oklahoma complete health

SoonerSelect

2024 Provider Manual

OklahomaCompleteHealth.com

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WELCOME

Welcome to Oklahoma Complete Health! Thank you for being part of our network of healthcare professionals. We look forward to collaborating with you to improve the health of our communities, one person at a time.

About Us

Oklahoma Complete Health is a Managed Care Organization (MCO), health plan, contracted with the Oklahoma Healthcare Authority (OHCA) to serve Members through the Medicaid managed care program SoonerSelect and is the statewide managed care health plan running the SoonerSelect Specialty Children's Plan program for over 30,000 children, youth and young adults including:

- Medicaid Eligible Children in Foster Care (FC)
- Designated Children in the custody of the Office of Juvenile Affairs (OJA)
- Former Foster Children (FFC)
- Children with an open prevention case through Child Welfare Services (CWS)
- Children Receiving Adoption Assistance (AA)

Our approach is based on the core belief that quality healthcare is best delivered at the local level through regional and community-based care. Oklahoma Complete Health's mission is to improve the health outcomes of our Members through focused, compassionate, and coordinated care, one person at time. Oklahoma Complete Health is providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government - sponsored healthcare programs.

Administrative Structure

Oklahoma Complete Health has an office in Oklahoma City, at which Key Staff Members physically perform their daily duties and responsibilities. Oklahoma Complete Health maintains the following roles and positions at the Oklahoma office:

a. Chief Executive Office (CEO);
b. Chief Financial Officer (CFO);
c. Chief Medical Officer;
d. Chief Operating Officer (COO);
e. Behavioral Health Director;
f. Care Management Director;
g. Compliance Officer;
h. Data Compliance Manager;
i. Grievance and Appeal Manager;
j. Information Systems Manager;
k. Pharmacy Director;
l. Program Integrity Lead Investigator;
m. Provider Services Director;
n. Quality Director;
o. Security and Privacy Officer;

p. SoonerSelect Member Advocate;
q. SoonerSelect Member Services Director;
r. Transition Coordinator;
s. Tribal Government Liaison;
t. UM Director;
u. SoonerSelect Children's Specialty Program Member Advocate;
v. SoonerSelect Children's Specialty Program Member Services Director;
w. Specialty Population Strategy Officer (Strategy Officer);
x. Claims Manager; and
y. Internal Audit Director;

In addition, Oklahoma Complete Health has a range of operational and support functions whose Members may be located in various locations throughout the State in order to best serve the needs of the Members:

a. Program Integrity staff
b. Member Services call center
c. Provider Services call center
d. Behavioral Health support staff;
e. Care Managers;
f. Grievance and Appeal staff;
g. Internal Audit staff;
h. Pharmacy support staff;
i. Provider services staff;
j. Quality management staff;
k. SoonerSelect Member care support staff;
l. SoonerSelect Member services staff;
m. Transition coordination staff;
n. UM staff;
o. SoonerSelect Children's Specialty Program Member Care support staff; and
p. SoonerSelect Children's Specialty Program Member services staff.

About This Manual

The Provider Manual contains comprehensive information about Oklahoma Complete Health's operations, benefits, policies, and procedures. The most up-to-date version may be viewed in the "For Providers" section of our website at www.oklahomacompletehealth.com. Providers will be notified of updates via notices posted on our website, bulletins and/or in Explanation of Payment (EOP) notices. To obtain a hard copy of this Manual, please contact Provider Services at 833-752-1664.

Nondiscrimination

Oklahoma Complete Health complies with guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials and physical locations that serve our Member.

All Providers who join the Oklahoma Complete Health network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

Oklahoma Complete Health requires Providers to deliver services to Oklahoma Complete Health Members without regard to race, color, national origin, age, disability, or sex. Providers must not discriminate against Members based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of Member financial responsibility from Oklahoma Complete Health Members.

Billing guidelines and information may be found in the Oklahoma Complete Health Provider Billing Manual, located in the "For Providers" section of our website at www.oklahomacompletehealth.com. The Provider Billing Manual includes information on:

- Encounter data submission guidelines
- Claims submission protocols and standards, including timeframe requirements
- Instructions/information for clean claims
- Claims dispute process
- Payment policies
- Client participation requirements
- Cost sharing requirements
- Third party liability and other instructions

KEY CONTACTS

The following chart includes a list of important telephone and fax numbers. When calling Oklahoma Complete Health, please have the following information available:

- National Provider Identifier (NPI) number
- Tax ID Number (TIN)
- Member's Oklahoma Complete Health ID number or Medicaid ID number

Health Plan Information		
Website	www.oklahomacompletehealth.com	
Primary Address	14000 Quail Springs Parkway Oklahoma City, OK 73134	
Hours of Operation	Provider Call Center 8:00am - 5:00pm CST, Monday – Friday* Member Call Center 8:00am - 5:00pm CST, Monday – Friday* Pharmacy Call Center 24 hours a day, 7 days a week **Excluding State Holidays* ***Excluding: New Year's Day, MLK Day, President's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day*	
Department	**Toll Free TTY Telephone Numbers**	**Fax Numbers**
Provider Services	SoonerSelect: 833-752-1664 SoonerSelect Children's Specialty Program 833-752-1665	833-611-2153
Member Services		833-705-2598
24 Hour Nurse Advice Line (24/7 Availability)		N/A
Evolent www.radmd.com		N/A

Prior Authorization Request		N/A
Oklahoma Complete Health Assessments	SoonerSelect: 833-752-1664	844-565-0862
Care Management	SoonerSelect Children's Specialty Plan 833-752-1665	N/A
Centene Pharmacy Services	(800) 460-8988 TTY: (866) 492-9674	(866) 399-0929
Non-Emergency Medical Transportation (NEMT) – MotivCare Provider Line Facility Line Reservation	866-354-7904 800-435-1276 877-718-4212	866-697-0497 800-597-2097
Oklahoma Medicaid Provider Service https://oklahoma.gov/ohca.html	800-522-0114	N/A
Oklahoma Medicaid Member Services https://oklahoma.gov/ohca/individuals/soonercare	800-987-7767 (TDD: 711)	N/A
To report suspected waste, fraud, and abuse to Oklahoma Complete Health	866-685-8664	N/A
Oklahoma Healthcare Authority	800-987-7767 (TDD: 711)	N/A

Paper Claims Submission
Oklahoma Complete Health Claims Attn: Claims PO Box 8060 Farmington, MO 63640-8060 For Claim Disputes or Medical Necessity Appeal: Toll Free: 833-752-1664
Electronic Claims Submission
Oklahoma Complete Health c/o Centene EDI Department payor ID: 68069 800-225-2573 ext. 25525 or by e-mail to: EDIBA@centene.com

AVAILITY PROVIDER PORTAL

The Availity Provider Portal allows Providers to check Member eligibility and benefits, submit and check the status of claims, and view authorization requirements.

Providers and designated office staff may register to use the Provider Web Portal in four simple steps. Once registered, tools are available that make obtaining and sharing information easy. Go to https://www.availity.com/Essentials-Portal-Registration to register.

Providers may use Availity to:

- Check Member eligibility
- View Member health records
- View the PCP panel (patient list)
- View and submit claims and adjustments
- Verify claim status
- Verify proper coding guidelines
- View payment history
- View Prior Authorizations
- Check Prior Authorization requirements
- Verify Prior Authorization status
- View Member gaps in care
- Contact us securely and confidentially
- Add/remove account users
- Determine payment/check clear dates
- Add/remove TINs from a user account
- View PCP Quality Incentive Report
- View and print Explanation of Payment (EOP)

Providers agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization available through Availity or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

ELECTRONIC VISIT VERIFICATION REQUIREMENTS

Oklahoma Complete Health contracts with OHCA's specified EVV vendor, AuthentiCare®, to continue the Statewide EVV system to monitor Member enrollment receipt and utilization of Home Health Services and State Plan Personal Care Services. Oklahoma Complete Health will ensure all participating Providers who provide services that are subject to EVV are participating in AuthentiCare's® system, unless granted and OHCA approved written exception.

Oklahoma Complete Health is responsible for any additional costs needed to support the operations or reporting capabilities related to EVV. AuthentiCare® will interface daily with Oklahoma Complete Health and send claims in the electronic 837 claims format for processing. As a part of its claims processing system, Oklahoma ensures system functionality to comply with all requirements for EVV requirements of the 21st Century CURES Act, including, but not limited to, the ability to:

a. Log the arrival and departure of the Provider delivering the service;
b. Verify, in accordance with business rules, that services are being delivered in the correct location (e.g., Member's home);
c. Verify the identity of the individual Provider who is providing the service to the Member;
d. Match services provided to the Member with services authorized in the Member's Care Plan;
e. Ensure that the Provider delivering the services is authorized to deliver such services; and
f. Reconcile paid claims with the PA's, as applicable.

Members enrolled in care management who are eligible for personal care or home health services receive a comprehensive assessment, and/or the state designed UCAT assessment to evaluate the need for Personal Care Services. After all assessments are completed, an individualized care plan is developed with agreement from the Member.

For more information about the AuthentiCare® system, visit www.oklahoma.gov/ohca/individuals/programs/electronic-visit-verification.html. The following Personal Care and Home Healthcare Services are required to use the Oklahoma AuthentiCare system. Note: Other codes may be added as directed by the State or Oklahoma Complete Health for future program expansion or monitoring.

Service Code	Service Modifier	Service Name	Unit Definition
T1001		State Plan Nursing Visit	1 visit
T1002		RN Assessment Evaluation	15 minutes
T1005		Respite In-Home	15 minutes
T1016		Case Management Standard	15 minutes
T1016	U3	Transitional Case Management Standard	15 minutes
T1016	TN	Case Management Very Rural	15 minutes

Service Code	Service Modifier	Service Name	Unit Definition
T1016	TN U3	Transitional Case Management Very Rural	15 minutes
T1019		Personal Care	15 minutes
T1019	U8	Personal Care (EVV Exempt Service)	15 minutes
T1019	TF	Advanced Supportive Restorative	15 minutes
T1019	TF U8	Advanced Supportive Restorative (EVV Exempt Service)	15 minutes
S9125		In-Home Respite 8 Plus Hours	1 visit
G0151		Physical Therapy	15 minutes
G0152		Occupational Therapy	15 minutes
G0153		Speech Therapy	15 minutes
G0237		Respiratory Therapy	15 minutes
G0299		RN Skilled Nursing	15 minutes
G0299	TF	Extended State Plan RN Skilled Nursing	15 minutes
G0300		LPN Or LVN Skilled Nursing	15 minutes
G0300	TF	Extended State Plan LPN or LVN Skilled Nursing	15 minutes
T2017	32	HTS	15 minutes
T2017	U1 TF	SDHTS	15 minutes
S5130	32	Homemaker	15 minutes
S5150	32	Homemaker-Respite	15 minutes
97802	U5	Nutritional Therapy – Initial Assessment	15 minutes
97803	U5	Nutritional Therapy – Re-Assessment	15 minutes

Service Code	Service Modifier	Service Name	Unit Definition
DDST1001		Nursing Intermittent Skilled Care	15 minutes
T1000		Nursing Extended Duty/ Private Duty Nursing	15 minutes
T1016	U7	Institutional Case Management	15 minutes
T1016	U7TN	Institutional Case Management – Very Rural	15 minutes
T1002	U3	RN Assessment Evaluation - Transitional	15 minutes

Monitoring and Service Delivery

Care Plans are developed and updated on schedule and in compliance with Oklahoma Healthcare Authority. Oklahoma Complete Health ensures service utilization is appropriate and provided as authorized through frequent review of data and touchpoints with the Member based on level of care. We ensure services are delivered and service gaps, including the use of back-up staff, are addressed in a timely manner through ongoing communication with Member and/or Provider, evaluation and completion of care plan, and data reporting.

PROVIDER RELATIONS AND SERVICES

Provider Relations

Oklahoma Complete Health's Provider Relations is committed to supporting Providers as they care for our Members. Through Provider orientation, ongoing training, and support of daily business operations, we will strive to be your partners in great care. Upon credentialing approval and contracting, each Provider will be assigned a Provider Relations Representative. The Provider Relations Representative will contact the Provider to schedule an orientation.

Reasons to Contact a Provider Relations Representative

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new Practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a Provider contract
- Request fee schedule information
- Obtain Member roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and Member eligibility
- Open/close patient panel

Provider Services

Provider Services is available toll-free at 833-752-1664 from 8:00am-5:00pm, Monday-Friday (excluding State holidays).

Community Education

Oklahoma Complete Health Community Educators

The Oklahoma Complete Health Community Education team provides no-cost training for Providers, caregivers, parents and, community partners on topics related to the needs of children in the child welfare and juvenile justice systems. Childhood trauma can have long-term health impacts on cognition, mental health, and physical health. Providing healthcare services using a Trauma Informed Care approach is critical to treating the whole person, breaking down access to care barriers, and improving the health of every young person enrolled in our health plan.

Oklahoma Complete Health encourages all Providers to view a child's healthcare needs through a trauma-informed lens.

Training topics include Trauma Informed Care, Adverse Childhood Experiences Study (ACEs), and Resilience. Contact BH_Training@Centene.com to learn more or request a training.

NETWORK DEVELOPMENT AND MAINTENANCE

Oklahoma Complete Health maintains a network of qualified Providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its Members, both adults and children, without excessive travel requirements, and that is in compliance with DHS' access and availability requirements.

Oklahoma Complete Health offers a network of PCPs to ensure every Member has access to a Provider within the required travel distance standards.

In the event Oklahoma Complete Health network is unable to provide medically necessary services required under the contract, Oklahoma Complete Health shall ensure timely and adequate coverage of these services through an out-of-network Provider until a network Provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for an Oklahoma Complete Health Member, please contact our Medical Management team at 833-752-1664 (SoonerSelect) or 833-752-1665 (SoonerSelect Specialty Children's Program) and we will identify a Provider to make the necessary referral.

Tertiary Care

Oklahoma Complete Health offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available 24-hours per day in the geographical service area. In the event Oklahoma network is unable to provide the necessary tertiary care services required, Oklahoma Complete Health shall ensure timely and adequate coverage of these services through an out-of-network Provider who is enrolled with SoonerSelect until a network Provider is contracted and will ensure coordination with respect to Prior Authorization and payment issues in these circumstances.

MEMBER ELIGIBILITY

Members who select or are assigned to Oklahoma Complete Health before the fifteenth (15) day of the month will be enrolled effective on the first day for the following month. Eligible Members who select or are assigned to Oklahoma Complete Health on the fifteenth (15) day of the month or later will be enrolled effective on the first day of the second following month. Prior to these enrollment dates, most eligibles will be covered by fee-for-service payment structure administered by OHCA. Deemed newborns eligible for the SoonerSelect program will be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.

For Children's Specialty Plan Members entering foster care or juvenile justice they will be deemed eligible the day they enter the custody of the state and enrolled with Oklahoma Complete Health Children's Specialty Plan. Deemed newborns eligible for the SoonerSelect Children's Specialty Plan program will be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect Children's Specialty Plan program. If the Member is in the hospital at the time of enrollment in the Children's Specialty Plan the Provider should bill the Managed Care Organization the Member was enrolled with at time of entry into hospital for the entire hospital stay.

American Indian and Alaskan Natives may opt into Oklahoma Complete Health and will not be automatically enrolled.

Verifying Eligibility

Oklahoma Complete Health Providers should verify Member eligibility before every service is rendered, using one of the following methods:

1. **Log on to our Secure Provider Web Portal at www.oklahomacompletehealth.com.** Using our secure Provider Portal, you can check Member eligibility. You can search by date of service and either of the following: Member name and date of birth, or Member Medicaid ID and date of birth.

2. **Call our automated Member eligibility IVR system.** Call our toll-free Provider Services number at 833-752-1664 from any touch-tone phone and follow the appropriate menu options to reach our automated Member eligibility verification system 24 hours a day. The automated system will prompt you to enter the Member Medicaid ID and the month of service to check eligibility.

3. **If you cannot confirm a Member's eligibility using the methods above, call our toll-free number at 833-752-1664 to speak to a live representative.** Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the Member name, Member Medicaid ID, and Member date of birth to check eligibility. Possession of an Oklahoma Complete Health Member ID card is not a guarantee of eligibility. Use one of the above methods to verify Member eligibility on the date of service.

Oklahoma Complete Health Secure Provider Portal allows PCPs to access a list of eligible Members who have selected their services or were assigned to them. The list of eligible Members also provides other vital information, including indicators for Members whose claims data shows a gap in care, such as the need for an adult BMI assessment. To view this list, log on to www.oklahomacompletehealth.com.

Eligibility changes can occur throughout the month and the Member eligibility list does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify Member eligibility on the date of service.

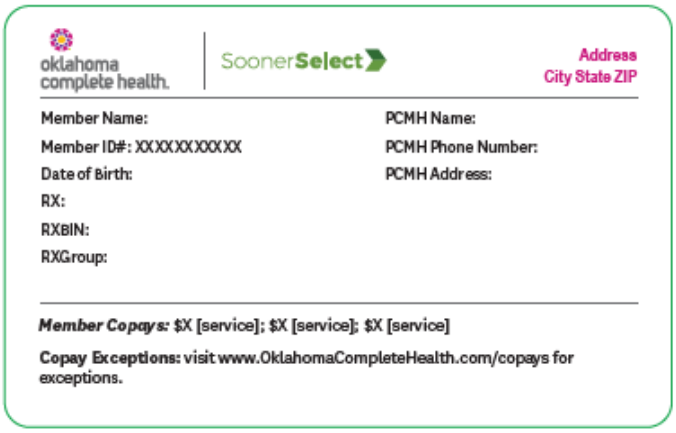
Member Identification Card

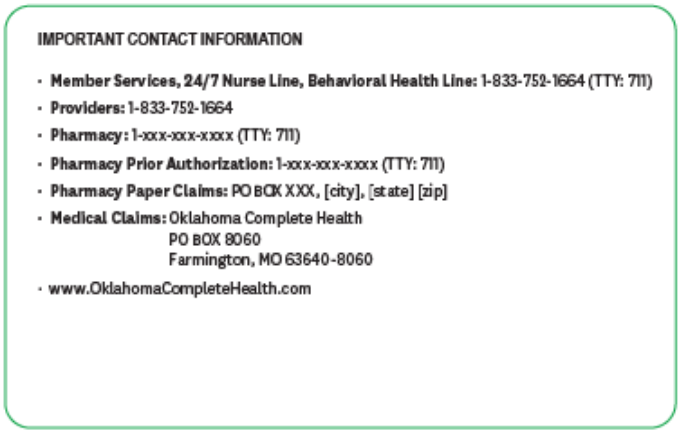
All new Oklahoma Complete Health Members receive an Oklahoma Complete Health Member ID card (pictured below). A new card is issued only when the information on the card changes, and Member loses a card, or a Member requests an additional card.

Members should present both their Oklahoma Complete Health Member ID card and a photo ID each time they seek services from a Provider. If you are not familiar with the person seeking care as a Member of our health plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services toll-free at 833-752-1664 immediately.

Members must also keep their state-issued Medicaid ID card in order to receive benefits that are not covered by Oklahoma Complete Health.





Enrollment Lock-in Period

Members are permitted to change CEs, without cause, during the first 90 days of enrollment with Oklahoma Complete Health, or during the 90 days following the date OHCA sends the Member notice of that enrollment, whichever is later. Once the Member's period for disenrollment has lapsed, the Member will remain enrolled with Oklahoma Complete Health until the next annual Open Enrollment Period, unless:

- The Member is disenrolled due to loss of SoonerCare eligibility;
- The Member becomes a foster child under custody of the State;
- The Member becomes juvenile justice involved under the custody of the State;
- The Member is a Former Foster Child, Child Receiving Adoption Assistance or has an open Prevention Services Case and opts to enroll in the SoonerSelect Specialty Children's Plan;
- A temporary loss of eligibility or enrollment has caused the Member to miss the annual disenrollment period, then the Member may disenroll without cause upon reenrollment; or
- OHCA imposes immediate sanctions on the CE and allows Members to disenroll without cause.

For a Former Foster Child, Child Receiving Adoption Assistance, or child with an open Prevention Services Case they can enroll at any time into the SoonerSelect Specialty Children's Plan with Oklahoma Complete Health from another CE.

Online Resources

The Oklahoma Complete Health website allows 24/7 access to Provider and Member information. The website is located at www.oklahomacompletehealth.com. Providers can find the following information on the website:

- Prior Authorization Requirements
- Applicable Forms
- Oklahoma Complete Health Plan News
- Clinical Guidelines
- Provider Bulletins
- Billing Manual
- Information on Disability Access
- Contract Request Forms
- Provider Relations Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

Please contact your Provider Relations representative or Provider Services toll-free at 833-752-1664 (SoonerSelect) or 833-752-1665 (SoonerSelect Children's Specialty)

with any questions or concerns regarding the website.

