SPECIAL PROVISIONS FOR GROUP

1. If PROVIDER has a current Indian Health Service, Tribal, or Urban Indian Hospital or Outpatient Clinic Agreement with OHCA, the General Agreement and Special Provisions 2 through 8 do NOT apply to PROVIDER. If PROVIDER has one of the aforementioned Hospital or Outpatient Clinic Agreements, Addendum 3 Regarding Group Reimbursement applies to PROVIDER.
2. PROVIDER states that it is a group composed of individual health-care professionals (hereinafter "Professional(s)") who each hold a license from the appropriate Oklahoma State licensing agency or the appropriate licensing agency in the state where SoonerCare services are rendered pursuant to this Agreement. Each Professional is an individual who has executed a current Individual Provider Agreement appropriate to Professional's Type with OHCA for provision of health-care services and has assured compliance with state and federal law. PROVIDER has supplied the required information about Professionals in its Provider Information.
3. In compliance with 42 CFR § 447.10(g), PROVIDER states that each Professional is one of the following:
   (a) an employee of PROVIDER who is required as a condition of employment to turn over his or her fees to PROVIDER;
   (b) a Professional who has made PROVIDER his or her agent for the submission of claims on Professional's behalf for health-care services performed by Professional and to receive payment for such claims on Professional's behalf; or
   (c) a health-care professional who has a contract with PROVIDER, which PROVIDER is a foundation, plan, or similar organization operating as an organized health-care delivery system, under which contract PROVIDER submits claims and receives payment for services rendered by Professional.
4. PROVIDER shall keep its listing of Professionals current by modifying its Provider Information online or by notifying OHCA in writing (facsimile acceptable) of each deletion or addition of a Professional at least fifteen calendar days prior to such occurrence; in the event of death, sudden illness or infirmity, unexpected license discipline, unexpected resignation, or similar event, PROVIDER shall:
   (a) modify its Provider Information online as soon as possible;
   (b) notify OHCA by facsimile as soon as possible; or
   (c) notify OHCA by telephone as soon as possible with follow up in writing within three days.
5. If PROVIDER indicates in the Provider Information that PROVIDER agrees to serve as a Choice primary care provider (hereinafter "PCP"), Addendum 1 is made part of this Agreement and incorporated by reference.
6. If PROVIDER indicates in the Provider Information that PROVIDER agrees to serve as an Insure Oklahoma PCP, Addendum 2 is made part of this Agreement and incorporated by reference. Addendum 2 expires December 31, 2014. If PROVIDER specifies a Medical Director for Addendum 1 and/or 2 in its Provider Information, PROVIDER states that the Medical Director is a licensed medical practitioner who is individually eligible to be a SoonerCare primary care provider. PROVIDER agrees that the Medical Director will be responsible for overseeing the care and management of members of PROVIDER's panel(s). PROVIDER shall notify OHCA within 10

days if the Medical Director is no longer responsible for the care of PROVIDER's members or if PROVIDER's Medical Director changes.

7. PROVIDER agrees that its clinical services shall be under the medical supervision of a physician licensed by the Oklahoma State Board of Medical Licensure and Supervision, the Oklahoma Board of Osteopathic Examiners, or the appropriate licensing body of the state where the PROVIDER's facility is located; PROVIDER shall state in writing its organizational policies, responsibilities, and lines of authority, including responsibilities of physicians, physician assistants, and nurse practitioners.
8. The term of this Agreement shall expire November 30, 2017.

ADDENDUM 1 TO SOONERCARE PROVIDER AGREEMENT FOR CHOICE MEDICAL HOME PRIMARY CARE PROVIDERS

1.0 PURPOSE

The purpose of this addendum (hereinafter "ADDENDUM 1") is for OHCA and PROVIDER to contract for primary care provider (hereafter PCP) services in OHCA's SoonerCare Choice Medical Home program.

2.0 DEFINITIONS

The terms used in ADDENDUM 1 have the following meanings:

a. **PANEL** means a group of members who have selected PROVIDER for PCP services.

b. **TIER** means the set of care coordination services for which PROVIDER has been approved for reimbursement by OHCA as shown in Attachment B to ADDENDUM 1.

3.0 PROVIDER QUALIFICATIONS AND SERVICES

3.1 Qualifications

A. If providing primary care to children under 18, PROVIDER has not been terminated from the Vaccines for Children (VFC) program for cause.

B. If PROVIDER's Type is Physician or Certified Nurse Practitioner, PROVIDER must have full prescriptive authority, including Drug Enforcement Administration (DEA) and Oklahoma Board of Narcotics and Dangerous Drugs (OBNDD) numbers or the appropriate authority in the state where services are rendered. If PROVIDER's Type is Group, PROVIDER must have on staff a sufficient number of practitioners with full prescriptive authority including DEA and OBNDD numbers or the appropriate authority in the state where services are rendered to serve the needs of PROVIDER's panel.

