one of your benchmark programs of an innovative approach you took to improve coordination with Medicare payers/providers, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
66	**Care and Disease Management: Coordination with non-Capitated Medicaid Service Providers** Describe your relevant experience and proposed approach for coordinating service delivery with providers of non-capitated Medicaid services to SoonerHealth+ members. As part of your response, discuss:

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	• The services to be monitored as part of care management activities; and • Steps that will be taken if service gaps are identified. In addition, provide an example from one of your benchmark programs of an innovative approach you took to improve coordination with non-capitated service providers, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
67	**Care and Disease Management: Coordination with Community-Based Organizations and Resources** Describe your relevant experience and proposed approach for coordinating with community-based organizations providing non-Medicaid services to SoonerHealth+ members. As part of your response, discuss: • The types of community-based organizations and resources to be targeted as part of your care management strategy; • Your activities to date to identify community-based organizations in the region(s) being bid; and • How care managers and other staff will integrate community-based services into member care plans and share data among service providers. In addition, provide an example from one of your benchmark programs of an innovative approach you took to integrate community-based services into your care management strategy, the results achieved and how you will apply this experience to SoonerHealth+. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
68	**Care and Disease Management: Disease Management Programs** Describe your relevant experience and proposed approach for incorporating evidence-based disease management into your broader care management strategy, in accordance with the requirements outlined in model Contract section 2.11.12.3, "Disease Management." As part of your response, discuss: • The types of disease management programs to be offered to SoonerHealth+ members and the basis for their inclusion; • How disease management will be provided to members and integrated into the broader care management strategy; • The types of training, monitoring and engagement tools that will be utilized

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	to empower members to self-manage and achieve self-established goals for their health and well-being; and • How the effectiveness of disease management interventions will be monitored over time. In addition, provide two examples from your benchmark programs of innovative approaches you took to maximize the effectiveness of evidence-based disease management programs, the results achieved and how you will apply this experience to SoonerHealth+. Limit your examples to calendar year 2012 or later. (Page Limit: 8 pages.)
69	**Care and Disease Management: Integration with CPC+ Program** Indicate whether you have entered into a Memorandum of Understanding to serve as a CPC+ payer partner in Oklahoma and, if not, whether you intend to apply to serve as a payer partner in 2017 (if permitted by CMS). If you are a payer partner, or intend to apply in 2017, describe your proposed approach for meeting the requirements outlined in model Contract section 2.11.10, "CPC+ Care Management Procedures." As part of your response, discuss: • How you will maintain existing PCMH relationships for members aligned with a CPC+ provider in your network at their time of enrollment, as part of your PCMH selection or assignment process; • Whether and how you will take into consideration a member's risk level and a CPC+ provider's track when making PMCH assignments to a CPC+ provider; • How you will share risk screening and risk stratification results with CPC+ providers; • How you will support CPC+ provider care management activities and ensure members do not experience care gaps; • How you will interact with the MyHealth HIE used by CPC+ providers and incorporate CPC+ provider care plan data into the MCO-level care plan; and • Whether your care management staff qualifications will differ for members aligned with CPC+ providers, either within specific risk levels or overall. (Page Limit: 1 page if bidder is not a CPC+ payer partner and does not intend to apply; 8 pages for all others.)
70	**Care and Disease Management: Monitoring Service Delivery** Describe your relevant experience and proposed approach for monitoring and evaluating service delivery in accordance with requirements outlined in model

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	Contract section 2.11.11, "Monitoring Service Delivery." As part of your response, discuss: • How you will ensure care management tools and procedures are applied in a consistent and objective manner; • How you will track findings at the individual level to identify systemic issues; • How you will track that members are obtaining services when referrals for services have been authorized; and • How you will ensure service gaps are identified and addressed in a timely manner. In addition, provide an example of a monitoring activity in one of your benchmark programs that resulted in the identification of a service delivery issue. Describe how the issue was identified, the corrective actions taken and the results achieved. Limit your example to calendar year 2012 or later. (Page Limit: 5 pages.)
71	**Care and Disease Management: Self-Direction** Describe your relevant experience and proposed approach for meeting the self-directed services requirements outlined in model Contract section 2.11.13, "Self-Direction." As part of your response, discuss: • Who will be responsible for performing member and care manager self-direction training and how training will occur; • The process to train, credential, and contract self-direction providers (including family members, if applicable); • How you will monitor self-direction providers and steps you will take if performance issues are identified; and • How you will interact with the member's Fiscal Management Services agency. (Page Limit: 5 pages.)
72	**Care and Disease Management: Electronic Visit Verification (EVV)** Describe your relevant experience using electronic visit verification for monitoring HCBS utilization and paying claims. Also discuss whether you intend to use the EVV for populations other than ADvantage waiver members. (Page Limit: 3 pages.)

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73	**Care and Disease Management: Behavioral Health Home** Describe the steps you will take to facilitate transition of care for members moving to a behavioral health home, in accordance with requirements outlined in model Contract section 2.11.5.3, "Behavioral Health Home Enrollment Procedures." (Page Limit: 3 pages.)

74	**Care and Disease Management: Case Study (Roger)**
	Roger is a 48-year-old male with diagnoses of congestive heart failure, hypertension, hyperlipidemia (high cholesterol), obesity, and a history of Type II diabetes with neuropathy. Roger has had three ER visits and one hospital admission in the last 12 months for congestive heart failure. Just two days ago, Roger was discharged from the hospital for a Stage 3 right foot ulcer with cellulitis. Roger is a new Medicaid member.
	
	Roger has a number of medications prescribed for him by his current cardiologist and PCMH provider. He has consistently refused insulin for fear of having a hypoglycemic episode. While he takes his other medications, he sometimes "forgets or doesn't feel he needs to take them every day."
	
	Roger lives with his wife, Olivia, 10-year-old son, Michael, and 6-year-old daughter, Amy. Roger lives a pretty sedentary lifestyle. Roger and his family reside in Tulsa, Oklahoma.
	
	Roger is depressed about his health issues. He recognizes his diabetes and eating habits are poorly controlled and are aggravating his foot ulcers and other conditions.
	
	<u>Instructions</u>
	Describe your strategy for managing the member's care. Address the following items in the order presented:
	
	• *Health Risk Screen*
	  ○ Describe the most pressing risk factors associated with this member that will need to be addressed.
	  ○ List any significant aspects that are unknown to this case that may be relevant in order to assign a risk level of 1, 2 or 3 per model Contract section 2.11.6, "Assigning Care Management Risk Levels."
	
	• *Care Management Risk Levels* - Identify the assigned risk level (i.e., 1, 2 or 3) and your rationale for the member's assigned risk level.

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	• *Comprehensive Assessment* - Provide the timeframe to complete the comprehensive assessment, sources used to obtain information and the type of care manager to be assigned to the member. • *Interdisciplinary Team (IDT)* - Identify the members of the IDT. • *Care Planning* – Describe the person-centered services to be provided to the member, in accordance with model Contract sections 2.11.8.2, "Care Plan Requirements" and 2.11.8.3, "Service Plans." At your option, also provide a care plan and service plan for the member in a template you propose to use for SoonerHealth+ or using a relevant template from one your benchmark programs. • *Providers and Services* - Discuss any challenges or barriers to ensuring member choice in the selection of providers and services and how they will be addressed. • *Ongoing Care Management* - List pertinent care management interventions, including care transitions (if applicable) for this member. • *Coordination Activities* – Discuss coordination with other payers, non-capitated Medicaid service providers and community-based organizations and resources, as applicable. • *Monitoring Service Delivery* - Identify the challenges to monitoring the member's service delivery, compliance and health status over time and how they will be addressed. (Page Limit: 8 pages, excluding care plan, if provided; there is no page limit for the care plan and related service plan. If providing, place the care plan/service plan at the end of your response, after the narrative.)
75	**Care and Disease Management: Case Study (Karen)** Karen is a 70-year-old female with diagnoses of COPD and atrial fibrillation. Karen had a recent fall and was seen in the ER for evaluation. It should be noted that Karen takes Coumadin, a blood thinner, as a result of her atrial fibrillation, and so is at risk for bleeding and bruising. She takes other medications for her breathing since she has had several COPD exacerbations. Karen is a dual eligible individual and has a Medicare Advantage plan. She has always been very independent and knowledgeable about her health care. Approximately two months ago, Karen relocated to Guthrie, Oklahoma to move in with her daughter, Mary, after the death of Karen's husband. Karen moved from Bartlesville, Oklahoma since she wanted to be closer to her daughter. Mary works

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	during the day and Karen does not drive so transportation to get Karen to and from medical appointments is difficult. As a result, most of Karen's care is rendered in the ER and hospital. Karen's Medicare Advantage case manager checks in via telephone from time-to-time after she has been to the ER or hospital. Mary is concerned about her mom's recent alcohol intake and is confused about what community or other services that may benefit her mother while she is at work. In the very least, she would like her mother's care to be better coordinated by "someone" and for her mother to see an outpatient provider to manage her chronic conditions rather than go to the ER or hospital. <u>Instructions</u> Follow the same instructions as presented for proposal submission item 74. The same page limits apply.
76	**Care and Disease Management: Case Study (Awinita)** Awinita is a 77-year-old female, Cherokee member who is new to Medicaid and the ADvantage waiver. Awinita has diagnoses of hypertension and hypothyroidism. Six weeks ago, she had a stroke that left her with right-sided weakness. She spent several weeks in a short-term nursing facility receiving therapies to improve her ADLs, speech and swallowing. Awinita responded well to the therapy and regained some of the lost function, though she still requires assistance to complete most of her ADLs. She was able to feed herself and usually was able to tell someone when she needed to toilet. Awinita moved into the Tahlequah home of her daughter and son-in-law (Doya and Viho) two weeks ago, following discharge from the nursing facility. She was ambulating with a cane and stand-by assist prior to leaving the nursing facility but, after two weeks at home, became quite unsteady without physical assistance leading to two falls. (Neither fall resulted in injuries.) Doya and Viho's house is not wheelchair accessible. There are three steps at the front entrance and Awinita's wheelchair barely fits through the doorway of her bathroom. The bathroom has a tub/shower combination and Awinita needs assistance to transfer into it. No modifications have been made to the bathroom. Awinita's cognitive status appears to have been affected by the stroke as well. She has exhibited increased confusion and agitation since coming home and has frequent crying spells. She also has had several episodes of incontinence.

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	Doya does not want her mother to return to the nursing facility but instead wants to keep her at home for as long as possible. Viho works full-time and travels out of state frequently. Doya works as a restaurant hostess with a mixture of day and evening shifts. The couple has two daughters, ages eight and 14. The younger sister moved into her older sister's room when Awinita arrived so that Awinita could have her own room. While still at the nursing facility, Doya was told by Awinita's care manager that Awinita would qualify for the ADvantage waiver program and that Awinita could self-direct her care under the CD-PASS program. Doya was interested in this option. <u>Instructions</u> Follow the same instructions as presented for proposal submission item 74. The same page limits apply.
77	**Care and Disease Management: Case Study (Eric)** Eric is a 20-year-old male with diagnoses of cerebral palsy, chronic constipation, gastric reflux, epilepsy, autism spectrum disorder (ASD) and anxiety. Eric's cerebral palsy affects his limbs and swallowing. He requires physical therapy, occupational therapy and speech therapy (swallow therapy) and has an orthotic device. He is able to walk but needs some assistance with his ADLs and IADLs. Eric has challenges with social interactions, transitions and when someone or something disrupts his environment or daily routine. When faced with any of these challenges, Eric becomes extremely anxious, agitated and has verbal and physical outbursts. When this occurs, it is next to impossible for Eric to self-soothe. He also has trouble sleeping and engages in repetitive activities, which lead to intense preoccupations with certain things. Eric lives with his father, Raymond, and 14-year-old sister, Kate, in Lawton, Oklahoma. Last month, Eric's mother died in a car accident. His outbursts and behaviors have intensified since this event. Kate, of whom Eric has always been very fond, is now fearful of her brother and avoids spending time with him. Raymond is taking a leave of absence from work to care for Eric but he needs to return to work next month. Eric is wait-listed for enrollment into one of IID waiver programs. He currently receives state plan Medicaid services. Eric's father and sister are feeling very "burned out." Eric wants to continue living at home with his family. He graduated

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	from high school last year and has not yet decided what he wants to do but fears becoming isolated at home when Raymond returns to work. This has added to his recent anxiety and frustration. Instructions Follow the same instructions as presented for proposal submission item 74. The same page limits apply.
78	**Care and Disease Management: Case Study (Kyle)** Kyle is a 12-year-old male with a diagnosis of muscular dystrophy and TEFRA eligibility. He is an existing SoonerCare Choice member with special health care needs. Kyle is ventilator dependent at night and requires tube feedings during the day. Kyle is totally wheelchair dependent. He requires numerous medications for his condition, including but not limited to steroids, anticonvulsants and antibiotics. Kyle receives respiratory, physical and occupational therapy as well as private duty nursing. Kyle has a PCMH provider and sees numerous specialists, including a neurologist, pulmonologist, cardiologist and gastroenterologist. Kyle has an existing OHCA case manager in the Care Management Unit of the Population Care Management Department. Kyle lives at home with his parents (Elizabeth and Dan) and five-year-old brother, Michael, in Oklahoma City. His parents are concerned about his prognosis and quality of life. They provide care to Kyle when he is not receiving private duty nursing. His family is concerned about what will happen to his services and who coordinate his care when he transitions to the SoonerHealth+ Program. Instructions Follow the same instructions as presented for proposal submission item 74. The same page limits apply.
79	**Native Americans: Native American Liaison** Describe your relevant experience and proposed approach for undertaking an outreach strategy for Native American members and how you will use the Native American Liaison position to support Native American members and IHCPs in accordance with the requirements outlined in model Contract section 2.12.1, "Native American Liaison." (Page Limit: 3 pages.)

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80	**Native Americans: Care Management** Describe how you will make Native American care managers available to Native American members, in accordance with the requirements outlined in model Contract section 2.12.3.5, "Care Management." Discuss whether and on what basis you will contract with qualified IHCPs to perform care management activities. (Page Limit: 3 pages.)
81	**Native Americans: Indian Health Care Providers** Describe how you will meet the network requirements outlined in model Contract section 2.12.4, "IHCPs." (Page Limit: 3 pages.)
82	**Quality Improvement: Quality Assurance and Performance Improvement (QAPI) Program** Describe your relevant experience and proposed approach for implementing and administering QAPI programs in accordance with the requirements specified in model Contract section 2.13.3, "QAPI Program." In your description, address all of the following: • The QAPI governance and committee structure, responsibilities and functions; • Provider representation on the QIC and other quality committees, including the total number and types of specialties represented; • The individuals responsible for HCBS quality oversight; • How the larger organization, including plan leadership, is committed to quality improvement; • How you will ensure that providers actively participate in the QAPI program; and • How you will make information about the QAPI program available to providers and members. In addition, provide two examples from your benchmark programs of quality improvement initiatives undertaken in collaboration with network providers. Discuss the basis for their selection, the involvement of network providers in their design and implementation and results achieved. Limit your examples to calendar year 2012 or later. Also provide a sample QAPI program description, work plan and program evaluation from one of your benchmark programs. Include the materials after your narrative.

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	(Page Limit: 8 pages, excluding sample QAPI program description, work plan and program evaluation; there is no page limit for the sample materials.)
83	**Quality Improvement: Accreditation** Provide your current accreditation status. If not currently accredited, discuss your plan for achieving accreditation within 18 months of Contract award from a CMS-recognized accrediting entity in accordance with the requirements outlined in model Contract section 2.13.4, "Accreditation." Identify the entity from which you will be seeking accreditation. (Page Limit: 2 pages.)
84	**Quality Improvement: Quality Performance Measures** Select up to three measures from model Contract Appendix 2, "Quality Performance Measures" and describe strategies you employed in one or more of your benchmark programs to improve performance on the measure(s). As part of your response, discuss: • Why the measure(s) were selected for improvement; • Populations targeted; • Specific interventions undertaken; • Intervention time period; and • Results achieved. (Page Limit: 9 pages.)
85	**Quality Improvement: Quality Performance Measures: HEDIS** Provide the two most recent years of audited HEDIS reports available for each of your benchmark programs. The reported results must have undergone a HEDIS compliance audit conducted by an NCQA-certified HEDIS compliance auditor. The reports must be the final, auditor-locked version reported to the NCQA's interactive database. Provide reference to the population(s) for which you are reporting, including geographic location and member demographics. If you do not have data for a program that meets the above specifications, indicate such in your response. (Page Limit: N/A.)
86	**Quality Improvement: Member Satisfaction** Provide the two most recent years of CAHPS data available for each of your benchmark programs. If you do not have CAHPS data but have other member

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	satisfaction data, provide the substitute data along with a description of the methodology employed in its collection and analysis. (Page Limit: N/A.)
87	**Quality Improvement: Quality Improvement Case Study (Jane)** Jane is a 79-year-old plan member who receives ADvantage services. She has a history of Alzheimer's Disease (early stage), incontinence, arthritis in her lower extremities and colon cancer. Jane requires hands-on assistance with her activities of daily living (ADLs). She elected to self-direct these services and hired an agency provider, Barbara, for this purpose. Jane's daughter, Vanessa, visits with her a couple of evenings each week after work and on Sunday for a few hours. Last month, Vanessa called Jane's care manager, Tim, expressing concern about discovering on a few occasions that Jane had not been bathed or toileted that day. Jane advised Vanessa that Barbara "tries to do these things but sometimes she has to leave early to get to her next client." When asked about changing providers, Jane refused because she "does not have an issue with Barbara." Tim conducted a home visit during Barbara's next scheduled day at the house but did not observe any issues during the supervised visit. Barbara appeared very compassionate, attentive to Jane's needs and performed the required services. Tim evaluated Barbara's timesheet and it appeared that Jane was signing for Barbara's hours and the hours worked were in line with the amount allotted in Jane's individualized budget allocation (IBA) and service plan. Tim called the home health agency to advise them about the need for Barbara to remain at Jane's house for the allotted time and to ensure her services were being performed according to the care plan. Today, Vanessa called Tim in great distress, contending that Barbara engaged in unprofessional behavior toward her mother and that immediate action is needed. Vanessa stated that Jane called her at work crying and told her that Barbara had to leave in a hurry again and this time Barbara got angry when she (Jane) didn't sign her timesheet like she "always does." When Jane asked her for assistance to the bathroom, Barbara was "very rough" and now there is a large bruise on Jane's arm. Jane said that Barbara smelled like alcohol and was very rude and short with her today. Barbara told Jane that if she wasn't going to sign her timesheet that she would need to find someone else to care for

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	her. Jane and Vanessa do not know what to do but Jane is very fearful of Barbara now. Instructions Describe in detail the steps you will take to respond to and investigate the incidents. Address the following items in the order presented. Include headers corresponding to the bullets. • *Reporting* - Identify the entities with whom you must file reports and the timelines for reporting based on the incidents. • *Continuity of Care* - Explain the steps you will take to ensure there is no interruption in the member's services. Since the services are self-directed, identify how Jane will be involved in this process. • *Member Protections* - Describe the required actions to be taken pending an investigation to protect the member and to ensure the member is able to continue self-directing the services. • *Investigation* - Provide details regarding who will be responsible for performing the investigation (e.g., Contractor, the OHCA, home health agency, Adult Protective Services, or all parties), the processes and timeframes for conducting the investigation and the desired outcomes of the investigation as it relates to this member. • *Monitoring* - Discuss the monitoring procedures that you will be put in place to prevent similar incidents in the future. (Page Limit: 6 pages.)
88	**Complaints and Appeals** Describe your proposed structure and process for meeting the requirements outlined in model Contract section 2.14, "Member Complaints and Appeals." As part of your response discuss: • How you will provide assistance to members in filing complaints or appeals; • Who in your organization will serve as decision makers when reviewing complaints and appeals; • How you will ensure compliance with timeliness requirements; • Where complaint and appeal records will be maintained; and • How you will incorporate complaint/appeal data into your quality improvement process. In addition, provide an example from one of your benchmark programs of a trend you identified through analysis of complaint data, the steps you took to address and

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	the results achieved. Provide a separate example for a trend identified through analysis of appeal data. Limit your example to calendar year 2012 or later. Also include a copy of **Form 8070000933-T-Member Complaints Appeals Resolution**. (Page Limit: 7 pages, excluding Form 8070000933-T.)
89	**Management Information System** Describe your capacity and proposed processes for meeting the requirements outlined in model Contract section 2.15, "Information Technology and Data Management." As part of your response provide an overview of your existing information system and major subsystems and describe any major modifications or enhancements scheduled over the next 24 months. Also describe: • How program data will be integrated within your system, including data from partner organizations, as applicable; • Your process for reporting encounters accurately and timely, including obtaining encounter data from providers and subcontractors, as applicable; • Your process for reporting other data (e.g., enrollment data) accurately and timely; • Your system security protocols, including role-based security for access to care management data; • Data retention and storage processes and capacity; • System scalability; and • Disaster preparation and data recovery protocols. (Page Limit: 12 pages.)
90	**Claims Processing** Describe your claims system and proposed processes for meeting the requirements outlined in model Contract section 2.16, "Claims Processing." As part of your response, describe: • Procedures for receipt and adjudication of electronic and paper claims; • Strategy for educating HCBS providers and assisting in proper claims submission; • Process for ensuring Medicare crossover claims are paid correctly and members are not balance billed by providers; • Process for identification and resolution of provider- or system-level issues; and

ITEM	INSTRUCTIONS
	• Procedures for management of claims from non-traditional provider types (e.g., home modification firms). Also include a copy of **Form 8070000933-U-Claims Processing**. (Page Limit: 10 pages, excluding Form 8070000933-U.)
91	**General Reporting Requirements** Describe your relevant experience and proposed approach for meeting the requirements outlined in model Contract section 2.17, "Reporting." As part of your response, discuss: • Your monitoring and evaluation procedures for ensuring reports are accurate and submitted timely; • Your ability to generate ad hoc reports if requested by the OHCA; • How changes to reporting requirements will be addressed, including testing and QA procedures; and • Your capability to produce system-generated reports versus manual. (Page Limit: 5 pages.)
92	**Financial Standards, COB and TPL** Describe your relevant experience and proposed approach for identification and management of COB/TPL in accordance with the requirements outlined in model Contract sections 2.18.2, "Coordination of Benefits" and 2.18.3, "Third Party Liability." (Page Limit: 4 pages.)
93	**Marketing** Describe your approach for meeting the requirements outlined in model Contract section 2.19, "Marketing." As part of your response, describe the types of marketing you intend to undertake. Also discuss how you will ensure compliance with state and federal marketing standards within your organization and at partner organizations, including through training and monitoring activities. (Page Limit: 4 pages.)
94	**Program Integrity and Compliance** Describe your structure and proposed processes for meeting the requirements outlined in model Contract section 2.20, "Program Integrity/Compliance." As part of

ITEM	INSTRUCTIONS
	your response, provide an overview of your Compliance Program and discuss: • Your procedures for educating and training both employees and subcontractors in accordance with model Contract section, "2.20.2.2, "Education and Training"; • Your fraud and abuse detection methodology, including analytics and reporting; • Your procedures for reporting changes in member or provider circumstances; and • Your procedures for verifying delivery of services to members. (Page Limit: 6 pages.)
95	**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: • The role individual departments will play in monitoring performance; • Whether there will be a centralized function within the plan responsible for monitoring performance; and • Process for identifying, reporting and remediating performance issues. In addition, describe any performance incentive payments you were eligible to receive, and whether you received them, in any of your benchmark programs. Limit the time period addressed to calendar year 2014 or later. Also include a copy of **Form 8070000933-V- Contractor Performance History**. (Page Limit: 5 pages, excluding Form 8070000933-V.)
96	**Pro Forma Financial Statement** Provide a monthly pro forma financial statement for your SoonerHealth+ line-of-business, beginning with execution of Contracts and continuing through year two of enrollment. Solely for the purpose of preparing the pro forma financial statement, assume Contract execution occurs in July 2017 and enrollment in Bidder's plan will equal 33 percent of the enrollment in the region(s) being proposed. Use the most recent year of historical enrollment, as presented in the actuarial data book, to calculate the 33 percent enrollment value. Assume that enrollment will be divided geographically and demographically in proportion to the program in total, as presented in the actuarial data book.

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	Present a statement of monthly revenue and expenses, monthly cash flow analysis and balance sheet. Present administrative and medical expenses as separate line items. (Page Limit: N/A.)

SoonerHealth+ Solicitation Forms - Summary Listing (Forms are located in Bidder's Library)

Form Number	Form Title
Form 8070000933 - A	SoonerHealth+ Solicitation Questions
Form 8070000933 - B	Bidder Proposal Submission Checklist
OMES-CP-004	Certification for Competitive Bid and/or Contract
OMES-CP-076	Responding Bidder Information
Form 8070000933 - C	Bidder Representations and Certifications
Form 8070000933 - D	SoonerHealth+ Regions
Form 8070000933 - E	Oklahoma Experience
Form 8070000933 - F	Medicaid and Medicare (Dual-Eligible) Experience (Non-Oklahoma)
Form 8070000933 - G.1	Identification of Bidder References
Form 8070000933 - G.2	Oklahoma SoonerHealth+ Program Reference
Form 8070000933 - H	Identification of Major Subcontractors
Form 8070000933 - I	Plan Management
Form 8070000933 - J	Plan Staffing
Form 8070000933 - K	Economic Impact
Form 8070000933 - L	Value-Added Benefits
Form 8070000933 - M	New Member Contact Rates
Form 8070000933 - N	Call Center Performance
Form 8070000933 - O	Network Summary and Rosters
Form 8070000933 - P	Hospital Utilization
Form 8070000933 - Q	Emergency Room Utilization
Form 8070000933 - R	Health Risk Screening Activity Rates
Form 8070000933 - S	Comprehensive Assessment Activity Rates
Form 8070000933 - T	Member Complaints & Appeals Resolution
Form 8070000933 - U	Claims Processing
Form 8070000933 - V	Contractor Performance History

3.7 Written Clarification and Oral Presentations

The OHCA at its discretion may require Bidders to submit written clarification of proposals by responding to OHCA questions. The OHCA also may schedule oral presentations as part of proposal evaluation activities. The OHCA may invite some or all bidders to participate in oral presentations. If only some bidders are invited, the OHCA will invite bidders with the highest evaluation scores. Further information on oral presentation schedule and content requirements will be provided prior to the proposal submission deadline.

3.8 Proposal Evaluation

The OHCA will evaluate proposals based on their responsiveness to RFP submission requirements and the extent to which bidder proposals advance the OHCA's objective of ensuring the delivery of accessible, high quality and person/family-centered care to SoonerHealth+ members.

The OHCA reserves the right to favor statewide proposals over single region proposals if deemed in the best interest of the program.

The OHCA also reserves the right to favor proposals from organizations participating or planning to participate as payer partners in the CPC+ program.

The OHCA will not provide additional detail on its evaluation methodology or criteria during the question and answer process.

3.9 Debriefings

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

3.10 Protests

Protest of awards under this solicitation will be addressed by the OHCA in accordance with administrative rules found at OAC 317:2. Any claims, disputes or litigation relating to the solicitation shall be governed by the laws of the State of Oklahoma. Venue for any action, claim, dispute or litigation relating in any way to the solicitation shall be in Oklahoma County, Oklahoma.

3.11 Readiness Review

Bidders awarded a Contract will be required to participate in a readiness review process prior to the start of enrollment. Bidders must complete readiness activities to the satisfaction of the OHCA and CMS before being opened to members as an enrollment option. Further information on the process will be provided on or around the time of Contract award.

Appendix 1 – Definitions and Acronyms

A.1.1 Interpretation of Definitions

Listed below are the Definitions used in this Contract. These terms shall be construed and/or interpreted as follows, unless the 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 CFR Chapter IV and 45 CFR Parts 160 and 164.

The following terms shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules: Breach, Business Associate, Covered Entity, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor and Use.

Unsecured Protected Health Information shall have the same meaning as in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A.1.2 Oklahoma SoonerHealth+ Program - Contract Definitions

Abuse (for program integrity functions) - Member or provider actions that defraud the OHCA and/or the Contractor, cause unnecessary medical expenses to the program or over-utilize services provided by the Contractor. It shall also mean causing unnecessary or excessive claims to be submitted to the Contractor.

Abuse - Means causing or permitting:

- the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement or mental anguish, or
- the deprivation of nutrition, clothing, shelter, health care or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult.

Activities of Daily Living (ADLs) - Activities that reflect the member'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.

Adult Protective Services (APS) - A program within the Oklahoma Department of Human Services that provides vulnerable adults protection from abuse, neglect or exploitation and offers services. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter and protection.

Advance Directive - Any writing executed in accordance with the requirements of 63 O.S. § 3101.3, which may include a living will, the appointment of a health care proxy or both relating to the provision of health care when an individual is incapacitated.

Advanced Personal Services Assistance - A self-directed service option under the ADvantage waiver Consumer Directed Personal Assistance Services and Supports Program, defined as maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their PCMH who may, if appropriate, order home health services. The service of advanced personal services assistance includes assistance with health maintenance activities that may include:

- Routine personal care for persons with ostomies (including tracheotomies, gastrostomies and colostomies with well-healed stoma) and external, in dwelling, and suprapubic catheters which includes changing bags and soap and water hygiene around ostomy or catheter site;
- Remove external catheters, inspect skin and reapplication of same;
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) with members without contraindicating rectal or intestinal conditions;
- Apply medicated (prescription) lotions or ointments and dry, non-sterile dressings to unbroken skin;
- Use lift for transfers;
- Manually assist with oral medications;
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology;
- Apply non-sterile dressings to superficial skin breaks or abrasions; and
- Use Universal precautions as defined by the Center for Disease Control.

ADvantage Waiver - An Oklahoma Medicaid HCBS Waiver used to finance non-institutional long term care services through Oklahoma's Medicaid program for elderly and disabled individuals. To receive ADvantage Program services, individuals must meet the nursing facility level of care criteria, be age 65 years or older or age 21 or older if physically disabled and not intellectually disabled, or if developmentally disabled and between the ages of 21 and 65, not have an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program members must be Medicaid eligible. The ADvantage Waiver limits the number of members eligible for ADvantage services.

Adverse Benefit Determination - Pursuant to 42 CFR § 438.400(b), means:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, health care setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the OHCA;
- The failure of the Contractor to act within the timeframes provided in § 438.408(b)(1) and (b)(2) regarding the standard disposition of complaints and standard disposition and resolution of appeals;
- For a resident of a rural area with only one MCO, the denial of a SoonerCare member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Advisory Board - Contractually-mandated body that includes members, member representatives (e.g., family members and caregivers), advocates and providers. Members and member representatives shall constitute a majority of the Advisory Board. The Contractor shall consult the Advisory Board on matters affecting member and provider experience as specified in Contract section 2.2.2.3, "Advisory Board."

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.

American Indian/Alaska Native - 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 CFR § 136.12. This means the individual:

- Is a member of a Federally recognized Indian tribe;
- Resides in an urban center and meets one or more of the four criteria;

  - Is a member of 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,
  - Is an Eskimo or Aleut or other Alaska Native,
  - Is considered by the Secretary of the Interior to be an Indian for any purpose, or
  - Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

Appeal - A review of an adverse benefit determination by the Contractor. The appeal can be initiated by a member or a provider or an authorized representative acting on behalf of the member, if written consent is obtained from the member.

Area Agencies on Aging (AAAs) - The Aging Services Division of the Oklahoma Department of Human Services contracts with 11 AAAs to provide services to individuals who are age 60 and older. AAAs were established under the Older Americans Act (OAA) in 1973 to plan for and provide services to the elderly and disabled within a defined geographic area.

Authorized Representative - As it relates to self-direction, a member may choose to designate an authorized representative to assist in executing the employer functions. Services may be directed by:

- An adult member, if the member has the ability to self-direct;
- A legal representative of the member, including a parent, spouse or legal guardian who is at least 18 years of age; or
- A non-legal representative freely chosen by the member or the member's legal representative.

Back-up Plan - As it relates to section 2.11, "Care and Disease Management," a component of the care plan that specifies alternative providers, self-direction providers and unpaid persons who have agreed to serve as back-up and can be contacted to deliver needed care in situations when regularly scheduled providers are unable or do not arrive as scheduled. Every SoonerHealth+ Program member in care management Levels 2 and 3, as well as any member who self-directs a service, will be required to have a back-up plan in the event a provider of services and supports essential to the member's health and welfare is not available.

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

Behavioral Health and Substance Use Disorder Assessments - Instruments used to diagnose mental health or substance use disorder conditions in order to determine severity and whether an individual qualifies for a Behavioral Health Home.

Behavioral Health Home - An optional Medicaid State Plan benefit that provides an opportunity to build a person-centered system of care that achieves improved outcomes and better services and value for the Oklahoma SoonerCare program for individuals with complex needs. The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has partnered with the OHCA to expand upon the patient-centered medical home model to provide coordinated primary and behavioral health integration for Adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbance (SED).

Behavioral Health Services - A wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance use disorder and co-occurring disorders.

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

Calendar Days - Defined as all seven days of the week, including State of Oklahoma holidays.

Capitation Payment - A payment the OHCA will make periodically to the Contractor on behalf of each member enrolled under the SoonerHealth+ Program Contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The OHCA shall make the payment regardless of whether the particular member receives services during the period covered by the payment.

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

Care Coordination/Care Management - A process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member's needs using advocacy, communication and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the member, and in collaboration with the Interdisciplinary Team, the care manager arranges services and

supports across the continuum of care, while ensuring that the care provided is person-centered.

Care Management Risk Level - A numeric value between one and three (i.e., level 1 is low risk, level 2 is moderate risk and level 3 is high risk) assigned to SoonerHealth+ Program members based on the results of their Health Risk Screening, existing care plans, utilization data and other relevant information. This level will be used in determining the level of care management intervention needed.

Care Manager - The Contractor's primary point of contact for SoonerHealth+ Program members who has the primary responsibility for performance of care management activities as specified in section 2.11.1.1, "Care Manager Responsibilities" and meets the qualifications specified in section 2.11.1.2, "Care Manager Qualifications."

Care Plan - A comprehensive set of actions and goals for the member developed by the care manager, in collaboration with the Interdisciplinary Team (if applicable), based on a member's unique needs. The Contractor shall develop and implement care plans for all SoonerHealth+ Program members. Depending on a member's risk level, the care plan may also include a service plan and/or a back-up plan.

Caregiver - For purposes of the SoonerHealth+ Program, a person who is (a) a family member or is unrelated to the member but has a close, personal relationship with the member and (b) routinely involved in providing unpaid support and assistance to the member.

Carved-out Services - A component of care that the Contractor will not be expected to provide or be responsible for under the SoonerHealth+ Program.

Case File - An electronic record that includes member information regarding the management of health care services including but not limited to: member demographics; Health Risk Screening; comprehensive assessment (if applicable); care plan (including a service plan and back-up plan, if applicable); reassessments; referrals and authorizations and member case notes.

CFR - Code of Federal Regulations.

Choice Counseling - The provision of information and services designed to assist beneficiaries in making enrollment decisions. It includes answering questions and identifying factors to consider when choosing among managed care organizations and primary care providers ("Patient Centered Medical Home Providers"). Choice counseling does not include making recommendations for or against enrollment into a specific Contractor.

