AMENDMENT to the AGREEMENT
Between
Magnum Regional Medical Center and Humana

This Amendment to the Hospital Participation Agreement ("**Amendment**") is hereby made and entered Into by and between **Magnum Regional Medical Center** ("**Hospital**") and **Humana Insurance Company and Humana Health Plan, Inc. ("Humana").**

WHEREAS, Hospital and **Humana** entered into a Hospital Participation Agreement ("Agreement") which was effective as of February 1, 2018.

WHEREAS, to the extent that this Amendment conflicts with the terms and conditions of the Agreement, including any prior amendments, addenda, exhibits, or attachments, this Amendment controls the relationship between the parties.

WHEREAS, any term not otherwise defined herein shall have the meaning as set forth in the Agreement.

NOW THERFORE, in consideration of the mutual promises and covenants contained herein, the parties agree to amend the Agreement as follows:

1. **Hospital** agrees to participate as a Participating Provider in Oklahoma Medicaid Network(s).

2. The Product Participation List Attachment is hereby incorporated herein.

3. The attached, OKLAHOMA MEDICAID PROVIDER REGULATORY ATTACHMENT, shall be added to and incorporated into the Agreement.

4. The attached, PAYMENT ATTACHMENT – OKLAHOMA MEDICAID, shall be added to and incorporated into the Agreement.

Except as specifically amended hereby, all other terms and conditions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have the authority necessary to bind the entities identified herein and have executed this Amendment to be effective as of .

HOSPITAL

Legal Entity: **Mangum City Hospital Authority dba Magnum Regional Medical Center**

Signature:

Printed Name:

Title:

Date:

Tax ID: 822087512

HUMANA

Signature:

Printed Name:

Title:

Date:

PRODUCT PARTICIPATION LIST

ATTACHMENT

Hospital agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by **Humana.**

Health Benefit Plans

Medicare PPO Plans	X
Medicare Network PFFS Plans	X
Medicare HMO Plans	X
Oklahoma Medicaid Plans	X

OKLAHOMA MEDICAID PROVIDER REGULATORY ATTACHMENT

The following additional provisions apply specifically to **Humana's** Oklahoma Medicaid products and plans and are hereby incorporated by reference into the Agreement. The provisions in this Oklahoma Medicaid Provider Regulatory Attachment ("**Attachment**") are required by the Oklahoma Health Care Authority ("OHCA") to be included in agreements between **Humana** and **Hospital**. In the event of a conflict between the terms and conditions of the Agreement and this Attachment, the terms and conditions of this Attachment shall control as they apply to **Humana's** Oklahoma Medicaid products and plans.

1. DEFINITIONS FOR THIS ATTACHMENT:

1.1 Member: A person enrolled in a **Humana** Oklahoma Medicaid managed care plan. Member may be referred to as patient, enrollee, client, customer, or beneficiary of Oklahoma's Medicaid products.

1.2 Provider Agreement: The provider participation agreement between **Humana** and **Hospital** to serve **Humana's** Members. This Attachment is attached to the Agreement. For purposes of this Attachment, "affiliate" means, when used with reference to a specific Humana Inc. organization, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with Humana Inc. Under this Agreement, Humana Wisconsin Health Organization Insurance Corporation is an affiliate and licensee of the Oklahoma Insurance Department authorized to transact business within the State of Oklahoma.

1.3 Contract: The agreement between **Humana** and Oklahoma Health Care Authority ("OHCA") for the provision of benefits to Members.

1.4 Covered Services: Medically necessary services for which benefits are payable under a Oklahoma Health Care Authority Medicaid managed care plan and pursuant to the Contract.

1.5 State: The State of Oklahoma or any other State of Oklahoma regulator authorized to oversee Sooner Select.

1.6 Sooner Select: The Oklahoma Medicaid medical assistance and benefit program under the Ensuring Access to Medicaid Act (56 O.S. 2021, Section 4002.1 et al.), as amended, Oklahoma Statute Title 56 et al., as amended, applicable Oklahoma Statutes and Oklahoma Administrative Code, and federal laws and regulations.