C. If PROVIDER's Type is Group, PROVIDER states it consists of Professionals who:

1. are physicians in general practice or board certified in family medicine, internal medicine or pediatrics who provide health care either through the practice of allopathic medicine as defined by 59 Okla. Stat. § 492, or through the practice of osteopathic medicine as defined by 59 Okla. Stat. § 621 and are licensed as required by 59 Okla. Stat. §§ 491 or 622 or the appropriate licensing agency in the state where services are rendered; and/or
2. provide health care services as defined by the Physician Assistant Act 59 Okla. Stat. § Supp. 519.2(3) and are licensed as physician assistants as required by 59 Okla. Stat. Supp. 1997 § 519.4 or the appropriate licensing agency in the state where services are rendered; and/or
3. provide health care services through the practice of advanced practice registered nursing as defined in 59 Okla. Stat. § 567.1 et seq and are licensed and certified as advanced practice registered nurses as required by Okla. Stat. § 567.1 et seq or the appropriate licensing agency in the state where services are rendered.

4. PROVIDER, if employing any medical resident providing services under ADDENDUM 2, states that such resident:
    a. Is licensed to practice medicine in the State of Oklahoma or the state in which he/she practices;
    b. Is at the Post-Graduate (PG-2) level or higher;
    c. Serves within his/her continuity clinic (e.g., family practice residents may only serve within the family practice residency clinic setting);

D. Works under the supervision of a licensed attending physician.

E. If PROVIDER's Type is Physician, PROVIDER states that he/she:
    1. Is in general practice or is board eligible or certified in family medicine, internal medicine or pediatrics;
    2. If a medical resident serving as a PCP, is:
        a. At the Post-Graduate (PG-2) level or higher;
        b. Serving as a PCP only within his/her continuity clinic (e.g., family practice residents may only serve as PCP's within the family practice residency clinic setting);
        c. Working under the supervision of a licensed attending physician.
    3. Is not a primary supervising physician for more than two mid-level practitioners who are SoonerCare and/or Insure Oklahoma PCP's, whether nurse practitioners or physician assistants. Mid-level practitioners rendering care to PROVIDER's panel shall be individually contracted with OHCA.

3.2 Provider Services and Responsibilities

PROVIDER shall:

A. Complete the Tier One, Tier Two or Tier Three Medical Home Self Evaluation Form and notify the OHCA Provider Services Unit within 30 days of any substantive change to the responses on the Self Evaluation Form; assignment to any particular tier is at the sole discretion of OHCA and providers who complete the Tier 2 or Tier 3 form may be assigned to a lower tier; PROVIDER may apply for assignment to a higher tier only after PROVIDER has completed a minimum of one calendar year at the current tier; requests for tier changes are due each year by October 31 and, if granted, are effective on January 1 of the following year;

B. Coordinate care for all Choice members assigned to PROVIDER's panel; Care coordination means: i) coordinating and monitoring all medical care for panel members; ii) making medically necessary specialty referrals for panel members; iii) coordinating panel members' admissions to the hospital; iv) making appropriate referrals to the Women, Infants and Children (WIC) program; v.) coordinating with mental health professionals involved in panel members' care; vi.) educating panel members to appropriately use medical resources such as the emergency room;

C. Provide all required and at least the minimum number of optional care coordination services for all Choice members assigned to PROVIDER's panel

as indicated on the PROVIDER's completed Self-Evaluation Form and as appropriate to PROVIDER's assigned Tier;

D. Ensure that medical services provided to panel members are sufficient in amount, duration, and scope to reasonably meet the health care needs of the members assigned to PROVIDER;

E. Not require a member to obtain a referral for the following services:
   1. Primary care services rendered by another SoonerCare contracted provider;
   2. Behavioral health services;
   3. Vision services, meaning examinations and refractive services provided by optometrists or ophthalmologists within the legal scope of their practice;
   4. Dental services;
   5. Child abuse/sexual abuse examinations;
   6. Prenatal and obstetrical supplies and services, meaning prenatal care, delivery, and sixty (60) days of postpartum care;
   7. Family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a pap smear;
   8. Women's routine and preventive health care services,
   9. Emergency services;
   10. Specialty care for members with special health care needs as defined by OHCA;
   11. Services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

F. If PROVIDER's Type is Group,
   Comply with OHCA rules regarding Early and Periodic Screening, Diagnosis and Treatment **(**EPSDT) screening found at OAC 317:30-3-65 et seq if PROVIDER provides primary care services to member under the age of twenty-one (21); EPSDT screenings must contain all elements shown at OAC 317:30-3-65.2. PROVIDER shall:
   1. Educate families who have members under 21 about the EPSDT Program and its importance to the health of children and adolescents;
   2. Conduct and document EPSDT outreach to ensure that members are current with respect to the periodicity schedule;
   3. Document follow up with members who have missed appointments.

