Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 27, 2023

The proposed policy is an Emergency Rule. The proposed policy was presented at the September 6, 2022 and January 3, 2023 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on March 2, 2023 and the OHCA Board of Directors on March 22, 2023.

SUMMARY:
Transition to SoonerSelect - As directed by the Legislature, the Oklahoma Health Care Authority will transition to a new health care program, called SoonerSelect. The proposed policy changes will comply with Senate Bill 1337 (SB1337) and Senate Bill 1396 (SB 1396), by addressing the specific delivery reform requirements, defining terms and processes and regulations outlined throughout the bills and the published Request for Proposal (RFP)/Model Contract, respectively.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Title 56 of the Oklahoma Statutes, Sections 4002-4004; Title 42 of the Code of Federal Regulations, Part 438

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 23-06B

A. Brief description of the purpose of the rule:

As directed by the Legislature, the Oklahoma Health Care Authority (OHCA) will transition to a new health care program, called SoonerSelect. The proposed policy changes will comply with Senate Bill 1337 (SB1337) and Senate Bill 1396 (SB 1396), by addressing the specific delivery reform requirements, defining terms and processes and regulations outlined throughout the bills and the published Request for Proposal (RFP)/Model Contract, respectively. Additionally, the current Chapter 55 OHCA managed care rules, which were promulgated during the previous managed care effort will be updated to reflect changes made to the new RFP and legislative requirements as well as other grammatical and formatting changes as needed.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost

impacts received by the agency from any private or public entities:

Certain SoonerCare members and providers, who will be involved in the SoonerSelect program, will be affected by the proposed rule. This rule should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule will benefit SoonerSelect members by ensuring the seamless delivery of the same health care services offered by SoonerCare while receiving additional value-added services to improve quality and health outcomes of members.

The proposed rule will benefit SoonerSelect providers by offering them a value-based payment model that incentivizes, empowers, and rewards providers for the quality of care, and at the same time help improve the health of their patients.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule changes upon any classes of persons or political.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The OHCA Board approved expenditure authority for the SoonerSelect RFP at the January 18, 2023 meeting. The goal of the SoonerSelect delivery model over the term of the contracts (first year, plus 5 renewal years) is budget neutrality.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact or require the cooperation of any political subdivisions.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act at this time.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule at this time. Measures included a formal public comment period and tribal consultation.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have a positive effect on the public health, safety, and environment. If OHCA enters into a contract(s) with contracted entities and/or dental benefits managers, SoonerCare members will have access to additional services like enhanced care management and other value-added benefits offered by the contracted entities and/or dental benefits managers.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The agency has determined that the proposed rule changes will not have a detrimental effect on the public health, safety, and environment; however, if the rules are not implemented, the Agency will be out of compliance with Title 56 of the Oklahoma Statutes, Sections 4002-4004.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: January 11, 2023
Modified: January 23, 2023

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by ~~managed care organizations~~contracted entities or dental benefits managers as required by the "Ensuring Access to Medicaid Act", ~~2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131)~~, Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

317:55-1-2. Monitoring system for all managed care programs [REVOKE]

~~In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in~~

all major operational areas.

317:55-1-3. Definitions

The following words and terms, when used in this Chapter, will have the following meaning, unless the context clearly indicates otherwise:

"**1115 waiver**" means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of section 1115 of the Act.

"**1915(c) waiver**" means any waiver, authorized by section 1915(c) of the Act, that allows specific coverage of home- and community-based services to a limited group of Medicaid-eligible individuals as an alternative to institutional care.

"**Accountable care organization**" or **"ACO"** means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.

"Act" means the Social Security Act.

"**Adult**" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"**Adverse determination**" means a determination by a health carrier, including an managed care organization (MCO) or dental benefits manager (DBM), or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.

"**Alternative benefit plan**" means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

"**American Indian/Alaska Native"** or "**AI/AN**" means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12.

"**Appeal**" means a review by an MCO or DBM of an adverse benefit determination.

"**Authorized representative**" means a competent adult who has the managed care enrollee's signed, written authorization to act on the managed care enrollee's behalf during the grievance, appeal, and State fair hearing process. The written authority to act will specify any limits of the representation.

"**Capitation payment**" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"**Capitation rate**" means the actuarially sound per-enrollee, per-month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"**Children's Health Insurance Program**" or **"CHIP"** means a federal Medicaid program

authorized under Title XXI of the Social Security Act.

"**Choice counseling**" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"**Chronic condition**" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"**Civil monetary damage**" means a damage imposed by OHCA which the MCO must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

"**Claims denial error rate**" means the rate of claims denials that are overturned on appeal.

"**Clean claim**" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"**C.F.R.**" means the Code of Federal Regulations.

"**Contract**" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

"**Copayment**" means a fixed amount that an enrollee pays for a covered health care service when the enrollee receives the service.

"Cost sharing" means the State's requirement that an enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"**Deemed newborn**" means children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

"**Dental benefits manager**" or "**DBM**" means a health plan under contract with the OHCA to manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"**Dental home**" or "**DH**" means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"**Disenrollment**" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"**Eligible**" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"**Emergency services**" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious

dysfunction of any bodily organs or parts.

"**Enrollee**" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"**Enrollee handbook**" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"**Enrollment"** means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"**Enrollment activities**" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

"**Essential community provider**" means a provider defined by 45 C.F.R. § 156.235.

"**Essential hospital services**" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"**Expansion adult**" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119), and who are not categorically related to the aged, blind, and disabled.

"Former foster children" or "**FFC**" means individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"**Foster children (FC)"** means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"**Fraud**" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"**Grievance**" means an enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. A grievance includes an enrollee's right to dispute an extension of time to make an authorization decision when proposed by the MCO or DBM.

"**Grievance and appeal system**" means the processes the MCO or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle enrollee grievances and appeals, as well as the processes to collect and track information about them.

"**Health care services**" means all Medicaid State Plan services provided, according to contract, by the MCO or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"**Health plan**" means the same in these rules as at 36 O.S. § 4405.1.

"**Implementation**" means the process by which OHCA and the MCO or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"**Implementation period**" means the period of time, as defined in contract, during which

implementation occurs.

"**Indian health care provider**" or "**IHCP**" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"**Initial enrollment**" means an eligible's enrollment in an MCO or DBM during the initial enrollment period.

"**Initial enrollment period**" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.

"**Managed care organization**" or "**MCO**" means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.

"**Managed care program**" or "**managed care**" or "**MCP**" means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"**Manual**" or "**guide**" means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"**Material change**" means, but not limited to, any change in the overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the MCO or DBM.

"**Medical necessity**" means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

"National Provider Identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all MCOs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"**Non-participating provider**" means a physician or other provider who has not contracted with or is not employed by the MCO or DBM to deliver services under the managed care program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent in nature but which requires face-to-face medical attention within seventy-two (72) hours of enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

"**Open enrollment**" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.

"**Open enrollment period**" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.

"**Parent and caretaker relative**" means an individual determined eligible under 42 C.F.R. § 435.110.

"**Participating provider**" means a physician or other provider who has a contract with or is

employed by an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.

"Patient-centered medical home" or **"PCMH"** means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.

"**Pregnant women**" means women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

"**Presumptive eligibility**" means limited period of managed care program eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.

"**Primary care dentist**" or "**PCD**" means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".

"**Primary care provider**" or "**PCP**" means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".

"**Prior authorization**" or "**PA**" means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

"**Provider**" means a health care services provider licensed or certified in this State.

"**Provider agreement**" means an agreement between the MCO or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to enrollees.

"**Risk contract**" means a contract between OHCA and an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

"**SoonerCare**" means the Oklahoma Medicaid program.

"**Soon-To-Be-Sooner**" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"**Specialty Children's Plan**" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"**Steady state enrollment**" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in

~~and select an MCO or DBM for the managed care program.~~

~~"**Steady state operations**" or "**steady state**" means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.~~

~~"**Third party liability**" or "**TPL**" means all or part of the expenditures for a managed care enrollee's medical assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity or program.~~

~~"**Value-added benefit**" means any benefit or service offered by an MCO or DBM when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the MCO or DBM and OHCA.~~

~~"**Value-based payment arrangement**" means a payment arrangement between an MCO or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the MCO or DBM.~~

~~"**Value-based purchasing**" means the provisions of a contract for managed care services when those provisions intentionally align OHCA payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.~~

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**1115 waiver**" means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one (1) or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of Section 1115 of the Act.

"**1915(c) waiver**" means any waiver, authorized by Section 1915(c) of the Act, that allows specific coverage of home and community-based services to a limited group of Medicaid-Eligible individuals as an alternative to institutional care.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care (as defined at 42 C.F.R. § 455.2). It also includes Eligible and Health Plan Enrollee practices that result in unnecessary cost to the Medicaid program.

"**Accountable care organization**" or **"ACO"** means a network of physicians, hospitals, and other health care providers that provide coordinated care to Medicaid members.

"Accrediting entity" means an entity recognized by CMS under 45 C.F.R. § 156.275. Current CMS-recognized accrediting entities include Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). To the extent CMS recognizes additional accrediting entities, OHCA will also permit the CE or DBM to achieve accreditation from such entity to meet the requirements.

"Act" means the Social Security Act.

"Activities of daily living (ADL)" means activities that reflect the Health Plan Enrollee's ability to perform self-care tasks essential for sustaining health and safety such as: bathing; eating; dressing; grooming; transferring (includes getting in and out of the tub, bed to chair, etc.); mobility; toileting and bowel/bladder control. The services help with proper medical care, self-maintenance skills, personal hygiene, adequate food, shelter, and protection.

"Administrative remedies" means an action taken by the OHCA in response to the DBM's failure to comply with a requirement or performance standard. Remedies, include but are not limit to, liquidated damages, capitation payment suspension, auto-assignment suspension, contract

termination, and any other remedies outlined in the Contract.

"**Adult**" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"**American Indian/Alaska Native"** or "**AI/AN**" means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined Eligible as an Indian under 42 C.F.R. § 136.12.

"**Appeal**" means a review by an CE or DBM of an adverse benefit determination.

"Applicant" means an individual who seeks SoonerCare coverage.

"**Authorized representative**" means a competent adult who has the Enrollee's signed, written authorization to act on the Enrollee's behalf during the grievance, appeal, and state fair hearing process. The written authority to act will specify any limits of the representation.

"Behavioral health services" means a wide range of diagnostic, therapeutic and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"Business days" means Monday through Friday and is exclusive of weekends and State of Oklahoma holidays.

"Calendar days" means all seven (7) days of the week, including State of Oklahoma holidays.

"Capitated contract" means a contract between OHCA and a contracted entity for the delivery of services to Medicaid members in which OHCA pays a fixed, per-member per-month rate based on actuarial calculations.

"Capitation payment" means a payment OHCA will make periodically to the CE or DBM on behalf of each Health Plan Enrollee enrolled under the SoonerSelect program and based on the actuarially sound capitation rate for the provision of services under the State Plan. OHCA shall make the payment regardless of whether the Health Plan Enrollee receives services during the period covered by the payment.

"Capitation rate" means the per Health Plan Enrollee, per-month amount, including any adjustments, that is paid by OHCA to the CE or DBM for each Health Plan Enrollee enrolled in the SoonerSelect program for the provision of services during the payment period.

"Care coordination/care management" means a process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the Health Plan Enrollee's needs using advocacy, communication, and resource management to promote quality and cost-effective interventions and outcomes. Based on the needs of the Health Plan Enrollee, the care manager arranges services and supports across the continuum of care, while ensuring that the care provided is person-centered.

"Care manager" means the CE's staff primarily responsible for delivering services to Health Plan Enrollees in accordance with its OHCA-approved risk stratification level framework, and meets the qualifications specified in the Contract.

"Care plan" means a comprehensive set of actions and goals for the Health Plan Enrollee developed by the care manager based on the unique needs of Health Plan Enrollee(s). The CE shall develop and implement care plans for all Health Plan Enrollees with a special health care need determined through the comprehensive assessment to need a course of treatment or regular care monitoring and in accordance with Section 1.8.3: **"**Care Plans" of the Contract.

"Case file" means an electronic record that includes Enrollee information regarding the management of health care services including but not limited to: Enrollee demographics; comprehensive assessment (if applicable); care plan; reassessments; referrals and authorizations and Enrollee case notes.

"CDT" means current dental terminology (dental procedure codes).

"CEO" means Chief Executive Officer.

"Certified community behavioral health clinic (CCBHC)" means entities designed to provide a comprehensive range of mental health and substance use disorder services as defined under the Excellence in Mental Health Act and certified by the Oklahoma Department of Mental Health and Substance Abuse Services.

"**C.F.R.**" means the Code of Federal Regulations.

"**Child"** means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"**Children's Health Insurance Program**" or **"CHIP"** means a Medicaid program authorized under Title XXI of the Social Security Act.

"Children's Specialty Plan" or **"Children's Specialty Program"** means the single statewide health care plan that covers all Medicaid services other than dental services and is designed to provide care to children in foster care children, former foster care children up to twenty-five (25) years of age, juvenile justice involved children, and children receiving adoption assistance.

"Child welfare services" means the Oklahoma Human Services (OKDHS) division responsible for administering Oklahoma's child welfare services.

"**Choice counseling**" means the provision of information and services designed to assist Eligibles in making enrollment decisions as described in 42 C.F.R § 438.2.

"**Chronic condition**" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"**Civil monetary damage**" means a damage imposed by OHCA which the CE must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

"**Clean claim**" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), fourth edition or a more recent edition, the tenth revision of the International Classification of Diseases (ICD) or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"**Clinical practice guidelines"** means systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The CE or DBM shall adopt clinical practice guidelines in accordance with 42 C.F.R. § 438.236, ensuring they are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of Enrollees; are adopted in consultation with participating providers; and are reviewed and updated periodically as appropriate.

"**CMS"** means Centers for Medicare & Medicaid Services.

"Commercial plan" means an organization or entity that undertakes to provide or arrange for the delivery of health care services to Medicaid members on a prepaid basis and is subject to all applicable state and federal laws and regulations.

"Continuity of care period" means the ninety (90) day period immediately following an Enrollee's enrollment with the CE or DBM whereby established Enrollee and provider relationships, current services and existing prior authorizations and care plans shall remain in place.

"**Contract**" As a result of receiving an award from OHCA and successfully meeting all Readiness Review requirements, the agreement between the Contractor and OHCA where the Contractor will provide Medicaid services to SoonerSelect Enrollees, comprising of the Contract and any Contract addenda, appendices, attachments, or amendments thereto, and be paid by OHCA as described in the terms of the agreement.

"Contract year" means the period during which the Contract is in effect. The initial Contract year shall be from date of award through the end of the state fiscal year. Each subsequent Contract year shall be based on state fiscal year.

"Contracted entity" or **"CE"** means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority (OHCA) for the delivery of services that will assume financial risk, operational accountability, and statewide or regional functionality in this act in managing comprehensive health outcomes of Medicaid members. This includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the OHCA.

"**Contractor"** means a contracted entity with which OHCA has entered into a binding agreement for the purpose of procuring services to SoonerSelect program Enrollees as specified in the Contract. The term "Contractor" includes all such Contractor's affiliates, agents, subsidiaries, any person with an ownership or control interest, officers, directors, manager, employees, independent contractors, and related parties working for or on behalf of the Contractor and other parties.

"**Copayment**" means a fixed amount that an Enrollee pays for a covered health care service when the Enrollee receives the service.

"Corrective action plan" or **"CAP"** means the detailed written plan that may be required by OHCA to correct or resolve a deficiency, event, or breach.

"Cost sharing" means the state's requirement that an Enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"Credibility adjustment" means an adjustment to the medical loss ratio (MLR) for a partially credible CE or DBM to account for a difference between the actual and target MLRs that may be due to random statistical variation.

"Crisis intervention services" means face-to-face services for the purpose of responding to acute behavioral or emotional dysfunction as evidenced by psychotic, suicidal, homicidal severe psychiatric distress and/or danger of alcohol or drug relapse.

"Critical incident" means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a SoonerSelect program Health Plan Enrollee.

"**Deemed newborn**" means children born to SoonerCare enrolled mothers and determined Eligible under 42 C.F.R. § 435.117.

"**Dental benefits manager**" or "**DBM**" means an entity that meets the definition of a Prepaid Ambulatory Health Plan (PAHP) as per 42 C.F.R. § 438.2 and is under contract with the OHCA to manage and deliver all services described in this SoonerSelect Dental Contract and who handles claims payment and prior authorizations and coordinates dental care with participating providers and Enrollees. Also referred to as a "Contractor".

"Dental related emergency services" means services provided to a SoonerSelect Dental Enrollee that are necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infections, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

"DIR" means direct and indirect remuneration.

"Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent pursuant to 42 C.F.R. § 455.101.

"**Disenrollment**" means OHCA's removal of an Enrollee from participation in a specific CE or DBM or from participation in the SoonerSelect program.

"**DSH"** means disproportionate share hospital.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means screening and diagnostic services to determine physical or mental defects in Eligibles or Health Plan Enrollees under age twenty-one (21) and health care, treatment, and other measures to correct or ameliorate any existing defects and/or chronic conditions discovered.

"Electronic Visit Verification (EVV) system" means an electronic system that documents the time that providers begin and end the delivery of services to Health Plan Enrollees and the location of services. The EVV system shall comply with Section 12006 of the 21st Century Cures Act and associated CMS requirements.

"**Eligible**" means an individual who has been deemed Eligible for the SoonerSelect program but who is not yet enrolled in a CE or DBM.

"Emergency medical condition" means a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"**Emergency services**" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"Encounter data" means information relating to the receipt of any item(s) or service(s) by an Enrollee under the Contract that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

"**Enrollee**" means an individual who has been deemed Eligible for Medicaid in the State of Oklahoma, who has been deemed Eligible for enrollment in the SoonerSelect program, and who is currently enrolled in the SoonerSelect program.

"**Enrollee handbook**" means a guidebook that explains the SoonerSelect program that the Contactor shall distribute to every Enrollee. It shall be designed to help the Enrollee understand the CE or DBM, the SoonerSelect program and the rights and responsibilities that come with membership in the program.

"**Enrollment**" means the OHCA process by which an Eligible becomes an Enrollee with an CE or DBM.

"EOB" means explanation of benefits.

"**Essential community provider**" means a provider defined by 45 C.F.R. § 156.235.

"**Essential hospital services**" means tertiary care hospital services to which the CE must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"Excluded benefits" means Medicaid-covered services that are not the responsibility of the CE.

"**Expansion adult**" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined Eligible in accordance with 42 C.F.R. § 435.119~~)~~, and who are not categorically related to the aged, blind, and disabled.

"Excluded populations" means populations that are excluded from participation in the SoonerSelect program as specified in the Contract.

"Exploitation" means an unjust or improper use of the resources of a vulnerable Enrollee for the profit or advantage, pecuniary or otherwise, of a person other than the vulnerable Enrollee

through the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense.

"External Quality Review (EQR)" means the analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness and access to the health care services that the CE or DBM furnishes to Enrollees.

"Family planning services and supplies" means services and supplies described in § 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which OHCA claims or could claim federal match at the enhanced rate under § 1905(a)(5) of the Act.

"Federally Qualified Health Center (FQHC)" or **"Health Centers"** or **"Centers"** means an organization that qualifies for reimbursement under Section 330 of the Public Health Service Act. FQHCs qualify to receive enhanced reimbursements from Medicare and Medicaid, must serve an underserved population or area, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

"**Former foster care children**" or "**FFC**" means individuals under age twenty-six (26) determined Eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"Foster care" means planned, goal-directed service that provides twenty-four (24) hour a day substitute temporary care and supportive services in a home environment for children birth to eighteen (18) years of age in OKDHS custody.

"**Foster children (FC)"** means children in foster care under the responsibility of the State, including children and youth who are in State custody due to abuse or neglect.

"FPL" means federal poverty level.

"**Fraud**" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

"**Grievance**" means an Enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the Enrollee's rights regardless of whether remedial action is requested. A grievance includes an Enrollee's right to dispute an extension of time proposed by the CE or DBM to make an authorization decision.

"**Grievance and appeal system**" means the processes the CE or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle Enrollee grievances and appeals, as well as the processes to collect and track information about them.

"**Health care services**" means all services outlined in the Oklahoma Medicaid State Plan, the Alternative Benefit Plan, and the 1115 IMD Waiver that are provided, according to contract, by the CE or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"**Health plan**" means the same in these rules as at 36 O.S. § 4405.1.

"Health risk screening" means a screening tool developed by the contracted entity, and approved by the OHCA, to obtain basic health and demographic information, identify any immediate needs a Health Plan Enrollee may have and assist the contracted entity to assign a risk level for the Health Plan Enrollee to determine the level of care management needed.

"Hospitalization" means care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

"**Implementation**" means the process by which OHCA and the CE or DBM performs actions

and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"**Indian health care provider**" or "**IHCP**" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"**Initial enrollment**" means an Eligible's enrollment in an CE or DBM during the initial enrollment period.

"Intermediate sanction(s)" means the sanctions described in 42 C.F.R § 438.702, which the OHCA may impose for the contracted entities non-compliance for any of the conditions in 42 C.F.R. § 438.700.

"Juvenile justice involved" means any person in custody or under the supervision of the Oklahoma Office of Juvenile Affairs (OJA) for whom OJA is required to provide services by law or court order.

"Local Oklahoma provider organization" means any state provider association, accountable care organization, Certified Community Behavioral Health Clinic, Federally Qualified Health Center, Native American tribe or tribal, association, hospital or health system, academic medical institution, currently practicing licensed provider, or other local Oklahoma provider organization as approved by the Authority.

"**Manual**" or "**guide**" means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"**Medical necessity**" or **"medically necessary"** means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

"National provider identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all CEs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"Non-compliance remedy" means an action taken by OHCA in response to the Contractor's failure to comply with a contract requirement or performance standard.

"**Non-participating provider**" means a physician or other provider who has not contracted with or is not employed by the CE or DBM to deliver services under the SoonerSelect program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent, but which requires face-to-face medical attention within seventy-two (72) hours of Enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

"OAC" means Oklahoma Administrative Code.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"**Open enrollment period**" means the annual period of time, as defined by contract, when Enrollees and Eligibles can enroll in and select an CE or DBM for the SoonerSelect program.

"O.S." means Oklahoma Statutes.

"OSDE" means the Oklahoma State Department of Education.

"**Parent and caretaker relative**" means an individual determined Eligible under 42 C.F.R. § 435.110.

"**Participating provider**" means a physician or other provider who has a contract with or is employed by a CE or DBM to provide health care services to Enrollees under the SoonerSelect Medical or Dental program.

"Patient-centered medical home" or **"PCMH"** means, in this Chapter, the care coordinated delivery system as defined within the contract between OHCA and a CE.

"Pharmacy Benefit Manager" means a third-party responsible for operating and administering the CE's pharmacy program**.**

"Post-stabilization care services" means covered services related to an emergency medical condition that are provided after a Health Plan Enrollee is stabilized to maintain the stabilized condition or under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Health Plan Enrollee's condition.

"**Pregnant women**" means women determined Eligible for SoonerCare under 42 C.F.R. § 435.116.

"Prepaid Ambulatory Health Plan" or **"PAHP"** means a DBM and/or an entity as per 42 C.F.R. § 438.2 that:

(A) Provides services to Enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates;

(B) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and

(C) Does not have a comprehensive risk contract.

"Prepaid dental plan" means a contractual arrangement in accordance with 36 O.S. § 6142, whereby any prepaid dental plan organization undertakes to provide payment of dental services directly, or to arrange for prepaid dental services, or to pay or make reimbursement for any dental services not provided for by other insurance.

"Prepaid dental plan organization" means any person who undertakes to conduct one (1) or more prepaid dental plans providing only dental services in accordance with 36 O.S. § 6142.

"**Presumptive eligibility**" means a period of temporary SoonerCare eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified entity, on the basis of applicant self-attested income information, to meet the eligibility requirements for a Modified Adjusted Gross Income (MAGI) eligibility group.

"Primary care" means the provision of integrated, equitable, and accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

"**Primary care dentist**" or "**PCD**" means a dental care professional providing comprehensive dental care for a Dental Health Plan Enrollee.

"**Primary care provider**" or "**PCP**" means the following:

(A) Family medicine physicians in an outpatient setting when practicing general primary care;

(B) General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

(C) Geriatric medicine physicians in an outpatient setting when practicing general primary care;

(D) Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care);

(E) Obstetrics and gynecology physicians in an outpatient setting when practicing general primary care;

(F) Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; or

(G) Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.

"**Prior authorization**" or "**PA**" means a requirement that an Enrollee, through the Enrollee's provider, obtain the CEs or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

"Protected health information" or **"PHI"** means information considered to be individually identifiable health information, per 42 C.F.R.§ 160.103.

"**Provider**" means a health care services provider licensed or certified in this State.

"**Provider agreement**" means an agreement between the CE or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to Enrollees.

"Provider-led entity" means an organization or entity that meets the criteria of at least one (1) of the following:

(A) A majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in the state; or

(B) A majority of the entity's governing body is composed of individuals who:

(i) Have experience serving Medicaid members and:

(I) Are licensed in the state as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists;

(II) At least one (1) board member is a licensed behavioral health provider; or

(III) Are employed by a hospital or other medical facility licensed by the state and operating in the state or an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by the state and operating in the state.

(ii) Represent the providers or facilities including, but not limited to, individuals who are employed by a statewide provider association; or

(iii) Are nonclinical administrators of clinical practices serving Medicaid members.

"Quality Assessment and Performance Improvement" or **"QAPI"** means a process designed to address and continuously improve CE and DBM quality metrics.

"Quality Improvement Committee" or **"QIC"** means a committee within the CE or DBM's organizational structure that oversees all QAPI functions.

"**Risk contract**" means a contract between OHCA and a CE, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the Contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the Contract.

"Rural area" means a county with a population of less than fifty thousand (50,000) people.

"Rural Health Clinic" or **"RHC"** means clinics meeting the conditions to qualify for RHC reimbursement as stipulated in Section 330 of the Public Health Services Act.

"**SoonerCare**" means the Oklahoma Medicaid program.

"SoonerSelect" means the CEs and DBMs with whom the OHCA contracts with to provide SoonerCare covered medical, dental, pharmacy, and behavioral health benefits.

"**Soon-To-Be-Sooner**" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"**Steady state operations**" or "**steady state**" means the time period beginning ninety (90) days after initial program implementation.

"Telehealth" means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. In accordance with Oklahoma law, including OAC 317:30-3-27 and 59 O.S. § 478, telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure videoconference, or facsimile transmission.

"**Third party liability**" or "**TPL**" means all or part of the expenditures for an Enrollee's medical or dental assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity, or program.

"Urban area" means a county with a population of fifty thousand (50,000) people or more.

"U.S.C." means United States Code.

"**Value-added benefit**" means any benefit or service offered by a CE or DBM when that benefit, or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the CE or DBM and OHCA.

"**Value-based payment arrangement**" means a payment arrangement between a CE or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the CE or DBM.

"Waste" means the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid program; generally, not considered to be caused by criminally negligent actions but rather the misuse of resources.

317:55-1-4. Eligible entities

(a) **Eligible entities.** The OHCA shall enter into a capitated contract for the delivery of statewide Medicaid services. Eligible entities include an accountable care organization, a provider-led entity, a commercial plan, or any other entity as determined by OHCA. The CE or DBM shall meet the following requirements:

(1) **Licensure and certificate of authority.**

(A) The CE must be licensed as a Health Maintenance Organization (HMO) pursuant to 36 O.S. § 6901 et seq.

(B) The CE must furnish OHCA with a certificate of authority, to operate as an HMO, prior to contract implementation.

(C) The DBM must be licensed and authorized, as prepaid dental health plan, and able to transact dental business in the State of Oklahoma in accordance with 36 O.S. § 6141 et seq.

(D) The DBM must furnish OHCA with a certificate of authority for accident and health insurance or pre-paid dental prior to contract implementation in accordance with 36 O.S. § 703.

(E) Any changes to the certificate of authority, for CE and DBM, must be reported immediately to the OHCA.

(2) **Accreditation.** The CE or DBM shall seek accreditation from a private independent accrediting entity, as well as, earn a National Committee for Quality Assurance (NCQA) Health Equity Accreditation in the State of Oklahoma, within eighteen (18) months of initial enrollment implementation. When undergoing accreditation, the CE or DBM shall submit reports documenting the status of the accreditation process as required in the Contract and reporting manual.

(A) **Accreditation review.** The CE or DBM shall authorize the accrediting entity to provide the OHCA a copy of the CE's or DBM's most recent accreditation review including:

(i) Accreditation status, survey type, and level (as applicable);

(ii) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

(iii) Expiration date of the accreditation.

(B) **Reaccreditation.** The CE and DBM shall undergo reaccreditation in accordance with the timeframes required by the accrediting entity and federal regulations.

(C) **Failure to achieve or maintain accreditation for a CE.** Failure to achieve or maintain accreditation shall be considered a breach of the CE Contract and may result in intermediate sanctions/penalties or termination in accordance with OAC 317:55-5-10(e)

(D) **Failure to achieve or maintain accreditation for a DBM.** Failure to achieve or maintain accreditation shall be considered a breach of the DBM Contract and may result in administrative remedies, including liquidated damages or termination, in accordance with OAC 317:50-5-11 and 317:55-5-12.

317:55-1-5. Program administration requirements

(a) **Compliance**. The CE or DBM shall comply with all applicable state and federal laws and regulations, including, but not limited to, 42 C.F.R. Part 438, and HIPAA privacy and security law, as defined in Section 3009 of the Public Health Service Act.

(b) **Subcontracting.** The CE or DBM shall seek approval from the OHCA prior to the effective date of any subcontract for performance of certain Contract responsibilities.

(1) The CE or DBM shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with OHCA, notwithstanding any relationship(s) with any subcontractors. The CE or DBM shall actively monitor subcontractors to ensure their compliance with the Contract and verify the quality of their services.

(2) The CE or DBM is prohibited from entering into any subcontract for the performance of any duty under the Contract in which such services are to be transmitted or performed outside of the United States.

(c) **Staffing.** The CE or DBM shall have sufficient staff to operate efficiently and meet all Contract

obligations and standards. Additionally, the CE or DBM shall ensure staff and subcontractor staff receive detailed training on the requirements, policies, and procedures of the SoonerSelect program. All CE or DBM staff, including subcontractor staff, shall receive initial and ongoing training and education necessary to fulfill their job responsibilities under the Contract.

(d) **Policies and procedures.** The CE or DBM and any subcontractor shall:

(1) Develop and maintain written policies and procedures describing in detail how the CE or DBM and any subcontractor will fulfill the responsibilities outlined in the Contract.

(2) Submit all policies and procedures for OHCA's review and approval prior to adoption and implementation.

(3) Submit an annual certification in which the CE or DBM attests to the creation of updated policies and procedure.

(e) **Readiness review.**

(1) In accordance with 42 C.F.R. § 438.66(d)(1), the CE or DBM is required to participate, submit documentation, and satisfactorily pass the readiness review process in the following situations:

(A) Prior to initial implementation;

(B) When the specific CE or DBM has not previously contracted with the state; or

(C) When the CE or DBM, which is currently contracted with the state, will begin to provide, or arrange for covered benefits to new eligibility groups.

(2) All readiness review activities shall be completed to the satisfaction of OHCA and CMS pursuant to the Contract and/or any other policy guidelines/memorandum before being eligible to receive enrollment of Eligibles.

(3) Additionally, the state will conduct a desk review / optional on-site review of new subcontracts executed during the Contract term, or when the subcontract undertakes new eligibility groups or services. CEs, DBMs, and their subcontractors must adhere to all the contractual obligations found at 42 C.F.R. Part 438.

(f) **Marketing**. The CE or DBM must provide each Enrollee with an Enrollee handbook within ten (10) days and identification card within seven days (7) days after receiving notice of the Enrollee's enrollment or within ten (10) days of the Enrollee's request for the Enrollee handbook. The CE or DBM shall not falsify or misrepresent information that furnishes to an Enrollee, Eligible or provider. All marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the Contractor and Contract terms. The OHCA shall approve all marketing materials, which must comply with federal funding requirements, including 42 C.F.R. § 438.10 and 42 C.F.R. § 438.104.

(g) **Accessibility**. The CE or DBM shall ensure Enrollees and providers have continuous access to information as determined by OHCA and that complies with the requirements at Section 508 of the Rehabilitation Act of 1973, Pub. L. No. 93-112, and the Oklahoma Electronic and Information Technology Accessibility law, 2004 HB 2197. To ensure ongoing accessibility standards are met, the CE or DBM shall:

(1) Provide its URL to the OHCA and any changes to the URL shall be approved by the OHCA.

(2) Assign and maintain a point of contact to assist the OHCA with interfacing/exchanging data in the CE's or DBM's system.

(h) **Disaster preparation and data recovery**. The CE and DBM shall submit to the OHCA and maintain a written disaster plan for information resources that will ensure service continuity as required by the Contract.

(i) **System performance.** The CE and DBM shall meet performance requirements pursuant to the Contract.

(j) **Call center standards.** The CE and DBM shall provide assistance to Enrollees and providers through a toll-free call-in system that meets the performance standards and requirements outlined in the Contract.
(k) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-1-5, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY, ENROLLMENT AND CONTINUITY OF CARE

317:55-3-1. ~~**Mandatory populations**~~**Mandatory, voluntary, and excluded populations**
~~(a) **Mandatory MCO enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with an MCO:~~
~~(1) Expansion adults;~~
~~(2) Parents and caretaker relatives;~~
~~(3) Pregnant women;~~
~~(4) Deemed newborns;~~
~~(5) Children; and~~
~~(6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435, Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.~~
~~(b) **Mandatory Specialty Children's Plan enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:~~
~~(1) Foster children (FC); and~~
~~(2) Certain children in the custody of OJA.~~
~~(c) **Mandatory Specialty Children's Plan enrollment, opt out.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:~~
~~(1) Former foster care (FFC); and~~
~~(2) Children receiving adoption assistance (AA).~~
~~(d) **Mandatory DBM enrollment.** Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:~~
~~(1) Expansion adults;~~
~~(2) Parents and caretaker relatives;~~
~~(3) Pregnant women;~~
~~(4) Deemed newborns;~~
~~(5) Former foster children;~~
~~(6) Certain children in the custody of OJA;~~
~~(7) Foster care children;~~
~~(8) Children receiving adoption assistance; and~~
~~(9) Children.~~
(a) **Mandatory populations.** The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:
(1) Expansion adults;
(2) Parents and caretaker relatives;

(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Juvenile justice involved children;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

(b) **Voluntary populations.** SoonerCare Eligible individuals may voluntarily choose to enroll in the SoonerSelect Dental and Medical program through an opt-in process if they are American Indians and/or Alaskan Natives. AI/AN populations will have the option to:

(1) Voluntarily enroll in the DBM and/or CE through an opt-in process;
(2) Enroll in a DBM and/or CE at each open enrollment period, regardless of initial selection or past disenrollment from the DBM and/or CE;
(3) When enrolled, AI/AN populations shall:
(A) Receive services from an IHCP;
(B) Choose the IHCP as the Enrollee's provider, if the provider has the capacity to provide such services;
(C) Obtain services covered under the Contract from out-of-network IHCPs when the Enrollee is otherwise Eligible to receive the IHCP's services;
(D) Self-refer for services provided by IHCPs to AI/AN Enrollees;
(E) Obtain services covered under the Contract from out-of-network IHCPs when the AI/AN Enrollee is otherwise Eligible to receive the IHCP's services; and
(F) Disenroll from any DBM and/or CE at any time without cause.

(c) **Excluded populations.** The following individuals are excluded from enrollment in the SoonerSelect program:

(1) Dual-eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or ICF-IID level of care, except for Enrollees with a pending level of care determination;
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis Eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined Eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a § 1915(c) Waiver;
(8) Undocumented persons Eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Medicaid State Plan;
(10) Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon- to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined Eligible for Medicaid on the basis of age, blindness, or disability.

(d) **Additional eligibility criteria.** For additional eligibility criteria, refer to Chapter 35 Medical Assistance for Adults and Children Eligibility Manual, Subchapter 5 Eligibility and Countable Income.

317:55-3-2. ~~Excluded populations~~Enrollment and disenrollment process

~~(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:~~

~~(1) Dual eligible individuals;~~

~~(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);~~

~~(3) Persons with a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;~~

~~(4) Individuals during a period of presumptive eligibility;~~

~~(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;~~

~~(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;~~

~~(7) Individuals enrolled in a 1915(c) waiver;~~

~~(8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;~~

~~(9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;~~

~~(10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and~~

~~(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.~~

~~(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:~~

~~(1) Dual eligible individuals;~~

~~(2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;~~

~~(3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from the DBM.~~

~~(4) Individuals during a period of presumptive eligibility;~~

~~(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;~~

~~(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;~~

~~(7) Individuals enrolled in a §1915(c) waiver;~~

~~(8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;~~

~~(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;~~

~~(10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and~~

~~(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.~~

(a) **Enrollment process.** The OHCA beneficiary support system will provide choice counseling to all potential Enrollees at the time of initial enrollment, during the annual open enrollment period and for Enrollees who disenroll from a CE or DBM for good cause as described in the Contract and in this Section. The OHCA, or its designee, will provide information about individual CE or DBM benefit structures, services, and network providers, as well as information about other Medicaid programs as requested by the Eligible to assist the Eligible in making an informed selection.

(1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to sixty (60) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

(2) **Exemptions to auto-assignments**

(A) The OHCA will not make auto-assignments to the CE if:

(i) The CE's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;

(ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or

(iii) The CE has failed to meet readiness review requirements.

(B) The OHCA will not make auto-assignments to the DMB if:

(i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;

(ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or

(iii) The DBM has failed to meet readiness review requirements.

(3) **Enrollment effective date**

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.

(B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16^{th}) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

(C) Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA.

(D) Deemed newborns eligible for the CE and/or DBM shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.

(E) Notwithstanding the foregoing, the effective date of enrollment with the CE or DBM shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(4) **Enrollment lock-in period.** An Enrollee may, within the first ninety (90) days of initial enrollment, request to change enrollment without cause from the CE and/or DBM, or during the ninety (90) days following the date OHCA sends the Enrollee notice of initial enrollment, whichever is later. Enrollees will also be permitted to change CEs and/or DBMs, without cause,

at least once every twelve (12) months during the open enrollment period. After the disenrollment period from the CE or DBM has lapsed, the Enrollee will remain enrolled with the CE or DBM until the next annual open enrollment period, unless:

(A) The SoonerSelect Medical Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Becomes a foster child under custody of the state;

(iii) Becomes juvenile justice involved under the custody of the state;

(iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;

(v) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(VI) The Enrollee has been enrolled in error, as determined by the OHCA.

(vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.

(B) The SoonerSelect Dental Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(V) The Enrollee has been enrolled in error, as determined by the OHCA.

(iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll

without cause upon reenrollment; or

(iv) The DBM is terminated.

(5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM. OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:

(A) In the event of the early termination of a CE or DBM under the process described in the Contract; or

(B) The loss of a major participating provider(s) places the CE or DBM at risk of failing to meet service accessibility standards and the CE or DBM does not have an acceptable plan for mitigating the loss or finding of non-compliance.

(6) **Enrollment caps.** OHCA, at its sole discretion, may impose a cap on the CE or DBM's enrollment, in response to a request by the CE or DBM or as part of a corrective action in accordance to the respective Contract.

(b) **Disenrollment**. The OHCA shall have sole authority to grant or deny a disenrollment request from the Enrollee, and/or CE or DBM.

(1) **CE or DBM-requested disenrollment**. Pursuant to 42 C.F.R. § 438.56(b)(2), the CE or DBM cannot request a disenrollment based on adverse change in the member's health status or utilization of medically necessary services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued Enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

(A) The CE may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(ii) The Enrollee has been enrolled in error, as determined by OHCA;

(iii) The Enrollee has exhibited disruptive behaviors to the extent the CE cannot effectively manage their care, and the CE has made all reasonable efforts to accommodate the Enrollee; or

(iv) The Enrollee has committed fraud, including but not limited to, loaning an identification (ID) card for use by another person.

(B) The DBM may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee has been enrolled in error, as determined by OHCA;

(ii) The Enrollee has exhibited disruptive behaviors to the extent the DBM cannot effectively manage their care, and the DBM has made all reasonable efforts to accommodate the Enrollee; or

(iii) The Enrollee has committed fraud, including but not limited to, loaning an ID card for use by another person.

(2) **Enrollee-requested disenrollment.** Enrollees shall seek redress through the CE's or DBM's grievance process before OHCA will make a determination on an Enrollee's request for disenrollment. The CE or DBM shall accept Enrollee requests for disenrollment orally or in writing. The CE or DBM shall complete a review of the request within ten (10) days of the Enrollee filing the grievance. If the Enrollee remains dissatisfied with the result of the grievance

process, the CE or DBM shall refer the disenrollment request to OHCA. The Contractor shall send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA.

(A) The Enrollee may request disenrollment from the CE or DBM as allowed by 42 C.F.R. § 438.56(c).

(B) An Enrollee may request disenrollment from the CE or DBM at any time based on any cause listed at 42 C.F.R. § 438.56(d)(2).

(C) An Enrollee may request disenrollment at any time in accordance with (a)(4)(A)(v)(I)-(VI) and (B)(ii)(I)-(V) of this Section and the applicable Contract.

(3) **Disenrollment by OHCA.** The CE or DBM shall report to OHCA, within five (5) business days of learning of any change in an Enrollee's status affecting the Enrollee's eligibility.

(A) The OHCA will initiate disenrollment of SoonerSelect Medical Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Medical program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) Enrollee becomes a foster child under the custody of the state;

(vi) Enrollee becomes juvenile justice involved under the custody of the state;

(vii) The Enrollee becomes an inmate of a public institution;

(viii) The Enrollee commits fraud or provides fraudulent information; or

(ix) Disenrollment is ordered by a hearing officer or court of law.

(B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) The Enrollee becomes an inmate of a public institution;

(vi) The Enrollee commits fraud or provides fraudulent information; or

(vii) Disenrollment is ordered by a hearing officer or court of law.

(4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective on the first day of the second following month.

(A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
(iii) Enrollee becomes a foster child under the custody of the state;
(iv) Enrollee becomes JJ Involved under the custody of the state;
(v) Enrollee becomes eligible for Medicare;
(vi) Death;
(vii) Enrollee becomes an inmate of a public institution;
(viii) Enrollee commits fraud or provides fraudulent information;
(ix) Disenrollment is ordered by a hearing officer or court of law; or
(x) Enrollee requiring long-term care.
(I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.
(II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.

(B) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the SoonerSelect Dental Enrollee's oral health care needs, or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the Contractor fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the SoonerSelect Dental Enrollee's SoonerSelect Dental program eligibility status changes:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;
(iv) Death;
(v) SoonerSelect Dental Enrollee becomes an inmate of a public institution;
(vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;
(vii) Disenrollment is ordered by a hearing officer or court of law; or
(viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.

(C) Notwithstanding the foregoing, the effective date of disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.

(1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.

(2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.

(3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

(d) **Re-enrollment following loss of eligibility.** Enrollees who lose and regain eligibility for SoonerSelect Medical or Dental program within a period of sixty (60) days or less will be re-enrolled automatically with their prior CE and/or DBM unless the CE and/or DBM is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE/DBM in accordance with this Section and the Contract.

(e) **Eligibles voluntarily opting out of SoonerSelect Children's Specialty program.** FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty program. These Eligibles may opt-out of enrollment in the Children's Specialty program; however, the legal guardian of the Eligible will be required to enroll the Eligible with a CE.

(f) **Non-discrimination**. The CE or DBM may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against Eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the Enrollee's health in enrollment, disenrollment, or re-enrollment. If the CE or DBM fails to comply with OAC 317:55-3-2, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-3. ~~Voluntary enrollment and disenrollment~~Enrollee rights

~~(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:~~

~~(1) Voluntarily enroll in the MCP through an opt-in process;~~

~~(2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;~~

~~(3) Receive services from an IHCP;~~

~~(4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;~~

~~(5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;~~

~~(6) Self-refer for services provided by IHCPs to AI/AN enrollees;~~

~~(7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and~~

~~(8) Disenroll from any MCO or DBM at any time without cause.~~

~~(b) Children receiving prevention services from child welfare services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.~~

(a) In accordance with 42 C.F.R. § 438.100, state and federal regulations, and all contractual requirements, the CE and DBM shall allow the Enrollee the right to:

(1) Receive information on the SoonerSelect program and the CE or DBM;

(2) Receive information on all available treatment options and alternatives;

(3) Participate in decisions regarding their healthcare;

(4) Free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; and

(5) Request and receive a copy of their medical records in accordance with all HIPAA rules.

(b) Each Enrollee is free to exercise their rights without the CE or DBM treating them adversely.

(c) The CE or DBM may not otherwise discriminate against Enrollees on the basis of race, color,

national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. If the CE or DBM fails to comply with OAC 317:55-3-3, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

PART 3. ~~SCOPE AND ADMINISTRATION~~ACCESS TO COVERED SERVICES AND PROVIDER NETWORK STANDARDS

317:55-3-10. ~~Grievances and appeals~~Covered services

~~(a) **Filing**. Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.~~

~~(b) **Levels of appeal**. Pursuant to 42 C.F.R. § 438.402, MCOs and DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.~~

~~(c) **Governing rules.** The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.~~

(a) **Amount, duration, and scope of services.** The CE or DBM must ensure members have timely access to all medically necessary services, as applicable, covered by SoonerCare under the Medicaid State Plan, the Alternative Benefit Plan (ABP), and the 1115 IMD Waiver. The CE or DBM must ensure:

(1) Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are provided;

(2) The amount, duration, and scope of a required service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) PA is available for services on which the CE or DBM has placed a pre-identified limitation to ensure the limitation may be exceeded when medically necessary.

(A) The CE or DBM may propose to impose alternative PA requirements, subject to OHCA's review and approval, except for those benefits identified as exempt from PA. The CE or DBM may be less restrictive on the requirements of a PA than OHCA but may not impose greater restrictions.

(B) PA shall be processed in accordance with timeliness requirements specified in the Contract.

(4) Coverage decisions are based on the coverage and medical necessity criteria published in Title 317 of the Oklahoma Administrative Code and practice guidelines/manual; and

(5) If a member is unable to obtain medically necessary services offered by SoonerCare from a CE or DBM network provider, the CE or DBM must adequately and timely cover the services out of network, until the CE or DBM is able to provide the services from a network provider.

(b) **Emergency services**. The CE or DBM shall provide emergency services to Enrollees in accordance with the respective CE or DBM Contract.

(c) **Post-stabilization services.** In accordance with the provisions set forth at 42 C.F.R. § 422.113(c), the CE shall provide post-stabilization care services are:

(1) Obtained within or outside the CE network that are:

(A) Pre-approved by a CE or representative; or

(B) Not pre-approved by a CE or representative but administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the CE for pre-approval of further post-stabilization care services.

(2) Administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within the CE network when the CE:

(A) Did not respond to a request for pre-approval within one (1) hour;

(B) Could not be contacted; or

(C) Representative and the treating physician could not reach agreement concerning the Enrollee's care and a CE physician was not available for consultation.

(3) In accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c)(2)(iv), the CE shall limit charges to Enrollees for post-stabilization care services to an amount no greater than what the CE would charge the Enrollee if they obtained the services through the CE. Additionally, the CE's financial responsibility for post-stabilization care services if not pre-approved ends when:

(A) A CE physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;

(B) A CE physician assumes responsibility for the Enrollee's care through transfer;

(C) A CE representative and the treating physician reach an agreement concerning the Enrollee's care; or

(D) The Enrollee is discharged.

(d) **Continued services to Enrollees.** The CE and DBM shall take all the necessary steps to ensure continuity of care when Enrollees transition to the CE or DBM from another CE/DBM or SoonerCare program. The CE and DBM shall ensure that established Enrollee and provider relationships, current services and existing PAs and care plans will remain in place during the continuity of care period in accordance with the requirements outlined in this Section.

(1) Transition to the CE/DBM shall be as seamless as possible for Enrollees and their providers.

(2) The CE shall take special care to provide continuity of care for newly enrolled Enrollees who have physical health conditions, behavioral health conditions and/or functional needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization or institutionalization, if covered services are disrupted or interrupted.

(3) The DBM shall take special care to provide continuity of care for newly enrolled SoonerSelect Dental Enrollees who have oral health care needs and are under the care of existing treatment providers and whose health could be placed in jeopardy, or who could be placed at risk of hospitalization, if covered services are disrupted or interrupted.

(4) The DBM shall work with SoonerSelect and SoonerSelect Children's Specialty CEs to transition and coordinate care after a dental related emergency service pursuant to the Contract.

(5) The CE/DBM shall make transition of care policies available to Enrollees and provide instructions to Enrollees on how to access continued services during the continuity of care period.

(6) The CE/DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period.

(e) **Non discrimination.** The CE or DBM shall not discriminate an Enrollee on the basis of the Enrollee's health or need for medical services.

(f) **Failure to comply.** If the CE or DBM fails to comply with OAC 317:55-3-10, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-11. ~~Intermediate sanctions~~Cost sharing

~~(a) **Intermediate sanctions obligation.** OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)-(d).~~

~~(b) **Adoption of intermediate sanctions.** OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.~~

~~(c) **Imposition of sanctions.** If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.~~

~~(d) **Required imposition of temporary management.** In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.~~

~~(e) **Retained authority.** OHCA retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.~~

~~(f) **Notice.** Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.~~

~~(g) **Right to request fair hearing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.~~

~~(1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.~~

~~(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.~~

~~(3) At the ALJ's discretion, the ALJ will:~~

~~(A) Establish a scheduling order;~~

~~(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;~~

~~(C) Rule on all interlocutory motions;~~

~~(D) Require briefing of any or all issues;~~

~~(E) Conduct hearings in a forum and manner as determined by the ALJ;~~

~~(F) Rule on the admissibility of all evidence;~~
~~(G) Question witnesses;~~
~~(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:~~
~~(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;~~
~~(ii) Excluding all testimony of an unresponsive or evasive witness; or~~
~~(iii) Expelling the person from further participation in the hearing;~~
~~(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;~~
~~(J) Administer oaths or affirmations;~~
~~(K) Determine the location of the hearing and manner in which it will be conducted;~~
~~(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;~~
~~(M) Recess and reconvene the hearing;~~
~~(N) Set and/or limit the time frame of the hearing;~~
~~(O) Make proposed findings of facts and conclusions of law; and~~
~~(P) Sustain or deny OHCA's imposition of the sanction(s).~~

The CE or DBM shall ensure that all Enrollees are held harmless by providers for payment for any existing covered services, other than required cost sharing, during the continuity of care period. The CE or DBM shall not impose premiums or charges on Enrollees that are in excess of those permitted in the SoonerCare program in accordance with OAC 317:30-3-5 and the Oklahoma Medicaid State Plan. If the CE or DBM fails to comply with OAC 317:55-3-11, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-12. ~~Non-compliance damages and remedies~~Provider contracting and network requirements

~~If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or Federal law.~~

(a) **Provider contracts**. A CE or DBM must provide or arrange for the delivery of covered health care services described in OAC 317:55-3-5 through a provider agreement with SoonerCare-contracted providers. All provider agreements must be in writing and in accordance with the Contract and 42 C.F.R. §§ 434.6 and 438.6. The CE's or DBM's execution of a provider agreement does not terminate the CE's or DBM's legal responsibility to the OHCA to ensure all the CE's and DBM's activities and obligations are performed in accordance with Okla. Admin. Code § 317, as applicable, the CE's or DBM's Contract with the OHCA, and all applicable federal, state, and local regulations. The CE or DBM shall maintain, and have available, written policies and procedures on:

(1) Participating provider selection;

(2) Retention and termination of a provider's participation with the CE or DBM;

(3) Responding to changes in the CE'S or DBM'S network of participating providers that affect access and ability to deliver services in a timely manner; and

(4) Access standards.

(b) **Provider network.**

(1) The CE and DBM must maintain, in accordance with 42 C.F.R. § 438.206(b)(1), a network of appropriate participating providers that is supported by a signed provider agreement and is sufficient to provide adequate access and availability to all services covered under the Contract with the OHCA, including those with limited English proficiency or physical or mental disabilities.

(2) The CE and DBM must ensure that all requirements found at 42 C.F.R. § 438.3(q)(1) and (q)(3) are met.

(3) The CE and DBM must meet and require its participating providers to meet state standards for timely access to care and services, in accordance with 42 C.F.R. § 438.206(c) and all contractual requirements.

(4) The OHCA shall monitor and review the CE's and DBM's compliance with all standards as part of all ongoing oversight activities.

(c) **Credentialing and recredentialing.**

(1) All CE and DBM must utilize the same single Credential Verification Organization (CVO) that is certified by a CMS-approved accrediting organization and approved by OHCA as part of its provider credentialing and recredentialing process. The CE and DBM credentialing and re-credentialing processes shall comply with relevant state and federal regulations, including, but not limited to, 42 C.F.R. §§ 438.12, 438.206(b)(6), and 438.214, and all applicable contractual requirements.