REFERRALS

Oklahoma Complete Health prefers the PCP to coordinate healthcare services. PCPs are encouraged to refer a Member to another Provider when medically necessary care is needed that is beyond the scope of what the PCP can provide. Obtaining referrals from the PCP is not required by Oklahoma Complete Health as a condition of payment for services.

The PCP must obtain Prior Authorization from Oklahoma Complete Health for referrals to certain specialty Providers, as noted on the Prior Authorization list. All out-of-network services require Prior Authorization as further described in this manual, except for family planning, emergency room, and table-top x-ray services. Providers are also required to promptly notify Oklahoma Complete Health when prenatal care is rendered.

Oklahoma Complete Health encourages specialists to communicate to the PCP when there is the need for a referral to another specialist. This allows the PCP to better coordinate the Member's care and ensure the referred specialists is a participating Provider within the Oklahoma Complete Health network and that the PCP is aware of the additional service request. The specialists may order diagnostic tests without PCP involvement.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the Provider or a Member of the Provider's family has a financial relationship.

APPOINTMENT AVAILABILITY AND ACCESS STANDARDS

Oklahoma Complete Health follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Oklahoma Complete Health monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Patient Centered Medical Homes	**Timeframe**
Emergency Medical Condition	24 hours a day, 7 days a week
Urgent Medical Condition	Within 24 hours
Non-Urgent Sick Visits (w/persistent symptoms)	Within 72 hours
Routine Appointments	Not to exceed 30 days
Obstetrics and Gynecology (OBGYN)	**Timeframe**
Urgent Care	Within 24 hours
Non-Urgent Sick Visits	Within 24 hours
Routine Appointments	Within 30 days
Maternity Care	1st Trimester- Not to exceed 14 calendar days. 2nd Trimester- Not to exceed 7 calendar days. 3rd Trimester- Not to exceed 3 business days
Specialists	**Timeframe**
Specialty Providers - Urgent	Within 24 hours
Specialty Providers - Routine	Within 60 days
Hospitals - Emergency	24 hours a day, 7 days a week

Adult Mental Health - Urgent	Within 24 hours
Adult Mental Health – After Hospital discharge	Within 7 days of hospitalization
Adult Mental Health – Routine	Within 30 days
Adult Substance Use - Urgent	Within 24 hours
Adult Substance Abuse – After Hospital discharge	Within 7 days of hospitalization
Adult Substance Use - Routine	Within 30 days
Pediatric Mental Health - Urgent	Within 24 hours
Pediatric Mental Health – After hospital discharge	Within 7 days of hospitalization
Pediatric Mental Health – Routine	Within 30 days
Pediatric Substance Use - Urgent	Within 24 hours
Pediatric Substance Use - After hospital discharge	Within 7 days of hospitalization
Pediatric Substance Use - Routine	Within 30 days

Covering Providers

PCPs and specialists must arrange for coverage with another Provider during scheduled or unscheduled time off, preferably with another Oklahoma Complete Health network Provider. In the event of unscheduled time off, please notify Provider Services of coverage arrangements as soon as possible. The covering Provider is compensated in accordance with the fee schedule in their agreement, and, if not an Oklahoma Complete Health network Provider, they will be paid as a non-participating Provider.

Telephone Arrangements

PCPs and Specialists, must:

- Answer the Member's telephone inquiries on a timely basis.
- Prioritize appointments.
- Schedule a series of appointments and follow-up appointments as needed by a Member.
- Identify and, when possible, reschedule cancelled and no-show appointments.
- Identify special Member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those with cognitive impairments).
- Adhere to the following response time for telephone call-back waiting times:
    - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes.
    - Same day for non-symptomatic concerns.
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a Provider's absence.
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the Member's medical record.

Oklahoma Complete Health will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement (QI) Program.

24-Hour Access

Oklahoma Complete Health PCPs and specialists are required to maintain sufficient access to facilities and personnel in order to provide covered services and shall ensure that such services are accessible to Members as needed 24 hours a day, 365 days a year as follows:

- A Provider's office phone must be answered during normal business hours.
- During after-hours, a Provider must have arrangements for one of the following:
    - Access to a covering Practitioner.
    - An answering service.
    - Triage service.
    - A voice message that provides a second phone number that is answered.
    - Any recorded message must be provided in English and Spanish if the Provider's practice includes a high population of Spanish speaking Members.

Examples of unacceptable after-hours coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours.
- The Provider's office telephone is answered after-hours by a recording that tells patients to leave a message.
- The Provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed.

- A clinician returning after-hours calls outside 30 minutes.

The selected method of 24-hour coverage chosen by the Member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialist, or covering medical professional must return the call within thirty (30) minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Oklahoma Complete Health will monitor Providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Oklahoma Complete Health Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential Provider and Member information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information Protected Health Information (PHI). "Individually identifiable health information," including demographic data, is information that relates to:

- The individual's past, present or future physical or mental health or condition.
- The provision of healthcare to the individual.
- The past, present, or future payment for the provision of healthcare to the individual.
- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
- Many common identifiers (e.g., name, address, birth date, social security number).

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the family educational rights and privacy act, 20 u.s.c. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Oklahoma Complete Health.

Release of data to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among Providers, releases authorized by Members or releases required by court order, subpoena, or law.

MEMBER PRIVACY RIGHTS

Oklahoma Complete Health privacy policy assures that all Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Oklahoma Complete Health privacy policy conforms to 45 c.f.r. (code of federal regulations): relevant sections of the HIPAA that provide Member privacy rights and place restrictions on uses and disclosures of PHI (§164.520, 522, 524, 526, and 528).

Oklahoma Complete Health policy also assists our personnel and Providers in meeting the privacy requirements of HIPAA when Members or authorized representatives exercise privacy rights through privacy request including:

Use and Disclosure Guidelines

Oklahoma Complete Health is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Oklahoma Complete Health may deny a privacy request under any of the following conditions:

- Oklahoma Complete Health does not maintain the records containing the PHI.
- The requester is not the Member and we're unable to verify his/her identity or authority to act as the Member's authorized representative.
- The documents requested are not part of the designated record set (e.g., credentialing information).
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the Member or another person.
- Oklahoma Complete Health is not required by law to honor the particular request (e.g., accounting for certain disclosures).
- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA.

CULTURAL COMPETENCY

Oklahoma Complete Health views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among Providers and staff to ensure that services are delivered in a culturally competent manner.

Oklahoma Complete Health is committed to the development, strengthening, and sustaining of healthy Provider/Member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every Member regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, Providers are expected to act in a manner that is sensitive to the ways in which the Member experiences the world. When healthcare services are delivered without regard for cultural differences, Members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Oklahoma Complete Health Cultural Competency Program, Providers must:

- Facilitate Member access to Cultural and Linguistic Services, including Informing Members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services.
    - To support informing Members of their right to access free language services, it is recommended that Providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance the top 15 languages utilized in Oklahoma as identified by Section 1557 of the ACA and include at least one tagline in 18-point font.
- Provide medical care with consideration of the Members' primary language, race ethnicity and culture;
- Participate in cultural competency training annually and ensure that office staff routinely interacting with Members have also been given the opportunity to participate in, and have participated in, cultural competency training;
- Ensure that treatment plans are developed with consideration of the Member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the Member's perspective on healthcare;

- Ensure an appropriate mechanism is established to fulfill the Provider's obligations under the Americans with Disabilities Act including that all facilities providing services to Members must be accessible to persons with disabilities. Additionally, no Member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Oklahoma Complete Health considers mainstreaming of Members a vital component of the delivery of care and expects Providers to treat Members without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program Membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a Member a covered service or availability of a facility; and
- providing an Oklahoma Complete Health Member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay Members (examples: separate waiting rooms, delayed appointment times).

Providers may take Oklahoma Complete Health's cultural competency training, located on the Provider portal, to meet annual cultural competency training requirements. Providers are able to participate in training opportunities administered by the State, nationally recognized organizations, or training provided by other organizations. For additional information regarding resources and trainings, visit:

- On the Office of Minority Health's website, you will find "A Physician's Practical Guide to Culturally Competent Care." By taking this course online, you can earn up to nine CME credits, or nine contact hours for free. The course may be found at cccm.thinkculturalhealth.hhs.gov/.
- Think Cultural Health's website includes classes, guides, and tools to assist you in providing culturally competent care. The website www.thinkculturalhealth.hhs.gov.
- The Agency for Healthcare Research and Quality website, which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at www.ahrq.gov.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at www.hrsa.gov. Providers can find free online courses on topics such as addressing health literacy, cultural competency, and limited English proficiency.

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, Section 1557 of the Patient Protection and Affordable Care Act, the Health Plan and its Providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Oklahoma Complete Health Members and Providers without unreasonable delay at all medical points of contact. The Member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation
- Oral translation (reading of English material in a Members preferred language)
- Face to Face non-English interpretation
- American Sign language
- Auxiliary aids, including alternate formats such as large print and braille
- Written translations for materials that are critical for obtaining health insurance coverage and access to healthcare services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to healthcare services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a Member, contact Oklahoma Complete Health Provider Services. Face to Face and American Sign Language services should be requested as soon as possible, or at least 5 business days before the appointment. All Providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center at 833-752-1664 (TDD/TTY 711).

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication.
- Exceptions to these expectations include:
    - In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
    - Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.
- Providers are encouraged to document in the Member's medical record any Member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

For more information, call Provider Services toll-free at 833-752-1664 (TDD/TTY: 711).

Provider Accessibility Initiative

Oklahoma Complete Health is committed to providing equal access to quality healthcare and services that are physically and programmatically accessible for our Members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's Providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and

transparency of Provider self-reported disability access data in Provider Directories so that Members with disabilities have the most accurate, accessible, and up-to-date information possible related to a Provider's disability access. To accomplish this, Providers are asked to complete a self-report of disability access that will be verified by Oklahoma Complete Health through an onsite Accessibility Site Review (ASR).

Oklahoma Complete Health's expectation, as communicated through the Provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Oklahoma Complete Health Providers.

Americans With Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs, or activities of a public entity.
- Denial of the benefits of services, programs, or activities of a public entity.
- Discrimination by any such entity. Oklahoma Complete Health Providers must provide physical access, accommodations, and accessible equipment for Members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Oklahoma Complete Health must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally and programmatically accessible to persons with disabilities. Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities, and equipment.

If any disability access barriers are identified, the Provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within one hundred eighty (180) days after Oklahoma Complete Health has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to: an in-person interpreter upon a Member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.
- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but not be limited to oral interpretation for other languages upon

request; accessible formats (e.g., documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.

- Provide Reasonable Accommodations that facilitate access for Members. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).
- Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.
    - Oklahoma Complete Health and participating Providers shall also facilitate access to these services and document a request and/or refusal of services in CRM or the Provider's Member data system.

Call your Provider Relations Representative at 833-752-1664 (TDD/TTY: 711) for more information.

Important Points to Remember: Word Choice

Avoid words with negative connotations like "handicapped," "afflicted," "crippled," "victim", "sufferer", etc. Do not refer to individuals by their disability. A person is not a condition.

Emphasize "person first" terminology:

• Handicapped	A PERSON with a disability
• Deaf	A PERSON who is deaf
• Mute	A PERSON without speech
• Confined/Wheelchair-Bound	A PERSON who uses a wheelchair

If you happen to not have a disability at this time in your life, that DOES NOT make you "normal" or "able-bodied." It makes you "non-disabled."

Call your Provider Relations Representative at 833-752-1664 (TDD/TTY: 711) for more information.

The term "disability" means, with respect to an individual. Disability is any substantial limitation of one or more of a person's daily life activities and may be present from birth or may occur during a person's lifetime. Any individual meeting any of these conditions is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of Members with disabilities to receive the same quality of care as other persons. Common Methods to Ensure Equal

Communication and Access to Information:

- Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded other Members.
    - Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location
- Provision for a presence of sign language interpreters to enable full communication with deaf or hard of hearing Members who use sign language.
- Provision for making auditory information (e.g., automated messages) available via alternative means.
    - Written communication or secure web-based methods may be used as possible substitutes.
- Provision for communicating with deaf or hard of hearing Members by telephone.
    - Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means

Policies for Scheduling and Waiting:

- Policies that allow scheduling additional time for the duration of appointments for Members with disabilities who may require it.
    - Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
- Policies to enable Members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival.
    - Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious.
- Policies to allow flexibility in appointment times for Members who use paratransit.
    - Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability.
- Policies to enable compliance with federal law that guarantees access to Provider offices for people with disabilities who use service animals.
    - Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Accessible Equipment:

- Training of healthcare Providers in operation of accessible equipment
    - Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral

- Current or potential Members including people with disabilities should only be referred to another Provider for established medical reasons or specialized expertise.
    - Referral results in a delay of treatment and subjects Members to additional time, expense, and reduces Member choice of Providers.

- Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which Members are referred.
    - Members may be unable to comply with medical referrals if referred location is not accessible and/or not prepared to provide the recommended service.

MANDATORY REPORTING OF SUSPECTED CHILD AND DEPENDENT ADULT ABUSE

Oklahoma Complete Health Providers who are mandatory reporters under Oklahoma law have a responsibility to report known or suspected child or dependent adult abuse in accordance with all applicable laws.

If you suspect a child under the age of 18 is abused or neglected, call the Oklahoma Department of Human Services (OKDHS) hotline at 1-800-522-3511. More information is available at oklahoma.gov.

To report abuse, neglect, exploitation, or self-neglect of a dependent adult, call 1-800-522-3511. More information is available at oklahoma.gov.

ADVANCE DIRECTIVES

Oklahoma Complete Health Providers are required to provide adult Members with written information about the Members' right to have an Advance Directive as defined in 42 C.F.R. 489.100. An Advance Directive is a legal document, such as a living will or Durable Power of Attorney, where a Member may provide directions or express preferences concerning their medical care and/or may appoint someone to act on their behalf. Members can use Advance Directives when the Member is unable to make or communicate decisions about their medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the Member to be unable to actively make a decision about their medical care.

Oklahoma Complete Health is committed to ensuring that Members are aware of and are able to avail themselves with information regarding their right to execute Advance Directives. Oklahoma Complete Health is equally committed to ensuring its Providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

Oklahoma Complete Health will provide and ensure that Providers are sharing written information with all adult Members receiving medical care with respect to their rights under all applicable laws so Members may make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.

Advance Directives are addressed by a Provider with the Member:

- When a Member visits the Provider's office.
- At a hospital at the time of a Member's admission as an inpatient.
- At a skilled nursing facility at the time of a Member's admission.
- Prior to or on the first visit when a Member begins receiving care with a home health agency.
- At the time a Member begins hospice care.

Neither Oklahoma Complete Health nor Providers will condition the authorization or provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advance Directive. Oklahoma Complete Health will facilitate communications between a Member or Member's authorized representative and the Member's Provider if the need is identified to ensure they are involved in decisions to withhold resuscitative services, or to forego or withdraw life-sustaining treatment.

Oklahoma Complete Health is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. Oklahoma Complete Health will annually assess and document the Advance Directive status in the Care Management systems for Members who receive Long Term Services and Supports.

Providers must document that a Member received information on Advance Directives that informed them of their right to execute and have one in the Member's permanent medical record.

Oklahoma Complete Health recommends the following:

- The first point of contact for the Member in the PCP's office should ask if the Member has executed an Advance Directive and the Member's response should be documented in the medical record.
- If the Member has executed an Advance Directive, the first point of contact should ask the Member to bring a copy of the Advance Directive to the PCP's office and document this request in the Member's medical record.
- An Advance Directive should be a part of the Member's medical record and include mental health directives.

If an Advance Directive exists, the Provider should discuss potential medical emergencies with the Member and/or designated family Member/significant other (if named in the Advance Directive and if available) and with the referring Provider, if applicable. Any such discussion should be documented in the medical record.

Oklahoma Complete Health requires contracted Providers to maintain written policies and procedures regarding Advance Directives and provide staff education related to it. Members can file a grievance regarding noncompliance with Advance Directive requirements with Oklahoma Complete Health and/or with the Oklahoma DHS. Oklahoma Complete Health provides information about Advance Directives to Members in the Member Handbook, including the Member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or healthcare power of attorney, and general instructions.

STATE COVERED SERVICES

Some services are carved-out and covered by the State's fee-for-service (FFS) program instead of Oklahoma Complete Health. While Oklahoma Complete Health does not cover these services, Providers and specialists must provide required referrals and assist in setting up these services. For details on how and where to access these services, Members can call the Oklahoma Complete Health Member Services Unit toll-free at 1-833-752-1664, Monday-Friday from 8:00am – 5:00pm, Monday-Friday.

COVERED BENEFITS AND LIMITATIONS

Oklahoma Complete Health network Providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services toll-free at 833-752-1664.

In the case where a counseling or referral service is not rendered to a Member because of moral or religious objections, Oklahoma Complete Health will inform the Member that the service is not covered and advise the Member to contact OHCA at 1-800-987-7767 or 711 (TDD).

Oklahoma Complete Health covers, at a minimum, those core benefits and services which includes Fee-for-Service (FFS) services covered under the Oklahoma Medicaid program specified in our agreement with the State of Oklahoma Department Human Services as set forth below:

	Children (Under 21 years old)	Adults (21 years old and over)
Medical and Related Benefits		
Advanced Practice Registered Nurse (APRN)	Covered	Covered
Allergy Testing	Covered	Covered, but limited to 60 tests over three years. ABP: Limit can be exceeded based on Medical Necessity
Alternative Treatment for Pain Management	Covered	Physical Therapy when provided in a non-hospital-based setting: a. Initial evaluation covered without PA; b. Twelve (12) hours per year requires PA. Chiropractic Services: a. Initial evaluation covered without PA; b. Twelve (12) visits per year requires PA. Limits can be exceeded based on medical necessity.
Ambulance or Emergency Transportation	Covered	Covered
Ambulatory Surgical Center	Covered	Covered; Reimbursement is outlined in Oklahoma Medicaid State Plan.
Bariatric Surgery	Covered upon meeting pre-surgical evaluation and weight loss requirements. Prior authorization required.	Covered upon meeting pre-surgical evaluation and weight loss requirements. Not covered for the treatment of obesity alone. Prior authorization required.

Certified Registered Nurse Anesthetist and Anesthesiologist Assistants	Covered	Covered
Chemotherapy	Covered	Covered
Clinic Services	Covered	Covered
Diabetes Education	Covered: 1. Ten (10) hours per first year 2. Two (2) hours per subsequent year Limits can be exceeded based on medical necessity and under EPSDT.	Covered: 1. Ten (10) hours per first year 2. Two (2) hours per subsequent year
Diagnostic Testing Entities	Covered; Some services may require prior authorization.	Covered; Some services may require prior authorization
Donor Human Breast Milk (Effective on or before 11/7/2022)	Covered during the first year of life. Prior authorization required.	Not Covered
Durable Medical Equipment Supplies and Appliances	Covered; Requires prescription by a medical Provider. May require prior authorization. Contractors shall utilize Oklahoma-based DME/Medical Supply Dealers unless out-of-state Providers are needed in order to maintain network adequacy.	Covered; Requires prescription by a medical provide. May require prior authorization. Contractors shall utilize Oklahoma-based DME/Medical Supply Dealers unless out-of-state Providers are needed in order to maintain network adequacy.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Early intervention Services (Including but not limited to health and immunization history; COVID-19 vaccine counseling; physical exams, various health assessments and counseling; lab and screening tests; and necessary follow-up care.)	Covered; Some services may require prior authorization.	Not Covered
Emergency Department	Covered	Covered
Eye Care to treat a medical or surgical condition	Covered	Covered

Family Planning Services	Covered	Covered
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services	Covered	Covered
Genetic Counseling and Testing	Covered for pregnant Members and Members meeting Medical Necessity criteria. May require prior authorization.	Covered for pregnant Members and Members meeting Medical Necessity criteria. May require prior authorization.
Hearing Services	Prior authorization required.	Prior authorization required.
Home Healthcare Services	Covered	Covered
Hospice Care	Covered for Members with a life expectancy of six (6) months or less.	Not Covered ABP: Covered for Members with a life expectancy of six (6) months or less.
Immunizations as recommended by the Advisory Committee of Immunization Practices (ACIP)	Covered	Covered
Infusion Therapy	Covered	Covered when Medically Necessary and not considered a compensable part of the procedure.
Inpatient Hospital Services	Covered	Covered a. Inpatient hospital services (inpatient stay): No limit b. Inpatient Physician Services: Covered c. Inpatient surgical services: No limit d. Inpatient rehab hospital services: Ninety (90) Days per individual per SFY ABP: a. Inpatient hospital services (inpatient stay): No limit b. Inpatient Physician Services: Covered

		c. Inpatient surgical services: No limit d. Inpatient rehab hospital services: Ninety (90) Days per individual per SFY Amount limits can be exceeded based on Medical Necessity
Laboratory, X-ray, Diagnostic Imaging, Imaging (CT/PET Scans; MRIs)	Covered; May require prior authorization.	Covered; May require prior authorization.
Lactation Consultant	Covered for pregnant and postpartum Members.	Covered for pregnant and postpartum Members.
Lodging and Meals for the Member and/or one (1) approved medical escort	Covered; prior authorization required.	Covered; prior authorization required.
Long-Term Care Hospital for Children	Covered	Not Covered
Mammograms	Covered	Covered
Non-Emergency Medical Transportation (NEMT)	Covered	Covered
Maternal and Infant LCSW Services	Covered for pregnant and postpartum Members.	Covered for pregnant and postpartum Members.
Nurse Midwives	Covered for pregnant and postpartum Members.	Covered for pregnant and postpartum Members.
Nutrition Services (Dietician)	Covered with prior authorization.	Covered: up to six (6) Hours per year. Nutritional services for treatment of obesity are not covered. Services must be expressly for diagnosing, treating, or preventing, or minimizing effects of illness. ABP: Limits can be exceeded based on Medical Necessity.
Orthotics	Covered	Not Covered ABP: Covered without limitations when Medically Necessary.
Outpatient Hospital and Surgery Services	Covered	Covered
Parenteral / Enteral Nutrition	Covered; May require prior authorization.	Covered; May require prior authorization.
Personal Care	Covered	Covered
Physician and Physician Assistant Services	Covered	Covered

Podiatry	Covered	Covered
Post-Stabilization Care Services	Covered	Covered
Pregnancy and Maternity Services, including Prenatal, Delivery, and Postpartum	Covered	Covered
Prescription Drugs	Covered	Covered: a. Up to six (6) prescriptions per month, including up to two (2) brand name drugs without PA, and b. Up to three (3) brand name drugs with PA (within the six (6) prescription limit).
Preventive Care and Screening	Refer to EPSDT coverage	Covered as outlined in the State Plan pages for Outpatient Hospital Services, Other Laboratory and X-ray Services, Diagnosis and Treatment of Conditions Found, Clinic Services, Screening Services, and Rehabilitative Services. There is not a standalone preventive services benefit package for adults providing coverage for all services identified with an A or B rating by the USPSTF.
Private Duty Nursing	Covered: Up to sixteen (16) Hours per day, with exceptions made to the sixteen (16) Hour limit for up to thirty (30) Days immediately following Hospitalization or the temporary incapacitation of the primary caregiver.	Not Covered ABP: This service is substituted with skilled nursing under the home health services benefit.
Prosthetic Devices	Covered when prior authorized	Limited coverage: Only breast prosthesis and support accessories and prosthetic devices inserted during surgery are covered with required prior authorization. ABP: Covered without limitations when Medically Necessary.
Public Health Clinic Services	Covered	Covered, but may require prior authorization.

Radiation	Covered	Covered
Reconstructive Surgery	Covered; May require prior authorization.	Covered: Non-cosmetic Breast reconstruction /implantation / removal is covered only when it is a direct result of a mastectomy which is medically necessary. May require prior authorization.
Renal Dialysis Facility Services	Covered	Covered
Routine Patient Cost in Qualifying Clinical Trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57.	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial, is a covered State Plan / 1115 waiver service, and meets the requirements in OAC 317:30-3-57.
School-Based Health Related Services	Covered	Not Covered
Telehealth	Covered	Covered
Therapy Services: Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	OT and PT: a. Initial evaluation covered without prior authorization; b. Treatment requires prior authorization. ST: a. Evaluation and treatment require prior authorization.	Rehabilitative Services: Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty- five (45) visits). Habilitative Services: Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty- five (45) visits). Rehabilitative Services: Fifteen (15) visits per year for each OT, PT, and ST (cumulative total: Forty-five (45) visits).
Tobacco Cessation Services	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal spray)	Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers, and nasal

	and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to one hundred eighty (180) Days per twelve (12) months. Tobacco cessation products are covered without duration limits, prior authorization, or Co-payment and do not count against monthly prescription limits.	spray) and Zyban®/Bupropion to include combination therapy of these products are covered. Chantix®/Varenicline is covered up to one hundred eighty (180) Days per twelve (12) months. Tobacco cessation products are covered without duration limits, prior authorization, or Co-payment and do not count against monthly prescription limits.
Transplant Services	Covered when prior authorized. Cornea and kidney transplants do not require prior authorization.	Covered when prior authorized. Cornea and kidney transplants do not require prior authorization.
Urgent Care Centers / Facilities	Covered	Covered
Vision Services	Covered under EPSDT with a limit of two (2) eyeglass frames per year.	Adults over 21 and ABP: Coverage to treat a medical or surgical condition only; no coverage for routine eye exams.
Behavioral Health Benefits		
Applied Behavioral Analysis	Covered; prior authorization required.	Not Covered
Certified Community Behavioral Health (CCBHC) Services	Covered	Covered
Day Treatment Services	Covered when prior authorized for a minimum of three (3) Hours per day for four (4) Days per week.	Not Covered
Inpatient Hospital – Freestanding Psychiatric	Covered; prior authorization required.	Ages 21-64: Covered when prior authorized in accordance with the 1115 IMD waiver for a maximum of 60 Days per episode. Ages 65 and older: Covered when prior authorized.
Inpatient Hospital – General Acute	Covered; prior authorization required.	Covered; prior authorization required.
Inpatient Mental Health and Substance Abuse Treatment	Covered under EPSDT	Covered
Licensed Behavioral Health Provider (who can bill independently)	Covered; prior authorization required.	Not Covered
Medication Assisted Treatment (Suboxone® (buprenorphine/	Covered	Covered

naloxone SL films), Vivitrol, Methadone)		
Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disorder (ICF/IID) Services	Covered by Contractor for up to sixty (60) Days pending the level of care determination.	Covered by Contractor for up to sixty (60) Days pending the level of care determination.
Opioid Treatment Programs	Covered; prior authorization required.	Covered; prior authorization required.
Outpatient Behavioral Health Agency Services	Covered; prior authorization required.	Covered; prior authorization required.
Partial Hospitalization	Covered when prior authorized for a minimum of three (3) Hours per day for five (5) Days per week.	Covered when prior authorized for a minimum of three (3) Hours per day for five (5) Days per week.
Peer Recovery Support Services	Covered for ages sixteen (16) and through twenty-one (21) when prior authorized.	Covered when prior authorized
Program for Assertive Community Treatment (PACT) Services in accordance with OAC 450:55	Covered for ages eighteen (18) through twenty-one (21).	Covered
Therapeutic Behavioral Services, Family Support and Training	Covered for Children with SED in a systems of care wraparound team.	Not Covered
Psychiatric Residential Treatment Facility	Prior authorization required.	Not Covered
Psychiatrist	Covered	Covered
Psychologist (who can bill independently)	Covered; prior authorization required.	Covered; prior authorization required.
Substance Abuse Treatment (Outpatient, Inpatient, and Residential)	Outpatient substance abuse treatment: Covered when prior authorized. Residential substance abuse treatment: Covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver.	Outpatient substance abuse treatment: Covered when prior authorized. Residential substance abuse treatment: Covered in accordance with the Title XIX State Plan and accordance with 1115 IMD waiver.
Targeted Case Management	Covered; No prior authorization required.	Covered; No prior authorization required.
Therapeutic Foster Care	Covered when prior authorized	Not Covered

Family Planning Services and Supplies

In accordance with Section 1902(a)(23) of The Act and 42 C.F.R. § 431.51(b)(2), Oklahoma Complete Health will not restrict Members' free choice of Providers for family planning services and supplies and provides all family planning benefits in accordance with Oklahoma Healthcare Authority's policies, rules, and federal regulations.

The Plan covers family planning services provided by any qualified Provider whether or not the Provider is in-network. Referral/authorization is not required if a Member chooses to receive family planning services and supplies from outside the network. Family planning services are also exempt from any out-of-pocket costs for the Member. Family planning services are furnished on a voluntary and confidential basis, even if the Member is less than 18 years of age.

Family planning services and supplies include at a minimum:

- Education and counseling necessary to make informed choices and understand contraceptive methods
- Initial and annual complete physical examinations
- Follow-up, brief, and comprehensive visits
- Pregnancy testing
- Contraceptive supplies and follow-up care
- Diagnosis and treatment of sexually transmitted diseases, and
- Infertility assessment

Family planning services and supplies are provided in a manner that protects and enables the Members' freedom to choose the method of family planning to be uses consistent with 42 CFR § 441.20.

Oklahoma Complete Health allows Members to directly access a Specialist for treatment or regular care monitoring. Members are permitted to self-refer to:

- Behavioral Health Services, including substance use disorder (SUD) treatment
- Vision services
- Emergency Services
- Family Planning Services and Supplies
- Prenatal care
- Department of Health Providers, including mobile clinics; and
- Services provided by Indian Healthcare Providers (IHCP) to American Indian/Alaska Native (AI/AN) Member.

Members can access a list of in-network Specialists in their area via the Provider Directory. Information such as phone numbers, fax numbers, office hours and much more is available for Members to directly access the Specialist of their choice.

Abortions or Abortion-Related Services

Abortions or abortion-related services performed for family planning purposes are not covered services.

Abortions are covered services if a Provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest.

Oklahoma Complete Health covers treatment of medical complications occurring because of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

Out of Network Services

In cases where family planning services cannot be reasonably obtained by a network Provider, out-of-network services can be rendered if the services are medically necessary, covered, and authorized by Oklahoma Complete Health. Additionally:

- The decision to authorize use of an out-of-network Provider is based on continuity of care, complexity of the case and the lack of availability of an in-network Provider of the same specialty and expertise.
- Services are authorized for as long as the service is needed or until the service can be provided by an in-network Provider.
- Oklahoma Complete Health coordinates payment with the out-of-network Provider and ensures the cost to the Member is not greater than it would be if the services were furnished by an in-network Provider.
- Oklahoma Complete Health coordinates with the out-of-network Provider about payment and communication between the Member's primary care physician (PCP).

Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) is a covered benefit for all Medicaid beneficiaries, including Oklahoma Complete Health Members, who have no other way to get to their healthcare appointments. Oklahoma Complete Health pays for transportation services to get Members to and from needed non-emergency healthcare appointments. For more information on scheduling transportation, call Transportation Services at 1-877-718-4212 or Member Services at 1-833-752-1664. In addition to the standard NEMT benefits Oklahoma Complete Health offers the following value-added transportation benefits:

SoonerSelect Plan

- Five roundtrips per Member per year to support SDOH needs (e.g., grocery, food pantries, farmer's markets, WIC, childcare, job interviews, educational activities, and support groups).
- One (1) round-trip ride per day to parents/guardian who are visiting their child in the hospital.
- SoonerSelect Children's Specialty Program Five roundtrips per Member per year for social outings and visits with biological family
- Five roundtrips per Member per year to support SDOH needs (e.g., food resources, WIC, childcare, job interviews, education, and support groups)
- Transportation for biological parents to attend medical appointments in support of reunification as requested by Oklahoma Human Services (OHS)

- Transportation for youth and a caregiver to attend Office of Juvenile Affairs appointments.

Urgent Care Services

Oklahoma Complete Health defines Urgent Care as the existence of conditions due to an illness or injury which are not life threatening but require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

If a Member is unsure as to whether or not their situation is an emergency, they may contact their PCP or Oklahoma Complete Health's 24-hour Nurse Advice Hotline during regular or after business hours and on weekends; however, this is not a requirement to access these services. Members may access urgent care services at any time without Prior Authorization from Oklahoma Complete Health.

Emergency Care Services

Emergency Care Services must be accessible 24 hours a day, seven days a week. They are provided in a hospital or comparable facility in order to stabilize the Member and determine the severity of the condition and the appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization from Oklahoma Complete Health.

Emergency services are covered by Oklahoma Complete Health when provided by a qualified Provider, including out-of-network Providers, and will be covered until the Member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Oklahoma Complete Health. Oklahoma Complete Health will not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition; or
2. A representative from the Plan instructs the Member to seek emergency services.

Once the Member's emergency medical condition is stabilized, Oklahoma Complete Health requires notification for hospital admission or Prior Authorization for follow-up care, as noted elsewhere in this manual.

Emergency Care Co-payments

A copayment is not required for Oklahoma Complete Health Members for use of a hospital Emergency Room (ER) visit to treat non-emergent conditions.

Before providing non-emergency services and imposing copayments, the hospital providing care must:

- Conduct an appropriate medical screening to determine that the Member does not need emergency services.
- Inform the Member of the amount of his or her copayment for non-emergency services provided in the hospital ER.
- Provide the Member with the name and location of an available and accessible alternative non-emergency services Provider.

- Determine that the alternative Provider can provide services to the Member in a timely manner with a lesser or no copayment.
- Provide a referral to coordinate scheduling for treatment by the alternative Provider.

If the Member has been advised of the available alternative Provider and of the amount of the copayment and chooses to continue to receive treatment for a non-emergency condition at the hospital ER, the hospital will assess the copayment.

Emergency services rendered for emergent conditions are exempt from any copayment.

Telehealth Services

Eligible in-network Oklahoma Complete Health Providers may provide telehealth offers telehealth services to Members when appropriate. Telehealth visits are subject to the same co-payments, coinsurance, and/or deductible amounts as expected when services are rendered in-person.

For billing requirements, please see the Oklahoma Complete Health Provider Billing Manual at www.oklahomacompletehealth.com/Providersresources.

Note: An originating site fee is not applicable when services are rendered virtually.

THIRD PARTY LIABILITY / COORDINATION OF BENEFITS

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, commercial carrier, automobile insurance, or worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the Member. Any other insurance, including Medicare, is always primary to Medicaid coverage.

Oklahoma Complete Health, like all Medicaid programs, is always the payer of last resort. Oklahoma Complete Health Providers will make reasonable efforts to determine the legal liability of third parties with Providers to pay for services furnished to Oklahoma Complete Health Members. If a Member has other insurance that is primary, the Provider must submit the claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB), Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a Member with insurance primary to Medicaid, the claim will pend and/or deny until this information is received. If a Member has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted through EDI or the secure web portal and must be submitted on a paper claim.

If the Provider is unsuccessful in obtaining necessary cooperation from a Member to identify potential third-party resources, the Provider(s), subcontractor(s), or OHCA contractor(s) will inform Oklahoma Complete Health that efforts have been unsuccessful. Oklahoma Complete Health will make every effort to work with other Providers, subcontractors, and OHCA contractors to determine liability coverage.

If third party liability coverage is determined after services are rendered, Oklahoma Complete Health will coordinate with Providers to pay any claims that may have been denied for payment due to third party liability.

Oklahoma Complete Health will coordinate benefits with all other Providers, any subcontractors, and OHCA's contractors.

INTEGRATED HEALTH SERVICES

Overview

Oklahoma Complete Health Population Health and Care Management department hours of operation are Monday through Friday from 8:00am-5:00pm CST (excluding State holidays).

Integrated Health Services include the areas of utilization management, care management, population health, Social Determinants of Health, and Health Equity. Clinical services are overseen by the Oklahoma Complete Health Medical Officer. The Vice President of Population Health and Clinical Operations (VP-PHCO) has responsibility for direct supervision and operation of the department. To reach the Medical Director or VPMM, please contact Medical Management toll-free at 833-752-1664.

The mission of the Population Health and Care Management Department is to educate Members and coordinate timely, cost-effective, and integrated services for individual health needs of Members to promote positive clinical outcomes. Integrated program components include complex case management, case management, disease management, behavioral health management, services to support social determinants of health, and transitional case management. Care Management utilizes multiple data sets to identify and treat identified at-risk Members. Care Management employs a multidisciplinary population health model to approach outlying Members from a variety of perspectives. Population Health and Care management staff are trained in person-centered thinking and motivational interviewing to guide Member goal identification and actions. The Mission of the Care Management Program is to:

- Assist Members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist Members in determining and accessing available benefits and resources.
- Work collaboratively with Members, family and significant others, Providers, and community organizations to develop goals and assist Members in achieving those goals.
- Assist Members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.
-

Integrated Medical and Behavioral Healthcare

Oklahoma Complete Health uses a multi-disciplinary Integrated Medical and Behavioral Care Team to offer coordinate care. Our coordinated care team is structured on an interdisciplinary approach that allows for the input of staff, Members, caregivers and treating Providers. Oklahoma Complete staff may include physical health and behavioral healthcare managers, social workers, pharmacists, health coaches and medical director. Our staff coordinates care with all the necessary individuals on the Member's care team, including the Member's primary and specialty Providers, other care team Members, and those identified as having a significant role in the Member's life, as appropriate.

Our goal is to help each, and every Oklahoma Complete Health Member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the

range of services we provide to all Members. Through this, we continually strive to achieve optimal health status through Member engagement and behavioral change motivation using a comprehensive approach that includes:

- Dedicated support for the integration of both physical and behavioral health services.
- Assisting Members in achieving optimum health, functional capability, and quality of life.
- Empowering Members through assistance with referrals and access to available benefits and resources.
- Working collaboratively with Members, family and significant others, Providers, and community organizations to assist Members using a holistic approach to care.
- Maximizing benefits and resources through oversight and cost-effective utilization management.
- Rapid and thorough identification and assessment; especially Members with special healthcare needs.
- A team approach that includes staff with expertise and skills that span departments and services.
- Information technologies that support care coordination within plan staff and among a Member's Providers and caregivers.
- Multifaceted approach to engage Members in self-care and improve outcomes.
- Continuous quality improvement processes that assess the effectiveness of integrated care and identify areas for enhancement to fully meet Member priorities.
- Assessment of Member's risk factors and needs.
- Contact with high-risk Members discharging from hospitals to ensure appropriate discharge appointments are arranged and Members understand treatment recommendations.
- Active coordination of care for Members with coexisting behavioral and physical health conditions; residential; social and other support services where needed.
- Development of an integrated plan of care.
- Referrals and assistance to community resources and/or behavioral health Providers.

The model emphasizes direct Member contact (i.e., telephonic out-reach; face-to-face meetings; and written educational materials). In some circumstances, face-to-face education is preferred because it more effectively engages Members, allows staff to provide information that can address Member questions in real time and better meets Member needs. Participating Members also receive preventive care and screening reminders, invitations to community events, and can call any time regarding healthcare and psychosocial questions or needs.

Practitioners can refer Members for chronic care management by phone at 833-752-1664.

Not all participants having the targeted diagnoses will be enrolled in the CCMP. Participants with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk participants with co-morbid or complex conditions will be referred for care management program evaluation.

Specialty Integrated Programs

- Members Empowered to Succeed (METS) takes a unique approach to ensuring Member recovery and resiliency by engaging them in their overall health and treatment, giving them the ability to remain in the community as they progress through treatment. The program focuses on the Member's individualized needs to create a recovery roadmap that is as unique as the individual Member. METS connects Providers and Members and works hand-in-hand with your already established care management process. The METS program can also be used

with Members who do not qualify for traditional care management, helping more of your population. The METS objective is to use an integrated, holistic, and recovery-centered approach for individuals with mental health needs and heightened outpatient behavioral health utilization. Our Care Managers are licensed clinicians who work in collaboration with Providers to match the treatment plan to the Member's goals and desired outcome. This coordination allows for identification and linkage of healthcare and community-based supports and resources that fit Member's strengths and health needs, while addressing everyday barriers they may be facing. Member Engagement Coordinators who are experienced in working with individuals with behavioral health diagnoses reach out to Members and utilized motivational interviewing techniques to assist the Member in accessing supportive services. The outcome is decreased dependence or unnecessary services and improved overall Member care.

- Behavioral Health Medication Monitoring (BHMM) is a retrospective review of data, taking in to account the prescriber's clinical records, identifying potential considerations to reduce polypharmacy within treatment plans for those using psychotropic medications. The BHMM programs do not authorize or deny medication fills. The primary objectives of BHMM include:
    - Providing care shaping and education for Providers to improve prescribing patterns;
    - Minimizing polypharmacy while maximizing therapeutic outcomes;
    - Identifying opportunities for consolidation of medications and reduction of dosage;
    - Reviewing for opportunities of non-pharmacological, psychosocial treatments
    - Assessing for evaluation of side effects and co-occurring medical complications

  BHMM reviews Members for psychotropic medication prescribing patterns to ensure prescribers are following evidence-based practices and Clinical Practice Guidelines (CPGs) as set forth by organizations such as but not limited to the American Psychiatric Association (APA) and/or the American Academy of Child and Adolescent Psychiatry (AACAP), when prescribing medications. The Behavioral Health Medication Monitoring (BHMM) team will identify potential prescribing opportunities to align with best practice and CPGs for clinical enhancement, including but not limited to metabolic monitoring, drug interactions, polypharmacy, under-utilization, over-utilization, and possible improper use of medications. BHMM provides a comprehensive case review, identifies alternative therapeutic options and social determinants of health barriers, recommends additional care practices, and can refer Members to case management for further interventions. This level of expertise and collaboration sets the stage for quality outcomes, improved Member and Provider satisfaction, and a true whole health approach. The BHMM Program recognizes that the management of each patient's care depends upon an assessment of the individual's entire clinical situation of which may be unavailable in record reviews.