1.7 Regulatory Rules: All applicable statutes, codes, regulations, including, but not limited to, 42 C.F.R. 422; 438 et al.; Oklahoma Statute Title 56 et al., including but not limited to 56 O.S. 2021, Section 4002.1 et al.; Oklahoma Administrative Code, including but not limited to Title 317 et al.; OHCA policy, guidance, and program requirements issued by the State including without limitation the Request for Proposals Solicitation Number 8070000052 and OHCA Sooner Select policies and program manuals and guides.

2. GENERAL:

2.1 Humana shall be responsible for maintaining the Agreement in accordance with *42.C.F.R. §* 438.214.

2.2 Notwithstanding anything to the contrary in the Provider Agreement, **Humana** may modify this Attachment to include provision(s) required by OHCA by providing thirty (30) days' advance written notice to **Hospital,** or any such shorter notice if required by OHCA. Upon the conclusion of the notice period, the provision(s) set forth in the notice shall be incorporated into the Provider Agreement as if fully set forth therein and shall be binding on the parties. **Humana** will secure OHCA's approval prior to any such updates becoming effective. A current version of this Attachment is available in the online **Humana** Oklahoma Medicaid Provider Manual.

2.3 Incorporation of Contract. All applicable provisions of the Contract and other requirements imposed by the OHCA on SoonerSelect or similar Medicaid benefit offered in Oklahoma and administered by Humana are incorporated herein and shall at all times be administered in accordance and consistent with the Contract. Contract requirements that are not set forth in this underlying

Agreement are included in Exhibits, Schedules, Attachments, and Addendums to this Agreement and include the applicable Contract requirements attached hereto. Notwithstanding the foregoing, any Contract requirements applicable to the performance of this Agreement by **Humana** or **Hospital** (or its delegate or subcontractor) shall bind **Humana** and **Hospital** whether or not expressly set forth herein. **Hospital** agrees to comply with all applicable terms and conditions of the Contract as well as all Regulatory Rules and applicable OHCA and federal statutes, regulations, policies, procedures and rules.

2.4 Hospital certifies that **Hospital** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally funded health care program or the Oklahoma Medicaid program.

2.5 OHCA shall have the right to amend these regulatory requirements as it deems necessary.

2.6 Notwithstanding anything to the contrary in the Agreement, parties represent, independently and not on behalf of the other, each respectively: (i) is properly licensed and insured per State limits, (ii) is legally organized and validly existing under Regulatory Rules, (iii) is in good standing with the State, and (iv) intends to transact intrastate business within the State of Oklahoma.

3. PROVDER REQUIRED PROVISIONS:

3.1 Hospital shall indemnify and hold the State and OHCA harmless from all claims, losses, or suits relating to activities undertaken by the **Hospital** pursuant to the Contract.

3.2 If the OHCA determines that any provision in the Agreement conflicts with the Contract, such provision shall be null and void and all other provisions shall remain in full force and effect.

3.3 Hospital is not a third-party beneficiary **Hospital** is not a third-party beneficiary to the Contract. **Hospital** shall be considered an independent contractor performing services as outlined in the Contract**.**

3.4 Hospital shall maintain through the terms of the Agreement and at its own expense professional and comprehensive general liability and medical malpractice insurance at no less than OHCA minimums, as directed.

3.5 Hospital agrees to adhere to all **Humana** credentialing and recredentialing and State enrollment requirements under the Agreement and Regulatory Rules, without limitation **Humana** Manual and State Manuals.

4. MARKETING:

4.1 The **Hospital** shall adhere to the Regulatory Rules marketing restrictions as applicable and requirements described in the Contract.

4.2 In accordance with § 1932 (b)(3)(A) of the Social Security Act, **Humana** shall not prohibit or otherwise restrict **Hospital** acting within the scope of the **Hospital's** license from advising or advocating on behalf of Members for the following:

a. Member health status, medical care or treatment options, including any alternative treatment that may be self-administered;
b. Any information a Member needs to decide among all relevant treatment options;
c. The risks, benefits and consequences of treatment or non-treatment; or
d. Member’s right to participate in decisions regarding Member’s health care, including the right to refuse treatment and to express preferences about future treatment decisions.

