

**PLEASE NOTE: This Signature Form must be accompanied by a fully-completed Provider Information Form.**

**SOONERCARE PROVIDER AGREEMENT  
NEW PROVIDER SIGNATURE FORM**

**Agreement Name(s) and Number(s): General Agreement 2009-2  
Special Provisions appropriate to PROVIDER's  
Type**

If PROVIDER is an individual person, the undersigned PROVIDER agrees to all terms and conditions of the SoonerCare Agreement and Special Provisions listed above.

If PROVIDER is an entity other than an individual person, PROVIDER's Authorized Representative agrees to all terms and conditions of the SoonerCare Agreement and Special Provisions listed above. PROVIDER's Authorized Representative states that he or she has authority to execute this Agreement on behalf of PROVIDER pursuant to its organizational documents, bylaws, or properly enacted resolution of its governing authority.

PROVIDER or Authorized Representative certifies that:

1. If PROVIDER is an entity other than an individual person, the person signing below is the duly Authorized Agent of PROVIDER under the Agreement which is attached to this statement, for the purpose of certifying the facts pertaining to the giving of things of value to government personnel in order to procure said contract;
2. Neither PROVIDER nor anyone subject to PROVIDER's direction or control has paid, given or donated or agreed to pay, give or donate to any officer or employee of the State of Oklahoma any money or other thing of value, either directly or indirectly, in procuring this contract herein;
3. No person who has been involved in any manner in the development of the Agreement to which this statement is attached while employed by the State of Oklahoma shall be employed by PROVIDER to fulfill any of the services provided for under said contract.

\_\_\_\_\_  
Signature of PROVIDER or Authorized Representative

\_\_\_\_\_  
Date

## SoonerCare Provider Information FOR BUSINESS

### APPLICATION INFORMATION

Section 1

Are you currently or have you ever been enrolled in the Oklahoma SoonerCare Program?

Yes, I am currently enrolled       Yes, I was enrolled in the past.       No, I am not currently enrolled

If **currently enrolled**, please check one of the following:

First Date Of Service \_\_\_\_\_

Change of Ownership      Change Effective Date \_\_\_\_\_      Current Provider ID \_\_\_\_\_

Additional Service Location      Effective Date \_\_\_\_\_      Current Provider ID(s) \_\_\_\_\_

Renewal      Provider ID \_\_\_\_\_      Effective Date \_\_\_\_\_

### FACILITY IDENTIFICATION

Section 2

Do you want to enroll as a Choice Primary Care Provider?       Yes       No

Do you want to enroll as a provider for the Insure Oklahoma Program?       Yes       No

Contract Type \_\_\_\_\_      Primary Specialty \_\_\_\_\_

Hospital Type     Acute       Critical Access      Sub Specialty \_\_\_\_\_

Psychiatric     Residential Treatment Center

### PROFESSIONAL PRACTICE

Section 3

Name of Facility or Organization \_\_\_\_\_

Doing Business As (DBA) \_\_\_\_\_      NPI (National Provider Identifier) \_\_\_\_\_      NPI Effective date \_\_\_\_\_

Medicare NPI \_\_\_\_\_      CLIA # \_\_\_\_\_      CLIA Certification Date \_\_\_\_\_

Type Of Practice:

For Profit Corporation     Estate/Trust       Government Owned       Limited Liability Company

Non - Profit       Partnership       Public Service Corporation       Sole Proprietorship

Facility Administrator      Facility Director of Nursing

Last      First      MI      Last      First      MI

Facility Medical Director

Last      First      MI

Is this facility operated by a management company or leased in whole or part by another organization?     Yes       No  
*(If yes, please fill out the information below)*

Name of Management Company or Leasing Organization \_\_\_\_\_

Total # of Medicare Beds in the facility \_\_\_\_\_      Total # of Medicaid Beds in the facility \_\_\_\_\_

Is this a compounding pharmacy?     Yes       No      Is this pharmacy chain affiliated?     Yes       No

### PATIENT INFORMATION

Section 4

Are you accepting new patients?      Do you accept Medicare Patients?

Yes       No       Yes       No

Age of patients you wish to treat: \_\_\_\_\_ - \_\_\_\_\_      Patients you wish to treat?

From      To       Male     Female     Both

Are you enrolled in the Vaccine for Children (VFC) Program?     Yes     No    VFC # \_\_\_\_\_

Will you provide OB/GYN care?     Yes     No

License Number (Attach a copy of current license)    Issuing State    Original Issue Date    Expiration Date

Section 4 (cont)

Accrediting Entity \_\_\_\_\_ Accreditation Program \_\_\_\_\_ Effective Date \_\_\_\_\_ End Date \_\_\_\_\_ Accreditation Type \_\_\_\_\_  
 Full  Prelim  Provisional

Do you render home health agency services pursuant to OAC 317:30-5-545 through 317:30-5-549 and are Medicare certified or deemed eligible to participate in Medicare through accreditation by an outside organization?  Yes  No

Do you render private duty nursing (PDN) services pursuant to OAC 317:30-5-558 et seq.?  Yes  No

List any focus items \_\_\_\_\_

**CHOICE / INSURE OKLAHOMA**

Section 5

**Choice**

Desired total # of Choice patients? \_\_\_\_\_

Desired total # of Choice non AI / AN patients? \_\_\_\_\_

Which age of Choice members do you wish to treat? (Please only select one age range.)

- |           |                          |           |                          |           |                          |           |                          |           |                          |           |                          |
|-----------|--------------------------|-----------|--------------------------|-----------|--------------------------|-----------|--------------------------|-----------|--------------------------|-----------|--------------------------|
| Any Age   | <input type="checkbox"/> | Age <1    | <input type="checkbox"/> | Age 0-5   | <input type="checkbox"/> | Age 0-14  | <input type="checkbox"/> | Age 0-18  | <input type="checkbox"/> | Age 0-20  | <input type="checkbox"/> |
| Age 0-21  | <input type="checkbox"/> | Age 0-45  | <input type="checkbox"/> | Age 1-4   | <input type="checkbox"/> | Age 1-5   | <input type="checkbox"/> | Age 1-99  | <input type="checkbox"/> | Age 4-99  | <input type="checkbox"/> |
| Age 6-99  | <input type="checkbox"/> | Age 10-99 | <input type="checkbox"/> | Age 14-99 | <input type="checkbox"/> | Age 16-99 | <input type="checkbox"/> | Age 18-99 | <input type="checkbox"/> | Age 21-99 | <input type="checkbox"/> |
| Age 45-99 | <input type="checkbox"/> | Age 55-99 | <input type="checkbox"/> | Age 6-14  | <input type="checkbox"/> | Age 12-20 | <input type="checkbox"/> | Age 15-20 | <input type="checkbox"/> | Age 21-44 | <input type="checkbox"/> |

What gender Choice patients do you wish to treat?  Male  Female  Both

What percentage of your total office hours are available for serving Choice members at this location? \_\_\_\_\_

**Insure Oklahoma**

Desired total # Insure Oklahoma patient capacity? \_\_\_\_\_

Desired total # of Insure Oklahoma non AI / AN patients? \_\_\_\_\_

What gender Insure Oklahoma patients do you wish to treat?  Male  Female  Both

What percentage of your total office hours are available for serving members at this location? \_\_\_\_\_

**OFFICE INFORMATION**

Section 6

What hours are you available to see patients? Are you available 24/7?  Yes  No

Monday – Friday \_\_\_\_\_ Saturday – Sunday \_\_\_\_\_ Other \_\_\_\_\_

What Languages are you or your staff fluent in? \_\_\_\_\_

**ADDRESSES**

Section 7

Service Location Address (PO Box is not acceptable) \_\_\_\_\_

Mail To (If different from Service location) \_\_\_\_\_

Suite / Bldg # \_\_\_\_\_

Suite / Bldg # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ 4 digit zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ 4 digit zip \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Pay To (If different from Service location) \_\_\_\_\_

Suite / Bldg # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ 4 digit zip \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_  
Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**CONTACT INFORMATION**

**Enrollment Contact**

First Name (Enrollment Contact) \_\_\_\_\_ Last Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Email \_\_\_\_\_

**Clinical Services Contact** (If different from Enrollment)

First Name (Clinical Services Contact) \_\_\_\_\_ Last Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Email \_\_\_\_\_

**Electronic Payment Contact** (If different from Enrollment)

First Name (Electronic Payment Contact) \_\_\_\_\_ Last Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ ext \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_  
Email \_\_\_\_\_

Do you have a website you want listed in a provider directory? If yes, include the web address.

**Provider Website** \_\_\_\_\_

Section 8

**PAYMENT AND TAX REPORTING**

Tax ID \_\_\_\_\_  
IRS Legal Name \_\_\_\_\_  
(Must match with IRS Form SS4 or IRS Letter 147C. A copy should be attached.)  
Transit routing Number \_\_\_\_\_  
Account Number \_\_\_\_\_  
Financial Institution \_\_\_\_\_ Account Type  Checking  Savings

Please include a voided check or a letter verifying your account number from your financial institution.

Section 9

**DISCLOSURE**

**If you need to add additional Owner or Board of Director information, please attach an additional sheet.**

Are there any individuals who have direct or indirect ownership or controlling interest, separately or in combination, of 5% or more of your business?  
 Yes  No (If yes, please fill out the information below)

Name	Title	Address, City, Zip +4	SSN	Percentage
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Has any person listed above been convicted of a criminal offense related to his or her involvement in any program under Medicare, Medicaid, or the Title XIX Services program since the inception of those programs?  Yes  No (If yes, please fill out the information below)

Name	Title	Address, City, Zip+4	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Section 10

Has any person listed above been suspended or disbarred from participation in Medicare, Medicaid, or the Title XIX Services program since the inception of those programs?  Yes  No (If yes, please fill out the information below)

<i>Name</i>	<i>Title</i>	<i>Address, City, Zip+4</i>	<i>SSN</i>

List below any individuals who have an ownership interest of 5% or more in **any other disclosing entity**?  
 Yes  No (If yes, please fill out the information below)

<i>Name</i>	<i>Title</i>	<i>Address, City, Zip+4</i>	<i>SSN</i>	<i>Percentage</i>

Are there any corporations, organizations or other entities with an ownership or controlling interest of 5% or more of the business?  
 Yes  No (If yes, please fill out the information below)

<i>Name</i>	<i>Title</i>	<i>Address, City, Zip+4</i>	<i>SSN/TIN</i>	<i>Percentage</i>

Section 10 (cont)

Does your business have direct or indirect ownership or controlling interest amounting to an ownership interest of 5% or more of any subcontractor?  
 Yes  No (If yes, please fill out the information below)

Individual

<i>Name</i>	<i>Address, City, Zip+4</i>	<i>SSN/TIN</i>	<i>Percentage</i>

Organization

<i>Name</i>	<i>Address, City, Zip+4</i>	<i>SSN/TIN</i>	<i>Percentage</i>

Now tell us about those individuals who have 5% or more about those individuals who have 5% or more ownership interest in this subcontractor.

<i>Name</i>	<i>Address, City, Zip+4</i>	<i>SSN/TIN</i>	<i>Percentage</i>

Section 10 (cont)

Is there a Board Of Directors for your business?  Yes  No (If yes, please fill out the information below)

Name Title Address, City, Zip+4 SSN

Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

Yes  No (If yes, please enter date of filing) MM DD YYYY

**OHCA will provide a directory of providers on a public website. If you do not want to be listed in the directory, check the following box:**

Print Authorized Representative Name Authorized Representative Signature Date

**PROVIDER – Keep this copy for your records. It does not need to be returned to OHCA.**

## **SOONERCARE GENERAL PROVIDER AGREEMENT**

### **ARTICLE I. PURPOSE**

The purpose of this Agreement is for Oklahoma Health Care Authority (OHCA) and PROVIDER to contract for health-care services to be provided to members in Oklahoma Medicaid, known as SoonerCare, programs.

### **ARTICLE II. PARTIES AND DEFINITIONS**

#### **2.1 OHCA**

- a) OHCA is the single state agency that the Oklahoma Legislature has designated through 63 Okla. Stat. § 5009(B) to administer Oklahoma's Medicaid program, known as SoonerCare.
- b) OHCA has authority to enter into this Agreement pursuant to 63 Okla. Stat. § 5006(A). OHCA's Chief Executive Officer has authority to execute this Agreement on OHCA's behalf pursuant to 63 Okla. Stat. § 5008(B).
- c) OHCA's mailing address is: Oklahoma Health Care Authority, Attention: Provider Contracting, P.O. Box 54015, Oklahoma City, Oklahoma 73154.

#### **2.2 PROVIDER**

PROVIDER is an individual or entity that has supplied Provider Information to OHCA and executed this Agreement in order to provide health-care services to SoonerCare members.

#### **2.3 DEFINITIONS**

- a) **Choice** means a medical home program where members choose a primary care provider for care coordination and primary care provider. All other services are reimbursed on an FFS basis, but services not rendered by the primary care provider may require a referral.
- b) **Insure Oklahoma/Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan (IO IP)** means a comprehensive SoonerCare package that requires members to share in the cost through premiums and co-payments. IO members choose a primary care provider who is paid a monthly rate for case management. IO reimburses all other member benefits on a fee-for-service basis, but services not rendered by the primary care provider may require a referral.
- c) **Member** means a person receiving health care benefits from a SoonerCare program.
- d) **OHCA** means Oklahoma Health Care Authority.
- e) **Provider Information** means all information requested from and supplied by PROVIDER to OHCA through its Electronic Provider Enrollment (EPE) system or through a paper application form or other written communication from PROVIDER.
- f) **SoonerCare** means all OHCA medical benefit packages including Traditional, Choice, Insure Oklahoma, SoonerPlan and Supplemental.
- g) **SoonerPlan** means a limited package of family planning benefits.
- h) **Supplemental** means a SoonerCare plan that provides medical benefits to supplement those services covered by Medicare (sometimes called "crossover".)
- i) **Traditional** means a comprehensive SoonerCare package that pays providers for services on a fee-for-service basis.
- j) **Type** means the category of health-care services provider as delineated in OAC § 317: 30-1-1-et seq.

### **ARTICLE III. TERM**

- 3.1** This Agreement shall be effective upon completion when: (1) it is executed by Provider; (2) all necessary documentation has been received and verified by OHCA; and (3) it has been accepted by OHCA. OHCA acceptance is complete only upon written notification to PROVIDER by mail or electronic mail. The term of this Agreement shall expire as indicated in the Special Provisions for PROVIDER's Type.
- 3.2** PROVIDER shall not assign or transfer any rights, duties, or obligations under this Agreement without OHCA's prior written consent except as otherwise provided in this Agreement and applicable Addenda.

## ARTICLE IV. SCOPE OF WORK

### 4.1 General Provisions

Unless otherwise specified in the Special Provisions for PROVIDER's Type, PROVIDER agrees:

- a) To provide health-care services to SoonerCare members appropriate to PROVIDER's Type and in accordance with applicable professional standards;
- b) That all Provider Information supplied by PROVIDER is correct; PROVIDER may correct or update Provider Information through EPE or in writing (facsimile acceptable) to OHCA;
- c) To comply with all applicable statutes, regulations, policies, and properly promulgated rules of OHCA;
- d) That the state has an obligation under 42 USC § 1396a(a)(25)(A) to ascertain the legal liability of third parties who are liable for the health care expenses of members under the care of PROVIDER. Because of this obligation, PROVIDER agrees to assist OHCA, or its authorized agents, in determining the liability of third parties;
- e) To maintain all applicable licenses, certifications and/or accreditations as specified in the Special Provisions for PROVIDER's type during the term of this contract. Should PROVIDER's licenses, certifications and/or accreditations be modified, suspended, revoked, or in any other way impaired, PROVIDER shall notify OHCA in writing within three business days of such action. In the event PROVIDER's licenses, certifications and/or accreditations are modified, PROVIDER shall abide by the terms of the modified licenses, certifications and/or accreditations. In the event of suspension, revocation, or other action making it unlawful for PROVIDER to provide services under this Agreement, the Agreement shall terminate immediately. A violation of this paragraph, at the time of execution or during any part of the Agreement term, shall render the Agreement immediately void;
- f) That provision of services for purposes of this Agreement shall be limited to those services within the scope of the Oklahoma Medicaid State Plan reflected by properly promulgated rules; to the extent that services are not compensable under SoonerCare, the services may be provided but shall not be compensated by OHCA; PROVIDER acknowledges that covered services may vary between SoonerCare benefit plans;
- g) To maintain a clinical record system as follows:
  - (i) The system shall be maintained in accordance with written policies and procedures, which shall be produced to OHCA or its agent upon request;
  - (ii) PROVIDER shall designate a professional staff member to be responsible for maintaining the records and for ensuring they are completely and accurately documented, readily accessible, and systematically organized;
  - (iii) Each patient's record shall include, as applicable and in addition to other items set forth herein: member identification and personal, demographic and social data; evidence of consent forms; pertinent medical history; assessment of patient's health status and health-care needs; report of physical examination; brief summary of presenting episode and disposition; education and instruction to patient; all physician orders; diagnostic and laboratory test results; consultative findings; reports of treatments and medications; immunization records; preventive services; and other pertinent information necessary to monitor the patient. All entries must be legible, dated and include signatures of the physician and other health care professionals rendering the patient's care;
- h) To render services in an appropriate physical location, which shall include barrier-free access, adequate space for provision of direct services, appropriate equipment, proper exit signs, and a safe environment for patients;
- i) To train staff in handling medical and non-medical emergencies to ensure patient safety.
- j) To have a preventive maintenance program to ensure essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition.
- k) To develop and enforce policies and procedures in accordance with laws regarding communicable diseases. These policies and procedures shall include universal precautions. Including precautions related to Human Immunodeficiency Virus (HIV) serologically positive patients, which equal or exceed such standards established by the U.S. Occupational Safety and Health Administration;
- l) To comply and certify compliance with 42 USC §§1395 cc(a)(1), 1395cc(f), and 1396a(w) which require SoonerCare providers to provide patients with information about patients' rights

to accept or refuse medical treatment. PROVIDER shall educate staff and SoonerCare members concerning advance directives. PROVIDER shall include in each member's individual medical record documentation as to whether the member has executed an advance directive. PROVIDER shall not discriminate on the basis of whether an individual has executed an advance directive.

#### **4.2 Rights and Responsibilities Related to Member Co-payments and Collections**

- a) Pursuant to 42 CFR § 447.15, payments made by OHCA shall be considered payment in full for all covered services provided to a member, except for OHCA-allowed member co-payments.
- b) PROVIDER shall not bill a member or attempt in any way to collect any payment from a member for any covered service, except for co-payments allowed by OHCA. This provision is in force even if PROVIDER elects not to bill OHCA for a covered service. Violation of this provision may result in suspension of payments, recoupement of OHCA reimbursements and/or contract action up to and including contract termination.
- c) PROVIDER shall not require members to pay for services in advance, except for OHCA-allowed member co-payments.
- d) PROVIDER may collect an OHCA allowed co-payment from a member for a covered service and may use any legal means to enforce the member's liability for such co-payment.
- e) PROVIDER shall not deny covered services to eligible members because of their inability to pay a co-payment unless the member is enrolled in the IO IP benefit plan. PROVIDER may deny covered services to eligible IO IP members if they are unable to pay a co-payment. Provision of a covered service to a member unable to pay a co-payment does not eliminate the member's liability for that co-payment.