Continuity of Care

When Members are newly enrolled and were previously receiving services, Oklahoma Complete Health will continue to authorize care as needed during a 90-day continuity of care period and 180-day continuity of care period for Children's Specialty Program Members to minimize disruption. Oklahoma Complete Health will work with non-participating Providers to continue treatment or create a transition plan to facilitate transfer to a participating Network Provider. In the event of a change of MCO for the Member during an episode of care, Oklahoma Complete Health will work with the

Provider and the new MCO in order to ensure any needed continued authorization of care that is medically necessary are in place.

Oklahoma Complete Health will ensure that established Provider relationships, current services and existing prior authorizations and care plans remain in place during the Continuity of Care period. Transition to the Oklahoma Complete Health shall be as seamless as possible for Members and Providers.

CHILDREN'S SPECIALTY PROGRAM

Oklahoma Complete Health Children's Specialty Program (CSP) is a local, statewide Oklahoma Provider Led Entity (PLE) that combines Medicaid managed care experience with vested Provider leadership in our health plan. With leaders from OU Health (OUH), OU Tulsa, OU Children's Hospital, the Alliance for Mental Health Providers of Oklahoma (Alliance), Hillcrest HealthCare System (Hillcrest), Sunbeam Family Services, and the Foster Care and Adoptive Association as Members of our board, our Governing Body is 90% led by Local Oklahoma Provider Organizations (LOPOs).

We employ our **Families and Futures Model**®: which is based on the four pillars of Care Management, partnership, a specialized network, and training, for the Children's Specialty Program (CSP)**.** This model ensures equity, safety, stability, and compassionate family-centered care through the building blocks of this approach. Our Families and Futures Model was developed with the belief that children and youth who have experienced trauma are resilient, and with the commitment to support these children and youth with evidenced based programs that contribute to successful adulthoods. Designed and proven to bring about system transformation, the CSP program supports Oklahoma in meeting federal Child and Family Services Review goals of safety, permanency, and well-being and be adaptable to meet the specific needs of Oklahoma's rural and urban communities.

CARE MANAGEMENT PROGRAM

Care Management is the heart and soul of the CSP. We believe in the resilience of children and youth to overcome trauma and transition to successful adulthood. Through our CM activities, we integrate and coordinate the full spectrum of physical, behavioral, pharmacy, dental, and vision services with the mission to improve outcomes and contribute to achieving stability and permanency for children in our care. Oklahoma Complete Health takes seriously our role as a stable presence for our children, guiding them, with their OHS Child Welfare Specialist (CWS) and Office of Juvenile Affairs (OJA) case manager, through the complexity of not only their medical and behavioral conditions but also through child welfare and juvenile justice services. We walk alongside our children, youth, and young adults as they move through many transitions, to guide and keep their Care Plan for well-being, growth, health, and safety intact.

With this in mind, Oklahoma Complete Health will assign a specific Care Manager to each youth enrolled in the Children's Specialty Program. Youth are assigned to a Care Manager based on level of need and condition. The Care Management team is multidisciplinary and includes Registered Nurses, Licensed Behavioral Health clinicians, and Social Workers. All youth are assigned to one of the following risk categories:

- Complex Care Management
- High Risk Care Management
- Moderate Risk Care Management
- Low Risk Care Management

My Health Screening

Upon Enrollment, Oklahoma Complete Health will conduct a health screening using a tool approved by the Department of Human Services to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or needs for care management. Any youth whose screening reflects unmet needs, service gaps, or a need for Care Coordination will be referred for a Comprehensive Assessment. The Comprehensive Assessment must be completed within the first 90 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.

Comprehensive Assessment

The Comprehensive Assessment will be scheduled within 30 days of identification of potential need for Care Management. Reassessment will occur at a minimum of every twelve (12) months thereafter unless there is a change in condition or significant health event or requested by the youth/caregiver. This Comprehensive Assessment is approved by the Oklahoma Department of Human Services and is used to help identify supports and services the youth and family may need. All support and services needs are reviewed and agreed upon by the youth and/or their identified caregiver/support. All documentation will be placed into our clinical documentation system which will support the development of the Care Plan(CP). All CPs will require agreement and signature by the youth or their authorized representative as well as all Providers that are part of the youth's CP (unless the Member requests to not share the CP with a Provider(s)).

Care Managers will consult with the CP, specialists, and behavioral health Providers other Providers and IDT experts, as needed when developing the CP.

The Care Management team is available to help all Providers manage their Oklahoma Complete Health CSP Members. Listed below are programs and components of special services that are available and can be accessed through the Care Management team. We look forward to hearing from you about any Oklahoma Complete Health CSP Members that you think can benefit from the addition of an Oklahoma Complete Health CSP Care Management team Member.

- Link the Member to a Medical Home
- Educate Members about Self-Management of their condition
- Ensure Member awareness of and compliance with medications
- Connect the Member to needed supports
- Transition of Care Program
- ER Diversion Program
- Whole-Person Care Coordination
- Discharge planning/coordination

To contact a Care Manager for Sooner Select call toll free number at 833-752-1664 or Sooner Select Children's Specialty plan at 833-752-1665.

High Risk Pregnancy Program

The Maternity Team will implement our *Start Smart for Your Baby*® Program (SSFB), which incorporates care management and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. SSFB is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant Members and providing care management to high and moderate risk Members through the postpartum period. A nurse care manager with obstetrical experience will serve as lead Care Manager for Members at high risk of premature delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead Care Manager (CM) for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity Team has Provider oversight advising the team on overcoming obstacles, helping identify high risk Members, and recommending interventions. These Providers will provide input to Oklahoma Complete Health Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Oklahoma Complete Health offers a premature delivery prevention program by supporting the use of 17-P. When a Provider determines that a Member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Oklahoma Complete Health CM who will check for eligibility.

The CM will arrange for 17-P to be administered via a home health agency in the Member's home, or in the practitioner's office as part of the Member's medical benefit. The nurse manager will contact the Member and do an assessment regarding compliance. The nurse will remain in contact with the Member and the prescribing Provider during the entire

treatment period. The Maternity Team works in collaboration with local PCP's, FQHC's, Health Homes and local Health Departments to support this program with the goal of improved maternity/neonate care in Oklahoma.

Contact the Oklahoma Complete Healthcare Management department for enrollment in the obstetrical program.

Children's Specialty Program Plan Care Management

Oklahoma Complete Health (OCH) has a team of Care Managers and Care Coordinators dedicated to the Specialty Children's Specialty Plan (CSP). All children and youth enrolled in the CSP will be assigned to a Member of this dedicated team who is specially trained and uniquely matched to the Members' needs and preferences to assist in the coordination of healthcare services and community supports. The care management team at OCH will collaborate with the DHS Child Welfare Specialists and OJA Targeted Case Managers for children and youth in the custody of DHS and OJA to avoid duplication of care coordination activities. To access a child or youth's assigned care manager, please call 833-752-1665.

The Children's Specialty Plan provides a variety of CM and Population Health programs and supports to address the needs of our Members and help parents/caregivers enhance skills and resolve problems to promote optimal child development. Below are examples of the types of services and supports we offer for the CSP population, which will be incorporated into the Care Plan.

Programs and Supports	Description
Adolescence to Adulthood (a2A)	Our a2A program identifies youth who are reaching age 18 to assist them with learning skills for managing their condition and independent living and prepare them for aging out of the foster care system and related service eligibility changes. Care Managers will work with the Member, their parent/caregiver, Providers, and CWS/ OJA case manager to complete a screening and transition plan.
Promoting Adoption Success Program (PASP)	Our PASP focuses on the needs of adoptive families to link to services to prevent adoption disruption. This initiative includes specialized training for CM staff to prepare them to support complex and unique needs often faced by adoptive parents and children. Staff connect families with the resources they need to meet both the physical and emotional health needs of the child.
Breathe Better at Home	As part of our asthma CM program, we will provide a home visit to assess triggers, in-home asthma management, and tobacco cessation education, and supplies to mitigate triggers (e.g., hypoallergenic bedding, pest control, carpet cleaning, etc.)
Pyx Health (Pyx) ***(available to 18+)***	Pyx is a mobile app that reduces social isolation and feelings of loneliness by providing companionship and resources including linkages to social services, benefits, and CM programs. Pyxir, a friendly chatbot available 24/7, reaches out to Members daily, providing an engaging, interactive, and supportive experience. Members can also interact with a live person. As SDOH needs are identified, Pyx connects Members to community resources.

Behavioral Health Medication Management (BHMM)	This program identifies psychotropic prescribing that exceeds state parameters, using claims data. When a child has a medication regimen that is outside the parameters, a BH clinician requests information from the prescriber. After a record review, the clinician may refer for a peer-to-peer P2P) review with our BH Medical Director (BHMD). Our BHMD conducts a P2P with the prescriber to explain the review and together they discuss considerations for a plan of treatment. BH clinician staff will report any Provider who persistently refuses to follow the plan of treatment to QI staff as a Quality-of-Care concern.
Start Smart for Your Baby (SSFB) and First Year of Life (FYOL) CM Program	We understand that multiple factors impact health outcomes, and engaging Members in the right type of care is the first step in addressing these factors. CM staff reach out to pregnant Members to educate them about Start Smart and FYOL benefits, including incentives and engaging them in prenatal care. We will help Members select a PCP, dental, women's health, OB/GYN Provider, and pediatrician for their newborn and connect them to postpartum care and resources that address SDOH needs. We facilitate communication between Providers involved in the Member's care to promote a healthy birth and quickly address and identify medical, behavioral, or social risks through tailored interventions.
Health, Wellness, and Health Literacy	Children will receive access to our Krames Staywell Health Library, which provides information on more than 4,000 health topics in simple, straightforward language. Our Healthy Kids Club provides a new book, welcome packet, quarterly newsletter, and online activities for children and parents or guardians.
Home Delivered Meals & Nutritional Support	Children experiencing certain conditions and situations will have access to home-delivered meals following the identification of the Member's need. The meals provided are tailored to each child's situation and conditions to support recovery. Participating Members and their caregivers also receive education on healthy, disease-focused meal planning, and are entitled to receive one home visit from a licensed dietician.
Care Grants	Through these Care Grants, we will provide up to $150 per Member per year to support services or supplies that each Member can use for social, physical, or educational activities. These activities support the social, physical, and educational development of the Member and are not Medicaid- covered benefits. This may include swimming lessons, sensory interventions, art supplies for art therapy, or items to meet concrete needs, like shoes, winter jackets, culturally appropriate hair care, or air purifiers, to name a few.
Comfort To Go Bags	We will provide OHS with duffle bags that contain age-appropriate personal care items, clothing, and hobby supplies for children who are changing placement.
Community- Based Specialty Services	For CSP Members ages three and older who are living with BH conditions and/or histories of trauma, we will offer access to community-based specialty services and sensory-based

	interventions, including art therapy, equine therapy, yoga classes, and swimming classes.
Customized Sensory Support Kits	We will offer a sensory support kit tailored to a Member's developmental and diagnosis needs, including swinging/sensory swings; exercise balls for bouncing or rocking; weighted vests or blankets; warm compresses; and manipulative toys, headphones, and/or ear plugs.
Keeping Kids Safe Medication Lockbox	As needed, (i.e., caregivers who have opioid pain medication prescriptions), we will provide caregivers with a Medication Lockbox to secure their medications.
SafeLink Phone Program	We support Members and their caregivers without reliable phone access in applying for free cell phones and monthly wireless service through the Federal SafeLink Wireless program. Each month, Members with SafeLink phones have unlimited text messages, talk, and data including the ability to connect with our CM Team, our 24/7 nurse advice line, 988, and the child or youth's PCP.

Therapeutic Foster Care and Intensive Treatment Family Care Services

Oklahoma Complete Health (OCH) has developed a strong understanding of Therapeutic Foster Care (TFC) and Intensive Treatment Family Care Services (ITFC) and current clinical criteria for youth and families served by SoonerSelect CSP. We will participate in treatment team meetings and joint rounds for children with complex needs or high acuity to discuss and implement the most appropriate treatment and supports needed for each child. Our Tribal Government Liaison, and Care/UM Staff will support Indian Child Welfare (ICW), OHS and OJA to evaluate each child, develop Integrated Plans of Care (IPC), and identify culturally responsive TFC and ITFC Providers. BH Providers that are culturally responsive, and trauma informed are essential to comprehensive care for CSP Members. As such, we prioritized agreements with our TFC and ITFC Providers, in addition to offering our new TFC Providers 1:1 support via our specialized Therapeutic Foster Care Provider (TFC) Liaisons.

Enhanced Foster Care:

The CSP supports Enhanced Foster Care (EFC) Programs as well, including Provider and Member Education to improve timeliness of initial assessment and service initiation, ensure alignment between treatment recommendations and service delivery, and increase provision of crisis services by the Provider (rather than the mental health crisis line).

Care Management Staff Training:

Dedicated CSP CM Staff will participate in comprehensive training curriculum specifically designed for those dedicated to working with the CSP population. This includes participation in the National Adoption Competency Mental Health Training Initiative (NTI) that will enable staff to better address the BH and developmental needs of children adopted from foster care.

CSP CM staff training focuses on:

- Addressing the BH needs of children and youth to enhance their well-being.

- Professional skills needed to promote stability and permanency for children, youth, and their families from entry into child welfare to post-adoption or guardianship.
- Trauma-informed, attachment-based casework skills.
- Adoption, kinships, and guardianship.

Additional staff trainings include:

Oklahoma Complete Health CSP Care Management Staff Trainings

- CSP CM program and CM responsibilities
- Covered benefits and services
- Social Determinants of Health
- Motivational Interviewing
- Abuse, Neglect, and Exploitation
- Trauma Informed Care, Science of HOPE Training, and evidence-based care
- Psychotropic and antipsychotic medication use in children
- Resiliency and Recovery
- Person-centered service planning
- Cultural competency/Health Equity Improvement Model
- Human Trafficking – the Risk within Child Welfare
- The role of foster care stakeholders, including dedicated foster care Providers, community agencies, and resources
- Co-management of PH and BH conditions
- Zero Suicide and Counseling on Access to Lethal Means (CALM)
- An overview of the Oklahoma child welfare (CW) and juvenile justice systems, processes, and terminology
- Informed consent and assent
- Treatment of ADHD in children and adolescents
- Teledoc Mental Health BH tool
- Social isolation and loneliness
- DYS/CD resources to support Members including residential care programs and levels of care
- Disease Management
- Transitions of Care
- Behavioral Health Essentials
- Motivational Interviewing
- Intellectual and Developmental Disabilities
- Conversations about Substance Use Disorder

Provider Education and Training:

Oklahoma Complete Health's CSP Provider training support is highly customized to meet the needs of Providers serving CSP Members. The CSP model supports "Clinical Well-being" via tailoring education and training to the needs of the Provider so that they can fully meet the needs of the children and youth they serve. Education will include recognizing signs of abuse or neglect and how to screen for BH conditions and SDOH needs so that Providers can help families enrolled in SoonerSelect CSP provide safety and stability for all children. Offerings provide practical, relevant, and ongoing support to prepare CSP Providers to serve Members. Trainings are offered in multiple subject areas, such as Managed Care, Quality and Performance, Evidence Based Practices and Caring for Children in the CSP. We will offer Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Components for Effecting Clinical Experience and Reducing Trauma (CE-CERT) to address and mitigate Provider burnout. We tailor additional training based on Provider type, services rendered, and level of support needed, understanding that some Providers may prefer a more hands-on, in-person approach to onboarding. We create curricula to support Providers and other stakeholders to address other topics as identified. Trainings are also available for child welfare and juvenile justice stakeholders.

Members with Mental Health and Substance (Alcohol and Drug) Use Disorders

Oklahoma Complete Health uses an intensive Care Management (CM) Program to address the unique needs of Members related to Mental Health and Substance Use Disorders (SUD), including frequent co-morbid and co-occurring conditions which require an integrated approach to all aspects of care coordination and treatment. The program incorporates interventions such as structured post-discharge telephone or in-person contact; assessing satisfaction with outpatient Providers; careful attention both to compliance with prescribed medications as well as potential impact of each medication on all Physical Health (PH) and Behavioral Health (BH) conditions.

The following programs will be initiated for Members identified with needs related to Mental Health and SUD as indicated:

- Intensive Care Coordination
- Utilize Community Health Workers to engage Members
- Transition of Care from different care settings/levels

The Care Manager will complete an assessment to confirm Member needs related to Mental Health and/or SUD, assessing medical, BH, social, and other needs. Within 30 calendar days of identification, or sooner as dictated by Member needs, a Care Manager will outreach to Members identified to complete a comprehensive assessment, develop a care plan, and provide other needed assistance. Other outreach processes and initiatives will include:

- Partnering with community care managers, and peer supports to outreach to Members with SMI, SUD, and other BH needs.
- Identifying agencies serving the homeless population and coordinate with those agencies on initiatives geared toward identifying and connecting our difficult to reach Members with supportive resources and stable housing.
- Building relationships with local hospitals to notify Oklahoma Complete Health when our Members visit the ER.
- Education and enrollment of eligible Members as applicable

Staff will use comprehensive assessments to identify Members who could benefit from a Community Mental Health Center (CMHC) or Certified Community Behavioral Health Center (CCBHC) to receive integrated behavioral and physical healthcare coordination from nurses and behavioral health case managers. For Members who are already enrolled or choose to enroll in a CMHC or CCBHC, the -Care Manager will coordinate with the Member's chosen CCMHC or CCBHC Provider to ensure continuity of care. Once the Member is enrolled in the their CCMHC or CCBHC program, our Care Manager will then work with the staff and/or other Members of the community-based team to promote recovery through a care plan, developed in collaboration with the Member, that includes treatment referrals; self-management tools to help the Member understand triggers; and use of local support groups and resources. Care plans will also include coordination with the CMHC or CCBHC Provider, other involved Providers (including OB/GYNs, behavioral health Providers, PCPs, and specialists), as well as family and community supports as desired by the Member or authorized representative.

New Provider orientation and our Provider Portal will provide information on behavioral health, and co-occurring conditions, as well as our requirements and processes for screening, referring, and coordinating care for individuals with these disorders. We will provide PCPs with screening tools for mental health issues and SUD and provide training on their use.

Referrals for Care Management of Members with needs related to Mental Health and/or SUD can be made via the Web Portal or by calling Oklahoma Complete Health toll-free at 844-565-0867 and completing a referral telephonically.

SAMSHA Programs

The Substance Abuse and Mental Health Services Administration, better known as SAMSHA, offers a trauma-informed approach that reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

- Safety
- Trustworthiness and Transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, Historical, and Gender Issues

Visit www.samhsa.gov/programs for more information.

Additional Resources

Use the following websites to learn more about traumatic stress reactions, the long-term impact of trauma, and evidence-based practices:

- Hope Research Center The University of Oklahoma-Tulsa
- Substance Abuse and Mental Health Services Administration (SAMSHA) - Understanding Child Trauma
- National Child Traumatic Stress Network
- Healthcare Toolbox - Helping Children and Families Cope with Illness and Injury
- CDC - Adverse Childhood Experiences (ACEs)
- Center for Youth Wellness

MEDICALLY NECESSARY

Medically Necessary means a service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability such that Medically necessary services:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
- Will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
- Will assist the Member in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity or the Member and those functional capacities are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or on an exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker, and the PCP, as well as any other Providers, programs, and agencies that have evaluated the Member.

All such determinations must be made by qualified and trained healthcare Providers.

24 Hour Nurse Advice Line

Our Members have many questions about their health, their PCP, and access to emergency care. Therefore, we offer a Nurse Advice Line to help Members proactively manage their health needs and decide on the most appropriate care and encourage Members to talk with their Provider about preventive care. We provide this service to support your practice and offer our Members access to a registered nurse at any time — day or night. The toll-free telephone number for SoonerSelect is 833-752-1664 and SoonerSelect Children's Specialty is 833-752-1665.

The Nurse Advice Line is always open and always available for Members. Registered Nurses (RNs) provide basic health education and nurse triage, and they answer questions about urgent or emergency access. Nursing staff Members often answer basic health questions but are also available to triage more complex health issues using nationally recognized protocols. Nurses will refer Members with chronic problems, like asthma or diabetes, to our Care Management or Member Service departments for follow-up assistance, education, and encouragement to improve their health. Members can call the Nurse Advice Line to request information about Providers and services available in the community after hours, when the Oklahoma Complete Health Member Service department is closed. The staff is proficient in both English and Spanish and can provide additional translation services if necessary.

Member Rewards Program

The Oklahoma Complete Health rewards program is a Member incentive program widely used to promote personal healthcare responsibility. The program is designed to increase utilization of preventive services by rewarding Members for completing a healthy activity. Members receive dollar rewards on a prepaid card to purchase personal and healthcare items at approved retailers across Oklahoma. When a Member completes a qualifying activity, we load the reward onto a health plan-issued rewards card. Our rewards program supports the positions taken by the American College of Physicians for ethical use of incentives to promote personal responsibility for health. Visit www.oklahomacompletehealth.com for details.