3.3 Access to Care

PROVIDER shall:

A. Establish office hours of access and availability for appointments of at least twenty (20) hours per week; hours of operation shall be 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;

B. Arrange for call coverage when unavailable to members and provide all panel members with the information necessary to ensure member access;

C. Evaluate members' needs for hospital admissions and services and coordinate necessary referrals; if PROVIDER does not have hospital admitting privileges, PROVIDER shall make arrangements with the practitioners specified on PROVIDER's Choice 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.

3.4 OHCA shall provide support services to PROVIDER in the areas of referral arrangements, overall utilization management, claims submission, administrative case management, and member education and discrimination policies;

3.5 Emergency Services

PROVIDER shall not refer members to the emergency room for non-emergency conditions. Medical care for non-emergency medical conditions shall be provided in the office setting. OHCA may levy penalties as provided in Section 5.4 if PROVIDER violates this provision. 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.

3.6 Record Keeping and Reporting

PROVIDER shall:

A. Document in the member's medical record each referral to other health care providers and any known self-referrals made by member and retain medical records and reports submitted to PROVIDER by such providers. If PROVIDER makes a referral to other health care providers or is informed by member about services received from another provider and does not receive a report within a reasonable period, PROVIDER will contact the health care provider to whom the referral was made to obtain such reports;

B. Report to the SoonerCare Call Center any member status changes such as births, deaths, marriages, and changes of residence in a timely manner when known; the current number for reporting is 1-800-987-7767; OHCA shall notify PROVIDER if this number changes;

C. Obtain proper consent and transfer member medical records one time free of charge, if requested, in the event that a member disenrolls from the PCP's panel.

D. Provide data as requested by OHCA to support research and quality improvement initiatives.

3.7 Quality Assurance / Improvement Compliance

PROVIDER shall:

A. Comply with scheduling OHCA Quality Assurance and Improvement (QA/QI) audits and allow designated staff access to medical charts and billing records during onsite review for the purpose of conducting evaluation of access to care and the quality of health services for members;

B. Provide supplemental charts and records after on-site audits in order for QA/QI staff to have complete information demonstrating that access to care and quality services have been assured;

C. If the QA/QI audit determines that PROVIDER has not fulfilled contract requirements, submit a written Corrective Action Plan acceptable to OHCA within a timeframe specified by OHCA; if PROVIDER does not submit an acceptable or timely written Corrective Action Plan, OHCA may levy penalties as provided in Section 5.3;

D. Implement such a Corrective Action Plan to the satisfaction of OHCA within a period specified by OHCA; in the event that PROVIDER does not satisfactorily complete the Corrective Action Plan, OHCA may levy penalties as provided in Section 5.3;
E. Cooperate with OHCA's designated peer review/quality improvement agent in a review of services as required by the Social Security Act, section 1154, in the event that the QA/QI audit determines that PROVIDER may have failed to meet recognized quality of care standards.
F. If PROVIDER participates in a Health Information Exchange/Health Information Organization (HIE/HIO), PROVIDER agrees to allow OHCA access to any information related to PROVIDER's practice contained in such HIE, for performance or contract monitoring, quality assurance or research purposes as well as payment, care management and treatment authorizations, subject to state and federal law. OHCA may share a member's eligibility and claims data with all HIE/HIO members who are treating the same patients for the purpose of payment, treatment and authorizations.

4.0 PROVIDER PANEL REQUIREMENTS

4.1 Panel Capacity

A. PROVIDER shall specify a capacity of Choice members he/she/it is willing to accept under this Agreement.
   1. A full time Choice practitioner means a practitioner available for appointments a minimum of 30 hours per week who sees only Choice members. If the practitioner is available for appointments less than thirty (30) hours a week and/or sees a combination of Choice members and other patients, the practitioner's capacity shall be reduced proportionately. If the practitioner is also an Insure Oklahoma PCP, the practitioner shall not exceed this capacity for both panels combined.
   2. If PROVIDER's type is Physician, up to a maximum of two thousand five hundred (2,500) members for a full time Choice physician; if PROVIDER is a medical resident, enrollment shall not exceed eight hundred seventy-five (875) members for a full time Choice resident.
   3. If PROVIDER's Type is Group, up to a maximum of two thousand five hundred (2,500) members for each full time Choice physician Professional, a maximum of one thousand two hundred fifty (1,250) members for each full time Physician Assistant or Certified Nurse Practitioner Professional, and a maximum of eight hundred seventy-five (875) members for each full time medical resident Professional.
   4. If PROVIDER's Type is Physician Assistant or Certified Nurse Practitioner, up to a maximum of one thousand two hundred and fifty (1,250) members for a full time Choice Physician Assistant or Certified Nurse Practitioner.
B. PROVIDER shall specify a capacity of at least 50 members.
C. OHCA does not guarantee PROVIDER an enrollment level nor will OHCA pay for members who are not eligible or excluded from enrollment.