(2) The CE and DBM must ensure that providers have been properly credentialed to ensure provider facilities, organizations, and staff meet all qualifications and requirements for participation in the Oklahoma Medicaid program. All applications must be credentialed and the CE's or DBM's claim systems must be able to recognize the provider as a SoonerSelect program network provider, within all applicable timeframes as outlined within the Contract with the OHCA.

(3) The recredentialing process must take into consideration provider performance data including Enrollee grievance and appeal, quality of care, and utilization management.

(4) The CE and DBM must review and approve the credentials of all applicable licensed and unlicensed participating and contracted providers who participate in the CE's or DBM's provider network at least once every three (3) years.

(5) If the CE or DBM fails to comply with the credentialing and recredentialing standards per OAC 317:55-5-12(c), the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

(d) **Non-discrimination against providers.**

(1) The CE's and DBM's written policies and procedures shall not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, per 42 C.F.R. §§ 438.12(a)(2) and 438.214(a).

(2) In accordance with 56 O.S. § 4002.4(B), shall not exclude essential community providers, providers who receive directed payments in accordance with 42 C.F.R. Part 438, and such other providers, as directed by OHCA from execution of provider agreements.

317:55-3-13. ~~Termination of managed care contract~~Time, distance, and access standards

~~(a) **Termination of an MCO, permitted by 42 C.F.R. § 438.708**. Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:~~

(1) Failed to carry out the substantive terms of the contract; or

(2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.

(b) **Termination permitted by contract, MCO or DBM**. Grounds for termination include:

(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM of their choosing or, if no choice is made, a default MCO or DBM.

(2) **Termination for convenience**. OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.

(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.

(4) **Termination for lack of authority.** In the event that the State is determined, in whole or part, to lack Federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing**. Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the

time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of the decision affirming or reversing the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R. § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing**. Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

~~(O) Make proposed findings of facts and conclusions of law; and~~
~~(P) Sustain or deny OHCA's imposition of the termination(s).~~

(a) The CE and DBM must meet all time and distance standards as established by the OHCA in accordance with 42 C.F.R. § 438.68. The time and distance standards will apply to all geographic areas in which the CE or DBM operates, with standards varying for urban and rural areas, which will include, at a minimum:

(1) Anticipated enrollment;
(2) Expected utilization of services;
(3) Characteristics and health care needs of all covered populations;
(4) Provider-to-Enrollee ratios;
(5) Travel time or distance to providers;
(6) Percentage of contracted providers that are accepting new patients;
(7) Ability to communicate with limited English proficiency Enrollees;
(8) Ability to ensure physical access, reasonable accommodations, and accessible equipment for Enrollees with physical or mental disabilities;
(9) Maximum wait times; and
(10) Hours of operations.

(b) The standards listed in (a)(1) – (10) of this Section apply to the following medical provider types, in accordance with 42 C.F.R. § 438.68(b) and specified in the Medical and Children's Specialty Contract:

(1) Adult and pediatric PCPs;
(2) Obstetrics and Gynecology (OB/GYN) providers;
(3) Adult and pediatric mental health providers;
(4) Adult and pediatric substance use disorder (SUD) providers;
(5) Adult and pediatric specialists;
(6) Hospitals;
(7) Pharmacies; and
(8) Essential community providers.

(c) The standards listed in (a)(1) – (10) of this Section apply to the following dental provider types, in accordance with 42 C.F.R § 438.68(b) and specified in the DBM Contract:

(1) General dentistry providers;
(2) Pediatric specialty dental providers;
(3) Specialty dental providers; and
(4) Essential community providers.

(d) If the CE or DBM fails to comply with the standards as set forth in this Section, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-14. ~~Record retention~~Primary care requirements

~~In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.~~

(a) **Primary care spending/expenses.** No later than the end of the fourth (4th) year of the initial contracting period, each CE shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

(b) **Primary care expenditure reporting requirements.**

(1) The CEs must submit a primary care implementation plan which describes the CEs strategies for increasing the percentage of total medical expenditures allocated to primary care over the initial four (4) year contract period.

(2) The plan shall include target annual percentage increases over the previous year baseline data that demonstrate the CEs ability to achieve eleven percent (11%) by the end of year four (4).

(c) **Primary care expenditure calculations.**

(1) CEs shall submit data on an annual basis for primary care and total medical expenditures made through paid claims amounts and non-claims payments to the OHCA, in the manner and timeline prescribed in the SoonerSelect Contract.

(2) The OHCA will consider non-claims-based investments into primary care including but not limited to investments in electronic health record (EHR) systems, health information exchange (HIE) costs, care coordination activities and systems, and recruitment/retention incentives for primary care providers in rural and medically underserved areas.

(3) Other non-claims-based investments may be reviewed and approved by the OHCA.

317:55-3-15. Provider agreement/contract termination

(a) The CE and DBM and all participating providers have the right to terminate the Contract entered into with each other via a provider agreement.

(b) The CE and DBM and all participating providers may terminate the provider agreement for cause with thirty (30) days advance written notice and without cause with sixty (60) days advance written notice to the other party.

(c) The CE and DBM shall terminate its provider agreement with a participating provider immediately if any of the following circumstances occur:

(1) In order to protect the health and safety of all Enrollees;

(2) If a credible allegation of fraud results in a conviction of credible allegation on the participating provider;

(3) When the participating provider's licenses, certifications and/or accreditations are modified, revoked or in any other way making it unlawful for the provider to provide services under the Contract; or

(4) If requested by the OHCA.

(d) The OHCA reserves the right to terminate a provider from SoonerCare participation. The OHCA will notify the CE or DBM regarding any termination. The CE and DBM shall be responsible for monitoring all state registries to review any participating providers that are terminated by OHCA and excluded from participation in the CE's or DBM's participating provider network.

317:55-3-16. Non-licensed providers

(a) The CE and DBM must ensure that all non-licensed providers are educated, trained, and qualified to perform all job responsibilities.

(b) Background checks and database screening in accordance with state and federal laws must be completed to ensure the non-licensed provider has not been excluded or debarred from participation in Medicare, Medicaid, or any federal health care program.

(c) All applicable state and federal regulations and contractual requirements must be followed when employing non-licensed providers.

PART 5. ~~REQUIRED FEDERAL AUTHORIZATIONS~~GRIEVANCE, APPEAL AND PROVIDER COMPLAINT SYSTEM

317:55-3-20. ~~Authorizations~~SoonerSelect enrollee grievance and appeal system

~~Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:~~

~~(1) Federal authority through a State Plan Amendment or waiver of the Act;~~

~~(2) CMS approval of each contract in relation to the MCP;~~

~~(3) CMS approval of all contract rates authorized under the MCP; and~~

~~(4) CMS approval of direct payment arrangements authorized under the MCP.~~

(a) The CE or DBM shall have written grievance and appeal policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. § 438 Subpart F and OAC 317:2-3-3.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Grievances, pursuant to OAC 317:2-3-4;

(3) Appeals, pursuant to OAC 317:2-3-5;

(4) Grievance and appeal notices, pursuant to OAC 317:2-3-8;

(5) State fair hearings, pursuant to OAC 317:2-3-12;

(6) Recordkeeping, pursuant to OAC 317:2-3-11; and

(7) Continuation of benefits, pursuant to OAC 317:2-1-2.6 and 317:2-3-5.1**.**

(b) If the CE or DBM fails to meet performance standards, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

317:55-3-21. ~~Timing~~ Provider complaint system

~~OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.~~

The CE or DBM shall have written provider complaint policies and procedures for an Enrollee, or an Enrollee's authorized representative, to appeal a CE's or DBM's action and/or file a grievance. The policies must address contractual requirements, including performance standards, and federal funding requirements, including 42 C.F.R. Part 438 Subpart F and OAC 317:2-3-10.

(1) Timeframes, pursuant to OAC 317:2-3-2;

(2) Notices, pursuant to OAC 317:2-3-8; and

(3) Recordkeeping, pursuant to OAC 317:2-3-11.

SUBCHAPTER 5. REQUIREMENTS FOR ~~MANAGED CARE ORGANIZATIONS~~ CONTRACTED ENTITIES AND DENTAL BENEFITS MANAGERS

PART 1. ~~ACCREDITATION AND READINESS~~MONITORING, PROGRAM INTEGRITY, DATA, AND REPORTING

317:55-5-1. ~~MCO or DBM accreditation~~Monitoring system for all SoonerSelect programs

~~All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United States Department of Health and Human Services.~~

(a) In accordance with 42 C.F.R. § 438.66, the OHCA will monitor each CE or DBM to assess its ability and capacity to comply with program and Contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

(b) The CE or DBM shall have a reporting monitoring process for ensuring compliance with all Contract requirements, implementation deadlines for mandates and/or laws as directed by CMS, CDC, or other federal or state government entity. The CE or DBM shall report monthly on its compliance monitoring activities as required by the reporting manual.

317:55-5-2. ~~MCO or DBM readiness~~Program integrity; data and reporting

~~(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.~~

~~(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.~~

(a) **Program integrity standards.** The CE and DBM shall comply with all state and federal laws, regulations, and mandates including but not limited to 42 C.F.R. § 438.608. The CE and DBM shall have and implement written policies and procedures that are designed to detect and prevent fraud, waste, and abuse pursuant to the Contract and federal regulations. The CE and DBM shall:

(1) Provide a monthly report (by close of the last calendar day of each month), of all open Program Integrity related audits and investigations related to fraud, waste, and abuse activities for identifying and collecting potential overpayments, utilization review, and provider compliance.

(2) Refer credible allegations of fraud to OHCA's Legal Division in writing within three (3) business days of discovery.

(3) Suspend all payments to the provider when a credible allegation of fraud exists.

(4) Participate in good faith at monthly Program Integrity meetings held jointly with MFCU and OHCA.

(5) Participate in good faith at monthly meetings with OHCA Program Integrity and Accountability Unit.

(6) Disclose any change in ownership and control information to OHCA within thirty-five (35) calendar days.

(7) Submit to OHCA or HHS, within thirty-five (35) days of request, full and complete information about:

(A) The ownership of any subcontractor with whom the CE/DBM has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12-month) period ending on the date of the request; and

(B) Any significant business transactions between the CE/DBM and any wholly owned supplier, or between the provider and any subcontractor, during the five (5-year) period ending on the date of request.

(b) **Data and reporting standards.**

(1) The CE and DBM shall:

(A) Provide information responsive to specific requests made by OHCA, MFCU, or other authorized state and federal authorities (including, but not limited to, requests for records of

Health Plan Enrollee and provider interviews), within three (3) business days of said request, unless otherwise agreed upon by OHCA.

(B) Submit weekly encounter data by the deadline established by OHCA and in accordance with OHCA accuracy standards.

(C) Submit a required report timely and/or accurately.

(2) The CE or DBM shall not falsify or misrepresent information that it furnishes to CMS or OHCA.

