SPECIAL PROVISIONS FOR PHYSICIAN

1. Provider holds a license as a physician from the Oklahoma State Board of Medical Licensure and Supervision, the Oklahoma State Board of Osteopathic Examiners, or the appropriate licensing agency in the state where SoonerCare services are rendered.
2. "Practice of Medicine" means the practice of medicine and surgery as provided in 59 Okla. Stat. § 492 (C) and the practice of osteopathic medicine as provided in 59 Okla. Stat. § 621 or as defined in the appropriate licensure act in the state where services are rendered. Provider agrees to abide by all restrictions on the practice of medicine, as appropriate to physician's license, as expressed by the Oklahoma Statutes and Oklahoma State Board of Medical Licensure and Supervision or Oklahoma State Board of Osteopathic Examiners rules or the appropriate statutory and regulatory restrictions of the state where services are rendered.
3. 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. Unless otherwise deemed exempt, due to specialty, by the Oklahoma Health Care Authority (OHCA).
4. Provider agrees:
   A. To have in force medical malpractice insurance in the amount of no less than one million dollars ($1,000,000.00) per occurrence, unless all hospitals at which he/she has staff privileges require less; in which case he/she must carry insurance at the level of the most restrictive hospital requirement. A Physician covered by the Federal or State Tort Claims Act is exempt from this requirement;
   B. Comply with O.A.C. 317:30-5-14 regarding Vaccine for Children program if Provider provides primary care services to members under the age of eighteen (18); and
   C. To comply with OHCA rules regarding Early and Periodic Screening, Diagnosis and Treatment **("**EPSDT") screening found at O.A.C. 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 O.A.C. 317:30-3-65.2; Provider shall:
      a) Educate families who have members under 21 about the EPSDT Program and its importance to the health of children and adolescents;
      b) Conduct and document EPSDT outreach to ensure that members are current with respect to the periodicity schedule; and
      c) Conduct and document follow up with members who have missed appointments.

5. If Provider shall serve as a Primary Care Provider ("PCP") in the Choice program, then Addendum 1 is made part of this Agreement and incorporated by reference.
6. If Provider has a specialty of Psychiatrist and that he/she provides services under the Developmental Disabilities Services Home and Community Based Waiver Program, then Addendum 3 is incorporated by reference and made part of this Agreement.
7. The term of this Agreement shall expire on September 30, 2028.

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

1. PURPOSE:

   The purpose of this Addendum ("Addendum 1") is for OHCA and Provider to contract for Primary Care Provider ("PCP") services in OHCA's SoonerCare Choice Medical Home program.

2. DEFINITIONS:

   The terms used in Addendum 1 have the following meanings:

   A. Panel - A group of members who have selected Provider for PCP services.
   B. Level - The set of care coordination services for which Provider has been approved for reimbursement by OHCA as shown in Attachment B to Addendum 1.
   C. PCMH- Patient-Centered Medical Home.

3. PROVIDER QUALIFICATIONS AND SERVICES

   3.1 Qualifications

   A. 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. Unless otherwise deemed exempt, due to specialty, by the OHCA.
   B. If Provider's type is Group:
      1. Any Certified Nurse Practitioner or Physician shall have 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.
      2. Provider states it consists of professionals who 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 O.S. § 492, or through the practice of osteopathic medicine as defined by 59 O.S. § 621 and are licensed as required by 59.
         O.S. §§ 491 or 622 or the appropriate licensing agency in the state where services are rendered.
      3. Provider provides health care services as defined by the Physician Assistant Act 59 O.S. § 519.2(3) and are licensed as Physician Assistants as required by 59 O.S. § 519.4 or the appropriate licensing agency in the state where services are rendered.

4. Provider shall comply with OHCA rules regarding 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:
    i. Educate families who have members under 21 about the EPSDT Program and its importance to the health of children and adolescents;
    ii. Conduct and document EPSDT outreach to ensure that members are current with respect to the periodicity schedule; and
    iii. Conduct and document follow up with members who have missed appointments.
5. Provider provides health care services through the practice of Advanced Practice Registered nursing as defined in 59 O.S. § 567.1 *et seq.* and are licensed and certified as Advanced Practice Registered Nurses as required by O.S. § 567.1 *et seq.* or the appropriate licensing agency in the state where services are rendered.

C. 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. Is not a primary supervising Physician for more than two mid-level practitioners who are SoonerCare and/or Insure Oklahoma PCPs, whether Nurse Practitioners or Physician Assistants. Mid-level practitioners rendering care to Provider's panel shall be individually contracted with OHCA pursuant to the applicable regulations regarding their provider type.

3.2 Provider Services and Responsibilities

Provider shall:

A. Complete the Entry Level, Advanced Level, or Optimal Level PCMH SoonerCare Choice Application ("Application") and notify the OHCA Provider Services Unit within 30 days of any substantive change to the responses on the PCMH SoonerCare Choice application. Assignment to any particular level is at the sole discretion of OHCA and providers who complete the Advanced Level or Optimal Level application may be assigned to a lower level. Provider may apply for assignment to a higher level only after Provider has completed a minimum of one (1) calendar year at the current level. Provider shall be in compliance based on his/her/its last review to be considered for approval. Requests for level changes are due each year by September 30 and, if granted, are effective on January 1 of the following year. Upon execution of the Application by both the Provider and OHCA Provider Services Unit, the Application shall become part of this

Addendum pursuant to paragraph 6.2 hereof.

B. Coordinate care for all Choice members assigned to Provider's panel. Care coordination means:
   1. Coordinating and monitoring all medical care for panel members;
   2. Making medically necessary specialty referrals for panel members;
   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 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 PCMH SoonerCare Choice application and as appropriate to Provider's assigned level.

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; and/or
   11. Services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

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 for Entry level and of at least thirty (30) hours per week for an Advanced or Optimal level provider. 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 5.3 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.
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 furnish the Provider a monthly list of Choice panel members. This roster is available in the Provider's portal.

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/her/its 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-day 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 level to all of Provider's panel members as appropriate; optional and required services for each level are shown in Attachment B.

A. The term "established member", as used in this section, shall mean a member that has been seen by Provider for treatment purposes, at least every 15 months, after enrollment in that Provider's panel, unless the member disenrolls from that panel.
B. OHCA shall pay Provider's monthly fee for each member enrolled with Provider which is payment in full for all care coordination services.

C. Provider's care coordination fee is based on Provider's approved medical home level and the ages of members enrolled in Provider's panel. Care coordination fees are shown in Attachment A.

D. 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.

E. 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. 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 level; 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 Application, 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)

Current Care Coordination Rates can be found at:
http://www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165

**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 SERVICES FOR MEDICAL HOMES

Entry Level Medical Home

Provider shall:

1. Maintain a full-time practice, which is defined as having established appointment times available to patients during a minimum of 20 hours each week.
2. Provide all medically necessary primary and preventive services for panel members;
3. Organizes clinical data in a paper or electronic format as a patient-specific charting system for individual panel members. A patient-specific charting system is defined as charting tools that organize and document clinical information, such as the medical record: problem lists, medication list, etc., structured template for appropriate risk factors, structured templates for narrative progress notes;
4. Maintain a medication list within the medical record and should be updated during each office visit. This medication list includes chronic, acute, over-the-counter medications, and herbal supplements; to include all prescribing instructions, i.e. dosage, method of administration, frequency, start and stop dates, etc.;
5. Maintain a step-by-step system to track the entire process for lab/diagnostic tests. This should include the process of follow-up on test results as well as patient reminders and notifications as needed. This tracking method can be via written logs/paper-based documents or electronic reports. Provider must have written policies and procedures for this measure. The written policy and procedures should include the designated staff *(by position, i.e. nurse, medical assistant, clerk, etc.)* assigned to maintain and oversee this process;
6. Maintain a step-by-step system to track referrals including self-referrals communicated to provider by member. This should include the process of follow-up on consult notes and findings as well as to remind and notify patients to follow-up as needed. This tracking method can be via written logs/paper-based documents or electronic reports. Provider notifies panel members when a specialty appointment is made by the PCP. Provider documents attempts to obtain a copy of the specialist provider's consult notes and findings. Provider must have written policies and procedures for this measure. The written policy and procedures should include the designated staff *(by position, i.e. nurse, medical assistant, clerk, etc.)* assigned to maintain and oversee this process;
7. Supply Care Coordination for all SoonerCare members. This includes continuity of care through proactive contact with panel members and incorporates the family/support system with coordination of care. Provider will coordinate the delivery of primary care services with any specialist, case manager, and community-based entity involved with

the patient *(WIC, and Children's First program, home health, hospice, DME, etc.)* This includes but is not limited to: referrals, lab/diagnostic testing, preventive services and behavioral health screening;