#### **4.3 Payments from OHCA**

- a) Unless otherwise specified in the Special Provisions for PROVIDER's Type, OHCA shall pay PROVIDER for services in accordance with the appropriate part of OHCA's Provider Manual §317: 30-1-1-et seq., Coverage by category and limitations.
- b) PROVIDER agrees and understands that payment cannot be made by OHCA to vendors providing services under federally assisted programs unless services are provided without discrimination on the grounds of race, color, religion, sex, national origin or handicap.
- c) PROVIDER shall accept payment from OHCA by direct deposit to PROVIDER'S financial institution. OHCA shall make payment in accordance with the information supplied by PROVIDER on the attached electronic funds transfer (hereafter EFT) form. PROVIDER shall update direct deposit information as needed by sending a signed EFT form to OHCA.
- d) PROVIDER shall release any lien securing payment for any SoonerCare compensable service. This provision shall not affect PROVIDER's ability to file a lien for non-covered service or OHCA-permitted co-payment.
- e) Satisfaction of all claims will be from federal and state funds. Any false claims, statements, or documents, or any concealment of a material fact may be prosecuted.
- f) Payments will be made to PROVIDER within forty-five (45) days of submission of a "clean claim" as such term is defined at 42 CFR § 447.45 (b). PROVIDER is entitled to interest in accordance with 62 Okla. Stat. § 41.4B (1991) for all payments not made within forty-five days after the clean claim has been submitted to OHCA or its claims payment agent.
- g) PROVIDER certifies with each claim for payment that that the services or products for which payment is billed by or on behalf of PROVIDER were medically necessary as defined by OAC 317:30-3-1(f) and were rendered by PROVIDER.

#### **4.4 Billing Procedures**

- a) PROVIDER agrees all claims shall be submitted to OHCA in a format acceptable to OHCA and in accordance with OHCA regulations. Electronic and/or Internet submitted claims may receive priority handling.
- b) If PROVIDER enters into a billing service agreement, PROVIDER shall be responsible for the accuracy and integrity of all claims submitted on PROVIDER's behalf by the billing service.

- c) PROVIDER shall not use the billing service or any other entity as a factor, as defined by 42 CFR § 447.10.
- d) PROVIDER is responsible for verifying a member's appropriate eligibility by contacting OHCA's Eligibility Verification System (EVS).

#### **4.5 Secure Website**

- a) OHCA may assign PROVIDER a user ID number and password that allows PROVIDER to access the secure website for the purpose of retrieving information about SoonerCare programs and members.
- b) PROVIDER agrees to protect access to the website by safeguarding user ID numbers and passwords.
- c) Confidentiality requirements in Article VII apply to all member information on the secure website, including information related to third party liability and prior authorizations for medical services.
- d) Pursuant to 21 Okla. Stat. § 1953, any person who willfully misuses a computer or computer information may be prosecuted.
- e) Any violation of the terms of this section or the confidentiality requirements of Article VII, including unauthorized use or modification of any information on the secure website, may result in suspension or termination of PROVIDER's access to the secure website.

### **ARTICLE V. LAWS APPLICABLE**

**5.1** The parties to this Agreement acknowledge and expect that over the term of this Agreement laws may change. Specifically, the parties acknowledge and expect (i) federal Medicaid statutes and regulations, (ii) state Medicaid statutes and rules, (iii) state statutes and rules governing practice of health care professions, and (iv) any other laws cited in this contract may change. The parties shall be mutually bound by such changes.

