SPECIAL PROVISIONS FOR PHYSICIAN ASSISTANT

1. Provider holds a license as a Physician Assistant from the Oklahoma State Board of Medical Licensure and Supervision 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.

3. Provider agrees to abide by all restrictions on the practice of medicine, as appropriate to Physician Assistant’s license, as expressed by the Oklahoma Statutes and Oklahoma State Board of Medical Licensure and Supervision or the appropriate statutory and regulatory restrictions of the state where services are rendered.

4. If Provider has indicated in the Provider Information enrollment only as an “Ordering/Referring Provider”, this provision does not apply. Otherwise, Provider agrees:
   a. To participate in the Vaccine for Children Program if Provider provides primary care services to members under the age of eighteen (18);
   b. 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 Provider must carry insurance at the level of the most restrictive hospital requirement; a Physician, Physician Assistant, or Nurse Practitioner covered by the Federal or State Tort Claims Act is exempt from this requirement; and
   c. To comply with OHCA rules regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening found at OAC 317:30-3-65 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; and
      3. Conduct and document follow ups with members who have missed appointments.

5. If Provider indicates in the Provider Information that Provider shall serve as a Primary Care Provider (hereinafter “PCP) in the Choice program, then Addendum 1 is made part of this Agreement and incorporated by reference.

6. If Provider indicates in the Provider Information that Provider shall serve as a PCP in the IO program, then Addendum 2 is made part of this Agreement and incorporated by reference.

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/RESPONSIBILITIES
3.1 Qualifications Provider shall:
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 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.
C. If Provider’s type is Group:
   1. 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.
   2. Provider states it consists of professionals who:
      a. 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
      b. Provide health care services as defined by the Physician Assistant Act 59 Okla. Stat. § 519.2 and are licensed as Physician Assistants as required by 59 Okla. Stat. § 519.4 or the appropriate licensing agency in the state where services are rendered; and/or
      c. 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.
D. If Provider’s Type is Physician:
   1. 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.
   2. Provider states that he/she:
      a. Is in general practice or is board eligible or certified in family medicine, internal medicine or pediatrics; and
      b. 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 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. Provider shall be in compliance based on their last review to be considered for approval; requests for tier changes are due each year by November 30 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:
   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 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; and
11. Services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

F. If Provider’s Type is Group:
1. Provider shall 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 in OAC 317:30-3-65.2.
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. 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 for Tier 1 and of at least thirty (30) hours per week for a Tier 2 or Tier 3. 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 **Support Services**
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 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 Provider’s legal scope of practice in an emergency room setting.

3.6 **Record Keeping and Reporting**
Provider shall meet all of the following requirements:

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 meet all of the following requirements:

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.

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.
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’ Provider 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 per full-time Choice Physician.

3. If Provider’s Type is Group, up to a maximum of two thousand five hundred (2,500) members per each full time Choice Physician Professional and a maximum of one thousand two hundred fifty (1,250) members per each full time Physician Assistant or Certified Nurse Practitioner Professional.

4. If Provider’s Type is Physician Assistant or Certified Nurse Practitioner, a maximum of one thousand two hundred and fifty (1,250) members per 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 their 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
A. 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.
B. OHCA shall pay Provider a 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 tier 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. This payment will be made for all Provider’s panel members regardless of what, if any, covered services Provider renders during the 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 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;
B. Temporarily or permanently reducing Provider’s maximum panel size;
C. Downgrading Provider’s care coordination tier;
D. Reducing or suspending Provider’s care coordination fee;
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*

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*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

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 office hours to see patients a total of at least thirty (30) scheduled 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 panel members both inside and outside of the PCP practice.

2.3 Coordinate care and follow-up for panel members 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 management 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.

2.10 Use health assessment tools to characterize patient’s needs and risks utilizing any OHCA-recommended format, e.g. AAP approved standardized developmental screening tool, SoonerCare Health Assessment form, or disease-specific screening tool.
Tier Three – Optimal Medical Home
Provider shall meet all Tier One and Tier Two requirements shown as 1.1 through 2.10 and shall also:

3.1 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, and instruct on medication.

3.2 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.

3.3 Regularly measure PCP performance for quality improvement, using national benchmarks for comparison. Provider shall take necessary action to continuously improve services/processes and report information to OHCA regularly.
ADDENDUM 2 TO SOONERCARE PROVIDER AGREEMENT
FOR INSURE OKLAHOMA 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
Provider shall:
A. If Provider’s type is 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.
B. If Provider’s type is Group:
   1. 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.
   2. Provider states it consists of professionals who:
      a. 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
      b. Provide health care services as defined by the Physician Assistant Act 59 Okla. Stat. § 519.2 and are licensed as Physician Assistants as required by 59 Okla. Stat. § 519.4 or the appropriate licensing agency in the state where services are rendered; and/or
      c. 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.
D. If Provider’s Type is Physician:
   1. 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.
   2. Provider states that he/she:
      c. Is in general practice or is board eligible or certified in family medicine, internal medicine or pediatrics; and
d. 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. Provide case management services and primary care services for IO IP members assigned to Provider’s panel. Case management means:
   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 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;
   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.

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; and
   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; and
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:
      a. Placing the health of the individual (or with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy; or
      b. Serious impairment to bodily function; or
      c. A serious dysfunction of any body organ or part; and
   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; and

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 per full time IO IP physician.

3. If Provider’s Type is Group, up to a maximum of two thousand five hundred (2,500) members per 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.

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 per 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

A. 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.

B. 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; and
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
A. 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.
B. OHCA shall pay Provider a fee for each member enrolled with Provider which is payment in full for all case management services.
C. Rates for IO IP case management are available on the OHCA website.
D. 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 of Provider’s’ panel members regardless of what, if any, covered services Provider renders during the month.
E. 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 Coverage by Category and limitations, OAC 317:30-1-1 et seq.

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;
B. Permanently reducing Provider’s maximum panel size;
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.