No-cost Member Cell Phone Program

Oklahoma Complete Health is proud to work with SafeLink Wireless to offer Members this federal program. Eligible Oklahoma Complete Health Members get all the same benefits of a SafeLink phone, plus unlimited text messages and calls to Oklahoma Complete Health Member services. There is no added cost for these extras. Most Oklahoma Complete Health Members* are eligible for SafeLink which provides no cost phone service and a one time, no cost phone. The phone and monthly service are federally funded, no cost Lifeline program. Members receive the phone directly within 10-14 days of applying by phone, or online and have service for 12 months with option to renew each year. Eligible Members can call SafeLink at 1-800-SafeLink (723-3546) to apply over the phone or go online at www.safelink.com (one phone per household).

Members receive:

· A free smart phone and 350 minutes per month and 4.5 GB of data

· Unlimited text messages

· The option to buy extra minutes at a discount. Only $0.10 per extra minute

· The ability to make and receive calls from doctors, nurses, 911, family and friends

· Communication access 24 hours a day

· Calls to Oklahoma Complete Health toll free number will not count towards the 350 minutes.

Sooner Select toll free number at 833-752-1664 or Sooner Select Children's Specialty plan at 833-752-1665.

MemberConnections®

MemberConnections® is Oklahoma Complete Health's program designed to educate our Members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. MemberConnections® is integrated with our care management program. We recruit staff from the local community being served to establish grassroots support and awareness of Oklahoma Complete Health programs and resources within that community. MemberConnections® staff are trained as non-clinical Community Health Workers (CHW). Oklahoma Complete Health's CHWs are part of the Care management team working closely with both physical and behavioral health staff and provide health coaching, care coordination and community resource information.

Members can be referred to MemberConnections® through various sources, including our Member Services department, and care managers who know a Member would benefit from MemberConnections® support. Providers may request MemberConnections®. Community groups may request that a CHW come to their facility to present to groups or at special events or gatherings. MemberConnections® Referral Form can be found at www.oklahomacompletehealth.com.

ConnectionsPlus®

ConnectionsPlus® is a part of the MemberConnections® program that provides free cell phones to select high-risk Members, as identified by our Population Health and Clinical Operations team, who do not have safe, reliable access to a telephone and are not eligible for SafeLink or have an immediate need for phone communication to coordinate their care. Through our ConnectionsPlus® Program, we provide cell phones to certain high-risk Members who have complex conditions and or social needs. We pre-program the phones with important telephone numbers, such as their PCP office

number, other treating physicians, Oklahoma Complete Health contact numbers, the nurse advice line, and 911. By ensuring a Member has reliable phone access, we provide them with the means to contact key individuals on their healthcare team and empower them to take an active part of their healthcare journey and care coordination.

Start Smart for Your Baby® (SSFB)

SSFB is a comprehensive program for pregnant Members to promote healthy pregnancies and births. The objective of our SSFB program is to reduce the risk factors to pregnant and/or lactating mothers and newborn infants.

Interventions

We increase the knowledge and access to resources by offering pregnancy supports in all areas including medical, social, emotional, and infant care. The goal of SSFB program is healthy pregnancies, deliveries and infants accomplished by identifying and impacting any risk factors. Oklahoma Complete Health encourages prevention of recurrent preterm delivery by covering the cost of Makena 17P Alpha-Hydroxyprogesterone Caproate weekly injections to reduce the incidence of spontaneous Preterm Birth.

SSFB Program Route of Delivery

The SSFB program is a Telephonic Care Management program consisting of Registered Nurses with experience in Obstetrics and NICU care. Incentives such as car seats, breast pumps and text program may be available to participating Members.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Medicaid offers its covered children and youth under age 21 a comprehensive benefit for preventive health and medical treatment. Oklahoma Complete Health adheres to and offers or arranges for the full scope of preventive and treatment services available within the federal EPSDT benefit. Preventive (wellness) services are offered without copays or other charges, per the nationally recognized periodic schedule established by Bright Futures. Early Periodic Screening services include physical exams, up to date health histories, developmental, behavioral and risk screens, vision, hearing and dental health screens and all vaccines recommended by the Advisory Committee on Immunization Practices.).

OCH requires all primary care Providers (PCPs) to include the following components in each medical screening:

1. Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents."
2. Comprehensive health and development history (including assessment of both physical and mental development and/or delays at each visit through the 5th year; and Autistic Spectrum Disorder per AAP)
3. Comprehensive unclothed physical examination
4. Immunizations appropriate to age and health history, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices
5. Assessment of nutritional status
6. Laboratory procedures appropriate for age and population groups, including blood lead screening. Blood lead screening is required for infants/toddlers at age 12 and 24 months. Blood lead screening is also appropriate whenever the Provider suspects exposure or when they live in high-risk environments/areas.
7. Routine blood assay, including hemoglobin and hematocrit levels is required at 12 months and should be performed whenever clinical findings indicate medical necessity
8. Assessment of growth and development and administration of brief, scientifically validates developmental, emotional, behavioral, SDoH and risk screens during preventative visits.
9. An ASD screen may be administered at a "catch-up" visit if the 18- or 24-month visit was missed. Providers may screen for developmental risk for ASD at ages greater than 30 months when the Provider or caregiver has concerns about the child. Findings supporting use of a developmental screen for ASD may include:
10. observed difficulties in responsiveness, age-appropriated interaction, or communication.
11. a report by parent or caregiver
12. diagnosis of an ASD in a sibling
13. Vision screening and services, including at a minimum, diagnosis, and treatment for defects in vision, including eyeglasses.
14. Dental screening (oral exam by primary care Provider as part of comprehensive exam). Recommend that preventive dental services begin at age six (6) through 12 months and be repeated every six (6) months.
15. Hearing screening and services, including at a minimum, diagnosis, and treatment for defects in hearing, including hearing aids; and
16. Health education and anticipatory guidance

PCP's must clearly document provision of all components of EPSDT services in the medical records of each beneficiary.

"EPSDT Guarantee"

OCH does not require prior authorization for preventative care (early and periodic screens/wellness visits) for Medicaid Members less than twenty-one (21) years of age, however, prior authorization may be required for other diagnostic and treatment products and services provided under EPSDT. If a Provider requests a service for a Member that is not a covered benefit, Providers are required to submit a prior authorization. (See section: "Prior Authorization and Notifications" for prior authorization details).

Upon receipt of the request, it will be reviewed for medical necessity under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. The medical necessity criteria specific to EPSDT is defined in 42 U.S.C. § 1396d(r) and 42 C.F.R. §§ 441.50-62 and:

- Must be made on a case-by-case basis, taking into account the particular needs of the child.
- Should consider the child's long-term needs, not just what is required to address the immediate situation.
- Should consider all aspects of a child's needs, including nutritional, social development, and mental health and substance use disorders.
- May not contradict or be more restrictive than the federal statutory requirement.
- Must correct or ameliorate a defect, physical or mental illness.

Because medical necessity decisions are individualized, flat limits or hard limits based on a monetary cap are not consistent with EPSDT requirements.

Medically necessary care and treatment to 'correct or ameliorate' health problems must be provided directly or arranged by referral, even when a Medicaid coverable service is not available under the Oklahoma Medicaid plan. OCH will provide referral assistance for non-medical treatment not covered by the plan but found to be needed due to conditions disclosed during screenings and diagnosis.

Oklahoma Complete Health requires that Providers cooperate to the maximum extent possible with efforts to improve the health status of Oklahoma citizens, and to participate actively in the increase of percentage of eligible beneficiaries obtaining EPSDT services in accordance with the adopted periodicity schedules. Oklahoma Complete Health will cooperate and assist Providers to identify and immunize all beneficiaries whose medical records do not indicate up-to-date immunizations.

For EPSDT and immunization billing guidelines please visit our website at www.oklahomacompletehealth.com for the Oklahoma Complete Health Provider Billing Manual.

PRIMARY CARE PROVIDER (PCP)

The Primary Care Provider (PCP) is a specific Provider operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing primary care service; locating, coordinating, and monitoring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a Member. PCPs are the cornerstone of Oklahoma Complete Health service delivery model. The PCP serves as the "Medical Home" for the Member. The Medical Home concept assists in establishing a Member/Provider relationship, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

Oklahoma Complete Health offers a robust network of PCPs to ensure every Member has access to a Medical Home within the required travel distance standards.

- Urban PCPs: Within 10 miles of the Member's residence
- Rural PCPs: Within 45 miles of the Member's residence

Oklahoma Complete Health requires PCPs and specialists to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the Member. Attempts may include but are not limited to written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve As PCPs

A PCP shall be a medical Practitioner in our network including:

- Family Practitioner
- General Practitioner
- Internal Medicine
- Pediatrician
- Advanced Registered Nurse Practitioner (ARNP)
- Physician Assistant

PCP Responsibilities

Oklahoma Complete Health will monitor PCP actions for compliance with the following responsibilities. PCP responsibilities include, but are not limited to, the following:

- Providing primary and preventive care and acting as the Member's advocate.
- Providing, recommending, and arranging for care.
- Complying with all federal and state disability access laws and regulations and provide physical and programmatic access to Members with disabilities.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications.

- Maintaining continuity of each Member's healthcare.
- When needed, effectively communicating with the Member by using (free of charge to the Member):
    - Sign language interpreters for those who are deaf or hard of hearing.
    - Oral interpreters for those individuals with LEP (Limited English Proficiency).
- Making referrals for specialty care and other medically necessary services.
- Maintaining a current medical record for the Member, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services.
- Arranging for Behavioral Health Services.
- Allowing Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as Healthcare Effectiveness Data and Information Set (HEDIS) and other contractual, regulatory, or other programs.
- Ensuring coordination and continuity of care with Providers, including all Behavioral Health and Long-Term Care Providers, according to Oklahoma Complete Health policy; and
- Ensuring that the Member receives appropriate prevention services for the Member's age group.
- Referring a Member for Behavioral Services based on the following indicators:
    - Suicidal/homicidal ideation or behavior;
    - At-risk of hospitalization due to a Behavioral Health condition;
    - Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
    - Trauma victims;
    - Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;
    - Request by Member or authorized representative for Behavioral Health services;
    - Clinical status that suggests the need for Behavioral Health services;
    - Identified psychosocial stressors and precipitants;
    - Treatment compliance complicated by behavioral characteristics;
    - Behavioral and psychiatric factors influencing medical condition;

- Victims or perpetrators of abuse and/or neglect and Members suspected of being subject to abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact, or routine physical examination indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or
- The persistence of serious functional impairment.

PCP Assignment

Oklahoma Complete Health Members have the freedom to choose a PCP from our comprehensive Provider network. For those Members who have not selected a PCP during enrollment or within thirty (30) of enrollment, Oklahoma Complete Health will use a PCP auto-assignment algorithm to assign an initial PCP. Members reserve the right to change their PCP at any time. PCP's can be updated by calling our Member Services toll free at 833-752-1664.

The algorithm assigns Members to a PCP according to the following criteria:

1. Member selection
2. Member history
3. Member's claim history
4. Family history
5. Portico Provider Pool (auto-assign based on proximity and ~18 filters, including language preferences)

Member Panel Capacity

All PCPs reserve the right to determine the number of Members they are willing to accept into their panel. Oklahoma Complete Health **does not** guarantee any Provider will receive a certain number of Members. The PCP to Member ratio shall not exceed 1000 Members to a single PCP.

PCPs interested in exceeding the Member limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional Members.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Oklahoma Complete Health Provider Services toll-free at 833-752-1664. A PCP shall not refuse to treat Members as long as the Provider has not reached their requested panel size.

Providers shall notify Oklahoma Complete Health in writing at least forty-five (45) in advance of his or her inability to accept additional Medicaid covered persons under Oklahoma Complete Health agreements. In no event shall any established patient who becomes an Oklahoma Complete Health Member be considered a new patient.

Specialist Responsibilities

Oklahoma Complete Health encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the Members' care and ensure the referred specialists is a participating Provider within the Oklahoma Complete Health network and that the PCP is aware of the additional service request. The specialists may order diagnostic tests without PCP involvement.

Female Members will have direct access to an in-network OB/GYN, or other women's health specialist for routine OB/GYN services regardless of whether their PCP (general practitioner, family practitioner or internist) provides such women's health services, including routine gynecological exams.

Emergency admissions will require notification to Oklahoma Complete Health Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require Prior Authorization from Oklahoma Complete Health.

The Specialist must:

- Maintain contact with the PCP.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to Members with disabilities.
- Obtain Prior Authorization from Oklahoma Complete Health Medical Management department if needed before providing services.
- Coordinate the Member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available or provide on-call coverage through another source 24 hours a day for management of Member care.
- Maintain the confidentiality of medical information.
- Allow Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

Oklahoma Complete Health requires PCPs and specialists to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include but are not limited to written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

Hospital Responsibilities

Oklahoma Complete Health utilizes a network of hospitals to provide services to Oklahoma Complete Health Members. Hospital Services Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the participating Provider agreement.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the Member's Emergency Room (ER) visit.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to Members with disabilities.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current Prior Authorization list, except for emergency stabilization services.
- Notify Oklahoma Complete Health Medical Management department by sending an electronic file of the ER admission within 24 hours or the next business day. The electronic file should include the Member's name, Medicaid ID, presenting symptoms/diagnosis, Date of Service (DOS), and Member's phone number.
- Notify Oklahoma Complete Health Medical Management department of all admission within one business day.
- Notify Oklahoma Complete Health Medical Management department of all newborn deliveries within two (2) of the delivery.
- Allow Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- For SoonerSelect and SoonerSelect Specialty Children's Plan and Members whose enrollment begins while they are in the hospital
    - The Provider should bill the Managed Care Organization that the Member has at the time of admission to the hospital for the entire hospital stay. Oklahoma Complete Health should only be billed for services that occur after discharge from the hospital.

Voluntarily Leaving the Network

Providers must give Oklahoma Complete Health notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, Providers are required to send termination notices via certified mail (return receipt requested) or overnight courier to:

Oklahoma Complete Health
Attn: Provider Relations Department
14000 Quail Springs Parkway
Suite 650
Oklahoma City, OK 73127

In addition, Providers must supply copies of medical records to the Member's new Provider upon request and facilitate the Member's transfer of care at no charge to Oklahoma Complete Health or the Member.

Oklahoma Complete Health will notify affected Members in writing of a Provider's termination, within 15 calendar days of the receipt of the termination notice from the Provider, provided that such notice from the Provider was timely.

Providers must give Oklahoma Complete Health sixty (60) day's prior written notice of voluntary termination following the terms of their participating agreement with our Health Plan.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Provider is responsible for supervising, coordinating, and providing all authorized care to each assigned Member. In addition, the Provider is responsible for ensuring the receipt of an authorization for all services from the Member's Community Based Care Manager (CBCM), maintaining continuity of each Member's care and maintaining the Member's medical record, which includes documentation of all services provided by the Provider as well as the Member or responsible party's signature for receipt of covered services.

Role of the Community Based Care Manager (CBCM)

The CBCM's primary function is to support Members and facilitate their access to LTSS and other services. The CBCM is responsible to lead the Person-Centered Service Plan (PCSP) process and oversee the implementation of the Member's PCSP. The CBCM will identify, coordinate, and assist the Member in gaining access to all needed services including covered and non-covered services, medical, social, housing, educational, and other necessary services and supports. The CBCM is responsible for locating and coordinating Providers, specialists, or other entities essential for service delivery. This includes seamless coordination between physical, behavioral, and support services. CBCMs work with the Member to coordinate evaluations and reassessments, establish level of care, identify strengths and the Member's goals, and development and implementation of the PCSP. The CBCM will work with the Member to complete activities necessary to maintain LTSS eligibility. The CBCM will keep the Member informed during the process of facilitating, locating, and monitoring services and support. Service alternatives and other options will be taken into consideration, such as Consumer Choices Option (CCO), and other LTSS services. To contact a CBCM, please call Oklahoma Complete Health at 833-752-1664.

Provider's Role in Service Planning and Care Coordination

The Provider is responsible supervising, coordinating, and providing authorized services. The Provider will work with CBCMs to address necessary services and supports and participate in the PCSP to ensure Members' needs are addressed. The Provider will comply with the reporting requirements of the Member Complaint, Grievance, and DHS Fair Hearing Processes.

Service Request Process for LTSS

LTSS services require approval and Prior Authorization by Oklahoma Complete Health. Service request authorizations are sent to Providers by the Oklahoma Complete Health CBCM once the Member's comprehensive needs assessment is complete and the Member's PCSP is developed and agreed upon with the Member, their identified caregivers/supports, and their IDT.

PCSPs are reviewed with Members during regularly scheduled face–to-face visits and at the time of assessment and re-assessments. If a Member experiences a significant change in condition, if there is a change in level of support, or if the Member requests a change in service(s) or change in placement, there may be a need to amend the PCSP to ensure the Member's needs are met.

In addition, all services are subject to benefit coverage, limitations, and exclusions, as described in applicable State rules and regulations. Oklahoma Complete Health Providers are contractually prohibited from holding any Oklahoma

Complete Health Member financially liable for any service administratively denied by Oklahoma Complete Health. Continuity of care coverage begins on the Member's effective date of enrollment for any existing services and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

LTSS Provider Responsibilities

LTSS Providers are required to adhere to the following responsibilities:

- Provide Oklahoma Complete Health Members with a professionally recognized level of care and efficiency consistent with community standards, the health plan's clinical and non-clinical guidelines, and within the practice of your professional license.
- Abide by the terms of the Participating Provider Agreement.
- Comply with all plan policies, procedures, rules, and regulations, including those found in this manual.
- Maintain confidential medical records consistent with Oklahoma Complete Health's medical records standards, medical record keeping guidelines, IAC 79.3 sections (1), (2) and (3), and applicable HIPAA regulations.
- Maintain a facility that promotes Member safety.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to Members with disabilities.
- Participate in Oklahoma Complete Health's quality improvement program initiatives.
- Participate in Provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify the plan if you are undergoing an investigation or agree to written orders by the state licensing agency.
- Notify the plan if there is a change of status with Member eligibility.
- Ensure you have staff coverage to maintain service delivery to Members.
- Allow Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Continue to provide services to Members whose services are being transitioned to another Provider.

UTILIZATION MANAGEMENT

The Oklahoma Complete Health Utilization Management Program (UMP) is designed to ensure Members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible Members, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of Providers and plan performance in providing access to care, the quality of care provided to Members, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care, and ancillary care.

Oklahoma Complete Health UMP seeks to optimize a Member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the Member's condition, rendered in the appropriate setting, and that meet professionally recognized standards of care.

In addition, the SoonerSelect Children's Specialty Program supports access to services that promote holistic, effective combinations of interventions necessary to reverse trauma, build resilience, and prepare Members for successful adulthood.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization.
- Development and distribution of clinical practice guidelines to Providers to promote improved clinical outcomes and satisfaction.
- Identification and provision of care and/or population management for Members at risk for significant health costs or ongoing care.
- Development of an infrastructure to ensure Members establish relationships with their PCPs to obtain preventive care.
- Implementation of programs that encourage preventive services and chronic condition self-management.
- Creation of partnerships with Members/Providers to enhance cooperation and support for UMP goals.

Prior Authorizations

Failure to obtain the required Prior Authorization for a service may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions, as described in applicable plan coverage guidelines. All out-of-network services require Prior Authorization except for family planning, emergency room, post-stabilization services and tabletop x-rays.

Oklahoma Complete Health Providers are contractually prohibited from holding any Oklahoma Complete Health Member financially liable for any service administratively denied by Oklahoma Complete Health for payment due to the Provider's failure to obtain timely Prior Authorization.

Services That Require Prior Authorization

Please visit www.oklahomacompletehealth.com and use the Prior - Auth Check tool to determine if a service requires Prior Authorization. Prior Authorization requests should be submitted using OHCA's Provider Portal.

Requesting a Prior Authorization

- The preferred method for submitting Prior Authorizations is through the Availity Secure Provider Web Portal at www.availity.com. The Provider must be a registered user on the Secure Provider Web Portal. If the Provider is not a registered user and needs assistance or training on submitting Prior Authorizations there, the Provider should contact their assigned Provider Relations Representative.

Prior Authorization Determination Timelines

Oklahoma Complete Health medical Prior Authorization decisions are made as expeditiously as the Member's health condition requires but shall not exceed the timeframes listed below.

Type	Timeframe
Expedited Preservice/Urgent	24 hours
Standard Preservice/Non-Urgent	Within 72 hours
Concurrent review	24 hours

Clinical Information

Oklahoma Complete Health clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Oklahoma Complete Health is entitled to request and receive protected health information (PHI) for purposes of treatment, payment, and healthcare operations, with the authorization of the Member.