Chronic Condition - A condition that is expected to last one year or more and requires ongoing medical attention and/or limits activities of daily living.

Clean Claim - A claim or encounter which can be adjudicated and submitted without obtaining additional information from the provider of service or a third party.

Clinical Practice Guidelines - Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

Cognitive Impairment - A person who, as determined by the clinical judgment of a clinician, does not have the capability to think, reason, remember or learn required for self-care, communicating needs, directing care givers and/or using appropriate judgment for maintenance of their own health or safety. The clinical judgment of cognitive impairment is based on Mental Status Questionnaire performance in combination with a more general evaluation of cognitive function from interaction with the person during the Uniform Comprehensive Assessment Tool (UCAT) assessment.

Cold-call Marketing - Any unsolicited personal contact by the Contractor with a potential member or member for the purpose of marketing.

Community Waiver - An Oklahoma Medicaid HCBS Waiver that serves individuals who are three years of age or older who have mental retardation and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded (ICF/MR).

Complaint - For the purposes of this Contract, the term “complaint” shall be used instead of “grievance.” Complaint shall be understood to have the same definition as the term grievance under 42 CFR 438.400(b), which is an expression of dissatisfaction about any matter other than an adverse benefit determination. Complaints 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 member’s rights regardless of whether remedial action is requested. A complaint includes a member’s right to dispute an extension of time proposed by the Contractor to make an authorization decision.

Complaint and Appeal System - The processes the Contractor implements to handle appeals of an adverse benefit determination and complaints, the process to collect and track information about them and the process of reaching a resolution.

Comprehensive Assessment - For SoonerHealth+ Program members that are assigned to Risk Levels 2 and 3, an instrument used to evaluate the physical health, behavioral health, HCBS and community and social support needs of members to inform the development of a comprehensive care plan.

Confidential Information - Information in any medium (e.g., visual, written, numeric, verbal) that is in some capacity restricted in disclosure or distribution. This includes medical information of individuals or members, information given by the OHCA to the Contractor that is indicated to be proprietary, non-public information exchanged between the Contractor and its Subcontractors, or other.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - A survey administered to healthcare recipients to report on and evaluate their experiences with a particular health care system.

Consumer Directed Personal Assistance Services and Supports (CD-PASS) - Personal Services Assistance (PSA) and Advanced Personal Services Assistance (APSA) that enable an individual in need of assistance to reside in their home and in the community of their choosing rather than in an institution and to carry out functions of daily living, self-care and mobility. CD-PASS services are delivered as authorized under the service plan. The member employs the PSA and/or the APSA and is responsible, with assistance from a Financial Management Services entity, for ensuring that the employment complies with State and federal Labor Law requirements. The member may designate an adult family member or friend, an individual who is not a PSA or APSA to the member as an "authorized representative" to assist in executing these employer functions.

Contract - As a result of receiving an award from the OHCA and successfully meeting all health plan readiness review requirements, the agreement between the Contractor and the OHCA where the Contractor will provide Medicaid services to SoonerHealth+ Program members, comprising of the Contract and any Contract addenda, appendices, attachments or amendments thereto, and be paid by the OHCA as described in the terms of the agreement.

Contract Officer - A designated employee of the Contractor authorized and empowered to represent the Contractor with respect to all matters within such area of authority related to the implementation of the Contract.

Contractor - A managed care organization with which the OHCA has entered into a binding agreement for the purpose of procuring services to SoonerHealth+ Program members as specified in the agreement.

Coordination of Benefits - The process that allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

Copayment - A fixed amount that a member pays for a covered health care service when the member receives the actual service.

Cost Sharing - When the State requires that members bear some of the cost of their care through mechanisms such as copayments, deductibles and other similar charges on benefits.

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 use disorder crisis stabilization services including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services.

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 AOD relapse.

Critical Incident - Any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant or SoonerHealth+ Program member.

Days - Calendar days unless otherwise specified.

Developmental Disability - A severe, chronic disability of an individual that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the individual attains age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity:
    - self-care,
    - receptive and expressive language,
    - learning,

  - mobility,
  - self-direction,
  - capacity for independent living,
  - economic self-sufficiency; and
- Reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, supports or other assistance that is of lifelong or extended duration and is individually planned and coordinated.

Disease Management (DM) - A system of coordinated heath care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented. Disease management is the concept of reducing health care costs and improving quality of life for individuals with chronic conditions by preventing or minimizing the effects of the disease through integrated care.

Disenrollment - The removal of a member from participation in the Contractor's health plan.

Dual Eligible Individuals - People eligible for both Medicaid and Medicare.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) - A federally required program that covers screening and diagnostic services for members under the age of 21 to determine physical and mental defects and to ascertain health care treatment and other measures to correct or ameliorate any existing defects and/or chronic conditions discovered.

Electronic Visit Verification (EVV) System - An electronic system that documents the time that providers begin and end the delivery of services and the location of services to members. The EVV System will be used to submit claims to the Contractor.

Emergency Medical Condition - A medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

Emergency Services - Health care services that are (1) furnished by any provider qualified to furnish such services; and (2) needed to evaluate, treat, or stabilize an emergency medical condition.

Employer of Record - A member, or their authorized representative, who directs their own care and receives self-directed services from a self-direction provider who is hired, trained and supervised by the member or the member's authorized representative.

Employment Agreement - The agreement between a SoonerHealth+ Program member or authorized representative electing self-direction of eligible HCBS and the member's self-direction provider that specifies the roles and responsibilities of the member (or the member's representative) and the member's self-direction provider.

Encounter Data - Information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between the OHCA and the Contractor that is subject to the requirements of §§ 438.242 and 438.818.

Enrollee - For the purposes of this Contract, the term "member" shall be used instead of "enrollee."

Enrollment - The process by which an eligible Medicaid recipient becomes a member in the Contractor's health plan.

Environmental Modifications - Physical adaptations to the home, required by the member's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver member are excluded.

Essential Hospital Services - Tertiary care hospital services to which it is essential for the Contractor to provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

Excluded Populations - Populations that are excluded from participation in the SoonerHealth+ Program as specified in section 2.3.4, "Excluded Populations."

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

External Quality Review (EQR) - The analysis and evaluation by an EQRO, of aggregated information on quality, timeliness and access to the health care services that the Contractor furnishes to Medicaid beneficiaries.

External Quality Review Organization (EQRO) - An organization that meets the competence and independence requirements set forth in § 438.354 and performs external quality review and other EQR-related activities as set forth in § 438.358.

Facility Based Crisis Stabilization Services - Emergency psychiatric and substance use disorder services aimed at resolving crisis situations. The services provided are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment and medical assessment.

Federally Qualified Health Center (FQHC) - An organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program and have a governing board of directors.

Fiscal Management Services (FMS) - Entity that is currently under contract with the Oklahoma Department of Human Services to perform payroll and other employment related functions for the SoonerHealth+ self-direction program and with which the Contractor will be expected to subcontract.

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.

Health Care Services - All Medicaid services provided by the Contractor under contract with the OHCA in any setting, including but not limited to medical care, behavioral health care and long term services and supports (i.e., HCBS).

Healthcare Effectiveness Data and Information Set (HEDIS) - A tool supplied by the National Committee for Quality Assurance (NCQA) and used by health plans to measure performance on important dimensions of care and service. This information set contains a number of measures designed to evaluate quality of care in a standardized fashion that allows for comparison between health plans.

Health Risk Screening - A screening tool used by the Contractor to obtain basic health and demographic information, identify any immediate needs a member may have and assist the Contractor to assign a risk level needed for the member in order to determine the level of care management needed.

Home- and Community-Based Services (HCBS) - Services offered in the community setting designed to prevent or delay nursing facility placement of elderly or disabled individuals.

Indian Health Care Provider (IHCP) - A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian Managed Care Entity (IMCE) - An MCO, PIHP, PAHP, PCCM or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization or Urban Indian Organization or a consortium, which may be composed of one or more Tribes, Tribal Organizations or Urban Indian Organizations, and which also may include the Service.

Individual Budget Allocation (IBA) Expenditure Accounts Determination Process - The process used to calculate the required level of program financial resources necessary to meet a member's need for CD-PASS services. The member's IBA Expenditure Accounts calculation is performed annually or more often to the extent appropriate and necessary to meet the member's need.

In-Home Supports Waiver for Adults - An Oklahoma Medicaid HCBS Waiver that serves the needs of individuals 18 years of age or older with mental retardation who would otherwise require placement in an intermediate care facility (ICF) for people with mental retardation and developmental disabilities.

In-Home Supports Waiver for Children - An Oklahoma Medicaid HCBS Waiver that serves the needs of children ages 3 through 17 years with mental retardation who would otherwise require placement in an ICF/MR.

Instrumental Activities of Daily Living (IADL) - Those activities that reflect the member's ability to perform household chores and tasks within the community essential for sustaining health and safety such as:

- Shopping;
- Cooking;
- Cleaning;
- Managing money;
- Using a telephone;
- Doing laundry;
- Taking medication; and
- Accessing transportation.

Intellectual Disability - When a person has, as determined by a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation, substantial limitations in functional ability

due to significantly sub-average intellectual functioning related to an event occurring before the age of 18.

Interdisciplinary Team (IDT) - A team assembled by the member, in collaboration with the member's care manager, for the purpose of developing a comprehensive care plan. The Contractor shall ensure that all members assigned to Risk Levels 2 and 3 have an IDT. The member or the member's legal guardian, Member Care Support Staff, PCMH provider and the care manager shall comprise a minimum IDT.

Intermediate Care Facility for Individuals with Intellectual Disabilities - Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

- Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet;
- Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions;
- Learning. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders;
- Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device;
- Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision; and
- Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

Level of Care (LOC) Services - To be eligible for level of care services, meeting the minimum Uniform Comprehensive Assessment Tool (UCAT) criteria established for skilled nursing facility (SNF) or hospital level of care demonstrates the individual must:

- Require a treatment plan involving the planning and administration of services that require the skills of licensed or otherwise certified technical or professional personnel, and are provided directly or under the supervision of such personnel;

- Have a physical impairment or combination of physical, mental and/or functional impairments;
- Require professional nursing supervision (e.g., medication, hygiene and/or dietary assistance);
- Lack the ability to adequately and appropriately care for self or communicate needs to others;
- Require medical care and treatment in order to minimize physical health regression or deterioration;
- Require care that is not available through family and friends, Medicare, Veterans Administration, or other federal entitlement program with the exception of Indian Health Service; and
- Require care that cannot be met through Medicaid State Plan Services, including personal care, if financially eligible.

Limited English Proficiency (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English.

List of Covered Drugs - A list developed by the OHCA and shared with the Contractor to be displayed for all members. This common list of covered drugs will include preferred brands as indicated by their placement in lower tiers of tiered therapeutic categories.

Major Subcontractor - A Major Subcontractor is defined as:

- Major administrative Subcontractors are entities anticipated to be paid $2 million or more for administrative activities during the year one Contract period, or
- Major health service Subcontractors are entities anticipated to be paid $5 million or more for health services under a payment arrangement other than fee-for-service that includes a downside financial risk during the year one Contract period.

Managed Care Organization (MCO) - A health plan that has a Contract to participate in the SoonerHealth+ Program and to deliver benefits and services to members.

Managed Care Organization Accreditation - The process by which the Contractor is certified by a CMS-recognized accrediting entity to meet all necessary regulatory requirements and quality standards to operate as a managed care organization in the State of Oklahoma. The Contractor must undergo reaccreditation not less than once every three years and the OHCA reserves the right to specify a private, independent entity for the reaccreditation process.

Marketing - Any communication from the Contractor to a SoonerHealth+ Program beneficiary who is not enrolled with the Contractor, that can reasonably be interpreted as intended to influence the beneficiary to enroll in the Contractor's SoonerHealth+ product, or either to not enroll in, or to disenroll from, another MCO entity's SoonerHealth+ product.

Marketing Materials - Materials that are produced in any medium by or on behalf of the Contractor and can reasonably be interpreted as intended to market the Contractor to potential members (or its employees, network providers, agents or Subcontractors) to potential members.

Medical Management Program - Consists of a series of activities undertaken by providers and the Contractor to maintain and improve quality and medically necessary (or similar) service levels and respond to accreditation and regulatory requirements.

Medically Fragile Waiver - An Oklahoma Medicaid HCBS Waiver designed to give a home and community-based alternative to placement in a hospital or nursing facility to people who qualify as medically fragile under state rules. To be eligible for the Medically Fragile waiver program, a member must: qualify financially for SoonerCare; be at least 19 years of age; meet hospital and/or skilled nursing facility level of care; have a medically fragile condition as defined by the OHCA and be living at home or a residential setting.

Medically Necessary - A standard for evaluating the appropriateness of services. Medical necessity, as established under OAC 317:30-3-1, is established through consideration of the following standards:

- Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;
- Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records, evidence sufficient to justify the client's need for the service;
- Treatment of the member's condition, disease or injury must be based on reasonable and predictable health outcomes;
- Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family or medical provider;
- Services must be delivered in the most cost-effective manner and most appropriate setting; and
- Services must be appropriate for the client's age and health status and developed for the client to achieve, maintain or promote functional capacity.

Member - A member is a recipient of the SoonerHealth+ Program benefits and enrolled in the Contractor’s health plan. For the purposes of this Contract, the term “member” shall be used instead of “enrollee.” Member shall be understood to have the same definition as the term enrollee in applicable State and federal rules and regulations.

Member Care Support Staff - Positions within the Contractor's organization that support and protect the interests of SoonerHealth+ Program members. The Contractor shall include within Care Management, Member Services or both, Member Care Support Staff with responsibility for assisting members by:

- Advocating on behalf of a member and his or her preferences with respect to receiving member- and family-centered care;
- Assisting the member to access community-based resources to address non-medical needs and to support the member's care plan objectives and independence;
- Obtaining information about available services in and outside of the health plan; and
- Filing complaints and appeals.

Member Handbook - A guidebook that explains the SoonerHealth+ Program that the Contactor shall distribute to every SoonerHealth+ member. It shall be designed to help the member understand the health plan, the SoonerHealth+ Program and the rights and responsibilities that come with membership in the program.

Mental Status Questionnaire (MSQ) - A component of the Uniform Comprehensive Assessment Tool Part III that measures the member's cognitive abilities.

National Provider Identifier (NPI) - A unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Neglect - Means any act that constitutes:

- The failure to provide protection for a vulnerable member who is unable to protect his or her own interest;
- The failure to provide a vulnerable member with adequate shelter, nutrition, health care or clothing; or
- Negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable member through the action, inaction, or lack of supervision by a caretaker providing direct services.

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 SoonerHealth+ Program.

Non-Urgent Sick Visit - Medical care given for an acute onset of symptoms which is not emergent or urgent in nature. Examples of non-urgent sick visits include cold symptoms,

sore throat and nasal congestion. Requires face-to-face medical attention within 72 hours of member notification of a non-urgent condition, as clinically indicated.

Oklahoma Department of Human Services (Oklahoma DHS) - The Oklahoma DHS is the largest state agency in Oklahoma. Oklahoma DHS provides a wide range of assistance programs to help Oklahomans in need including: food benefits (SNAP); temporary cash assistance (TANF); services for persons with developmental disabilities and persons who are aging; adult protective services; child welfare programs; child support services and child care assistance, licensing and monitoring. DHS also handles applications and eligibility for Sooner Care, the State's Medicaid program offering health care to families with low incomes.

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) - The ODMHSAS is responsible for providing services to Oklahomans who are affected by mental illness and substance use disorder. The mission of the ODMHSAS is to promote healthy communities and provide the highest quality care to enhance the well-being of all Oklahomans.

Oklahoma Health Care Authority (OHCA) - The single State Agency for Medicaid in Oklahoma and the Agency with direct oversight of the SoonerHealth+ Program.

Oklahoma State Department of Health (OSDH) - The OSDH, through its system of local health services delivery, is ultimately responsible for protecting and improving the public's health status through strategies that focus on preventing disease. Three major service branches, Community & Family Health Services, Prevention & Preparedness Services and Protective Health Services, provide technical support and guidance to 68 county health departments as well as guidance and consultation to the two independent city-county health departments in Oklahoma City and Tulsa.

OMB Rate - The Medicaid reimbursement rate negotiated between CMS and Indian Health Services (IHS). Inpatient and outpatient Medicaid reimbursement rates for IHCPs (I/T/Us) are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition for placement on the list.

Open Enrollment Period - The annual period when individuals can enroll in a managed care organization for the SoonerHealth+ Program as defined by the OHCA.

Outcomes - Changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Participating Provider - A physician or other provider who has a contract with or is employed by the Contractor to provide services to members under the SoonerHealth+ Program.

Patient Centered Medical Home (PCMH) - The OHCA implemented a PCMH primary care delivery system in January 2009 for SoonerCare Choice members. This model incorporated a managed care component with traditional fee-for-service and incentive payments for medical homes. For the purposes of this Contract, the term "PCMH" shall be used instead of "primary care provider." PCMH providers include the provider types listed in Contract section 2.8.3.1, "PCMH Providers."

Performance Improvement Projects (PIPs) - A concentrated effort on a problem, consistent with 42 CFR. § 438.240, and designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction and must include the following elements:

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

Person-Centered Care - A health delivery system that provides care that is respectful of and responsive to individual SoonerHealth+ Program members' preferences, needs and values. Person-centered care ensures that a member's values guide all clinical and quality of life decisions.

Personal Care Services - Assistance to an individual in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member'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.

Personal Services Assistance - A self-directed service option under the ADvantage waiver Consumer Directed Personal Assistance Services and Supports Program that may include:

- Assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both;
- Assistance with routine bodily functions that may include:

  - bathing and personal hygiene,
  - dressing and grooming,
  - eating including meal preparation and cleanup;
- Assistance with homemaker type services that may include shopping, laundry, cleaning and seasonal chores; or
- Companion type assistance that may include letter writing, reading mail and providing escort or transportation to participate in approved activities or events. "Approved activities or events" means community civic participation guaranteed to all citizens including but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the Member that may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan.