5. PROVISION OF SERVICES:

5.1 Hospital shall provide Members all Covered Services that are within the normal scope of and in accordance with **Hospital’s** licenses and/or certifications, and Members access to those Covered Services through making appointments or otherwise making contact with the **Hospital**.

5.2 Any **Hospital**, including **Hospital** ordering or referring a Covered Service, must have a National Provider Identifier (NPI), to the extent such **Hospital** is not an atypical provider as defined by CMS.

5.3 Hospital shall meet applicable appointment waiting time standards set forth in the Contract and Regulatory Rules which include:

a. For Adult and Pediatric Primary Care Providers ("PCP's):
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seventy-two (72) hours for non-urgent sick visits;
   iii. Within twenty-four (24) hours for urgent care.
   iv. Each PCP shall allow for at least some same-day appointments to meet acute care needs.

b. For OB/GYN Providers:
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seventy-two (72) hours for non-urgent sick visits;
   iii. Within twenty-four (24) hours for urgent care.

   For maternity care:
   i. First Trimester – Not to exceed fourteen (14) calendar days;
   ii. Second Trimester – Not to exceed seven (7) calendar days;
   jjj, Third Trimester – Not to exceed three (3) calendar days.

c. For Adult and Pediatric Specialty Providers:
   i. Not to exceed sixty (60) days from the date of request for routine appointments;
   ii. Within twenty-four (24) hours for urgent care.

d. For Adult and Pediatric Mental Health and Substance Use Providers:
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seven (7) days for residential care and hospitalization;
   iii. Within twenty-four (24) hours for urgent care.

6. TERMINATION:

6.1 Humana may deny, refuse to renew or terminate any Provider Agreement in accordance with the terms of the Contract and any applicable statutes and regulations.

6.2 Humana and **Hospital** shall have the right to terminate the Provider Agreement . Either party may terminate the Provider Agreement for cause with thirty (30) Days advance written notice to the other party and without cause with sixty (60) Days advance written notice to the other party.

6.3 In the event of termination of the Agreement, the **Hospital** shall immediately make available to OHCA or its designated representative in a usable form any or all records whether medically or financially related to the terminated **Hospital's** activities undertaken pursuant to the Provider Agreement and that the provision of such records shall be at no expense to OHCA.

6.4 OHCA shall have the right to direct **Humana** to terminate any Provider Agreement if OHCA determines that termination is in the best interest of the State of Oklahoma.

6.5 OHCA shall have the right to deny enrollment or terminate a Provider Agreement with a **Hospital** as provided under State and/or federal law.

7. MEMBER SERVICES:

7.1 Hospital shall abide by Member rights and responsibilities denoted in the **Contract**. A listing of Member rights and responsibilities may be found within the Humana Healthy Horizons in Oklahoma Provider Policies and Procedures Manual available on Humana's website https://www.Humana.com/provider/news/publications

7.2 Hospital shall display notices of Member Rights to Grievances, Appeals, and State Fair Hearings in public areas of the **Hospital's** facility/facilities in accordance with all State requirements and any subsequent amendments.

7.3 Hospital shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3).

7.4 Hospital shall accommodate the presence of interpreters in accordance with SoonerSelect.

7.5 Hospital in accordance with § 1932(b)(6) of The Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), shall hold Member harmless for the costs of covered services except for any applicable Co-payment amount allowed by OHCA.

7.6 Hospital shall render emergency services without the requirement of prior authorization.

7.7 Member information shall be kept confidential, as defined by State and federal laws, regulations, and policy.

7.8 Hospital agrees to comply with necessary and authorized Member communications, movement, and/or re-assignment, as required or compelled by the State or authorized enforcement body under the Regulatory Rules.

7.9 Tobacco Free Requirements: **Hospital** shall be required to implement and provide a tobacco-free campus in accordance with the standards of the Tobacco Free policy of the State of Oklahoma 63 O. S. § 1-1523 and Executive Order 2013-43.

8. RECORDS MAINTENCE AND AUDIT REQUIREMNTS:

8.1 Hospital shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. Members and their representatives shall be given access to and can request copies of the Members' medical records to the extent and in the manner provided under State or federal law.