(c) **Request for information.** The CE or DBM shall provide and prioritize requests for information made by OHCA, MFCU, or other authorized state and federal authorities. The CE or DBM shall respond to urgent requests from OHCA within twenty-four hours (24-hours) and according to guidance and timelines provided by OHCA.

(d) **Record retention.** The CE or DBM shall retain records for a period of ten (10) years as well as comply with all state and federal regulations and contractual requirements.

(e) **Non-compliance actions**. If the CE or DBM fails to submit any OHCA-requested materials, as specified in this Section, without cause as determined by OHCA, on or before the due date, OHCA may impose any or all the CE sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative penalties, found at OAC 317:55-5-11 and the DBM Contract.

317:55-5-3. Critical incident reporting system

(a) The CE shall ensure that any serious incident that harms or potentially harms the Enrollee's health, safety, or well-being, including incidents of seclusion and restraint, are immediately identified, reported, reviewed, investigated, and corrected, in compliance with state and federal law.

(b) When the Enrollee is in the care of a behavioral health inpatient, PRTF, or crisis stabilization unit, critical incidents shall include, but are not limited to the following:

(1) Suicide death;

(2) Non-suicide death;

(3) Death-cause unknown;

(4) Homicide;

(5) Homicide attempt with significant medical intervention;

(6) Suicide attempt with significant medical intervention;

(7) Allegation of physical, sexual, or verbal abuse or neglect;

(8) Accidental injury with significant medical intervention;

(9) Use of restraints/seclusion (isolation);

(10) AWOL or absence from a mental health facility without permission; or

(11) Treatment complications (medication errors and adverse medication reaction) requiring significant medical intervention.

(c) The CE shall develop and implement a critical incident reporting and tracking system for behavioral health adverse or critical incidents and shall require participating providers to report adverse or critical incidents to the CE, OHS, and the Enrollee's parent or legal guardian.

(d) Participating providers shall contact the CE by phone no later than 5:00pm Central time on the business day following a serious occurrence and disclose, at a minimum:

(1) The name of the Enrollee involved in the serious incident;

(2) A description of the occurrence; and

(3) The name, street address, and telephone number of the facility.

(e) The participating provider must, within three (3) days of the serious occurrence, submit a written facility critical incident report to the CE.

(1) The facility critical incident report must include specific information regarding the incident

including the following:

(A) All information listed in OAC 317:55-5-3 (d)(1) through (3);

(B) Available follow-up information regarding the Enrollee's condition;

(B) Debriefings; and

(C) Any programmatic changes that were implemented.

(2) A copy of this report must be maintained in the Enrollee's record, along with the names of the persons at the CE and OHS to whom the occurrence was reported.

(3) A copy of the report must also be maintained in the incident and accident report logs kept by the facility.

(4) The CE shall review the participating provider's report and follow up with the participating provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

(f) The CE shall provide appropriate training and take corrective action as needed to ensure its staff and participating providers, as applicable, comply with all critical incident requirements, in the manner and format outlined in the reporting manual.

PART 3. ~~PROVIDER REQUIREMENTS~~NON-COMPLIANCE OF A CE AND/OR DBM AND NOTIFICATIONS

317:55-5-10. ~~Provider contracts and credentialing standards~~Non-compliance of contracted entities

~~(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.~~

~~(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any other providers as specified by OHCA through contract.~~

~~(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:~~

~~(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and~~

~~(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.~~

~~(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.~~

(a) **Failure to comply**. If the CE fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the CE Contract, OHCA will notify the CE of unmet performance expectations, violations or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the CE will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The CE's plan to address or cure the deficiency; and
(C) The date and time by which the deficiency will be cured.
(D) If the CE disagrees with OHCA's findings, the CE shall provide its reasons for disagreeing with OHCA's findings.
(2) The CE's proposed cure of a non-material deficiency is subject to the approval of OHCA.
(3) The CE's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**
(1) An item of material non compliance means a specific action of the CE that:
(A) Violates a substantive term of the Contract;
(B) Fails to meet an agreed upon measure of performance; or
(C) Represents a failure of the CE to be reasonably responsive to a reasonable request of OHCA relating to the Services for information, assistance, or support within the timeframe specified by OHCA.
(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, The CE may be required to submit a written CAP under the signature of the CE's CEO to correct or resolve a material breach of the Contract.
(A) The CAP must:
(i) Be submitted by the deadline set forth in the OHCA's request for a CAP.
(ii) Be reviewed and approved by the OHCA.
(B) Following the approval of the CAP, the OHCA may:
(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;
(ii) Disapprove portions of the CE's proposed CAP; or
(iii) Require additional or different corrective action(s) or timelines/time limits.
(C) The CE remains responsible for achieving the established performance criteria.
(3) OHCA may apply one (1) or more of the following non-compliance remedies for each item of material non-compliance listed in (2) of this Section.
(A) Conduct accelerated monitoring of the CE;
(B) Require additional, more detailed, financial and/or programmatic reports to be submitted by the CE;
(C) Decline to renew or extend the Contract;
(D) Require forfeiture of all or part of the CE's performance bond or other substitute; or
(E) Terminate the Contract in accordance with OAC 317:55-5-14.
(4) In addition to the non-compliance remedies, the OHCA may impose tailored remedies, including liquidated damages pursuant to (e) of this Section.

(d) **Imposition of intermediate sanctions.** In accordance with 42 C.F.R. § 438.702, if OHCA determines the CE is non-compliant and 42 C.F.R. § 438.700(b) is the basis for the Agency's determination, OHCA may impose the following intermediate sanctions:
(1) Imposition of civil money penalties in the amounts specified in 42 C.F.R. § 438.704;
(2) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;
(3) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE of a determination of a violation of any requirement under § 1903(m) or § 1932 of The Act;

(4) Suspend or recoup capitation payments to the CE for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur;

(5) Impose additional sanctions provided for under state statutes or regulations to address noncompliance in accordance with 42 C.F.R. § 438.702(b); and

(6) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The CE shall comply with the contractual requirements found in Section 1.26.3.5 "Intermediate Sanctions" of the Contract.

(7) The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

(e) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with Tit. 23 O.S. § 21, resulting from the CE's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the CE, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(f) **Other provisions.** The CE shall be responsible for all reasonable expenses related to the direct operation of the SoonerSelect Medical program, including but not limited to attorney fees, cost of preliminary or other audits of the CE and expenses related to the management of any office or other assets of the CE.

317:55-5-11. ~~Network adequacy standards~~Non-compliance of dental benefit managers

~~In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.~~

(a) **Failure to comply**. If the DBM fails to fulfill its duties and obligations or meet performance standards under 42 C.F.R. Part 438, 42 U.S.C. § 1396b(m), 42 U.S.C. § 1396u-2, Title 317 of the Oklahoma Administrative Code, or the DBM Contract, OHCA will notify the DBM of unmet performance expectations, violations, or deficiencies, and may impose corrective actions or any sanctions in addition to or instead of any actions or sanctions specified in the Contract.

(b) **Non-material compliance deficiencies.**

(1) If OHCA determines that unmet performance expectations, violations, or deficiencies do not result in a material deficiency or delay in the implementation or operation of services, the DBM will have five (5) business days (or the date specified by OHCA) of receipt of notice to provide the OHCA with a written response that:

(A) Explains the reasons for the deficiency;

(B) The DBM's plan to address or cure the deficiency; and

(C) The date and time by which the deficiency will be cured; or

(D) If the DBM disagrees with OHCA's findings, the DBM shall provide its reasons for disagreeing with OHCA's findings.

(2) The DBM's proposed cure of a non-material deficiency is subject to the approval of OHCA.

(3) The DBM's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by OHCA as a material deficiency and entitle OHCA to

pursue any other remedy provided in the Contract or any other appropriate remedy OHCA may have at law or equity.

(c) **Material compliance deficiencies.**

(1) An item of material non compliance means a specific action of the DBM that:

(A) Violates a substantive term of the Contract;

(B) Fails to meet an agreed upon measure of performance; or

(C) Represents a failure of the DBM to be reasonably responsive to a reasonable request of OHCA relating to the services for information, assistance, or support within the timeframe specified by OHCA.

(2) If OHCA determines that unmet performance expectations, violations, or deficiencies result in a material deficiency, the DBM may be required to submit a written CAP under the signature of the DBM's CEO to correct or resolve a material breach of the Contract.

(A) The CAP must:

(i) Be submitted by the deadline set forth in OHCA's request for a CAP.

(ii) Be reviewed and approved by OHCA.

(B) Following the approval of the CAP, the OHCA may:

(i) Condition such approval on completion of tasks in the order or priority that the OHCA prescribes;

(ii) Disapprove portions of the DBM's proposed CAP; or

(iii) Require additional or different corrective action(s) or timelines/time limits.

(C) The DBM remains responsible for achieving the established performance criteria.

(3) OHCA may apply one (1) or more of the administrative remedies found in (f) of this Section for each item of material non-compliance listed in (c)(2) of this Section.

(d) **Liquidated damages.** OHCA may impose actual, consequential, and liquidated damages in accordance with 23 O.S. § 21, resulting from the DBM's failure to comply with any of the terms of the Contract, Ch. 55, or any applicable state or federal regulations. Consequential and liquidated damages will be assessed if OHCA determines such failure is the fault of the DBM, including the CE's subcontractors and/or consultants, and is not materially caused or contributed to by OHCA or its agents.

(e) **Administrative remedies**. OHCA may impose the following remedies:

(1) Conduct accelerated monitoring of the DBM;

(2) Require additional, more detailed, financial and/or programmatic reports to be submitted by the DBM;

(3) Decline to renew or extend the Contract;

(4) Require forfeiture of all or part of the DBM's performance bond or other substitute; or

(5) Terminate the Contract in accordance with OAC 317:55-5-14.

(6) Grant Enrollee(s) the right to terminate enrollment without cause and notifying the affected Enrollees of their right to disenroll;

(7) Suspend all new enrollment of Enrollee(s), including default enrollment, after the date OHCA notifies the CE or DBM of a determination of a violation of any requirement;

(8) Suspend or recoup capitation payments to the DBM for Enrollees enrolled after the effective date of the sanction and until OHCA is satisfied that the reason for imposition of the sanction no longer exist and is not likely to recur; and

(9) Appoint temporary management in accordance with 42 C.F.R. § 438.706. The DBM shall comply with the contractual requirements found in the Contract at Section 1.26.3.5 "Imposition of Liquidated Damages".

(f) **Other provisions.** The DBM shall be responsible for all reasonable expenses related to the direct

operation of the SoonerSelect Dental program, including but not limited to attorney fees, cost of preliminary or other audits of the DBM and expenses related to the management of any office or other assets of the DBM.

