

Choose an item.

Medicaid Addendum

This Addendum supplements the Base Contract between Choose an item. and **Provider Name** effective **Date** and runs concurrently with the terms of the Base Contract. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

ADDENDUM DEFINITIONS

Agreement/ Base Contract	The contract between the MCP and the subcontractor (delegated entity).
Managed Care Plan (MCP)	A Medicaid managed care plan that enters into a provider agreement with ODM to serve Medicaid consumers, which may include dually-eligible consumers who are enrolled in the MyCare Ohio program (aka Integrated Care Delivery System or ICDS) Plans.
Medicaid	Medical assistance provided under a state plan approved under Title XIX of the Social Security Act.
Member	A Medicaid recipient enrolled under the care management system pursuant to ORC 5167.
OAC	Ohio Administrative Code.
ODM	Ohio Department of Medicaid.
ORC	Ohio Revised Code.
Provider	A hospital, health care facility, physician, dentist, pharmacy or otherwise licensed, certified, or other appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCP's member.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

Participating providers providing health care services to Choose an item.'s Medicaid members agree to abide by all of the following specific terms:

1. Provider agrees with the exception of any member co-payments the MCP elected to implement in accordance with OAC rule 5160-26-12, the MCP's payment constitutes payment in full for any covered service and will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise. This agreement does not prohibit Nursing Facilities (NFs) or waiver entities from collecting patient liability payments from members as specified in OAC rule 5160:1-3-24 or Federally Qualified Health Centers (FQHCs) and Rural

Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC rules 5160-28-07 and 5160-16-05.

A. MCP shall notify the provider whether the MCP elected to implement any member co-payments and if applicable under what circumstances member co-payments are imposed in accordance with OAC rule 5160-26-12.

B. Provider agrees member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

2. Provider agrees not to hold liable ODM and the member in the event the MCP cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exception that:
 - A. FQHCs and RHCs may be reimbursed by ODM in the event of MCP insolvency pursuant to Section 1902(bb) of the Social Security Act,
 - B. The provider may bill the member when the MCP has denied prior authorization or referral for the services and the following conditions are met:
 - i. The member was notified by the provider of the financial liability in advance of service delivery;
 - ii. The notification by the provider was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and
 - iii. The notification is dated and signed by the member.
3. Provider agrees to cooperate with the MCP's quality assessment and performance improvement (QAPI) program in all the MCP's provider subcontracts and employment agreements for physician and nonphysician providers.
4. The MCP shall disseminate written policies that include detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCP's policies and procedures for detecting and preventing fraud, waste and abuse; and the provider agrees to abide by the MCP's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.
5. Provider agrees to cooperate with the ODM external quality review as described in OAC Chapter 5160, including rule 5160-26-07.
6. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation and termination

apply to this Addendum.

7. Notwithstanding item 6 of this Addendum, the MCP must give the provider at least sixty days prior notice for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency or health or safety risks dictate that the Base Contract be terminated sooner.
8. Notwithstanding item 6 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:
 - A. The provider gives the MCP at least sixty days prior notice for the nonrenewal or termination of the Base Contract. The effective date for the nonrenewal or termination must be the last day of the month; or
 - B. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless whether the action is appealed. The provider's nonrenewal or termination notice must be received by the MCP within fifteen working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month
9. The procedures to be employed upon the ending, nonrenewal, or termination specified in the Base Contract, apply to this Addendum including an agreement to promptly supply all records necessary for the settlement of outstanding claims.
10. Notwithstanding Items 7 and 8 of this Addendum, in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider agrees to notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues fewer than forty-five days prior notice to the MCP, the notice to providers who have admitting privileges at the hospital must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.
11. Provider agrees to release to the MCP any information necessary for the MCP to perform any of its obligations under the ODM provider agreement, including, but not limited to compliance with reporting and quality assurance requirements. Provider agrees the released information will be shared with ODM upon request to the MCP.
12. Provider must supply, upon request, the business transaction information required under 42 C.F.R. 455.105.
13. Provider and all employees of the provider are duly registered, licensed or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract and provider and all employees of the provider are not excluded

from participating in federally funded health care programs.

14. If the provider is a Medicaid provider, provider must meet the qualifications specified in OAC Chapter 5160, including rule 5160-26-05(C).
15. All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.
16. Home health providers must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of the Ohio Revised Code.
17. Provider shall be compensated pursuant to the method and in the amounts specified in **Schedule, Exhibit, Appendix** of the **Agreement, Addendum, or Amendment**. Name the document and section of the document that specifies compensation. (Example: Schedule IV, Appendix B of the Agreement)
18. Provider agrees to provide services to all eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement. Indicate one or both:
 Medicaid non-dual populations MyCare Ohio Medicare/Medicaid populations
19. Provider agrees to provide services to MyCare Ohio consumers within the designated service area.
20. If the provider is a third party administrator (TPA), the provider agrees to include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontractors will forward information to ODM as requested.
21. Provider agrees to provide services as enumerated in **Attachment D** of this Addendum (within the provider's scope of practice).
22. Provider agrees to serve members through the last day the Base Contract is in effect.
23. Any amendment to the Attachment D and (Schedule, Exhibit, or Appendix) specified in item 17 of the addendum must be agreed to in writing by both parties.
24. If provider is a primary care provider (PCP), provider agrees to participate in the care coordination requirements outlined in OAC Chapter 5160, including rule 5160-26-03.1.
25. If provider is a hospital or hospital system, the Addendum must include the completed ODM Hospital Services Form, Attachment C of this addendum, which specifies which services of the hospital are included in the Base Contract.
26. MCP agrees not to prohibit, or otherwise restrict a provider acting within the lawful scope of

practice, from advising or advocating on behalf of a member who is his or her patient for the following:

- A. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - B. Any information the member needs in order to decide among all relevant treatment options.
 - C. The risks, benefits, and consequences of treatment versus non-treatment.
 - D. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
27. Provider agrees in providing health care services to members to identify and where indicated arrange, pursuant to the mutually agreed upon procedures between the MCP and provider for the following at no cost to the member:
- A. Sign language services.
 - B. Oral interpretation and oral translation services.
28. MCP agrees to fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCP's denial of payment of a Medicaid service, as specified in OAC Chapter 5160 including rule 5160-26-08.4, utilizing the procedures and forms as specified in OAC rule 5101:6-2-35.
29. Provider agrees to contact the MCP's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC Chapter 5160, including rule 5160-26-03(G).
30. Provider agrees not to identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.
31. Provider agrees not to bill members for missed appointments.
32. Provider shall not discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.
33. Provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

34. Provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status, or ancestry.
35. Provider shall be bound by the same standards of confidentiality which apply to ODM and the state of Ohio as described in OAC rule 5160:1-1-51.1 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).
36. Provider agrees their applicable facilities and records will be open to inspection by the MCP, ODM or its designee, or other entities as specified in OAC rule 5160-26-06.
37. Provider agrees the Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCP.
 - A. ODM will notify the MCP and the MCP shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCP.
 - B. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.
 - C. The MCP shall notify the provider of all applicable contractual obligations.
38. Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.
39. Provider must retain and agrees to allow the MCP access to all member medical records for a period of not fewer than eight years from the date of service or until any audit initiated within the eight year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06. At least three of the eight year-period of documentation must be readily available.
40. Provider agrees to make patient medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the patient.

The Ohio Department of Medicaid permit changes to Attachments A, B, C and/or D by mutual written agreement of both parties and without renegotiation of the Base Contract or this Addendum.

Signatures	
MCP Name: <u>Choose an item.</u>	Provider Name:
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

Attachment A: Primary Care Provider Attestation

To be completed for Primary Care Providers (PCPs) only. ‘Capacity’ represents the maximum number of the MCP’s Medicaid-only members the primary care provider (PCP) agrees to serve. PCPs individually or as part of a group, must serve a minimum of 50 of the MCP’s Medicaid members at each practice site in order to be listed in the MCP’s provider directory. **List all PCP names are contracted with to provide services to Medicaid Members.**

<u>Practice Site</u>	<u>Physician Name</u>	<u>Capacity Max.</u>
1. Group Name	Name	Maximum #
Address	Name	Maximum #
City Zip Code	Name	Maximum #
	Name	Maximum #
	Name	Maximum #
2. Group Name	Name	Maximum #
Address	Name	Maximum #
City Zip Code	Name	Maximum #
	Name	Maximum #
	Name	Maximum #
3. Group Name	Name	Maximum #
Address	Name	Maximum #
City Zip Code	Name	Maximum #
	Name	Maximum #
	Name	Maximum #

Total: _____

If the practice has more than two locations or more than five PCPs at a location, provide the information requested above in an attached document titled ‘Attachment A.’ If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Signatures	
MCP Name: <u>Choose an item.</u>	Provider Name:
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

Attachment B: Non-Primary Care Providers Only

List all **non-PCP** names are contracted with to provide services to Medicaid Members.

	<u>PRACTICE SITE</u>	<u>PROVIDER NAME</u>	<u>SPECIALTY</u>
1.	GROUP NAME	NAME	SPECIALTY
	ADDRESS	NAME	SPECIALTY
	CITY, ZIP CODE	NAME	SPECIALTY

2.	GROUP NAME	NAME	SPECIALTY
	ADDRESS	NAME	SPECIALTY
	CITY, ZIP CODE	NAME	SPECIALTY

3.	GROUP NAME	NAME	SPECIALTY
	ADDRESS	NAME	SPECIALTY
	CITY, ZIP CODE	NAME	SPECIALTY

If the practice has more than three locations or more than (5) providers at a location, please provide the requested information in a document titled 'Attachment B'. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the last page must be signed by the provider and the MCP.

Signatures	
MCP Name: <u>Choose an item.</u>	Provider Name:
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

Attachment C: Hospital Services Form

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the signature block must be included on the each page.

1. Name and Address

Hospital Name: Click here to enter text.
Address: (including county): Click here to enter text.

2. Hospital Services Categories

Please check the applicable line for each category of service the above-named hospital covers.

<input type="checkbox"/> