REIMBURSEMENT AGREEMENT
FOR PRIMARY CARE PROVIDER SERVICES
Between
OKLAHOMA HEALTH CARE AUTHORITY
And
SOONERCARE AMERICAN INDIAN/ALASKA NATIVE
TRIBAL HEALTH SERVICE PROVIDERS

ARTICLE 1. PURPOSE

The purpose of this Agreement is for OHCA and Provider to agree that OHCA will pay for Primary Care Provider (PCP) services provided by Provider.

ARTICLE II . HOSPITAL/CLINIC AGREEMENT INCORPORATED

Provider states that it has executed a current Hospital or Outpatient Clinic Reimbursement Agreement with OHCA. That Hospital or Outpatient Clinic Agreement is made part of this Agreement and incorporated by reference.

ARTICLE III. DEFINITIONS

Panel means members who have selected Provider for PCP services.

ARTICLE IV. PROVIDER QUALIFICATIONS

4.1 Provider states it consists of health care providers who:

a) Maintain current licenses, certifications, and permits required for such health care services in accordance with Federal statutes and regulations; and

b) Are physicians, physician assistants and/or nurse practitioners who are general practice or are board eligible or certified in family medicine, general internal medicine or general pediatrics, or are specialized in other areas of medicine but practicing in a more general capacity and, in either case, are authorized to serve as PCPs.

4.2 Provider, if employing a medical resident(s) serving as a PCP, states:

a) He/she is licensed to practice medicine;

b) He/she is at the Post-Graduate (PG-2) level or higher;

c) He/she serves as a PCP only within his/her continuity clinic (e.g., family practice residents may only serve as CMs within the family practice residency clinic setting);

d) He/she works under the supervision of a licensed attending physician.

ARTICLE V. PCP SCOPE OF WORK

5.1 Services and Responsibilities

Provider shall:

a) Provide case management services for members assigned to Provider's Panel which includes:

1. Coordinating and monitoring all medical care for Panel members;
2. Making medically necessary specialty referrals for Panel members, including standing referrals (i.e. a CM referral for a member needing to access multiple appointments with a specialist over a set period of time (such as a year), without

seeking multiple referrals that may include a limitation on the frequency or number of visits);
3. Coordinating Panel members' admissions to the hospital;
4. Making appropriate referrals to the Women, Infants and Children (WIC) program;
5. Coordinating with mental health professionals involved in Panel members' care; and
6. Educating Panel members to appropriately use medical resources such as emergency room;

b) Ensure that the services provided are sufficient in amount, duration, or scope to reasonably meet the health care needs of the members assigned to Provider; and

c) Be accountable for any functions and responsibilities that it delegates to any subcontractor; Provider shall have a written agreement with subcontractor that specifies subcontractor's activities and responsibilities and shall monitor such agreement on an ongoing basis; Provider shall also ensure that subcontractors comply with applicable Federal and State laws and regulations.

5.2 Access to Care

Provider shall:

a) Make a medical evaluation or cause such an evaluation to be made:
1. For new or existing members with urgent medical conditions: within twenty-four (24) hours with appropriate treatment and follow up as deemed medically necessary. Urgent medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that a reasonably prudent layperson could expect that the absence of medical attention within twenty-four (24) hours could result in: (i.) placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy; or (ii) serious impairment to bodily function; or (iii) a serious dysfunction of any body organ or part;
2. For new or existing members with non-urgent medical problems: within three (3) weeks. This standard does not apply to appointments for routine physical exams, nor for regularly scheduled visits to monitor a chronic medical condition, if that condition calls for visits to occur less frequently than once every three weeks**;**

b) Offer hours of operation that are no less than the hours of operation offered to commercial members or hours comparable to those offered to SoonerCare Traditional members if Provider serves only SoonerCare members;

c) Offer its panel members access to medical coverage through other SoonerCare contracted providers if Provider is unable to maintain regular office hours for a period of three or more consecutive days. This coverage must be arranged by Provider. OHCA will not pay in addition to the monthly capitated rate for alternate coverage;

d) Evaluate members' needs for hospital admissions and services and coordinate necessary referrals. If Provider's individual practitioners do not have hospital admitting privileges, Provider shall make arrangements with the practitioners specified on Provider's application form in order to coordinate the member's admission to the hospital. Provider shall coordinate the member's hospital plan of

care with the receiving practitioner if appropriate, until the member is discharged from the hospital; and

e) Not refer patients to the emergency room for non-emergency conditions, but provide medical care for non-emergency medical conditions in the office setting; Provider shall advise members of the proper use of the emergency room; nothing in this paragraph shall limit Provider's ability to provide emergency room services to a Panel member consistent with his/her legal scope of practice in an emergency room setting.

5.3 Record Keeping and Reporting

Provider shall:

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

b) Report to the Choice Helpline at 1-800-987-7767 or the Insure Oklahoma Helpline at 1-888-365-3742 any member status changes such as births, deaths, marriages, and changes of residence in a timely manner, when known;

c) Obtain proper consent and transfer a copy of member medical records free of charge, if requested, in the event the member moves or changes PCP/CMs.

5.4 Provider Panel Requirements

a) Provider shall specify a capacity of members he/she is willing to accept under this Agreement; the maximum capacity is two thousand five hundred (2,500) for each full-time physician in the Provider group; for each full-time physician assistant or advanced registered nurse practitioner in the Provider group, the maximum is one thousand two hundred fifty (1,250); for each medical resident in the Provider group, enrollment shall not exceed eight hundred seventy-five (875) members. If Provider has both Choice and IO panels, Provider shall not exceed these capacities for both panels combined.

b) OHCA does not guarantee Provider an enrollment level nor will OHCA pay for members who are not eligible or excluded from enrollment.

c) Provider may request a change in his/her capacity by submitting a written request signed by authorized representative of Provider group. This request is subject to review according to program standards. In the event Provider requests a lower capacity, OHCA may lower the capacity by dis-enrolling members to achieve that number or allowing the capacity to adjust as members change their PCP/CM or lose eligibility;

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

e) Provider shall provide medically necessary health care for any member who has selected or been assigned to Provider's panel until OHCA officially reassigns the member. Provider shall not notify the member of a change of PCP/CM until

Provider has received notification from OHCA; and

f) Provider may request that OHCA disenroll a member for cause. OHCA will give written notice of the disenrollment request to the member. If OHCA approves a disenrollment request for a Choice member, OHCA will enroll the member in SoonerCare Traditional for a period not to exceed six months. During this period, Provider must continue to provide services to the member as necessary for continuity of care.

ARTICLE VI. OBLIGATIONS OF OHCA

OHCA shall:

6.1 Mail Provider a monthly list of Panel members; this roster will be mailed to the service location address listed on the application;

6.2 Provide support services to the Provider in the areas of referral arrangements, overall utilization management, claims submission, administrative case management, and member education and discrimination policies;

6.3 Disenroll members from Provider's panel if this Agreement is terminated.

ARTICLE VII. FEE PAYMENTS AND REIMBURSEMENTS

7.1 Payment of Case Management Fee

a) OHCA shall pay Provider a monthly fee for each member enrolled with Provider, which is payment in full for all case management services.

b) Case management fees are shown in Attachment A. Attachment A may be amended by OHCA at any time by written notification to Provider.

c) OHCA shall make payments by the tenth (10) business day of each month. A single amount will represent payment for all eligible members enrolled with Provider as of the first day of that month. This payment will be made for all Provider's Panel members, regardless of what, if any, covered services Provider renders during the month.

d) OHCA will adjust payments based on the member's enrollment or disenrollment effective dates.

7.2 Penalties

If Provider fails to provide required case management services, or access to care as defined in Section 5.2, OHCA may notify Provider and impose penalties including:

a) "Freezing" Provider's panel, i.e. not allowing new member enrollments; and/or

b) Permanently reducing Provider's maximum panel size; and/or

c) Recouping and/or withholding an appropriate portion of the Provider's capitation rate based on the number of panel members affected, the time period of the infraction(s), and the capitation amount attributed to the service; and/or

d) Contract action including, but not limited to, termination of this Agreement and Provider's other SoonerCare Agreements.

ARTICLE VIII. OTHER TERMS AND CONDITIONS

8.1 This Agreement shall be effective upon completion when: (1) it is executed by Provider; (2) all necessary documentation has been received and verified by OHCA; and (3) it has been accepted by OHCA. OHCA acceptance is complete only upon written notification to Provider. The term of this Agreement shall expire March 31, 2021.

8.2 Recoupment of Payments

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

8.3 Incorporation of Attachments by Reference

Attachment A to this Agreement is incorporated by reference and made part of the Agreement.

ARTICLE IX. TERMS SPECIFIC TO SOONERCARE CHOICE

The following apply to Provider only if it is providing services to SoonerCare Choice members under this Agreement:

9.1 Provider may, upon request of a member or OHCA, refer a member to a qualified SoonerCare contracted health care provider for a second opinion. Provider will not be responsible for paying a contracted provider who provides a second opinion.

9.2 Referrals

Provider shall not require a member to obtain a referral for the following services:

a) behavioral health services,
b) vision services, meaning examinations and refractive services provided by optometrists or ophthalmologists within the legal scope of their practice,
c) dental services,
d) child abuse/sexual abuse examinations,
e) prenatal and obstetrical supplies and services, meaning prenatal care, delivery, and sixty (60) days of postpartum care,
f) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a pap smear;
g) women's routine and preventive health care services,
h) emergency services as defined in 5.2a,
i) specialty care for members with special health care needs as defined by OHCA,
j) services delivered to AI/AN members at IHS, tribal, or urban Indian clinics.

9.3 Provider shall furnish information to OHCA about any services Provider does not cover because of prohibitions delineated in Federal statutes and regulations. In the event a change in policy occurs during the term of Addendum 1, Provider must notify OHCA and panel members within thirty (30) days of the policy change.

ARTICLE X. TERMS SPECIFIC TO INSURE OKLAHOMA

The following apply to Provider only if it is providing services to Insure Oklahoma members under this Agreement:

10.1 Referrals

Provider shall not require a member to obtain a referral for the following services:

a) outpatient behavioral health services;
b) prenatal and obstetrical supplies and services, meaning prenatal care, delivery, and sixty (60) days of postpartum care;
c) emergency services;
d) services delivered to AI/AN members at IHS, tribal or urban Indian clinics.

10.2 Provider shall provide data as requested by OHCA to support research and quality improvement initiatives

ARTICLE XI. SEPARATE AGREEMENTS FOR AI/AN AND NON AI/AN MEMBERS

10.3 Provider agrees that this Agreement applies only to services provided to AI/AN members or that this Agreement applies only to services provided to non-AI/AN members. If Provider serves both AI/AN and non-AI/AN members, Provider must execute two separate Agreements and bill for AI/AN members and non-AI/AN members using the appropriate Provider Identification number.

ATTACHMENT A
Monthly Case Management
PMPM Rate Schedule

CHOICE

1. TANF Members

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

2. ABD Members

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

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

INSURE OKLAHOMA

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