8. Supply patient/family education and support utilizing varying forms of educational materials appropriate for individual patient needs/medical conditions to improve understanding of the medical care provided and plan of treatment. An example would include patient education handouts. This education must be documented within the patient medical record;
9. Explain the expectations of a patient-centered medical home with the patient. The defined roles should be explained within the context of all of the joint principles which reflect a patient- centered medical home.
10. Use scheduling processes to promote continuity of care through maintaining open appointment slots daily. Open scheduling is defined as the practice of having open appointments slots available in the morning and afternoon for same day/urgent care appointments. This does not include double-booking appointment times. Provider implements training and written triage procedures for the scheduling staff;
11. Supply voice-to-voice telephone coverage to panel members 24 hours a day, seven days a week. This must provide an opportunity for the patient to speak directly with a licensed health care professional. The number to call should connect to a person or message which can be returned within thirty minutes. All calls are triaged and forwarded to the PCP or on-call provider when necessary. This coverage includes after office hours and weekend/vacation coverage. Provider maintains a formal professional agreement with the on-call PCP or provider and notification is shared relating to panel members' needs and issues; and
12. Use behavioral screening, brief intervention, and referral to treatment for members five years of age and above. Behavioral screening is an annual requirement. Through the use of screening tools, the provider will coordinate treatment for members with positive screens with the goal of improving outcomes for members with mental health and/or alcohol or substance use disorders.

<u>Advanced Level Medical Home</u>

Provider shall meet all Entry Level requirements shown above as 1 through 12 and shall also:

1. Use data received from OHCA (i.e. rosters, patient utilization profiles, immunization reports, etc.) and/or information obtained from secure website (eligibility, last dates of EPSDT/mammogram/pap, etc.) to identify and track panel members utilization of services both inside and outside of the PCP practice;
2. Provide transitional care coordination for all panel members. This is the coordination and follow-up for any care/services received by member

in any outpatient and inpatient facilities. Information can be obtained from the member, OHCA or the facility. This information should be documented within the medical record and added to the problem list. Upon notification of member activity, the provider attempts to contact member and schedule a follow up appointment as appropriate; and

3. Implement processes to promote access to care and provider-member communication. PCP or office staff communicates directly with panel members through a variety of methods (email, scheduled and unscheduled postal mailings, etc.).
4. Implement post-visit outreach. The outreach effort should be done after an acute or chronic visit and is documented within the member's record. Outreach is overseen and directed by the provider but may be performed by the appropriate designated staff. Examples of outreach include phone calls to monitor medications changes, weight checks, blood glucose, blood pressure monitoring, etc.
5. Use health assessment tools (other than behavioral health) to identify potential patient needs and risks (e.g., developmental, or symptom-specific). Tools may address potential health risks such as demographics, lifestyle, medical history, illness, etc. Examples include AAP approved standardized developmental screening tool, disease-specific screening tool, etc.

Provider shall also meet at least two of the following requirements:

1. Implement a PCP- led practice by developing a healthcare team that provides ongoing support, oversight, and guidance of all medical care received by the member. Provider leads and oversees the healthcare team to meet the specific needs and plan of care for each panel member. This requirement also includes documentation of contact with specialist and other health care disciplines that provide care for the member outside of the PCP office. The team may include doctors, nurses, and other office staff.
2. Implement specific evidence-based clinical practice guidelines for preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.
3. Implement a medication management procedure to avoid interactions or contraindications. Examples may include using e-Pocrates, e-Prescribing, SoonerScribe Pro-DUR software screening for drug interactions, etc.
4. Offer at least 4 hours of after-hours care to SoonerCare members in addition to the required 30 hours per week for the full-time provider requirement. *(After hours care is defined as appointments, scheduled*

or work-ins, readily available to SoonerCare members outside the hours of 8 a.m. - 5 p.m. Monday – Friday). These hours should be included in the posted office hours.