317:55-5-12. ~~Prior authorization requirements, generally~~Termination of contract

~~The OHCA will establish prior authorization requirements that are consistent with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.~~

(a) The Contract may be terminated prior to its scheduled expiration date only for the reasons specified in this Section.

(1) **Termination for mutual consent.** OHCA and the CE or DBM may terminate the contract by mutual written agreement.

(2) **Termination for convenience.** The OHCA may terminate the contract, in whole or in part, for convenience if it is determined that termination is in the state's best interest.

(3) **Termination for default.** OHCA may, at its election, assign Enrollees to another DBM/CE or provide benefits through other State Plan authority if the DBM/CE has breached this contract and is unable or unwilling to cure such breach within the period of time as specified in writing by OHCA.

(4) **Termination for unavailability of funds.** If state, federal, or other funding is not sufficiently appropriated, or is withdrawn, reduced, or limited in any way after the effective date of the contract, OHCA may terminate this contract immediately, effective on the close of business on the day specified. OHCA shall be the final authority as to the availability of funds.

(5) **Termination for lack of authority.** If any necessary federal or state approval or authority to operate the SoonerSelect Medical or Dental program is not granted, or the Oklahoma Legislature prohibits OHCA from contracting with a CE or DBM for the provision of health care for Eligibles or Enrollees, OHCA may terminate this contract immediately, effective on the close of business on the day specified.

(6) **Termination for financial instability.** If the OHCA deems, in its sole discretion, that the CE or DBM is financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate this Contract effective on the close of business on the date specified.

(7) **Termination for debarment.** The CE or DBM will not knowingly have a relationship with an individual or affiliate, as defined in 42 C.F.R. § 438.610.

(b) **Transition period requirements.** A transition period begins upon notification by the OHCA of intent to terminate the contract, notice by the CE or DBM or OHCA of intent not to extend the contract for a subsequent extension period, or if the CE or DBM has no remaining extension periods.

317:55-5-13. Notification of material change

~~An MCO~~A CE or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the ~~MCP~~plan.

317:55-5-14. Patient data

~~An MCO~~A CE or DBM will provide patient data to a provider upon request to the extent allowed under federal or ~~State~~state laws, rules, or regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996.

PART 5. FINANCE

317:55-5-20. ~~Capitation rates~~Financial standards and third-party liability

~~OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.~~

(a) **Financial standards.** The CE or DBM shall comply with Oklahoma Insurance Department requirements for minimum net worth and risk- based capital in accordance with applicable Oklahoma Statutes found in Title 36 Insurance.

(b) **Insolvency protection.** In accordance with the requirements found at 42 C.F.R. §§ 438.106, 438.116, 36 O.S. § 6901, et seq., and all contractual requirements, the CE and DBM will provide satisfactory assurances to the OHCA to ensure that neither Enrollees nor the OHCA is held liable or responsible for any of the following:

(1) Any debts obtained by the CE or DBM;

(2) Covered services that are provided to the Enrollee for which the OHCA does not pay the CE or DBM; or

(3) Payment for covered services that are in excess of the amount that the Enrollee would owe the CE or DBM if those services were covered directly.

(c) **Medical loss ratio.** A CE or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. §§ 438.8, 438.74, and applicable Contract. OHCA will monitor compliance with this requirement. If CE or DBM are not compliant with submission of MLR reporting, OHCA will evaluate the CE's or DBM's status for penalties or termination. Monitoring procedures to ensure compliance with MLR reporting include review of timeliness and completeness of reporting requirement and audit of date contained within the report.

(d) **Third-party liability**. Medicaid should be the payer of last resort for all covered services pursuant to federal regulations including but not limited to 42 C.F.R. 433 Subpart D and 42 C.F.R. § 447.20. The OHCA will notify the CE and DBM for any known third-party resources identified or made available to OHCA at the time of an Applicant's or Eligible's eligibility determination or re-determination. The CE or DBM shall make every reasonable effort to:

(1) Determine the liability of third parties to pay for services rendered to Enrollees;

(2) Avoid costs which may be the responsibility of third parties;

(3) Reduce payments based on payments by a third-party for any part of a service;

(4) Recover any liability from responsible third-party sources, except for estate recovery and third-party subrogation which will remain OHCA's responsibility;

(5) Treat funds recovered from third parties as reductions to claims payments as required in the Contract; and

(6) Report all third-party liability collections as specified by the OHCA, the Contract, and reporting manual.

317:55-5-21. ~~Medical loss ratio~~Payment to CEs and DBMs

~~An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.~~

(a) **Capitation rates.** In consideration for all services rendered by a CE or DBM under a contract with the OHCA, the CE and DBM will receive a monthly capitation payment for each Enrollee pursuant to 42 C.F.R. §§ 438.3(c), 438.4 and any other applicable state and/or federal regulation.
(b) **Capitation reconciliation.** The CE and DBM shall perform monthly reconciliation of enrollment roster data against capitation payments and notify discrepancies to the OHCA on schedule and as defined by the OHCA.
(c) **Denial of payment.** Capitation payments to the CE or DBM will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS under 42 C.F.R. § 438.730(e). CMS may deny payment to OHCA for new Enrollees if its determination is not contested timely by the CE. OHCA will define in writing to the CE the conditions for lifting the payment denials.
(d) **Recoupment for Medicare eligible Enrollees.** In the event an Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility. The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement. OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

317:55-5-22. ~~Value-based purchasing~~Payment to providers

~~In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.~~

(a) **Provider payment.**

(1) The CE and DBM shall establish rates for participating providers are reasonable to cover access to services.

(2) The CE and DBM shall abide by state and federal requirements related to payment of specific provider types as described in the Contract.

(3) Pursuant to 56 O.S. § 4002.12, the OHCA shall establish minimum rates of reimbursement from CEs to providers who elect not to enter into a value-based payment arrangement or other alternative payment arrangements for health care services rendered to Enrollees.

(4) Applicable exceptions to OAC 317:55-5-22(3) can be found at 56 O.S. § 4002.12(I).

(b) **Non-participating provider payment.** If the CE or DBM is unable to provide covered services to an Enrollee within its network of participating providers, the CE or DBM must adequately and timely arrange for the provision and payment of these services by non-participating providers. Except as otherwise provided by law and/or specified for IHCPs, FQHCs, RHCs, and CCBHs, the CE or DBM will reimburse non-participating providers for covered services provided to Enrollees at a minimum of ninety percent (90%) of the current Medicaid fee schedule, unless the CE or DBM and the non-participating provider has agreed to a different reimbursement amount.
(c) **Value-based payments.** The CE and DBM shall implement value-based payment strategies and quality improvement initiatives to promote better care, better health outcomes, and lower spending for publicly funded health care services. OHCA will follow the withhold payment schedule and perform annual assessments to ensure CEs and DBMs are adhering to the VBP target requirements in accordance with the Contract. Pursuant to 42 C.F.R. § 438.10(f)(3), if the CE uses physician financial incentive plans, the Contractor must make available information about the incentive program. The CE shall also provide information about any physician incentive plans to OHCA prior to its initial use and prior to any subsequent revisions, and report information to OHCA as specified in the reporting manual. Any such incentive plans must comply with all applicable laws, including, without limitation 42 U.S.C. § 1395mm(i)(8) and 42 C.F.R § 417.479.

317:55-5-23. ~~Special contract provisions related to payment~~Timely claims filing and processing

~~(a) **Federal regulation.** Any special contract provision related to payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.~~

~~(b) **Provider payments.**~~

~~(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.~~

~~(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.~~

~~(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.~~

~~(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.~~

~~(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.~~

(a) **Timely claims filing.** The CE or DBM shall adjudicate provider claims in accordance with timely filing limits specified in OAC 317:30-3-11.

(b) **Timely payment.** The CE or DBM shall meet timely claims payment standards specified in the Contract and 42 C.F.R § 447.45.

317:55-5-24. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the ~~MCOs or DBMs~~CEs. The program will be fully described in the ~~managed care contract~~Contract so that the program will be founded on contract-current tools, populations, and other factors.

317:55-5-25. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The ~~MCO~~CE or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all ~~State and Federal~~state and federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six (6) months of the date the item or service was furnished will be considered timely, per ~~Oklahoma Administrative Code (~~OAC~~)~~ 317:30-3-11.

(c) **Clean claims.** The ~~MCO~~CE or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The ~~MCO~~CE or DBM will ensure that at least ninety percent (90%) of clean claims received

from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the ~~MCO~~CE or DBM may request medical records~~,~~ if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

(A) Detailed explanation of the basis for the denial; and

(B) Detailed description of the additional information necessary to substantiate the claim.

(2) The ~~MCO~~CE or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the ~~MCO~~CE or DBM will comply with the post payment audit process established by OHCA.

(2) The ~~MCO~~CE or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) ~~An MCO~~A CE or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the ~~managed care contract~~Contract.

317:55-5-26. Prohibited payments

(a) **Overpayment.** The CE or DBM shall report overpayments to OHCA and promptly recover identified overpayments.

(b) **Suspension of payments.** The CE or DBM shall suspend payments to providers for which the state determines there is a credible allegation of fraud in accordance with the Contract and 42 C.F.R. § 455.23.

(c) **Providers ineligible for payment.** The CE or DBM shall ensure that no Medicaid funds are reimbursed to a provider whose payments are suspended or that has been terminated by the OHCA.

(d) **Provider-preventable conditions.** In accordance with 42 C.F.R. §§ 438.3(g), 434.6(a)(12)(i) and 447.26(b), the CE or DBM shall not make any payment to a provider for provider-preventable conditions as defined at 42 C.F.R. § 447.26(b). A list of provider-preventable conditions including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs) for which payment shall not be made can be found at OAC 317:30-3-62 and 30-3-63.

PART 7. THE MANAGED CARE QUALITY ADVISORY COMMITTEE

317:55-5-30. ~~Managed care~~SoonerSelect quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the ~~MC~~Medicaid Delivery System Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO. The Committee will consist of:

(1) Participating providers as a majority of the Committee members;

(2) Representatives of hospitals and health systems;

(3) Members of the health care community; and

(4) Members of the academic community with an expertise in health care or other applicable field.

(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.
(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.
(d) The Committee will select from among its membership a chair and vice chair.
(e) The Committee may meet as often as may be required ~~in order~~ to perform the duties imposed on it.
(f) A quorum of the Committee will be required to approve any final ~~action~~recommendations of the Committee. A majority of the members of the Committee will constitute a quorum.

317:55-5-31. Quality scorecard
(a) Within one (1) year of beginning steady state operations of any ~~MCP~~plan, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares ~~MCOs~~CEs to one another and DBMs to one another.
(b) OHCA will provide the most recent quarterly scorecard for ~~initial enrollees~~first time Enrollees during choice counseling.
(c) OHCA will provide the most recent quarterly scorecard to all ~~enrollees~~Enrollees at the beginning of each open enrollment period.
(d) OHCA will publish each quarterly scorecard on its website.