8.2 Hospital shall maintain all records related to services provided to Members for a ten-year period. In addition, **Hospital** shall make all Member medical records or other service records available for any quality reviews that may be conducted by **Humana**, OHCA or its designated agent(s) during and after the term of the Provider Agreement.

8.3 In accordance with 42 C.F.R. § 438.208(b)(5), **Hospital** shall furnish services to Members to maintain and share Member health records in accordance with professional standards.

8.4 Hospital with CMS certified Electronic Health Records (EHR) systems shall connect to the State Health Information Exchange (HIE) for the purpose of bi-directional health data exchange. **Hospital** who do not have a certified EHR shall be required to use the State HIE provider portal to query patient data for enhanced patient care.

8.5 If **Hospital** does not have an EHR, they must still sign a participation agreement with the State HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other providers in their community of care.

8.6 Hospital shall sign a participation agreement with the State HIE within one month of contract signing.

8.7 Authorized representatives of OHCA and other State or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the Provider Agreement.

8.8 Hospital shall release to **Humana** any information necessary to monitor **Hospital** performance on an ongoing and periodic basis.

8.9 Network hospitals, long term care facilities and emergency departments (EDs) shall send electronic patient event notifications of a patient's admission, discharge, and/or transfer (ADT) to the state HIE.

9. QUALITY AND UTILZATION MANGEMENT:

9.1 Humana shall monitor utilization of the quality of services delivered under the Provider Agreement. **Hospital** shall participate and cooperate with any internal and external QM/QI monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or **Humana** and shall participate in any corrective action processes that will be taken where necessary to improve quality of care.

9.2 Hospital shall timely submit all reports, clinical information, and encounter data required by **Humana** and OHCA.

9.3 Hospital shall participate and cooperate in internal and external quality management or quality improvement activities, such as, monitoring, utilization review, peer review and/or appeal procedures established by **Humana** and/or OCHA.

9.4 Hospital shall follow the standards for medical necessity as required under the Contract and the Regulatory Rules.

9.5 Hospital and Humana agree to participate in **Humana** and OHCA directed and facilitated advisory board.

10. PROGRAM INTEGRITY:

10.1 As a condition of receiving any amount of payment, **Hospital** shall comply with program integrity requirements of the Contract and the Regulatory Rules, as applicable.

10.2 Hospital shall agree that no person, on the grounds of disability, age, race, color, religion, sex, bisexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of **Humana's** program or otherwise subjected to discrimination in the performance of the Provider Agreement with **Humana** or in the employment practices of the **Hospital**.

10.3 Hospital shall identify Members in a manner which will not result in discrimination against the Member in order to provide or coordinate the provision of Covered Services.

10.4 Hospital shall not use discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days or preference to private pay patients.

10.5 Hospital shall take adequate steps to promote the delivery of services in a culturally competent manner to Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

10.6 Hospital shall comply with all State and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with Members and/or access to Members' Protected Health Information. **Hospital** are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed in Section "Prohibited Affiliations and Exclusions" of the Contract.

10.7 Hospital shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with State and federal law. The **Hospital** shall be required to immediately report to **Humana** any exclusion information discovered.

11. PROVIDER COMPLIANCE PROGRAM:

11.1 Hospital agrees to maintain and update, as required, its compliance program with no less than written policies and procedures of its business model, roles and responsibilities of its treating and member-facing personnel, organizational chart, succession planning, ownership, background checks

for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste, and abuse employee training as required.

12. CLAIMS AND PAYMENT:

12.1 Hospital shall promptly submit all information needed for **Humana** to make payment for authorized items, services, or procedures under Member's Oklahoma health benefit plan.

12.2 Hospital shall submit timely, complete, and accurate encounter claims in accordance with the Contract and Regulatory Rules.

12.3 Hospital shall submit all claims that do not involved a third-party payer for services rendered to **Humana's** Members within one hundred and eighty (180) days or less from the date of service. Resubmitted claims, when applicable, shall be submitted within an additional one hundred and eighty (180) days from the date of service.

12.4 Humana shall make timely payment to the **Hospital** for Covered Services upon approval of a clean claim properly submitted by the **Hospital** within the required timeframes. **Humana** shall only accept uniform claim forms submitted by **Hospital** that have been approved by the Administration and completed according to Administration guidelines.