**5.2** As applicable, PROVIDER shall comply with and certifies compliance with:

- a) Age Discrimination in Employment Act, 29 USC § 621 et seq.;
- b) Rehabilitation Act, 29 USC § 701 et seq.;
- c) Drug-Free Workplace Act, 41 USC § 701 et seq.;
- d) Title XIX of the Social Security Act), 42 USC § 1396 et seq.;
- e) Civil Rights Act, 42 USC §§ 2000d et seq. and 2000e et seq.;
- f) Age Discrimination Act, 42 USC § 6101 et seq.;
- g) Americans with Disabilities Act, 42 USC § 12101 et seq.;
- h) Oklahoma Worker's Compensation Act, 85 Okla. Stat. § 1 et seq.;
- i) 31 USC § 1352 and 45 CFR § 93.100 et seq., which (1) prohibit the use of federal funds paid under this Agreement to lobby Congress or any federal official to enhance or protect the monies paid under this Agreement and (2) require disclosures to be made if other monies are used for such lobbying;
- j) Presidential Executive Orders 11141, 11246 and 11375 at 5 USC § 3501 and as supplemented in Department of Labor regulations 41 CFR §§ 741.1-741.84, which together require certain federal contractors and subcontractors to institute affirmative action plans to ensure absence of discrimination for employment because of race, color, religion, sex, or national origin;
- k) The Federal Privacy Regulations and the Federal Security Regulations as contained in 45 CFR Part 160 et seq. that are applicable to such party as mandated by the Health Insurance Portability and Accountability Act of (HIPAA), Public Law 104-191, 110 Stat. 1936, and HIPAA regulations at 45 CFR § 160.101 et seq.;
- l) Vietnam Era Veterans' Readjustment Assistance Act, Public Law 93-508, 88 Stat. 1578;
- m) Protective Services for Vulnerable Adults Act, 43A Okla. Stat. § 10-101 et seq.;
- n) Debarment, Suspension and other Responsibility Matters, 45 CFR §§76.105 and 76.110;
- o) With regard to equipment (as defined by 2 CFR 225) purchased with monies received from OHCA pursuant to this Agreement, 74 Okla. Stat. §§ 85.44(B) and (C), 45 CFR §74.34, 42 CFR 447.20 and 447.21.
- p) Federal False Claims Act, 31 USC § 3729-3733; 31 USC § 3801.

- 5.3 The explicit inclusion of some statutory and regulatory duties in this Agreement shall not exclude other statutory or regulatory duties.
- 5.4 All questions pertaining to validity, interpretation, and administration of this Agreement shall be determined in accordance with the laws of the State of Oklahoma, regardless of where any service is performed or product is provided.
- 5.5 The venue for legal actions arising from this Agreement shall be in the District Court of Oklahoma County, State of Oklahoma

#### **ARTICLE VI. AUDIT AND INSPECTION**

- 6.1 As required under 42 CFR 431.107, PROVIDER shall keep such records as are necessary to disclose fully the extent of services provided to members and shall furnish records and information regarding any claim for providing such service to OHCA, the Oklahoma Attorney General's Medicaid Fraud Control Unit (MFCU hereafter), and the U.S. Secretary of Health and Human Services (Secretary hereafter). PROVIDER agrees to keep records to disclose the services it provides for six years from the date of service. PROVIDER shall not destroy or dispose of records, which are under audit, review or investigation when the six-year limitation is met. PROVIDER shall maintain such records until informed in writing by the auditing, reviewing or investigating agency that the audit, review or investigation is complete.
- 6.2 Authorized representatives of OHCA, MFCU, and the Secretary shall have the right to make physical inspection of PROVIDER's place of business and to examine records relating to financial statements or claims submitted by PROVIDER under this Agreement and to audit PROVIDER's financial records as provided by 42 CFR § 431.107. If PROVIDER fails to submit records to OHCA or its agent within reasonable specified timeframes, all SoonerCare payments to PROVIDER may be suspended until records are submitted.
- 6.3 Pursuant to 74 Okla. Stat. § 85.41, OHCA and the Oklahoma State Auditor and Inspector shall have the right to examine PROVIDER's books, records, documents, accounting procedures, practices, or any other items relevant to this Agreement.
- 6.4 PROVIDER shall submit, within thirty-five days of a request by OHCA, MFCU, or the Secretary, all documents, as defined by 12 Okla. Stat. § 3234, in its possession, custody, or control concerning (i) the ownership of any subcontractor with whom PROVIDER has had business transactions totaling more than twenty-five thousand dollars during the twelve months preceding the date of the request, or (ii) any significant business transactions between PROVIDER and any wholly owned supplier or between PROVIDER and any subcontractor during the five years preceding the date of the request.
- 6.5 If PROVIDER is an entity other than an individual person, PROVIDER shall provide OHCA with information concerning PROVIDER's ownership in accordance with 42 CFR § 455.100 et. seq. PROVIDER agrees to update its Provider Information within twenty (20) days of any change in ownership. Ownership information is critical for determining whether a person with an ownership interest has been convicted of a program- crime under Titles V, XVIII, XIX, XX and XXI of the federal Social Security Act, 42 USC § 301 et seq. PROVIDER shall also furnish ownership information to OHCA upon further request.