Information necessary for Authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name if the request is for an inpatient admission or outpatient facility services.
- Provider location if the request is for an ambulatory or office procedure.
- Reason for the authorization request (e.g., primary, and secondary diagnosis, planned surgical procedures, surgery date)

- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date if the request is for a surgical procedure.
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Oklahoma Complete Health within 1 business days or before discharge.

If additional clinical information is required, an Oklahoma Complete Health representative will notify the requestor of the specific information needed to complete the Authorization process.

Clinical Decisions

Oklahoma Complete Health affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Oklahoma Complete Health does not reward Providers or other individuals for issuing denials of service or care.

Delegated Providers must ensure that compensation to individuals or entities that conduct Utilization Management (UM) activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Member.

The treating Provider, in conjunction with the Member, is responsible for making all clinical decisions regarding the care and treatment of the Member. The PCP, in consultation with the Oklahoma Complete Health Medical Director, is responsible for making UM decisions in accordance with the Member's plan of covered benefits and established PC criteria. Failure to obtain Prior Authorization for services that require plan approval may result in payment denials.

Review Criteria

Oklahoma Complete Health has adopted utilization review criteria developed by Change Healthcare, InterQual®, the American Society of Addiction Medicine (ASAM), and the State of Oklahoma DHS, as indicated, to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from Physicians. All criteria are utilized as screening guides and are not intended to be a substitute for Provider judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the Member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria. The needs of Members are unique, and in instance of complex healthcare needs that require additional input a Member's community base care manager will collaborate with the Oklahoma Complete Health chief medical officer as well as identified Members of the care team to determine the services necessary to best support a Member's needs to ensure successful, Member driven, outcomes.

Peer to Peer Review

Providers may request and obtain the criteria used to make a specific adverse determination by contacting Medical Management toll-free at 833-752-1664. Providers also have the opportunity to discuss any adverse decisions with a Physician or other appropriate reviewer at the time of notification to the requesting Practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling 833-752-1664 for SoonerSelect Members or 833-752-1665 for SoonerSelect Children's Specialty Plan Members and asking for a Peer-to-Peer review with the Medical Director. A CM may also coordinate communication between the Medical Director and requesting Provider.

Appealing an Adverse Benefit Determination

Members, their authorized legal representatives, or a Provider, with the Member's written consent, may request an appeal related to an adverse benefit determination. Instructions for how to file an appeal are provided in the Grievances and Appeal Processes section of this Manual.

Second Opinion

Members or a healthcare professional, with the Member's consent, may request and receive a second opinion from a qualified professional within the Oklahoma Complete Health network, without prior authorization. If there is not an appropriate Provider to render the second opinion within the network, the Member may obtain the second opinion from an out-of-network Provider at no cost to the Member. Out-of-network Providers require Prior Authorization by Oklahoma Complete Health.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

Notification Of Pregnancy

Members that become pregnant while covered by Oklahoma Complete Health may remain an Oklahoma Complete Health Member during their pregnancy. The managing Physician should notify the Oklahoma Complete Health prenatal team by completing the Notification of Pregnancy (NOP) form available at www.oklahomacompletehealth.com within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Care Management section for information related to our *Start Smart for Your Baby®* program and our 17-P program for women with a history of premature delivery.

Concurrent Review And Discharge Planning

Concurrent Review Nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods with the hospital's Utilization and Discharge Planning departments and when necessary, with the Member's attending

Physician. The Concurrent Review Nurse will review the Member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) business day of receipt of clinical information. For a length of stay extension request, clinical information must be submitted by 3:00 p.m. CST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Oklahoma Complete Health within 1 day of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a Member, but for which Prior Authorization and/or timely notification to Oklahoma Complete Health was not obtained due to extenuating circumstances (i.e., Member was unconscious at presentation, Member did not have their Medicaid ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined Member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 14 days of receipt.

Speech Therapy And Rehabilitation Services

Oklahoma Complete Health offers our Members access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior Authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to Oklahoma Complete Health as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our Members, Oklahoma Complete Health is using Evolent to provide prior authorization services and utilization. Evolent focuses on radiation awareness designed to assist Providers in managing imaging services in the safest and most effective way possible.

Prior Authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scans

Key Provisions

- Emergency Room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering Provider to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach Evolent and obtain prior authorization, please call our toll-free number at 866-249-1581. Evolent also provides an interactive website which may be used to obtain online authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Oklahoma Complete Health, in collaboration with Evolent, will launch a cardiac imaging program to promote healthcare quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How Does This Program Improve Patient Health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient.
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed.
- Quality assessment of imaging Providers to ensure the highest technical and professional standards.

How the Program Works

In addition to the other procedures that currently require prior authorization for Members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require prior authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services.
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call our toll-free number at 866-249-1581. Evolent also provides an interactive website, which may be used to obtain online authorizations. Please visit RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical, occupational and speech therapy) provided to our Members are consistent with nationally recognized clinical guidelines, Oklahoma Complete Health partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Oklahoma Complete Health Members.

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. There is no need to send patient records in advance. Evolent will contact the Provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Oklahoma Complete Health and Evolent, Oklahoma Complete Health oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

For additional information on this new program, please attend an upcoming Provider training webinar. Details of these webinars can be found on the Evolent website at www.RadMD.com, the www.oklahomacompletehealth.com, or by calling Evolent's Provider Services Line 866-249-1581.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

1. Spinal Epidural Injections
2. Paravertebral Facet Joint Injections or Blocks
3. Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
4. Sacroiliac Joint Injections
5. Spinal Cord Stimulators

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Oklahoma Complete Health. To obtain authorization through Evolent, visit RadMD.com or call 866-249-1581.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to Oklahoma Complete Health Members, Oklahoma Complete Health has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Oklahoma Complete Health Members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair

- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement – Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels
- Lumbar Artificial Disc – Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the "Solutions" tab on the Evolent home page at www.RadMD.com for additional information on the MSK program. Checklists and tip sheets are available there to help Providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have questions, please contact Evolent at 1-866-249-1581.

CLINICAL PRACTICE GUIDELINES

Oklahoma Complete Health clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Oklahoma Complete Health adopts guidelines that are published by nationally recognized organizations or government institutions, as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

Oklahoma Complete Health Providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program. The following is a sample of the clinical practice guidelines adopted by Oklahoma Complete Health:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Healthcare
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health
- American Psychiatric Association

For links to the most current version of the guidelines adopted by Oklahoma Complete Health, visit our website at www.oklahomacompletehealth.com. A paper copy of the practice guidelines can be requested by calling Provider Services toll-free at 1-833-752-1664.

PHARMACY

Oklahoma Complete Health provides pharmacy benefits in collaboration with Centene Pharmacy Services and its Pharmacy Benefit Manager, Express Scripts.

Oklahoma Complete Health adheres to the state of Oklahoma Preferred Drug List (PDL) to determine medications that are covered under the Oklahoma Complete Health Pharmacy Benefit, as well as which medications may require Prior Authorization (PA). Please visit the Oklahoma Complete Health website at www.oklahomacompletehealth.com for a link to the state's current PDL and PA criteria.

Some Members may have copayment or cost share when utilizing their prescription benefits. Please refer to the Oklahoma Complete Health Member ID card for information.

Working With the Pharmacy Benefit Manager (PBM)

Oklahoma Complete Health works with Express Scripts to administer pharmacy benefits. Certain drugs require Prior Authorization to be approved for payment Oklahoma Complete Health.

These include:

- Non-preferred medications
- Some preferred drugs (designated PA on the Preferred Drug List)

Pharmacy Prior Authorization

The state of Oklahoma PDL includes a broad spectrum of brand name and generic drugs. Prescribers are encouraged to prescribe from the state of Oklahoma PDL for their patients who are Members of Oklahoma Complete Health. Some drugs will require PA (Prior Authorization). In addition, all non-preferred drugs not listed on either the PDL or PA list will require Prior Authorization.

Drug Prior Authorization requests can be submitted to Centene Pharmacy Services by fax, phone or online through CoverMyMeds.com. To ensure timeliness of our Members' pharmacy needs, Oklahoma Complete Health has a strict twenty-four (24) hour turnaround time requirement to process these requests.

Phone

- Prescribers may call Centene Pharmacy Services to initiate a Prior Authorization by calling our Prior Authorization Department's toll-free number at 1-866-399-0928.
- The Centene Pharmacy Services Prior Authorization (PA) Help Desk is staffed with PA Triage Specialists 24-hours/ day every week throughout the year.
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist Providers.

Fax

- Prescribers may complete the Oklahoma Complete Health/Centene Pharmacy Services Medication Prior Authorization Request form, found on the Oklahoma Complete Health website at www.oklahomacompletehealth.com.
- Fax to Centene Pharmacy Services at 1-866-399-0929.
- Once approved, Centene Pharmacy Services notifies the prescriber by fax.
- When medical necessity criteria are not met based on the clinical information submitted, the prescriber will be notified of the reason via fax. The notification will include PDL alternatives if applicable.

Oklahoma Complete has a comprehensive Pharmacy Lock-In Program. The Pharmacy Lock-In Program detects and prevents abuse of the pharmacy benefit, as defined by specific criteria, by restricting Members to one specific pharmacy and controlled substance prescriber (if one is chosen) for a defined period of time. The Pharmacy Lock-In Program detects and prevents abuse of the pharmacy benefit, as defined by specific criteria, by restricting Members to one specific pharmacy and controlled substance prescriber (if one is chosen) for a defined period of time.

- Prescribers logs into CoverMyMeds.com which is a secure site where prescribers can electronically submit PA requests as well as receive the Plan's PA decision.
- Prescriber searches and selects Member name, drug name, strength, and form, and provides other details relevant to the PA request (urgency, qty, dose per day)
- Prescriber completes the required question set provided by CMM and submits the request electronically to Centene Pharmacy Services. A determination will be made, and notification will be sent to the physician electronically through CMM and also via fax.
- For select drugs, based on the Prescribers' answers to criteria questions, CMM may issue an immediate approval determination and update the Member's prior authorization file to permit adjudication of a claim.

All reviews are performed using the PA criteria established by the State of Oklahoma Drug Utilization Review (DUR) Commission. Once approved, Centene Pharmacy Services notifies the Prescriber by fax. If the clinical information provided does not meet the medical necessity and or Prior Authorization guidelines for the requested medication, Oklahoma Complete Health will notify the Member and the Prescriber of medication alternatives in addition to provide information for the appeal process.

Pharmacy Lock-In Program

Oklahoma Complete has a comprehensive Pharmacy Lock-In Program as part of the Program Integrity Program. The Pharmacy Lock-In Program detects and prevents abuse of the pharmacy benefit, as defined by specific criteria, by restricting Members to one specific pharmacy and controlled substance prescriber (if one is chosen) for a defined period of time.

To monitor and control suspected abuse of the pharmacy benefit by Oklahoma Complete Members, as identified and confirmed through analysis and monitoring by the Pharmacy Department, by restricting the Members to only one specific pharmacy and controlled substance prescriber (if one is chosen) for a defined period of time. Member can be locked into a prescriber only if Member meets or will meet for pharmacy lock-in. Exceptions are considered on a case-by-case basis.

Pharmacy claims will be audited on a monthly basis using selected criteria to identify potential misuse of the prescription benefit.

Criteria used to determine if a Member will be appropriate for BMP includes but is not limited to Fraud, Emergency Room Overutilization, Opioid Overutilization, Members that are identified as enrolled into a lock program with a previous MCO and have transitioned to Oklahoma.

Once audits have been performed, and Members identified and confirmed to have abused the pharmacy benefit, the following process shall occur:

The Member will be assigned to a pharmacy to which the filling of prescriptions will be restricted. The Member will also be restricted to one prescriber for controlled substances prescribing. Pharmacy Services sends a letter summarizing the decision to the Member at least ten days in advance of lock-in, with a copy sent to the designated pharmacy and control substance prescriber or other prescribers (i.e., primary care Provider). If the Member wishes to appeal the decision to be placed in lock-in or to designate an alternate pharmacy or prescribing prescriber, they may submit that request to the Oklahoma Complete Appeals and Grievances Department. The initial request may be made orally but must be followed within 30 days of the effective date on the lock-in letter by a written request for administrative review. The request must be sent to the following address:

Oklahoma Complete Health Plan
Appeals and Grievance Coordinator
14000 Quail Springs Parkway
Suite 650
Oklahoma City, Oklahoma 73134

Upon designation of the pharmacy and prescriber for lock-in, Oklahoma Complete Pharmacy Services coordinates the changes to the contracted Pharmacy Benefits Management Company to initiate the lock-in.

The Member will be permitted to change pharmacies for good cause, after discussion with the prescriber(s) and the pharmacist. Valid reasons include if a change of address which places the Member at a great distance from the designated pharmacy, if the lock-in pharmacy requests that the Member be removed from that pharmacy, or if the pharmacy does not provide the prescribed drug. The Member will be permitted to change prescribers for controlled substances if deemed medically necessary or if the prescriber refuses to see the patient. Change in prescriber may only occur if a new prescriber has been identified to continue prescribing for Member's controlled substance(s)

A Member will not be allowed to transfer more than one time a year to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program, except in extenuating circumstances.

Case management and education reinforcement of appropriate medication/pharmacy use shall be provided by Oklahoma Complete to "lock-in" Members.

All "lock-in" Members will be reviewed periodically (at least every year from the original lock-in effective date) for program adherence and prescription utilization.

Members who still utilize multiple prescribers for duplicative controlled substances, or any other behavior noted under the procedures section of this document during the initial lock-in year will be placed into the lock-in program for another year.

Each Member is given the opportunity to dispute the Lock-In determination by submitting an appeal to Oklahoma Complete Appeals and Grievance Department.

Provision shall be made for the Member to obtain a 72-hour emergency supply of medication at pharmacies other than the designated lock-in pharmacy or prescriber to assure the provision of necessary medication required in an emergency (e.g. when the designated pharmacy is closed, the Member cannot readily access the pharmacy, or the pharmacy does not have the required medication in inventory).

If the Member is compliant in the program for a period of four consecutive quarters, the Member will be notified by the Oklahoma Complete Pharmacy Department that the lock-in is being removed and the Member is free to access any Oklahoma Complete network pharmacy or prescriber.

Oklahoma Complete Health Plan will report on the lock-in program in accordance with the Reporting Manual requirements and on a quarterly basis.

Preferred Drug List (PDL)

Oklahoma Complete Health adheres to the state of Oklahoma Preferred Drug List (PDL) to determine medications that are covered under the Oklahoma Complete Health Pharmacy Benefit, as well as which medications may require Prior Authorization. The PDL is a list of drugs Members can receive at retail, mail order and specialty pharmacies. Please visit the Oklahoma Complete Health website at www.oklahomacompletehealth.com for a link to the state's current PDL and criteria.

The Preferred Drug List is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions, prior authorization requirements, and limitations;
- The pharmacy management program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing Providers can make an exception request; and;
- How Oklahoma Complete Health conducts generic substitution, therapeutic exchange, and step-therapy.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication.
- Substitute for the independent professional judgment of the Provider or pharmacist
- Relieve the Provider or pharmacist of any obligation to the Member or others.

The state of Oklahoma PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a notation throughout the PDL.

Pharmacy Value Added Benefit

Oklahoma Complete Health offers a value-added benefit of over-the-counter medications and supplies to all Members. Up to $30 per household per quarter and $30 per Member per quarter for Children's Specialty Plan. Members can receive cold, cough, allergy, vitamins, supplements, ophthalmic/otic preparations, pain relievers, gastrointestinal products, first aid care, hygiene products, insect repellant, oral hygiene products and skin care products.

Compounds

Compounded prescriptions must be submitted online, and each ingredient must have an active and valid NDC. Compounded medications may be subject to Prior Authorization based on ingredients submitted. Compounds that have a commercially available product are not reimbursable.

Pharmacy Copayments

Some Oklahoma Complete Health Members will have a copay for prescription medications. Copayments depend on the Member's plan. There are some Members who are exempt for copays. Members under the age of 21 do not have copays.

72-Hour Emergency Supply of Medications

Federal law allows dispensing of a 72-hour supply of medication in an emergency situation. Oklahoma Complete Health will allow a 72-hour supply of medication to any patient awaiting a PA determination, unless PA criteria does not allow. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72-hour supply of medication (unless PA criteria does not allow), whether or not the PA request is ultimately approved or denied. The pharmacy will contact the Centene Pharmacy Services Pharmacy Help Desk at toll-free (800) 460-8988for a prescription override to submit the 72-hour medication. The pharmacy help desk call center is available 24 hours a day, 7 days a week.

Some behavioral health medications may allow for 7-days' supply. Refer to state of Oklahoma PDL for information.

Newly Approved Products

New FDA approved drugs will be evaluated by the P&T Committee at the next scheduled meeting. They will require a PA prior to P&T Committee review. If Oklahoma Complete Health does not grant Prior Authorization, the Member and Provider will be notified and provided information regarding the appeal process.

Step Therapy, Generic Substitution and Therapeutic Interchange

Some medications listed on the state of Oklahoma PDL may require specific medications to be used before the Member can receive the medication. If Oklahoma Complete Health has a record that the required medication met the Step Therapy criteria, the medications are automatically covered. If Oklahoma Complete Health does not have a record that the required medication was tried, the Member or prescriber may be required to provide additional information. If Oklahoma Complete Health does not grant Prior Authorization the Member and prescriber, will be notified, and provided information regarding the appeal process.

Benefit Exclusions

The following drug categories are not part of the Oklahoma Complete Health benefit and are not covered:

- Fertility enhancing drugs

- Anorexia, weight loss, or weight gain drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective.
- Drugs and other agents used for cosmetic purposes or for hair growth.
- Erectile dysfunction drugs prescribed to treat impotence.

DESI drugs products and known related drug products are defined as less than effective by the FDA because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established.

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum of six prescriptions per month, including up to two brand name drugs without Prior Authorization and up to three brand name drugs with Prior Authorization (within the six-prescription limit). Dispensing outside the Quantity Limit (QL) or Age Limits (AL) requires Prior Authorization. Oklahoma Complete Health may limit how much of a medication a Member can get at one time. If the prescriber feels a Member has a medical reason for getting a larger amount, he or she can ask for Prior Authorization. If Oklahoma Complete Health does not grant a PA approval, we will notify the Member and prescriber and provide information regarding the appeal process. Some medications on the state of Oklahoma PDL may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns as well as current medically accepted quality standards of care as supported by clinical literature. There is always consideration for an exception during the PA review for medically necessary treatments.

Over-The-Counter Medications (OTC)

The pharmacy program covers approved OTC medications listed in the state of Oklahoma PDL. Some OTC medications may require prior authorizations. All OTC medications must be written on a valid prescription by a licensed Physician in order to be reimbursed. Refer to the state of Oklahoma PDL for a list of covered OTC products using the link provided on the Oklahoma Complete Health website, www.oklahomacompletehealth.com.

CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that Oklahoma Complete Health maintains a high-quality healthcare delivery system. The credentialing and re-credentialing process helps achieve by validating the professional competency and conduct of our Providers. This includes verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base. Network Providers must meet the criteria established by Oklahoma Complete Health, as well as government regulations and standards of accrediting bodies.

Oklahoma Complete Health requires re-credentialing at a minimum of every three years because it is essential to maintain current Provider professional information. This information is also critical for Oklahoma Complete Health's Members, who depend on the accuracy of the information in its Provider directory.

Note: In order to maintain a current Provider profile, Providers are required to notify Oklahoma Complete Health of any relevant changes to their credentialing information in a timely manner.

Which Providers Must Be Credentialed?

The following Providers are required to be credentialed:

Medical Practitioners

- Medical doctors
- Chiropractors
- Osteopathic doctors
- Podiatrists
- Nurse Practitioners
- Physician Assistants
- Other medical practitioners

Behavioral Health Practitioners

- Psychiatrists and other Physicians
- Addiction Medicine Specialists
- Doctoral or Master's-Level Psychologists
- Master's-Level Clinical Social Workers
- Master's-Level Clinical Nurse Specialists or Psychiatric Nurse Practitioners
- Other behavioral healthcare specialists

Facility and Other Providers

- Hospitals, Home Health agencies, skilled nursing facilities, FQHCs, RHCs, laboratory testing/diagnostic facilities, rehabilitation centers and free- standing surgical centers;

- Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or in an ambulatory setting; and
- Long Term Care (LTC) institutional-based services Providers.