D. PROVIDER may request a change in his/her/its capacity through the EPE system. This request is subject to review according to program standards. In the event PROVIDER requests a lower capacity, OHCA may lower the capacity by disenrolling members to achieve that number or allowing the capacity to adjust as members change their PCP or lose eligibility;
E. OHCA shall mail PROVIDER a monthly list of Choice panel members. This roster will be mailed to the service location address listed in the Provider Information.

4.2 Panel Enrollment Holds and Non-discrimination

A. PROVIDER shall accept members who request enrollment on PROVIDER's panel without restriction up to the capacity established by this Agreement; that is, PROVIDER shall not place enrollment on his or her panel "on hold".
B. OHCA may temporarily or permanently cease or restrict enrollment of members on PROVIDER's panel at its sole discretion.
C. PROVIDER shall not refuse a panel assignment or discriminate against members on the basis of health status or need for health care services or on the basis of race, color or national origin. PROVIDER shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

4.3 Disenrollment at Request of PCP with Cause

A. PROVIDER may request that OHCA disenroll a panel member for cause with 30 days notice to OHCA. OHCA will give written notice of the disenrollment to the member;
B. OHCA shall disenroll members from PROVIDER's panel if ADDENDUM 1 is terminated.

5.0 FEE PAYMENTS AND REIMBURSEMENTS

5.1 Payment of Care Coordination Fee

In exchange for a care coordination fee paid per member per month, the PCP provides or otherwise assures the delivery of services required for PROVIDER's assigned medical home tier to all of PROVIDER's panel members as appropriate; optional and required services for each tier are shown in Attachment B.

A. OHCA shall pay PROVIDER a monthly fee for each member enrolled with PROVIDER which is payment in full for all care coordination services.
B. PROVIDER's care coordination fee is based on PROVIDER's approved medical home tier and the ages of members enrolled in PROVIDER's panel. Care coordination fees are shown in Attachment A.
C. OHCA shall make fee payments by the tenth business day of each month. A single fee 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. Fee payments shall not be adjusted for enrollments or disenrollments that occur subsequent to the day of processing.

5.2 SoonerExcel quarterly incentive payments

OHCA shall pay PROVIDER quarterly incentive payments within four (4) months following the end of each quarter. Incentive payments shall be made in accordance with the OHCA SoonerExcel methodology effective January 1, 2009. All incentive payments are limited by the total amount of funds available. PROVIDER may view and/or download the SoonerExcel methodology on the OHCA website (http://www.okhca.org) or may request a written copy of the methodology by calling 1-800-522-0114 option 5. OHCA may modify the SoonerExcel methodology at any time by written notification to PROVIDER.

5.3 Penalties

If PROVIDER fails to meet any requirements of ADDENDUM 1 or other SoonerCare requirements, OHCA may notify PROVIDER and impose penalties including:

A. Allowing no new member enrollments to PROVIDER's panel; and/or
B. Temporarily or permanently reducing PROVIDER's maximum panel size; and/or
C. Downgrading PROVIDER's care coordination tier; and/or
D. Reducing or suspending PROVIDER's care coordination fee; and/or
E. Reducing or suspending PROVIDER's SoonerExcel quarterly incentive payments; and/or
F. Contract action up to and including terminating ADDENDUM 1 or PROVIDER's entire SoonerCare Physician Agreement.

6.0 OTHER TERMS AND CONDITIONS

6.1 Recoupment of Payments

In the event ADDENDUM 1 is terminated for any reason, OHCA may recoup any monies owed from PROVIDER to OHCA under this ADDENDUM 1 from PROVIDER's other SoonerCare reimbursements.

6.2 Incorporation by Reference

The completed Medical Home Self-Evaluation Form, Attachment A, Attachment B and the SoonerExcel Methodology are incorporated by reference and made part of this ADDENDUM 1. OHCA may amend any of these at any time by written notification to PROVIDER.

ATTACHMENT A
CARE COORDINATION FEES
Per Member Per Month
Effective 1/1/2012

	Tier 1	Tier 2	Tier 3
Children Only*	3.46	4.50	5.99
Children & Adults*	4.19	5.46	7.26
Adults Only*	4.85	6.32	8.41

*Note: Each PROVIDER designates acceptance of children only, children and adults, or adults only on PROVIDER's panel. Based on that designation, PROVIDER is paid the corresponding rate for ALL members assigned to the panel, regardless of their age.

ATTACHMENT B
REQUIRED AND OPTIONAL SERVICES FOR MEDICAL HOMES
Effective January 1, 2014

Tier One - Entry Level Medical Home

PROVIDER shall:

1.1 Provide or coordinate all medically necessary primary and preventive services;

1.2 Participate in the Vaccines for Children (VFC) program if serving members less than 18 years old, and meet all Oklahoma State Immunization Information System (OSIIS) reporting requirements;

1.3 Organize clinical data in a paper or electronic format as a patient-specific charting system for individual patients;

1.4 Review all medications a patient is taking including prescriptions and maintain the patient's medication list in the chart;

1.5 Maintain a system to track diagnostic tests and provide follow-up on test results, use a tickler system to remind and notify patients as necessary via written log/paper documents or electronic reports;

1.6 Maintain a system to track referrals including self referrals by members, notify panel members when specialty appointment is made by PROVIDER, document at least one attempt to obtain a copy of the specialist's consult and findings, and have written procedures that outline designated staff that maintain and oversee this process;

1.7 Provide care coordination as defined in this Addendum (Section 3.2) and continuity of care through proactive contact with panel members and encourages family participation in coordination of care; coordinates the delivery of primary care services with all specialists, case manager and community-based providers (such as school-based clinics, WIC, and Children's First program) involved with the member, including consultations and referrals;

1.8 Provide patient/family education and support utilizing various forms of educational materials appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided, e.g. patient information handouts found on the OHCA website.

1.9 Obtain written mutual agreement on the role of the medical home between provider and patient which explains defined roles within the context of all joint principles that reflect a patient centered medical home; maintain written agreement in patient's record;

1.10 Use scheduling processes to promote continuity with clinicians including open scheduling and maintaining open appointment slots to accommodate work-in, routine and urgent appointments; open scheduling is defined as the practice of having open appointment slots available for SoonerCare members in the morning and afternoon for same day/urgent care appointments; overbooking patients does not meet this requirement; implement training and written triage procedures for the scheduling staff.

1.11 Accept electronic communication from OHCA in lieu of written notification;

1.12 Provide 24 hours a day/7 days a week voice to voice telephone coverage with immediate availability of a licensed health care professional; all calls are triaged and forwarded to the PROVIDER or on-call covering medical professional when necessary; includes an after hours and weekend/vacation number to call that connects to a person or message that can be returned within one half hour; PROVIDER maintains a formal professional agreement with the on-call covering provider and notification is shared relating to panel members' needs and issues.

1.13 During annual visits PROVIDER uses behavioral screening, brief intervention, and referral to treatment for member 5 and above. Through the use of these screening tools the provider will expedite treatment for members with positive screens with the goal of improving outcomes for members with mental health and/or alcohol or substance use disorders.

Tier Two – Advanced Medical Home

PROVIDER shall meet all Tier One requirements shown above as 1.1 through 1.13 and shall also:

2.1 Maintain a full-time practice which is as defined as having established appointment times available to patients during a minimum of thirty (30) hours each week;

2.2 Use data received from OHCA (i.e. rosters, patient utilization profiles, immunization reports, etc.) and/or information obtained from the OHCA secure website (eligibility, last dates of EPSDT/mammogram/pap etc.) to identify and track medical home patients both inside and outside of the PCP practice;

2.3 Coordinate care and follow-up for patients who receive care in inpatient and outpatient facilities; information can be obtained from the member, OHCA, or the facility; maintain this information in the medical record; upon notification of member activity, attempt to contact member and schedule a follow-up appointment as needed;

2.4 Implement processes to promote access to care and provider-member communication; communicate directly with panel members through a variety of methods (email, mail, etc.).

PROVIDER shall also meet at least three of the following requirements:

2.5 Develop a health care team to provide ongoing support, oversight and guidance of all medical care received by the member; document contact with specialist and other health care disciplines that provide care for the member outside PROVIDER's office;

2.6 Provide post-visit follow up for panel members;

2.7 Implement specific evidence-based clinical practice guidelines for preventive and chronic care as defined by the appropriate specialty category, e.g. AAP, AAFP;

2.8 Implement a medication reconciliation procedure to avoid interactions of duplications, e.g. e-Pocrates, e-Prescribing, SoonerScribe Pro-DUR software, screening for drug interactions;

2.9 Make after hours care available to patients by offering panel members appointments (scheduled or work-ins) during at least four (4) hours each week outside of the hours of 8am to 5pm, Monday through Friday; solo practitioners may provide after-hours care through another OHCA-contracted SoonerCare

Choice PCP; multiple locations can provide after-hours care at a single location with written approval from OHCA; maintain availability of after hours care during PROVIDER vacations.

Tier Three – Optimal Medical Home

PROVIDER shall meet all Tier One and Tier Two requirements shown as 1.1 through 2.9 and shall also:

3.1 Use health assessment tools to characterize panel members' needs and risks utilizing any OHCA-recommended format, e.g. AAP approved standardized developmental screening tool, SoonerCare Health Assessment form, disease-specific screening tool;

OHCA recommends that PROVIDER also:

3.2 Use a secure electronic interactive web site to maximize communications with panel members/families to allow patients to request appointments, referrals, test results and prescription refills, as well as allow PROVIDER to contact patients to schedule follow-up appointments, relay test results, inform patients of preventive care needs, instruct on medication;

3.3 Utilize integrated care plans for panel members who are co-managed with specialists and/or other health care disciplines and maintain a central record or database that contains all pertinent information;

3.4 Regularly measure PCP performance for quality improvement, using national benchmarks for comparison; take necessary action to continuously improve services/processes; report information to OHCA regularly.

ADDENDUM 2 TO SOONERCARE PROVIDER AGREEMENT FOR INSURE OKLAHOMA/O-EPIC IP PRIMARY CARE PROVIDERS

1.0 PURPOSE

The purpose of this Addendum (hereinafter "ADDENDUM 2") is for OHCA and PROVIDER to contract for Insure Oklahoma (IO IP) PCP services.

2.0 DEFINITIONS

The terms used in ADDENDUM 2 have the following meanings:

A. **PANEL** means a group of members who have selected PROVIDER for PCP services.

3.0 PROVIDER QUALIFICATIONS AND SERVICES

3.1 Licenses and Permits

A. If PROVIDER's Type is Physician, PROVIDER states that he/she:

1. Is in general practice or is board eligible or certified in family medicine, internal medicine or pediatrics;
2. If PROVIDER's Type is Physician, Physician Assistant or Certified Nurse Practitioner, PROVIDER must have full prescriptive authority, including Drug Enforcement Administration (DEA) and Oklahoma Board of Narcotics and Dangerous Drugs (OBNDD) numbers or the appropriate authority in the state where services are rendered. If PROVIDER's Type is Group, PROVIDER must have on staff a sufficient number of practitioners with full prescriptive authority including DEA and OBNDD numbers or the appropriate authority in the state where services are rendered to serve the needs of PROVIDER's panel;
3. If a medical resident serving as a PCP, is:
    a. At the Post-Graduate (PG-2) level or higher;
    b. Serving as a PCP only within his/her continuity clinic (e.g., family practice residents may only serve as PCP's within the family practice residency clinic setting);
    c. Working under the supervision of a licensed attending physician.

B. If PROVIDER's Type is Group, PROVIDER states it consists of Professionals who:

1. are physicians in general practice or board certified in family medicine, internal medicine or pediatrics who provide health care either through the practice of allopathic medicine as defined by 59 Okla. Stat. § 492, or through the practice of osteopathic medicine as defined by 59 Okla. Stat. § 621 and are licensed as required by 59 Okla. Stat. §§ 491 or 622 or the appropriate licensing agency in the state where services are rendered; and/or
2. provide health care services as defined by the Physician Assistant Act 59 Okla. Stat. § Supp. 519.2(3) and are licensed as physician assistants as required by 59 Okla. Stat. Supp. 1997 § 519.4 or the appropriate licensing agency in the state where services are rendered; and/or

3. provide health care services through the practice of advanced practice registered nursing as defined in 59 Okla. Stat. § 567.1 et seq and are licensed and certified as advanced practice registered nurses as required by Okla. Stat. § 567.1 et seq or the appropriate licensing agency in the state where services are rendered.
4. PROVIDER, if employing any medical resident providing services under ADDENDUM 2, states that such resident:
    a. Is licensed to practice medicine in the State of Oklahoma or the state in which he/she practices;
    b. Is at the Post-Graduate (PG-2) level or higher;
    c. Serves within his/her continuity clinic (e.g., family practice residents may only serve within the family practice residency clinic setting);
    d. Works under the supervision of a licensed attending physician.