#### **ARTICLE VII. CONFIDENTIALITY**

- 7.1 PROVIDER agrees that member information is confidential pursuant to 42 USC § 1396a(7), 42 CFR § 431:300-306, and 63 Okla. Stat. § 5018. PROVIDER shall not release the information governed by these requirements to any entity or person without proper authorization or OHCA's permission.
- 7.2 PROVIDER shall have written policies and procedures governing the use and removal of patient records from PROVIDER's facility. The patient's written consent shall be required for release of information not authorized by law, which consent shall not be required for state and federal personnel working with records of members.
- 7.3 PROVIDER agrees to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically 45 CFR Part 164.

## **ARTICLE VIII. TERMINATION**

- 8.1** This Agreement may be terminated by three methods: (i) Either party may terminate this Agreement for cause with a thirty-day written notice to the other party; (ii) either party may terminate this Agreement without cause with a sixty-day written notice to the other party; or (iii) OHCA may terminate the contract immediately (a) to protect the health and safety of members, (b) upon evidence of fraud, or (c) pursuant to Paragraph 4.1 (e) above.
- 8.2** In the event funding of SoonerCare from State, Federal or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract and prior to the anticipated Agreement expiration date, this Agreement may be terminated immediately by OHCA.
- 8.3** In the event of termination, PROVIDER shall provide any records or other assistance necessary for an orderly transition of SoonerCare members' health care.

## **ARTICLE IX. OTHER PROVISIONS**

- 9.1** The representations made in this memorialization of the Agreement constitute the sole basis of the parties' contractual relationship. No oral representation by either party relating to services covered by this Agreement shall be binding on either party. Any amendment to this Agreement shall be in writing, signed by PROVIDER and accepted by OHCA; OHCA acceptance is complete only upon written notification to PROVIDER by mail or electronic mail.
- 9.2** Attachments to this Agreement which are made part of the Agreement and incorporated by reference are (i) Special Provisions for PROVIDER's Type; and (ii) Provider Information.
- 9.3** If any provision of this Agreement is determined to be invalid for any reason, such invalidity shall not affect any other provision, and the invalid provision shall be wholly disregarded.
- 9.4** Titles and subheadings used in this Agreement are provided solely for the reader's convenience and shall not be used to interpret any provision of this Agreement.
- 9.5** OHCA does not create and PROVIDER does not obtain any license by virtue of this Agreement. OHCA does not guarantee PROVIDER will receive any patients, and PROVIDER does not obtain any property right or interest in any SoonerCare member business by this Agreement.

### **SPECIAL PROVISIONS FOR MEDICARE CROSSOVER CLAIMS PROVIDER**

1. PROVIDER desires reimbursement from Medicaid for Medicare “crossover claims” on behalf of SoonerCare members.
2. OHCA agrees to reimburse PROVIDER for services within the scope of its programs on a basis established by OHCA. Such reimbursement shall be consistent with the requirements of Title XIX of the Social Security Act.
3. PROVIDER agrees:
  - a. To submit Medicare payment records on SoonerCare members;
  - b. That by acceptance of payment from SoonerCare, PROVIDER is certifying that the services shown on the Medicare Explanation of Benefits were provided to the SoonerCare member;
  - c. To follow the appropriate statutory and regulatory restrictions of the state in which services provided under this Agreement are rendered.
4. The term of this Agreement shall expire December 31, 2012.