Optimal Level Medical Home

Provider shall meet all Entry Level and Advanced requirements shown above and shall also use health assessment tools *(other than Behavioral Health)* to identify potential patient needs and risks; e.g. developmental or symptom specific. Tool may address potential health risks such as demographics, lifestyle, medical history, illness, etc. (examples include AAP approved standardized developmental screening tool, disease-specific screening tool, etc.

Provider shall also meet one of the following requirements:

1. Use a secure electronic interactive website to maximize communication with panel members
and families. This will allow patients to request appointments, referrals, test results and prescription refills. It also allows the practice to contact patients to schedule follow-up appointments, relay test results, and inform patients of preventive care needs and medication instructions.

2. Utilizes integrated care plans for panel members who are co-managed with specialist(s) or other healthcare disciplines and maintains a central record or database that contains all pertinent information.

3. Regularly measure performance for quality improvement using national benchmarks for comparison. Takes necessary actions to continuously improve services and processes. All quality improvement projects measured by the provider must be reported to OHCA on a quarterly basis.

ADDENDUM 3 FOR
HOME AND COMMUNITY-BASED SERVICES WAIVER PROVIDERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES PSYCHIATRIC SERVICES

A. Provider is an individual certified by the Oklahoma Department of Human Services ("DHS") Developmental Disabilities Services ("DDS") as eligible to provide services under the Home and Community Based Services ("HCBS") Waiver program.
B. Provider agrees that services will be monitored by DDS and assures reasonable access to its facilities, employees, members, services, and all records to enable DHS and its agents to monitor Provider's compliance with this Agreement.
C. Provision of services under this Addendum is limited to persons who have been certified by DHS as categorically needy and meet medical criteria for Home and Community Based (HCBS) Services for persons with developmental disabilities. This includes members enrolled in the Living Choice Program who may ultimately be enrolled in the HCBS Waiver.
D. Compensable services are described below. To the extent that HCBS are not compensable services, the services may be provided but shall not be compensated by OHCA.
E. Provider agrees to submit HCBS service claims to OHCA only:
    1. For services provided to individuals determined by DHS to be eligible for HCBS, except for claims in which eligibility has not been determined and failure to file a timely claim may jeopardize payment;
    2. In the amount, scope and duration specified in the Individual Plan (IP) and for whom they have received authorization from DHS; and
    3. After all other insurance or similar sources other than SoonerCare are exhausted; Provider shall bill other resources first.
F. Provider must deliver services in a manner that contributes to the member's enhanced independence, self-sufficiency, community integration and well-being.
G. Provider shall:
    1. Act immediately to remedy any situation that poses a risk to the health, well-being or provision of specified services to the member; in the event of such a threat, Provider must immediately notify DHS of the nature of the situation and must notify DHS upon resolution of the threatening situation;
    2. Cooperate with other entities supplying services to members served through this Agreement;
    3. Report all cases of suspected abuse or neglect of children in accordance with 10 O.S. § 7101 *et seq*. and all cases of suspected abuse, neglect or exploitation of adults in accordance with 43A O.S. § 10-101 *et seq.*;
    4. Not provide services that duplicate the services mandated to be provided by the public school district pursuant to the Individuals with Disabilities Education Act;

5. Supply services for which Provider has been determined responsible as reflected in the member's IP, at those times and places necessary to meet the member's needs; and
6. If applicable, make reasonable effort to ensure members are afforded freedom of choice in all aspects of service provision, for which Provider is responsible, unless such choice jeopardizes the member's independence.

H. Description of Services: Services provide out-patient services comprised of diagnosis, treatment, and prevention of mental illness. Services also include review, assessment and monitoring of psychiatric conditions, evaluation of the current plan of treatment and

recommendations for a continued and/or revised plan of treatment and/or therapy, including required documentation. Psychiatrists may provide instruction and training to individuals, family members, case management staff and/or provider staff in the recognition of psychiatric illness and adverse reactions to medications. Services may be provided to eligible members who are approved to receive DDS Home and Community Based Services HCBS. Services are provided in any community setting as specified in member's IP. Services are intended to contribute to the member's psychological well-being. A minimum of 30 minutes for encounter and record documentation is required. OHCA may change this Description of Services at any time by notification to Provider. No amendment executed by both parties is required for this purpose.

I. Provider serves as a member of the personal support team as described in O.A.C. 340:100- 5-50 through 100-5-58.