3.2 Provider Services and Responsibilities

PROVIDER shall:

A. Provide case management services and primary care services for IO IP members assigned to PROVIDER's panel. Case management means: i) coordinating and monitoring all medical care for panel members; ii) making medically necessary specialty referrals for panel members, including standing referrals (i.e. a PCP 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; iii) coordinating panel members' admissions to the hospital; iv) making appropriate referrals to the Women, Infants and Children (WIC) program; v.) coordinating with mental health professionals involved in panel members' care; vi.) educating panel members to appropriately use medical resources such as the emergency room;

B. Ensure that the services provided are sufficient in amount, duration, and scope to reasonably meet the health care needs of the members assigned to PROVIDER;

C. Not require a member to obtain a referral for the specialty care of members with special health care needs as defined by OHCA or for other services listed at OAC 317:45-11-10 which currently include:
    1. Behavioral health services
    2. Prenatal and obstetrical supplies, meaning prenatal care, delivery, and sixty (60) days of postpartum care,
    3. Emergency services
    4. Services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics;
    5. Family planning supplies and services, meaning an office visit for comprehensive family planning evaluation; including obtaining a Pap smear
    6. Women's routine and preventive health care services.

D. 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.

E. If providing primary care to children under 18, have not been terminated from the Vaccines for Children (VFC) program for cause.

F. If PROVIDER's type is GROUP, comply with OHCA rules regarding Early and Periodic Screening, Diagnosis and Treatment **(**EPSDT) screening found at OAC 317:30-3-65 et seq if PROVIDER provides primary care services to member under the age of twenty-one (21); EPSDT screenings must contain all elements shown at OAC 317:30-3-65.2. PROVIDER shall:
   1. Educate families who have members under 21 about the EPSDT Program and its importance to the health of children and adolescents;
   2. Conduct and document EPSDT outreach to ensure that members are current with respect to the periodicity schedule;
   3. Document follow up with members who have missed appointments.

3.3 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 lay person 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**;**

C. 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;

D. 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 and paid for by PROVIDER;

E. Evaluate members' needs for hospital admissions and services and coordinate necessary referrals. If PROVIDER does not have hospital admitting privileges, PROVIDER shall make arrangements with the practitioners specified on PROVIDER's application form 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.

3.4 Emergency Services

PROVIDER shall not refer patients to the emergency room for non-emergency conditions. Medical care for non-emergency medical conditions shall be provided 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.

3.5 Record Keeping and Reporting

PROVIDER shall:

A. Document in the member's medical record each referral to other health care providers. PROVIDER shall also 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 Insure Oklahoma Call Center any member status changes such as births, deaths, marriages, and changes of residence in a timely manner when known; the current number for reporting is 1-888-365-3742; OHCA shall notify PROVIDER if this number changes;
C. Provide data as requested by OHCA to support research and quality improvement initiatives;
D. Obtain proper consent and transfer member medical records free of charge, if requested, in the event that the member moves or changes PCPs.

4.0 PROVIDER PANEL REQUIREMENTS

4.1 Panel Capacity

A**.** PROVIDER shall specify a capacity of IO IP members he/she is willing to accept under this Agreement.

1. A full time IO IP practitioner means a practitioner available for appointments a minimum of 30 hours per week who sees only IO IP members**.** If the practitioner is available for appointments less than thirty (30) hours a week and/or sees a combination of IO IP members and other patients, the practitioner's capacity shall be reduced proportionately. If the practitioner is also a Choice PCP, the practitioner shall not exceed this capacity for both panels combined.
2. If PROVIDER's Type is Physician, up to a maximum of two thousand five hundred (2,500) members for a full time IO IP physician and a maximum of eight hundred seventy-five (875) members for a full time resident;
3. If PROVIDER's Type is Group, up to a maximum of two thousand five hundred (2,500) members for each full time IO IP Physician Professional, a maximum of one thousand two hundred fifty (1,250) for each full time Physician Assistant or Certified Nurse Practitioner Professional, and a maximum of eight hundred seventy-five (875) members for each medical resident Professional;

4. If PROVIDER's type is Physician Assistant or Certified Nurse Practitioner, up to a maximum of one thousand two hundred and fifty (1,250) members for a full time IO IP Physician Assistant or Certified Nurse Practitioner.

B. If PROVIDER initially enrolls as an IO IP PCP after October 1, 2008, PROVIDER shall specify a capacity of at least 50 members.

C. OHCA does not guarantee PROVIDER an enrollment level nor will OHCA pay for members who are not eligible or excluded from enrollment.