Pharmacy Benefit Manager (PBM) - A third party responsible for operating and administering the Contractor's pharmacy program. Pursuant to H.B. 2100, PBMs transacting business in Oklahoma are required to apply for and obtain a license from the Oklahoma Insurance Department.

Post-Stabilization Care Services - Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition or under the circumstances described in 42 CFR. § 438.114 (e), to improve or resolve the enrollee's condition.

Primary Care Provider (PCP) - A provider under contract with the Contractor to provide primary care services and case management, including securing all medically-necessary referrals for specialty services and prior authorizations. For the purposes of this Contract, the term "PCMH" shall be used instead of "PCP."

Prior Authorization/Service Authorization - A requirement that a member obtain the Contractor's approval before a requested medical service is provided or before services by an out-of-network provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim. For the purposes of this Contract, the term "prior authorization" shall be used instead of "pre-authorization."

Program of Assertive Community Treatment (PACT) Services - Services delivered within an assertive community-based approach to provide treatment, rehabilitation and essential behavioral health supports on a continuous basis to individuals 18 years of age or older with serious mental illness with a self-contained multi-disciplinary team.

Protected Health Information - Information considered to be individually identifiable health information, as described in 45 CFR § 160.103.

Protective Services - Services which are necessary to aid a vulnerable member in meeting the essential requirements for mental or physical health and safety that the vulnerable member is unable to provide or obtain without assistance. The term "protective services" includes but is not limited to services provided to or obtained for such person in order to prevent or remedy the abuse, neglect or exploitation of such person.

Quality Assessment and Performance Improvement (QAPI) - A process designed to address and continuously improve quality metrics within a health plan. The QAPI activities will provide the Contractor with data which it shall use, in conjunction with input from members and other stakeholders, to improve the delivery of care and care outcomes. The program shall evaluate all SoonerHealth+ Program population groups, care settings and types of services, including physical health services, behavioral health services and HCBS. The Contractor's QAPI program shall comply with every aspect of State and federal law, including final rule 42 CFR § 438.330 in its entirety.

Quality Improvement Committee (QIC) - A committee within the Contractor's organizational structure that oversees all QAPI functions. The Contractor's medical director shall chair the committee.

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

Rural Health Clinic - Clinics meeting the conditions to qualify for Rural Health Clinic reimbursement as stipulated in Section 330 of the Public Health Services Act. Rural Health Clinics (RHCs) certified for participation in the Medicare Program are considered eligible for participation in the Medicaid Program. Rural Health Clinics may be provider-based (i.e., clinics that are an integral part of a hospital, skilled nursing facility or home health agency that participates in Medicare) or independent (freestanding), and may include Indian Health Clinics. To participate, a Rural Health Clinic must have a current contract on file with the OHCA.

Self-Direction - A method of service delivery that allows members to have decision-making authority over certain services and to decide who provides them in order to live successfully in a home and community-based setting.

Self-Direction Provider - An individual who has been hired by a SoonerHealth+ member participating in self-direction or his/her representative to provide one or more eligible self-directed services to the member. The self-direction provider does not include an employee of an agency that is paid by the Contractor to provide HCBS to the member.

Serious Emotional Disturbance (SED) - A condition experienced by persons from birth to 18 that show evidence of points of: (a) The disability must have persisted for six months and be expected to persist for a year or longer; (b) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance use disorder, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance; and (c) The child must exhibit either of the following items below:

- Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
- Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):
    - Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs,
    - Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system,
    - Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults,
    - Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent), or
    - Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

Serious Mental Illness - A condition experienced by persons age 18 and over that show evidence of points of: (a) The disability must have persisted for six months and be expected to persist for a year or longer; (b) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance use disorder, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness; and (c) The adult must exhibit either of the following items below:

- Psychotic symptoms of a serious mental illness (e.g., schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or
- Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level);
    - Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs,
    - Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system,
    - Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers,
    - Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations), or
    - Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

Service Gap - A delay in initiating any service and/or a disruption of a scheduled, ongoing service that was not initiated by a member, including late or missed visits.

Service Plan - The service plan is a component of the care plan and contains all services (paid and unpaid) to be provided, including services paid by Medicare for dually eligible members, physical health, behavioral health/substance use disorder, HCBS and community and social supports. All needs, including unmet needs for non-covered services, shall be identified in the care plan and service plan. The Contractor shall ensure that all members that are assigned to a care management Risk Level 3 have a service plan.

Shall - A verb used to designate duties that will be a required condition of the Contract. Failure of a Contractor to perform a duty required as a condition of the Contract will be considered breach of Contract.

SoonerHealth+ Program - A program developed by the Oklahoma Health Care Authority in compliance with Oklahoma House Bill 1566, which was passed and signed into law in 2015. The Program is aimed at directing the OHCA to issue a Request for Proposal for a care coordination model for Oklahoma's SoonerCare ABD populations.

Standing Referral - A referral from a PCMH or the Contractor for a member needing access to multiple appointments with the specialist over a set period of time, such as a year, without seeking multiple referrals.

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

State Fair Hearing - The process set forth in subpart E of 42 CFR 431.

Steady State - The period following the Contractor's initial 90-day transition of care period.

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 network provider is not a subcontractor by virtue of the network provider agreement with the Contractor.

Telemedicine - The practice of healthcare delivery, diagnosis, consultation, treatment, including but not limited to, the treatment and prevention of conditions appropriate to treatment by telemedicine management, transfer of medical data or exchange of medical education information by means of audio, video or data communications. Telemedicine is not a consultation provided by telephone or facsimile machine (36 O.S § 6802). This definition excludes phone or Internet contact or prescribing and other forms of communication, such as web-based video, that might occur between parties that does not meet the equipment requirements as specified in OAC 435:10-7-13 and therefore requires an actual face-to-face encounter. Telemedicine physicians who meet the requirements of OAC 435:10-7-13 do not require a face to face encounter.

Transition Period - The period immediately following a member's enrollment into the Contractor's health plan whereby prior authorizations for covered services, including physical health, behavioral health, HCBS, medications and other specialty referrals, in place on the day prior to the date of enrollment to the Contractor's health plan shall remain in place for 90 days following a member's enrollment or until a comprehensive assessment and care plan have been developed, approved and implemented (if applicable), whichever comes sooner. Activities to be performed during the transition period are outlined in section 2.6.3, "Transition of Care Period."

Uniform Comprehensive Assessment Tool (UCAT) - The evaluation instrument used by Oklahoma DHS and the OHCA to establish an individual's level of care and eligibility requirements for care within a nursing facility or in the home setting.

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 use disorder), such that a reasonably prudent layperson could expect that the absence of medical attention within 24 hours could result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- A serious dysfunction of any body organ or part.

Value-Added Benefit - Any benefit or service offered by the Contractor that is not a covered benefit. These benefits are subject to change annually as determined by the Contractor and the OHCA.

Validation - The review of information, data and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

A.1.3 Oklahoma SoonerHealth+ Program – Acronyms

AAAs – Area Agencies on Aging

ABD – Aged, Blind and Disabled

ADL – Activities of Daily Living

APSA – Advanced Personal Services Assistance

CAHPS – Consumer Assessment of Healthcare Providers and Systems Survey

CCU – Chronic Care Unit

CD-PASS – Consumer Directed Personal Assistance Services and Supports

CMS – Centers for Medicare & Medicaid Services

DHS – Oklahoma Department of Human Services

DM – Disease Management

EPSDT – Early and Periodic Screening, Diagnosis and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

EVV – Electronic Visit Verification System

FMS – Fiscal Management Services

FQHC – Federally Qualified Health Center

HAN – Health Access Network

HCBS – Home- and Community-based Services

HEDIS – Healthcare Effectiveness Data and Information Set

HMP – Health Management Program

IADL – Instrumental Activities of Daily Living

ICF-I/D – Intermediate Care Facility for Persons with Intellectual/Developmental Disabilities

IDT – Interdisciplinary Team

IHCP – Indian Health Care Provider

IHS – Indian Health Service

IMCE – Indian Managed Care Entity

IID – Individuals with Intellectual Disabilities

I/T/Us – Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs

LOC – Level of Care

MCO – Managed Care Organization

MSQ – Mental Status Questionnaire

NF – Nursing Facility

NPI – National Provider Identifier

OAC – Oklahoma Administrative Code

ODMHSAS – Oklahoma Department of Mental Health and Substance Abuse Services

OHCA – Oklahoma Health Care Authority

OMB – Office of Management and Budget

OSDH – Oklahoma State Department of Health

PACE – Program of All-Inclusive Care for the Elderly

PBM – Pharmacy Benefit Manager

PCA – Personal Care Assistant

PCCM – Primary Care Case Management

PCMH – Patient Centered Medical Home

PCP – Primary Care Provider

PHI – Protected Health Information

PIPs – Performance Improvement Projects

PSA – Personal Services Assistance

QAPI – Quality Assurance and Performance Improvement

QIC – Quality Improvement Committee

RFI – Request for Information

RFP – Request for Proposals

RHC – Rural Health Clinic

SCC – SoonerCare Choice

SED – Serious Emotional Disturbance

SMI – Serious Mental Illness

SNF – Skilled Nursing Facility

TANF – Temporary Assistance for Needy Families

UCAT – Uniform Comprehensive Assessment Tool

Appendix 2 – Quality Performance Measures

A.2.1 SoonerHealth+ Program Quality-Related Goals

The Contractor shall have a documented QAPI program based on a model of continuous quality improvement. The program shall evaluate all SoonerHealth+ Program population groups, care settings and types of services, including physical health, behavioral health and HCBS. The OHCA, and DHS as applicable, shall perform oversight and monitoring functions for the Contractor's QAPI programs, reporting and all SoonerHealth+ Program contractual obligations. The Contractor shall report to the OHCA Quality Committee.

The goal of the Contractor's QAPI program is to assess, monitor and measure for improvement in all health care services provided to members. The Contractor shall be held accountable for the quality of care delivered by the Contractor's organization, providers and Subcontractors. This includes ensuring that a process is in place to monitor services provided in home- and community-based settings. The Contractor shall ensure quality medical care is provided to members, regardless of payer source or eligibility category.

Inherent in achieving these goals is the development of a process by which the OHCA and the Contractor can collaborate to establish objectives and timetables for improvements of health care service and delivery. The OHCA has identified the following quality-related goals for the SoonerHealth+ Program:

- Developing a comprehensive quality monitoring process in collaboration with stakeholders;
- Establishing a member-majority quality advisory board;
- Incorporating nationally validated measures that encompass the full continuum of care while addressing Oklahoma priorities;
- Measuring quality at both the individual and system level;
- Measuring both short- and long-term performance; and
- Rewarding care managers and providers who meet or exceed quality goals and taking corrective action with others where necessary.

A.2.2 SoonerHealth+ Program Performance Measures

Given the above-stated goals, performance measures were selected to provide evidence of the overall quality of care and specific services provided to each SoonerHealth+ Program population group. The Contractor shall report the performance measures listed below to the OHCA at a time and in a format specified by the OHCA. The Contractor shall be expected to meet or exceed annual benchmarks/targets for specific performance measures as developed by the OHCA prior to contract implementation.

The performance measures are only one form of performance requirements for the Contractor. The Contractor shall report on and comply with all State and federal HCBS waiver requirements regardless if there is a specific performance measure related to the requirement or not.

A.2.2.1 Physical Health Performance Measures

The Contractor shall be responsible for reporting on the physical health performance measures that are provided in the table below.

Physical Health Performance Measures	Frequency	Definition	Data Source
Medicaid HEDIS measures related to physical health: • Plan all-cause readmissions • Colorectal cancer • Cervical cancer screening • Breast cancer screening • Medication management for people with asthma and asthma medication ratio • Comprehensive diabetes care • Controlling high blood pressure • Follow-up after hospitalization for mental illness • Antidepressant medication management • Initiation and engagement of alcohol and other drug dependence treatment • Medical assistance with smoking and tobacco use cessation • Adult BMI assessment • Fall risk management • Medication management in the elderly • Physical activity in older adults • Flu vaccinations for adults aged 65 and older • Inpatient utilization – General hospital/acute care • Use of imaging studies for low back pain	Annual	NCQA definitions for each measure	Contractor's audited HEDIS reports

Physical Health Performance Measures	Frequency	Definition	Data Source
Prevention Quality Indicators (PQI): • COPD or asthma in older adults admission • Asthma in younger adults admission rate • Heart failure admission rate • Diabetes short-term complication • Diabetes long-term complication • Hypertension admission rate	Annual	Percentage of members who were discharged in the measurement year with a principal diagnosis for each of these conditions	Agency for Healthcare Research and Quality (AHRQ)
Hospital-wide all-cause unplanned readmission measure	Annual	Hospital-level risk-standardized readmission rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge	MMIS and encounter data
Heart Failure (HF): beta-blocker therapy for left ventricular systolic dysfunction (LVSD)	Annual	Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting or at hospital discharge	MMIS, encounter data and medical records
Comprehensive diabetes care: LDL-C Control <100 mg/dL	Annual	The percentage of members aged 18-75 with diabetes whose most recent LDL-C test is <100 mg/dL during the measurement year	MMIS, encounter data and medical records

Physical Health Performance Measures	Frequency	Definition	Data Source
Ischemic vascular disease (IVD): complete lipid profile and LDL control	Annual	Percentage of patients aged 18 and older with a diagnosis of IVD who have had a complete lipid profile test within 12 months and the most recent LDL < 100 mg/dl and triglycerides are < 400 mg/dl	MMIS, encounter data and medical records
Preventive care & screening: tobacco use: screening & cessation intervention	Annual	Percentage of patients aged 18 and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	MMIS, encounter data and medical records
Tobacco use: screening	Annual	Percentage of patients aged 12+ who were screened for tobacco use at every primary care visit	MMIS, encounter data and medical records
Body mass index (BMI) screening and follow-up	Annual	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or	MMIS, encounter data and medical records

Physical Health Performance Measures	Frequency	Definition	Data Source
		during the previous six months of the encounter	
Emergency room (ER) utilization: • ER visits per 1,000 member months • Potentially avoidable ER visits	Quarterly	Rate of ER visits per 1,000 member months and the number of ER visits that were potentially avoidable	MMIS and encounter data
Support for weight loss	Annual	Percentage of patients who received counseling and behavioral therapy to improve weight loss efforts	MMIS, encounter data and medical records
Use of high risk medications in the elderly	Annual	Percentage of Medicare members 66 years of age and older who received at least one high-risk medication	MMIS and encounter data
Dementia: cognitive assessment	Annual	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	MMIS and encounter data
Falls: screening for future fall risk	Annual	Percentage of patients aged 65 years and older who were screened for future fall risk at least once within 12 months	MMIS and encounter data

Physical Health Performance Measures	Frequency	Definition	Data Source
Closing the referral loop: receipt of specialist report	Annual	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred	MMIS, encounter data and medical records

A.2.2.2 Behavioral Health Performance Measures

The Contractor shall be responsible for reporting on the behavioral health performance measures that are provided in the table below.

Behavioral Health Performance Measures	Frequency	Definition	Data Source
Access to behavioral health services	Annual	Number and percentage of members receiving BH services	MMIS and encounter data
Access to substance abuse disorder (SUD) services	Annual	Number and percentage of members receiving SUD services	MMIS and encounter data
Inpatient care	Annual	Number and percentage of members using inpatient psychiatric services	MMIS and encounter data
Readmission to inpatient care	Annual	Number and percentage of members readmitted to inpatient care within 30 days of discharge	MMIS and encounter data
Depression screening	Annual	Percentage of population aged 12+ who were screened for depression using age-appropriate	MMIS, encounter data and medical records

Behavioral Health Performance Measures	Frequency	Definition	Data Source
		standardized instruments jointly selected by a primary care provider and behavioral health specialist during the measurement year	
Depression remission at 12 months	Annual	Percentage of patients age 18 years and older who have reached remission at 12 months (+/- 30 days) after diagnosis or initiating treatment, e.g., had a Patient Health Questionnaire-9 (PHQ-9) score less than 5 at 12 months (+/- 30 days)	PHQ-9, MMIS, encounter data and medical records
Screening for alcohol or drug dependence	Annual	Percentage of population aged 12+ who were screened for alcohol or other drug dependence during the measurement year	MMIS, encounter data and medical records
Treatment for alcohol or drug dependence	Annual	Percentage of patients who screened positive for alcohol or other drug dependence and who received treatment and follow-up	MMIS, encounter data and medical records

A.2.2.3 HCBS Performance Measures

The Contractor shall be responsible for reporting on the HCBS performance measures that are provided in the table below.

HCBS Performance Measures	Frequency	Definition	Data Source
National core indicators aging and disabilities (NCI-AD) consumer survey	Annual	Survey results	NCI-AD consumer survey results
HCBS member satisfaction and experience survey	Annual	Survey results	MCO uniform survey tool or HCBS questions added to the CAHPS surveys
Nursing facility level of care in the community	Annual	Number and percentage of people meeting nursing facility level of care who receive HCBS in the community	MMIS and encounter data
Critical incidents: number and type	Quarterly	Number of critical incidents by reporting category (abuse, neglect, exploitation, environment hazard, emergency services, law enforcement, elopement/missing and death)	MCO reports
Critical incidents: timeliness	Quarterly	Number and percentage of critical incidents that were initiated and reviewed within required timeframes	MCO reports
Critical incidents: process	Quarterly	Number and percentage of critical incidents for which MCO and providers followed the required process for evaluation	MCO reports
Critical incidents: causes	Quarterly	Number and percentage of critical incidents for which investigation revealed preventable causes	MCO reports