12.5 Hospital shall accept payment from **Humana** as payment for services performed and cannot request payment from the Administration or the Member, unless the Member is required to pay a Copayment for the service rendered.

12.6 Humana will provide at least thirty (30) days written notice to **Hospital** prior to any change in payment structure or reimbursement amount, unless mandated otherwise by OHCA upon which **Humana** will notify **Hospital** of the effective date of change. The written notice will contain clear and detailed information about the change and will not be retroactive, unless mandated by Administration.

12.7 Hospital shall adhere to the responsibilities and prohibited activities regarding SoonerSelect program cost sharing. When the covered service provided requires a copayment, as allowed by **Humana**, the **Hospital** may charge the Member only the amount of the allowed copayment, which cannot exceed the copayment amount allowed by OHCA. **Hospital** shall accept payment made by **Humana** as payment in full for Covered Services, and the **Hospital** shall not solicit or accept any surety or guarantee of payment from the Member, OHCA or the State.

12.8 Hospital shall be obligated to identify Member third party liability coverage, including Medicare and long-term care insurance as applicable; and except as otherwise required, the **Hospital** shall seek such third party liability payment before submitting claims to **Humana** by making all reasonable attempts, but no less than three good faith, documented attempts to pursue Third Party Liability of Members.

13. GRIEVANCES AND APPEALS:

13.1 In accordance with the Agreement and Regulatory Rules, including but not limited to 42 C.F.R. §§ 438.414 and 438.10(g)(2)(xi), the **Hospital** has the right to file an internal appeal with **Humana** regarding denial of the following:

a. A health care service;
b. Timely submitted claim for reimbursement;
c. Payment to **Hospital** on **Hospital's** clean claim.

Members may file a grievance at any time, but an appeal must be filed within sixty (60) days of notice of the adverse determination which the Member wishes to appeal. Assistance from Humana is available to Members for filing grievance and appeals. Members have a right to request a State Fair Hearing after Humana has made an adverse determination on the Member's appeal. Members have a right to request continuation of the benefits subject to the appeal or State filing, subject to timing requirements of the filing; and Members may be liable for the cost of any continued benefits while the appeal or State filing is pending if the final decision upholds **Humana's** adverse determination.

13.2 Humana shall take no punitive action against a **Hospital** who either requests an expedited resolution or supports a Member's grievance or appeal. Additional details on grievance and appeals process may be found within **Humana's** Oklahoma Provider Manual available on **Humana's** website (https://www.humana.com/provdier/news/publications).

14. PROVISIONS APPLICABLE TO PRIMARY CARE PROVIDERS:

14.1 If **Hospital** is considered a Primary Care Provider ("PCP"), **Hospital** shall also be responsible for the following:

a. Deliver primary care services and follow-up care;
b. Utilize and practice evidence-based medicine and clinical decision supports;
c. Screen Members for behavioral health disorders and conditions;
d. Make referrals for specialty care and other Covered Services and, when applicable, work with **Humana** to allow Members to directly access a specialist as appropriate for a Member's condition and identified needs;
e. Maintain a current medical record for the Member;
f. Use health information technology to support care delivery;
g. Provide care coordination in accordance with the Member's care plan, as applicable based on **Humana's** Risk Stratification Level Framework, and in cooperation with Member's care manager;
h. Ensure coordination and continuity of care with **Hospital**, including but not limited to specialists and behavioral health **Hospital**;
i. Engage in active participation with the Member and the Member's family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and care plan development;
j. Provide access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other **Hospital**, clinics and/or local hospitals;
k. Provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
l. Participate in continuous quality improvement and voluntary performance measures established by **Humana** and/or OHCA.

14.2 If the **Hospital** is eligible for participation in the Vaccines for Children program, **Hospital** shall comply with all program requirements as defined by OHCA.

15. MENTAL HEALTH PARITY:

15.1 Humana and **Hospital** must comply with applicable requirements of the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by **Humana** and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

16. PROVISIONS APPLICABLE TO BEHAVIORAL HEALTH SERVICE PROVIDERS:

16.1 Behavioral Health Providers providing inpatient psychiatric services to Members shall schedule the Member for outpatient follow-up or continuing treatment prior to discharge from the inpatient setting with the outpatient treatment occurring within seven calendar days from the date of discharge.

16.2 Behavioral Health **Hospital** shall complete the OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the Contract.

16.3 Behavioral Health **Hospital** shall provide treatment to pregnant Members who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.

16.4 Humana shall obtain the appropriate Member releases to share clinical information and Member health records with community-based behavioral health **Hospital**, as requested, consistent with all State and federal confidentiality requirements and in accordance with **Humana** policy and procedures.

17. PROVISIONS APPLICABLE TO PROVIDERS WITH LABORATORY SERVICES:

17.1 Hospital with laboratory testing sites shall either have a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Humana shall be responsible for maintaining a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Members.

18. NON-ALLOWABLE PROVISIONS:

18.1 Any non-compete contractual provision (that prohibits **Hospital** from entering into a contractual relationship with another managed care organization or Indian Managed Care Entity) between **Hospital** and **Humana** shall not apply to the Oklahoma Medicaid line of business.

18.2 The parties acknowledge and agree that nothing contained in this Agreement is intended to disrupt the **Hospital** and **Member** relationship, and **Hospital** acknowledges that all patient care and related decisions are the responsibility of the **Hospital** and attending physicians, and that Humana does not dictate or control clinical decisions with respect to the behavioral health care or treatment of Members.

PAYMENT ATTACHMENT – OKLAHOMA MEDICAID

INPATIENT / OUTPATIENT

Provider agrees to accept as payment in full from **Humana** one hundred percent (100%) of the current Oklahoma Medicaid Fee Schedule, or **Provider**'s usual and customary charges, whichever is less, for Oklahoma Medicaid **Covered Services** rendered to **Humana** Oklahoma Medicaid **Members**, less any applicable copayment, coinsurance, or deductible due from a **Member**.

For purposes of this Payment Attachment, "Oklahoma Medicaid Fee Schedule" shall mean the Medicaid fee-for-service fee schedule set and determined by the Oklahoma Health Care Authority ("OHCA")

In addition, **Provider** understands and agrees that the Oklahoma Medicaid Fee Schedule reimbursement rate shall be the reimbursement rate in effect on the date of service the **Covered Services** are rendered.

HOSPITAL-BASED RURAL HEALTH CENTER REIMBURSEMENT

The compensation for Covered Services rendered to a Member shall be the amount determined by federal law or regulation for Rural Health Clinics. 317 O.A.C. 55-5-23(b)(2). If Health Plan's payment obligation is secondary, Provider shall receive compensation as described above, less amounts paid by the primary payor and any applicable Cost-Sharing Amounts.

Humana acknowledges the SoonerCare Reimbursement Notice, OHCA PRN 2019-09, updating RHC methodology effective July 1, 2019, RHCs have the option to be paid using an alternative payment methodology (APM) if the RHC elects. RHC services paid using the APM are reimbursed at the rate indicated on the facilities periodic rate notification letter from the Medicare Fiscal Intermediary. In order to receive this rate, a RHC must agree to the APM and forward a copy of the facilities' periodic rate notification letter for its most recent full cost reporting year from the fiscal intermediary to the Health Plan within 30 days of receipt. The APM rate a facility receives will not be less than prospective payment system (PPS). There is no retroactive cost settlement.

Health Plan agrees to comply with the updated RHC methodology and reimburse Provider according to the most current periodic rate notification letter for its most current cost reporting year received from CMS Fiscal Intermediary. Provider's failure to provide a copy of the rate notification letter within 30 days of receipt may result in a reduction in payments by Health Plan.

OWNERSHIP DISCLOSURE FORM

Provider:

_____

(Must be identical to the name shown on the Cover Sheet.)

STATUS:

_____ Sole Proprietorship

_____ Professional Association

_____ Partnership or Limited Liability Company

_____ Corporation

List names and addresses of all principals and indicate percent of ownership, if applicable. ("Principal" means any shareholder, officer, director, partner, member, manager, joint venturer or anyone else having an ownership in or managerial control over IPA.) Attach additional sheets if necessary.

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