D. PROVIDER may request a change in his/her/its capacity through the EPE system. This request is subject to review according to program standards. In the event PROVIDER requests a lower capacity, OHCA may lower the capacity by disenrolling members to achieve that number or allowing the capacity to adjust as members change their PCP or lose eligibility;

4.2 Non-discrimination

Unless approved by OHCA, PROVIDER must accept members in the order in which they apply without restriction up to the capacity established by ADDENDUM 2. PROVIDER shall not refuse an assignment or discriminate against members on the basis of health status or need for health care services or on the basis of race, color or national origin. PROVIDER shall not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

4.3 Continuity of Care

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 until PROVIDER has received notification from OHCA.

4.4 Disenrollment at Request of PCP with Cause

PROVIDER may request OHCA to disenroll a member for cause. OHCA will give written notice of the disenrollment request to the member.

5.0 OBLIGATIONS OF OHCA

OHCA shall:

A. Mail PROVIDER a monthly list of IO IP panel members; this enrollment roster will be mailed to the service location address listed in the Provider Information;

B. 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;

C. Disenroll members from PROVIDER's panel if ADDENDUM 2 is terminated.

6.0 FEE PAYMENTS AND REIMBURSEMENTS

6.1 Payment of Case Management Fee

In exchange for a fee paid per member per month, the PCP provides or otherwise assures the delivery of case management services and referrals for specialty services for an enrolled group of eligible individuals.

A. OHCA shall pay PROVIDER a fee for each member enrolled with PROVIDER which is payment in full for all case management services.

B. Rates for IO IP case management are available on the OHCA website.
C. OHCA shall make payments by the tenth 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.

6.2 Payment for Services other than Case Management

OHCA shall pay PROVIDER for services in accordance with the appropriate Part of OHCA's Provider Manual OAC 317:30-1-1- et seq. Coverage by Category and limitations

6.3 Penalties

If PROVIDER fails to provide required case management services, or access to care as defined in Section 3.3, 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 case management fee based on the number of panel members affected, the time period of the infraction(s), and the amount attributed to the service; and/or
D. Contract action up to and including terminating ADDENDUM 2 or PROVIDER's entire SoonerCare Agreement.

7.0 OTHER TERMS AND CONDITIONS

7.1 Recoupment of Payments

In the event ADDENDUM 2 is terminated for any reason, OHCA may recoup any monies owed from PROVIDER to OHCA under ADDENDUM 2 from PROVIDER's other SoonerCare reimbursements.

ADDENDUM THREE TO REIMBURSEMENT AGREEMENT FOR HOSPITAL OR OUTPATIENT CLINIC SERVICES REGARDING GROUP REIMBURSEMENT For U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OKLAHOMA CITY AREA INDIAN HEALTH SERVICE Or TRIBAL HEALTH SERVICES PROVIDER Or URBAN INDIAN HEALTH CARE FACILITY

ARTICLE 1. PURPOSE

The purpose of this Addendum is to delineate Oklahoma Health Care Authority (OHCA) and PROVIDER'S agreement that PROVIDER will be reimbursed from OHCA for allowable inpatient physician charges outside of the OMB rate.

ARTICLE II. HOSPITAL/CLINIC AGREEMENT

The parties have a current provider Agreement for Hospital Services and/or Outpatient Clinic Services. That Agreement is incorporated by reference into this Addendum.

ARTICLE III. GROUP

3.1 PROVIDER states that its individual physicians are appropriately licensed to render the SoonerCare services reimbursed pursuant to this Addendum and that each physician has executed a current individual Reimbursement Agreement for Physician Services and supplied correct Provider Information.

3.2 In compliance with 42 C.F.R. § 447.10(g), PROVIDER states that each Practitioner is one of the following:

(a) an employee of PROVIDER who is required as a condition of employment to turn over his or her fees to PROVIDER;

(b) a Practitioner who has made PROVIDER his or her agent for the submission of claims on Practitioner's behalf for health-care services performed by Practitioner and to receive payment for such claims on Practitioner's behalf; or

(c) a Practitioner who has a contract with PROVIDER, under which contract PROVIDER submits claims and receives payment for services rendered by Practitioner.

3.3 PROVIDER shall complete Appendix A and submit it with this Addendum listing its Practitioners. It shall keep its listing of Practitioners current by modifying its Provider Information online or by notifying OHCA in writing via facsimile of each deletion or addition of a Practitioner at least fifteen calendar days prior to such occurrence. In the event of death, sudden illness or infirmity, unexpected

license discipline, unexpected resignation, or similar event, PROVIDER shall modify its Provider Information online or notify OHCA by facsimile as soon as possible.

ARTICLE IV. REIMBURSEMENT

OHCA shall reimburse PROVIDER for allowable inpatient charges outside of the Office of Management and Budget rate in accordance with the appropriate part of OHCA's Provider Manual § 317:30-1-1-et seq., Coverage by category and limitations.