Information Provided at Credentialing

All new Providers and those adding Providers to their current practice must be enrolled through the Oklahoma Medicaid Enterprise and submit at a **minimum** the following information when applying for participation with Oklahoma Complete Health:

- Completed, signed, and dated Oklahoma State Universal Practitioner Credentialing Application that is no older than 120 days, or
- Practitioners can authorize Oklahoma Complete Health to access their information on file with the Council for Affordable Quality Healthcare (CAQH) at: www.CAQH.org
- Current malpractice insurance coverage detailed on the credentialing application or a copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and Provider's name, or evidence of compliance with applicable Oklahoma regulations regarding malpractice coverage or alternate coverage.
- Copy of current Drug Enforcement Administration (DEA) registration Certificate, if applicable
- Copy of current Oklahoma Controlled Substance registration certificate, if applicable
- Completed and signed W-9 form.
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five-year work history (not required if work history is completed on the application)
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training.
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable

All Providers (Hospital, Facility, or Group, Clinic or Ancillary Provider) when applying for participation or recredentialing with Oklahoma Complete Health must be enrolled through the Oklahoma Medicaid Enterprise and submit:

- Completed, signed, and dated Oklahoma Complete Health Facility Application with attachments requested that is no older than 30 days.
- Copy of State Operational License
- Copy of Accreditation Certificates (by a nationally recognized accrediting body, e.g., TJC/JCAHO), if applicable
- If not accredited, a copy of Provider's most recent state or CMS survey, including response to any corrective actions, and response from surveyor recognizing corrective action taken by Provider.
- Completed and signed W-9 form.
- Other applicable State/Federal/Licensures (e.g., CLIA, DEA, Pharmacy, or Department of Health)
- Roster (in an approved Oklahoma Complete Health format) or CAQH data form for each practitioner employed by the Provider.
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)

Credentialing Process

Once Oklahoma Complete Health has received an application, it verifies the following information, at a minimum, submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current participation in the Oklahoma Medicaid Program
- A current Oklahoma license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions.
- Hospital privileges in good standing or alternate admitting arrangements
- Five-year work history
- Social Security Death Master File
- Federal and state sanctions and exclusions including the following sources:
    - Office of Inspector General (OIG)
    - The System for Award Management (SAM)
    - Medicare Opt-Out Listing

Once the application is complete, the Oklahoma Complete Health's Credentialing Committee renders a final decision on acceptance following its next regularly scheduled meeting.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for Provider participation. It is also responsible for the oversight and direction of the credentialing policy and procedures, including Provider participation, denial, and termination. Oklahoma Complete Health will ensure that credentialing of all Providers applying for network Provider status shall be completed within 45 days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the Provider notifying him or her of the decision on his or her application.

Site visits are performed at Provider offices within thirty (30) days of identification of a Member's complaint. Oklahoma Complete Health has up to sixty (60) days to complete the site visit if necessary. Oklahoma Complete Health may establish complaint categories and occurrence thresholds which include:

- Physical appearance;
- Physical accessibility; and
- Adequacy of waiting room and exam room space.

If anyone (1) complaint received in any of the three (3) categories identified above, the Provider may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices, and safety procedures.

Committee meetings are held monthly and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing

To comply with accreditation standards, Oklahoma Complete Health re-credentials Providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the Provider's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the Provider is under contract to provide. This process includes all Providers, PCPs, specialists, and ancillary Providers/facilities previously credentialed to practice within the Oklahoma Complete Health network.

In between credentialing cycles, Oklahoma Complete Health conducts ongoing monitoring activities on all network Providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined Providers and Providers with a negative change in their current licensure status. This monthly inquiry helps make certain that Providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Oklahoma Complete Health reviews monthly reports including OIG, SAM, and Medicare Opt-Out to identify network Providers who have been newly sanctioned or excluded from participation in federal and state programs.

Participating Provider Demographic Data

To ensure accurate information is provided to our beneficiaries, Oklahoma Complete Health requires advanced notice of any demographic changes such as location, office hours, hospital privileges, and phone and fax numbers. Please provide this information to Oklahoma Complete Health at least 30 days prior to the effective date of the change. Demographic changes can be submitted via the Oklahoma Complete Health secure Provider portal at oklahomacompletehealth.com.

Loss of Network Participation

A Provider's agreement may be terminated at any time if Oklahoma Complete Health Credentialing Committee determines that the Provider no longer meets the credentialing requirements.

Upon notification from the from the Regulatory agencies/State licensing board that a Provider with whom Oklahoma Complete Health has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, Oklahoma Complete Health will immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All Providers participating within the Oklahoma Complete Health network have the right to review information obtained by the health plan that is used to evaluate Providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a Provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a Provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the Provider, the Provider has the right to correct any erroneous information submitted by another party. To request release of such information, a Provider must submit a written request to Oklahoma Complete Health's Credentialing Department at:

Oklahoma Complete Health
Credentialing Manager
7700 Forsyth Boulevard
St. Louis, MO 63105

Upon receipt of this information, the Provider has to provide a written explanation detailing the error or the difference in information. The Oklahoma Complete Health Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All Providers who have submitted an application to join Oklahoma Complete Health have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Network Specialist toll-free at 833-752-1664.

Right to Appeal Adverse Credentialing Determinations

Oklahoma Complete Health may decline an existing Provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the Provider has the right to request reconsideration in writing within of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Oklahoma Complete Health network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than from the receipt of the additional documentation. Oklahoma Complete Health will send a written response to the Provider's reconsideration request within 60 days of the final decision.

The applicant will be sent a written response to his/ her request within two weeks of the final decision. A written request for appeal should be sent to:

Oklahoma Complete Health
Credentialing Manager
7700 Forsyth Blvd.
St. Louis, MO 63105

A Provider has the right to appeal Oklahoma Complete Health's decision and request a state fair hearing under Oklahoma Code sections 17A.4 through 17A.8.

MEMBER AND PROVIDER RIGHTS AND RESPONSIBILITIES

Member Rights

Oklahoma Complete Health expects Providers to respect and honor Members' rights, including the right to:

- Receive information about Oklahoma Complete Health, its services, its Providers and Member rights and responsibilities.
- Be treated with respect and with consideration for his or her dignity and privacy, including but not limited to the right to fully participate in the community and to work, live and learn to the fullest extent possible.
- Receive information on available treatment options and alternatives that are presented in a manner that the Member is able to understand.
- Participate in decisions about their healthcare. This includes the right to refuse treatment.
- A right to candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to get care right away for an Emergency Medical Condition.
- A right to decide about their healthcare and to give permission before the start of diagnosis, treatment, or surgery.
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected.
- A right to have the personal information in medical records kept private.
- A right to report any complaint or grievance about a Provider or their medical care.
- A right to file an appeal of an action that reduces or denies services based on medical criteria.
- A right to express a concern or appeal to the Ombudsman's office.
- A right to receive interpretation services.
- A right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A right to not be discriminated against due to race, color, national origin or health status or the need for healthcare services.
- A right to request a second opinion.
- A right to be notified at the time of enrollment and annually of disenrollment rights.
- A right to make an Advance Directive and to file a complaint with the Oklahoma DHS if they feel it is not followed.
- A right to choose a Provider who gives care whenever possible and appropriate.
- A right to receive accessible healthcare services equivalent in amount, duration, and scope to those provided under Medicaid FFS and sufficient in amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished.
- A right to receive appropriate services not denied or reduced solely because of diagnosis, type of illness or medical condition.
- Freedom to exercise the rights described herein without any adverse effect on the treatment by the Oklahoma Department of Human Services, Oklahoma Complete Health, its Providers, or contractors.
- A right to receive all written Member information from Oklahoma Complete Health:

    - At no cost to the Member.
    - In the prevalent non-English languages of Members in the service area.
    - In other ways, to help with the special needs of Members who may have trouble reading the information for any reason.

- A right to receive oral interpretation services free of charge for all non-English languages, not just those identified as "prevalent" and how to access them.
- A right to get help from both Oklahoma Department of Human Services and its Enrollment Broker in understanding the requirements and benefits of Oklahoma Complete Health.
- A right to make recommendations regarding the Oklahoma Complete Health Member rights and responsibilities policy.

Member Responsibilities

Members have certain responsibilities to:

- Inform Oklahoma Department of Human Services of changes in family size.
- Inform Oklahoma Department of Human Services if the Member moves out of the Region, out-of-state or have other address changes.
- Inform Oklahoma Complete Health if the Member obtains or has health coverage under another policy, other third party, or if there are changes to that coverage.
- Allow Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.
- Take actions toward improving their own health, their responsibilities and any other information deemed essential by Oklahoma Complete Health.
- Keep appointments and follow-up appointments.
- Access preventive care services.
- Receive Information on any of cost-sharing responsibilities.
- Learn about Oklahoma Complete Health coverage provisions, rules, and restrictions.
- Choose a PCP.
- Treat Providers and staff with dignity and respect.
- Inform Oklahoma Complete Health of the loss or theft of a Member ID card.
- Present Member ID card(s) when using healthcare services.
- Call or contact Oklahoma Complete Health to obtain information and have questions clarified.
- Provide Providers with accurate and complete medical information.
- Follow prescribed treatment of care recommended by a Provider or let them know the reason(s) treatment cannot be followed, as soon as possible.
- Ask questions of Providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors.

- Understand health problems and participate in developing mutually agreed upon treatment goals with their Provider to the highest degree possible.
- Make their PCP aware of all other Providers who are treating them. This is to ensure communication and coordination in care. This also includes Behavioral Health Providers.
- Follow the grievance process established by Oklahoma Complete Health (and as outlined in the Member Handbook) if there is a disagreement with a Provider.

Provider Rights

Oklahoma Complete Health Providers have the **right** to:

- Help Members or advocate for Members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments.
    - Provide information regarding the nature of treatment options.
    - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered.
    - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment, as well as the benefits of such treatment options.
- Be treated by their patients and other healthcare workers with dignity and respect.
- Receive accurate and complete information and medical histories for Members' care.
- Have their patients act in a way that supports the care given to other patients and does not interfere with their operations.
- Expect other network Providers to act as partners in Members' treatment plans.
- File a dispute with Oklahoma Complete Health for payment issues and/or utilization management, or a general complaint with Oklahoma Complete Health and/or a Member.
- File a grievance or an appeal with Oklahoma Complete Health on behalf of a Member, with the Member's written consent.
- Have access to information about Oklahoma Complete Health Quality Improvement (QI) programs, including program goals, processes, and outcomes that relate to Member care and services.
- Contact Oklahoma Complete Health Provider Services with any questions, comments, or problems.
- Collaborate with other healthcare professionals who are involved in the care of Members.
- Not be discriminated against by Oklahoma Complete Health based solely on any characteristic protected under state or federal non-discriminate laws. Oklahoma Complete Health does not, and has never had a policy of terminating a Provider who:
    - Advocated on behalf of a Member.
    - Filed a complaint against us.

- Appealed a decision of ours

- Not be discriminated against by Oklahoma Complete Health in the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This does not require Oklahoma Complete Health to contract with Providers beyond the number necessary to meet the needs of Members, preclude Oklahoma Complete Health from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude Oklahoma Complete Health from establishing measures that are designed to maintain quality of services and control costs, or consistency with responsibilities to Members.
- Not be discriminated against for serving high-risk populations or specializing in the treatment of costly conditions; for filing a grievance on behalf of and with the written consent of a Member or helping a Member to file a grievance; for protesting a plan decision, policy or practice the healthcare Provider believes interferes with its ability to provide medically necessary and appropriate healthcare.
- Not be discriminated against based on any of the following: race/ethnicity, color, national origin, gender, age, lifestyle, disability, religion, sexual orientation, specialty/licensure type, geographic location, patient type in which the practitioner specializes, financial status, or on the basis of the Providers association with any Member of the aforementioned protected classes.

Provider Responsibilities

Oklahoma Complete Health Providers have the **responsibility** to:

- Treat Members with fairness, dignity, and respect.

- Not discriminate against Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.

- Maintain the confidentiality of Members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

- Give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider's practice/office/facility.

- Provide Members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

- Allow Members to request restriction on the use and disclosure of their personal health information.

- Provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records, and be able to request that they be amended or corrected as specified in 45 CFR §164.524 and §164.526.

- Provide clear and complete information to Members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the Member to participate in the decision-making process.

- Tell a Member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment.
- Allow a Member who refuses or requests to stop treatment the right to do so, as long as the Member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Respect Members' Advance Directives and include these documents in the Members' medical record.
- Allow Members to appoint a parent, guardian, family Member, or other representative if they can't fully participate in their treatment decisions.
- Allow Members to obtain a second opinion, and answer Members' questions about how to access healthcare services appropriately.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Oklahoma Complete Health data collection initiatives, such as HEDIS and other contractual or regulatory programs.
- Cooperate with all Quality Improvement (QI) Activities to improve the quality of care and services and Member experience, including the collection and evaluation of data and participation in Oklahoma Complete Health QI Programs.
- Allow Oklahoma Complete Health to capture and use practitioner/Provider performance data to manage healthcare access, costs, quality of care and Member experiences. Performance data may include, but is not limited to:
    - Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
    - Provision of preventive and chronic care services
    - Member complaint and grievance data
    - Utilization management data such as, emergency room visits/1000 and bed days/1000 reports and cost data.
    - Critical Incident reporting, sentinel events and adverse outcomes.
    - Compliance with clinical practice guidelines.
    - Pharmacy data including use of generics or specific drugs.
- Review clinical practice guidelines distributed by Oklahoma Complete Health.
- Comply with Oklahoma Complete Health Medical Management program as outlined in this handbook.
- Disclose overpayments or improper payments to Oklahoma Complete Health.

- Not deny services to a Member due to inability to pay the copayment if the household income is at or below 100% FPL.
- Reimburse copayments to Members who have been incorrectly overcharged.
- Provide Members, upon request, with information regarding the Provider's professional qualifications, such as specialty, education, residency, and board certification status.
- Obtain and report to Oklahoma Complete Health information regarding other insurance coverage.
- Notify Oklahoma Complete Health in writing if the Provider is leaving or closing a practice.
- Update their enrollment information/status with the Oklahoma Medicaid program if there is any change in their location, licensure or certification, or status via the Oklahoma Medicaid's Provider Web Portal.
- Contact Oklahoma Complete Health to verify Member eligibility or coverage for services, if appropriate.
- After we receive a Member's call, written, or electronic appeal, we will send a letter within 3 business days of receipt of the appeal acknowledging the appeal has been received. If the appeal was received orally, we must receive a written appeal that is signed by the Member or the Member's authorized representative to complete the appeal.
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language.
- Office hours of operation offered to Medicaid Members will be no less than those offered to commercial Members.
- Not be excluded, penalized, or terminated from participating with Oklahoma Complete Health for having developed or accumulated a substantial number of patients in the Oklahoma Complete Health with high-cost medical conditions.
- Coordinate and cooperate with other service Providers who serve Medicaid Members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school-based programs as appropriate.
- Object to providing relevant or medically necessary services on the basis of the Provider's moral or religious beliefs or other similar grounds.
- Disclose to Oklahoma Complete Health, on an annual basis, any Physician Incentive Plan (PIP) or risk arrangements the Provider or Provider Group may have with Providers either within its group practice or other Providers not associated with the group practice even if there is no substantial financial risk between Oklahoma Complete Health and the Provider or Provider group.
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement.
- Allow Oklahoma Complete Health direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory, or other programs.

- Review and follow clinical practice guidelines distributed by Oklahoma Complete Health.
    - Expedited appeals will be reviewed as expeditiously as the Member's condition warrants and no later than within 72 hours of our receiving the request. To request an expedited appeal, please call Oklahoma Complete Health at 833-752-1664 (TDD/TTY: 711). Oklahoma Complete Health will make reasonable efforts to verbally notify the requestor and the Member of the expedited appeal decision.
    - Have been discharged from an inpatient-stay within the last twenty-four (24) hours since notification.
    - Have a gap-in-care overdue by thirty (30) or more days.
- Develop report based on Oklahoma Complete Health specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one year of enrolling in the Oklahoma Complete Health Provider Network.
- Comply with Oklahoma Risk Adjustment programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines.
- Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).
- Report all suspected physical and/or sexual abuse and neglect.
- Report Communicable Disease to Oklahoma Complete Health.
- Oklahoma Complete Health must work with DHS State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately report reportable conditions.

MEMBER GRIEVANCE AND APPEALS PROCESSES

A Member, a Member's authorized representative, or a Member's Provider (with written consent from the Member), may file an appeal or grievance either verbally or in writing.

Oklahoma Complete Health gives Members reasonable assistance in completing all forms and taking other procedural steps of the appeal and grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.

Grievances

Grievances are defined as any expression of dissatisfaction about any matter other than an adverse benefit determination provided to Oklahoma Complete Health by a Member and their authorized representative. Examples of these type of complaints include, but are not limited to:

- Unclear and inaccurate information from staff
- Quality of care or services provided to a Member.
- Rudeness of a Provider or employee
- Failure to respect a Member's rights.
- Harmful administrative processes or operations
- Disagrees with the decision to extend an appeal timeframe.

Oklahoma Complete Health wants to resolve Member concerns. We will not hold it against the Member if they file a grievance. We will not treat Members differently.

How to File a Grievance

A Member may file a grievance at any time by doing one of the following:

- Call Member Services toll-free at 833-752-1664 (TDD/TTY: 711)
- Send a fax to 833-838-0085
- Send an email to www.oklahomacompletehealth.com
- Give it to us in person or by mail at:

Oklahoma Complete Health
ATTN: Grievances
14000 Quail Springs
Suite 650
Attn: Appeals
Oklahoma City, OK 73134

Be sure to include:

- Member first and last name
- Member Medicaid ID number

- Member address and telephone number
- Member's complaint about why they are unhappy.
- What the Member would like to happen to resolve the complaint

Oklahoma Complete Health will send a letter within five (5) business days to acknowledge receipt of the grievance.

If another person files a grievance for a Member, Oklahoma Complete Health must have written permission from the Member for that person to act on the Member's behalf unless that person is the Member's legal authorized representative. No one can act on a Member's behalf without written permission.

If filing a grievance on behalf of a Member, you will need to provide an Authorized Representative Designation Form, signed by the Member, to Oklahoma Complete Health. To obtain this form, contact Member Services or find it on the Oklahoma Complete Health website at www.oklahomacompletehealth.com. You or the Member can return it by mail or fax. Members can also call Member Services for assistance with this.

A Member may have additional information supporting their grievance. If so, please send it along with the grievance so we can add it to our information. Members may ask to receive copies free of charge of any documentation Oklahoma Complete Health uses to make the decision about the Member's grievance.

Oklahoma Complete Health will work to resolve the grievance as expeditiously as the Member's condition warrants and will send a resolution notice within 30 calendar days of the receipt of the grievance.

Appeals

An appeal is a request for Oklahoma Complete Health to review an adverse benefit determination made by Oklahoma Complete Health. Members may appeal a service that has been denied, limited, reduced, or terminated.

Appeals may be filed by a Member (parent or guardian of a minor Member) or authorized representative with the written consent of the Member to act on their behalf. Appeals may be filed verbally or in writing. Verbal appeals must be followed by a written, signed appeal.

When Oklahoma Complete Health issues a "Notice of Adverse Benefit Determination" to the Member, the Member may file an appeal within 60 calendar days from the date on the Notice.

Members can request copies of any documentation Oklahoma Complete Health used to make the decision about their care or appeal. Members can also request a copy of their Member records. These copies will be free of charge. We will not hold it against a Member if he/she files an appeal. We will not treat Members differently in any way.

How to File an Appeal

Members may file an appeal by doing one of the following:

- Call Oklahoma Complete Health Member Services toll-free at 833-752-1664 (TDD/TTY: 711).
- Send it electronically by fax to833-522-2803.
- In-person
- By mail at:

Oklahoma Complete Health
ATTN: Appeals
PO Box 10353
Van Nuys, CA 91410-0353

For Behavioral Health Member Appeals:

- Send it electronically by fax to 866-714-7991
- By Mail at

Oklahoma Complete Health

ATTN: Appeals Department

PO Box 10378

Van Nuys, CA 91410-0378

After we receive a Member's call, written, or electronic appeal, we will send a letter within five (5) calendar days of receipt of the appeal acknowledging the appeal has been received.

Oklahoma Complete Health will send an appeal resolution letter within 30 calendar days of receipt of an appeal request. Oklahoma Complete Health wants to resolve appeal concerns quickly and will resolve Member appeals within 30 calendar days of filing with us. If we cannot resolve the Member's appeal in 30 calendar days, we may extend the timeframe by up to 14 calendar days to gather more information to assist in our decision. If Oklahoma Complete Health needs more than 30 calendar days to resolve the appeal, with approval of the State, Oklahoma Complete Health will notify the Member orally and in writing of the reason for the delay within 2 calendar days.

Members may also request an extension. To request an extension, call Member Services toll-free at 833-752-1664 (TDD/TTY: 711).

If a Member needs help filing an appeal, call Member Services. The phone number is at 833-752-1664 (TDD/TTY: 711). We have representatives to help Members Monday through Friday, 8:00am – 5:00pm (excluding State holidays).

Continuation of Benefits during the Appeal Process

Members may request services continue while Oklahoma Complete Health reviews their appeal and during the State Fair Hearing process, if it is not resolved at the first appeal level. Members must request to continue services within 10 days of the date on the Adverse Benefit Determination notice or the intended effective date of the proposed Adverse Benefit Determination.

Expedited Appeal Decisions

An expedited appeal may be filed when there is an immediate need for health services because a standard appeal could jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

The appeal process allows the Member, the Member's authorized representative acting on behalf of the Member, or Provider acting on the Member's behalf, to file an expedited appeal. For expedited requests made by Providers on behalf of Members, Oklahoma Complete Health presumes an expedited appeal resolution is necessary and will grant the request for expedited resolution. No punitive action will be taken against a Provider that requests an expedited resolution or supports a Member's appeal. In instances where the Member's request for an expedited appeal is denied, the appeal will be immediately transferred to a standard appeal timeframe and provide oral and written notice to the Member, and when applicable, an authorized representative, of the denial of the expedited resolution request.

Expedited appeals will be reviewed as expeditiously as the Member's condition warrants as and no later than within 72 hours of our receiving the request. To request an expedited appeal, please call Oklahoma Complete Health at 833-752-1664 (TDD/TTY: 711). Oklahoma Complete Health will make reasonable efforts to verbally notify the requestor and the Member of the expedited appeal decision.

State Fair Hearings

If a Member is not satisfied with an Oklahoma Complete Health appeal decision, they have the right to request a State Fair Hearing. Members must exhaust Oklahoma Complete Health internal appeal process before they may file a request for a State Fair Hearing. Members have 120 calendar days from the date on the appeal decision notice to request a State Fair Hearing. Members may request their services to continue during the State Fair Hearing process. A Member may request a State Fair Hearing by sending the request by mail or email to:

Oklahoma Healthcare Authority
Attn: Appeals Unit
4345 N Lincoln Blvd
Oklahoma City, OK 73105
Phone: (405) 522-7217
Email: docketclerk@okhca.org

PROVIDER GRIEVANCE AND APPEALS

A Grievance is a verbal or written expression by a Provider that indicates dissatisfaction or dispute with Oklahoma Complete Health policies, procedure, claims, or any aspect of Oklahoma Complete Health functions.

- Oklahoma Complete Health logs and tracks all grievances whether received verbally or in writing. For instructions on how to file a grievance, please see the How to File a Provider Grievance or Appeal subsection at the end of the Grievance an Appeals Processes section of this manual.
- After the complete review of grievances related to claims we will open communication with the Provider to review the status of the grievance, provide updates every 15 days and resolve grievances fully within 90 days.
- After the complete review of grievances not related to claims Oklahoma Complete Health shall open communication with the Provider to review the status of the grievance. If the grievance cannot be resolved in 15 days, the Plan will provide a status update at that time and will fully resolve all grievances within 30 calendar days from the date the grievance was received.

Appeal is the mechanism following the exhaustion of the grievance process that allows Providers the right to appeal actions of Oklahoma Complete Health such as a claim denial, prior authorization denial, or if the Provider is aggrieved by any rule, policy or procedure or decision made by Oklahoma Complete Health.

A Provider has 30 calendar days from Oklahoma Complete Health notice of action. The Plan will extend this timeframe by an additional 30 days for good cause, which may include, but is not limited to, the voluminous nature of required evidence or supporting documentation; or an appeal of an adverse quality decision as determined by the Plan. Oklahoma Complete Health will acknowledge receipt of each appeal within five (5) calendar days after receiving an appeal.

Oklahoma Complete Health will accept a written request for an appeal from the Provider within 30 calendar days if the Provider receives written notice from the Oklahoma Complete Health of the decision giving rise to the right to appeal; or if Oklahoma Complete Health should have taken a required action and failed to take such actions.

Eligible Reasons to File An Appeal

The list below outlines eligible reasons for which a Provider may appeal an adverse decision made by Oklahoma Complete Health.

For Network Providers

a. Program Integrity related findings or activities.

b. Finding of fraud, waste, or abuse by the PHP

c. Finding of or recovery of an overpayment by the PHP

d. Withhold or suspension of a payment related to fraud, waste, or abuse concerns.

e. Termination of, or determination not to renew, an existing contract based solely on objective quality reasons outlined in the PHP's Objective Quality Standards as described in Section V.D. Providers of the RFP, as provided under Section 5.(6)d. of Session Law 2015-245, as amended.

f. Termination of, or determination not to renew, an existing contract for LHD care/case management services.

g. Determination to lower an AMH Provider's Tier Status

h. Violation of terms between the PHP and Provider

For Out of Network Providers

a. A determination to not initially credential and contract with a Provider based on objective quality reasons outlined in the PHP's Objective Quality Standards as described in Section.

b. An out-of-network payment arrangement

c. Finding of waste or abuse by the PHP

d. Finding of or recovery of an overpayment by the PHP

Resolution of Appeals addresses the process by which Oklahoma Complete Health reviews Provider appeals and determines the most appropriate course of action in response. Oklahoma Complete Health will work to resolve appeals to the mutual satisfaction of both the health plan and the Provider in accordance with the standards laid out in this Provider Manual and other health plan documents.

Oklahoma Complete Health will establish and maintain a committee to review and decide on Provider appeals. The committee will be made up of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction which led to the appeal. The committee will also include an external peer reviewer when the issue on appeal involves whether the Provider met Objective Quality Standards.

For appeals not related to payment withhold, Oklahoma Complete Health shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the beneficiary's health condition requires, but shall not exceed thirty (30) calendar days from the date Oklahoma Complete Health receives the appeal. Please see the Appeals on Behalf of a Member section below for further details on this process.

For appeals related to payment withhold, the Plan will resolve each appeal within fifteen (15). If the review of an appeal related to payment results in the determination that the Plan did not have good cause for withholding or suspending payment and withheld or suspended payments will be made to the Provider within five (5) business days, and the Plan will pay interest in accordance with the Provider contract.

Oklahoma Complete Health will allow Providers to be represented by an attorney during the appeals process.

Suspension or Withhold of Provider Payment addresses nonpayment of an appealed claim by Oklahoma Complete Health.

In cases of a suspended or withheld payment, Oklahoma Complete Health will limit its consideration to whether there existed good cause to withhold or suspend Provider payment. Oklahoma Complete Health will not address whether the Provider has or has not committed fraud or abuse.

Oklahoma Complete Health will offer the Provider an in-person or telephonic hearing when the Provider is appealing whether Oklahoma Complete Health had good cause to withhold or suspend payment to the Provider.

Oklahoma Complete Health will pay interest and penalties for overturned denials, underpayment, or other determinations that did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial.

Appeals on Behalf of a Member

Expedited Appeals may be filed when either Oklahoma Complete Health or the beneficiary's Provider determines that the time expended in a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a Provider that requests an expedited resolution or supports a beneficiary's appeal. In instances where the beneficiary's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Expedited appeals will be acknowledged within twenty-four (24) hours, and determinations will be made as expeditiously as the beneficiary's health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal.

In order to file an appeal on behalf of a Member (such as for prior authorization or adverse benefit determination), please follow the instructions in the Beneficiary Appeal section of this manual.

How to file a Provider Grievance or Appeal (Claims Complaint Process):

This process can also be found in the Billing Manual

A Claims Reconsideration - is an expression by a Provider, which indicates dissatisfaction or dispute with Oklahoma Complete Health claim adjudication. This includes (but is not limited to) the amount reimbursed, claim coding edits, coordination of benefits, or timely filing denials. All claim requests for complaint must be received within 180 from the date of the Explanation of payment (EOP).

A Claims Appeal - is the mechanism that allows Providers the right to appeal actions of Oklahoma Complete Health related to denial of payment. This includes (but is not limited to) appeals for failure to authorize services and services denied based on Health Plan Policy such as medical necessity or payment policies. All claims' appeals must be submitted in writing from the Provider within 180 calendar days of the Explanation of Payment (EOP).

The Provider Claim Complaint/Appeal Form must be used if a claim has been processed and a Medicaid Remittance Advice has been issued from Oklahoma Complete Health. Please access this form www.oklahomacompletehealth.com/Providers.

Providers have a second level appeal available for any medical necessity claim appeal that resulted in an unfavorable decision for the Provider. A second level appeal must be requested within 60 calendar days from the date of the initial appeal determination notice. Second level medical necessity appeal will be reviewed by a medical professional with the same or similar specialty to the medical area that is the topic of the appeal.

Filing a Claims Reconsideration/Appeal

1. Fill out the Provider appeal form.
2. Send a letter explaining the nature of your appeal and any special circumstances that you would like considered as part of your appeal.
3. Attach a copy of the claim and documentation to support your position, such as medical records.

Oklahoma Complete Health
Attn: Appeals Department
P.O. Box 8060
Farmington, MO 63640-8060

PROVIDER COMPLAINTS

Complaint Process

Oklahoma Complete Health maintains written policies and procedures for the filing of Provider complaints. A Provider has the right to file a complaint with us. Provider complaints shall be resolved within 30 calendar days. If the Provider complaint is not resolved within 30 calendar days, we shall document the incident and notify the Provider and OHCA of outstanding issues, including a timeline for resolution for an extension.

Providers may file a complaint regarding Oklahoma Complete Health policies, procedures, or any aspect of Oklahoma Complete Health administrative functions. Complaints are spoken or written expressions of dissatisfaction.

Oklahoma Complete Health wants to resolve Provider concerns. We will not hold it against the Provider if he/she files a complaint. We will not treat Providers differently.

How to File a Complaint

A Provider can file a complaint in any way that works best for them. They can:

- Call Provider Services at 833-752-1664 (TDD/TTY:711)
- Send a fax to 833-611-2153
- Give it to us in person or by mail:

Oklahoma Complete Health
ATTN: Complaints
P.O. Box 8060
Farmington, MO 63640-8060

FRAUD, WASTE, AND ABUSE

Oklahoma Complete Health takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with state and federal laws.

Fraud means the intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts in order to receive reimbursement for which they are not entitled.

Waste means the incorrect submission of claims due to factors such as uneducated office staff, coding illiteracy, staff turnover, or keying errors. Wasteful billing can typically be resolved after the Provider or subcontractor and office staff is educated on proper billing requirements and/or claim submission.

Abuse: means practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the health plan. It includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for healthcare. Abuse also includes Member and Provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Oklahoma Complete Health successfully operates a Special Investigations Unit (SIU), with dedicated staff that reside in Oklahoma. This unit routinely inspects claims submitted to assure that Oklahoma Complete Health is paying appropriately for covered services. Oklahoma Complete Health performs front and back-end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim payment process. To better understand this system; please review the Billing Manual located on our website. Oklahoma Complete Health also performs retrospective audits, which in some cases these activities may result in taking actions against Providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity.
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of Provider agreement or other contractual arrangement
- Referral to the Oklahoma Program Integrity Unit
- Referral to the Medicaid Fraud Control Unit
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify.

Oklahoma Complete Health instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)

- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Oklahoma Complete Health requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons, or entities providing care or services to all Oklahoma Complete Health Members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, Physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or Members' medication fraud.

Training is available via our company website and can be downloaded in PDF format at: www.oklahomacompletehealth.com. We also include FWA training in our Provider Orientation packets.

To report any fraud, waste and abuse concerns please call the Fraud and Abuse Line at 1-866-685-8664.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Oklahoma Complete Health auditors request medical records for a defined review period. Providers have thirty (30) days to respond to the request; if no response is received, a second and final request for medical records is forwarded to the Provider. If the Provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Oklahoma Complete Health will recover all amounts paid for the services in question.

Oklahoma Complete Health auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the Member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered.

Oklahoma Complete Health auditors consider state and federal laws and regulations, Provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each Provider

upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Oklahoma Complete Health will seek recovery of all overpayments. Depending on the number of services provided during the review period, Oklahoma Complete Health may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Oklahoma Complete Health uses RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments. Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS and completing the extrapolation overpayment. Audit findings are reported to the Oklahoma OIG and the Office of the Attorney General Medicaid Fraud Control Section.

Suspected Inappropriate Billing

If you suspect or witness a Provider inappropriately billing or a Member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Oklahoma Complete Health takes all reports of potential fraud, waste, and/or abuse very seriously and investigates all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, Oklahoma Complete Health may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing, or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Fraud, Waste and Abuse Reporting

Providers may voluntarily disclose any suspected fraud, waste or abuse using the tool on the DHS website at https://oklahoma.gov.

QUALITY IMPROVEMENT

Oklahoma Complete Health culture, systems and processes are structured around its mission to improve the health of all enrolled Members. The Quality Improvement (QI) program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all Members; including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

Oklahoma Complete Health recognizes its legal and ethical obligation to provide Members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of Members.

Where the Member's condition is not likely to improve, Oklahoma Complete Health will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. This will include the identification of Members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Oklahoma Complete Health QI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of Members.

Program Structure

The Oklahoma Complete Health Board of Directors (BoD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to Members. The BoD oversees the QI Program and has established various committees and ad-hoc committees to monitor and support the QI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Oklahoma Complete Health network physician representation that is directly accountable to the BoD. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to Members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve Member outcomes, and the education of Members, Providers, and staff regarding the quality and medical management programs.

The following committees report directly to the Quality Management Committee (QIC):

- Grievance and Appeals Committee
- Vendor Oversight Committee

- Medical Management Committee (MMC)
- Pharmacy & Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Performance Improvement Team (PIT)
- Peer Review Committee (Ad Hoc Committee)

In addition to the committees reporting to the QIC, Oklahoma Complete Health has sub-committees and workgroups that report to the above committees including, but not limited to:

- Provider Advisory Board
- Member Advisory Board
- Health Equity Improvement Committee
- Specialized workgroups including a Tribal Workgroup, Behavioral Health Workgroup, and a EPSDT Workgroup

Provider Involvement

Oklahoma Complete Health recognizes the integral role Provider involvement plays in the success of its QI program. Provider involvement in various levels of the process is highly encouraged through Provider representation and participation on the Quality Committees. Oklahoma Complete Health encourages PCP, specialty, OB/GYN, Family Practice, Cardiology, Pediatrics, pharmacy, and Behavioral Health representation on key quality committees.

Quality Improvement (QI) Program Scope

The scope of the QI program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Oklahoma Complete Health Members. Oklahoma Complete Health QI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

Oklahoma Complete Health primary QI program goal is to improve Members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered. Across our markets, our QI goals and initiatives have three primary commonalities: alignment with the Quintuple Aim, alignment with state priorities and goals, and driven by local data. We will build on and expand our QI initiatives in Oklahoma by tailoring them to meet the needs of the local community. This includes a thorough understanding of the geographic, cultural, clinical, and social needs across all Oklahoma communities.

The Quintuple Aim for healthcare improvement goals are to improve the following:

- health outcomes
- Member experience
- Provider experience
- efficiency
- health equity

Patient Safety and Quality of Care

Patient Safety is a key focus of Oklahoma Complete Health QI program. Monitoring and promoting Member safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a Member.

Oklahoma Complete Health employees (including Medical Management, Member Services, Provider Services, Appeal Coordinators, etc.), panel Providers, facilities or ancillary Providers, Members or Member representatives, medical directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues requires investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee (Ad Hoc Committee) as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Oklahoma Complete Health QIC reviews and adopts an annual QI program and Work Plan aligned with Oklahoma Complete Health vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving Member health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow Oklahoma Complete Health to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve healthcare for Oklahoma Complete Health Members. The measures are HEDIS measures, integrated behavioral healthcare, along with identified state metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Oklahoma Complete Health develops a QI Work Plan for the upcoming year. The QI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QI Work Plan.

Oklahoma Complete Health communicates activities and outcomes of its QI Program to both Members and Providers through avenues such as the Member newsletter, Provider newsletter, and the Oklahoma Complete Health web portal at www.oklahomacompletehealth.com.

At any time, Oklahoma Complete Health Providers may request additional information on the Health Plan programs, including a description of the QI Program and a report on Oklahoma Complete Health progress in meeting the QAPI program goals, by contacting the QI department.

For any questions relative to Quality of Care or CIRs, please contact us at QOC_CIR@oklahomacompletehealth.com and Fax # <XXX-XXX-XXXX>.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual Provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Oklahoma Complete Health quality committees. This review of Provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age-appropriate screenings for detection of chronic diseases or conditions.
- OHCA priority measures, including HEDIS physical health and behavioral health performance measures and CAHPS Health Plan Survey 5.0H CHIP, Child, and Adult surveys.
- Member appeal and grievance data.
- Utilization management data including ER visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.
- Pharmacy data including use of generics or specific drugs.

As part of its motivational incentive strategies, Oklahoma Complete Health systematically profiles the quality of care delivered by high-volume PCPs to improve Provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network Providers to ensure the process has value to Providers, Members and Oklahoma Complete Health and may include a financial component.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the Oklahoma Department of Human Services.

As both Oklahoma and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming increasingly important; not only to the health plan, but to the individual Provider. Oklahoma purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate an improvement in preventive health outreach to its Members. Provider specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for Provider incentive programs, such as "Pay for Performance." These programs reward Providers based on scoring of such quality indicators used in HEDIS.

How Are HEDIS Rates Calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and submitted to the health plan. Measures calculated using administrative data may include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid rates consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Member medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the necessity of Medical Record Reviews (MRR); see Oklahoma Complete Health website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores. Measures typically requiring medical record review include diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

MRR audits for the HEDIS Hybrid season are usually conducted January through May each year. Oklahoma Complete Health QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Oklahoma Complete Health behalf may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Oklahoma Complete Health which allows them to collect PHI on our behalf.

What Can Be Done To Improve My HEDIS Scores?

- Understand the specifications established for each HEDIS measure.
- Comply with requests for medical records for HEDIS measures and related audits to ensure timely audit and HEDIS scoring for Providers by the health plan.
- Submit claim/encounter data for each and every service rendered. All Providers must bill or report by encounter submission for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately, they are not included in the

calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as, Body Mass Index (BMI) calculations, eye exam results and blood pressure readings.

If you have any questions, comments, or concerns related to the annual HEDIS project or the MRRs, please contact the Quality Improvement Department at toll-free 833-752-1664.

MEDICAL RECORDS REVIEW (MRR)

Oklahoma Complete Health Providers must keep accurate and complete medical records. Such records will enable Providers to render the highest quality healthcare service to Members. They will also enable Oklahoma Complete Health to review the quality and appropriateness of the services rendered. To ensure the Member's privacy, medical records should be kept in a secure location.

Oklahoma Complete Health requires Providers to maintain all records for Members for at least 10 years. See the Member Rights section of this handbook for policies on Member access to medical records. Oklahoma Complete Health may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and Member grievance/appeal investigation. Providers must meet 80%› of the requirements for medical record keeping; elements scoring below 80%› are considered deficient and in need of improvement. Oklahoma Complete Health will work with any Provider who scores less than 80%› to develop an action plan for improvement. MRR results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive Member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating PCP or Provider, that document all medical services received by the Member; this includes inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the Provider rendering the services.

Providers must maintain complete medical records for Members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the Provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An appropriate history of immunizations is made in chart for adults.

- Evidence that preventive screening and services are offered in accordance with Oklahoma Complete Health practice guidelines.
- Appropriate subjective and objective information pertinent to the Member's presenting appeal is documented in the history and physical.
- Past medical history (for Members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed including instructions to the Member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the PCP to signify review.
- Referrals to specialists and ancillary Providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- Appropriate notations concerning use of tobacco, alcohol, and substance use; for Members seen three or more times substance abuse history should be queried.
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the Member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of Member information and records protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older.

Nursing Facility records will also include:

- Substantiation of Preadmission Screening and Resident Review (PASRR).
- Documentation of specialized services delivery.
- Evidence of education regarding Patient Rights and Responsibilities.
- Acknowledgement that the Member was informed of any patient pay liability.
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts.
- Other processes identified by either Oklahoma Complete Health or the Department.

Medical Records Release

All Member medical records shall be confidential and shall not be released without the written authorization of the covered person or a Member's authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

As a reminder, PHI that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Oklahoma Complete Health which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the Member's medical record attempts to obtain historical medical records for all newly assigned Oklahoma Complete Health Members. If the Member or Member's authorized representative is unable to reenroll where they obtained medical care, or they are unable to provide addresses of the previous Providers, this should also be noted in the medical record.

Who Conducts Medical Record Reviews (MRR) for HEDIS?

Oklahoma Complete Health may contract with an independent national MRR vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted from February January through May each year. At that time, if any of your patients' medical records are selected for review, you will receive a call and/or letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

TABLE OF REVISIONS

Date	Section	Comments	Page	Change
4/8/2024	Covered Benefits and Limitations	Benefits & Limitations grid	41-48	Updated Chart
4/8/2024	Primary Care Provider (PCP)	Member Panel Capacity	73	Updated member panel capacity
4/8/2024	Credentialing and Re-Credentialing	Information Provided at Credentialing	95	Amended language

Date	Section	Comments	Page	Change
4/10/2024	Utilization Management	Retrospective Review	83	Amended language

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TTY: 711 (Hearing Impaired)

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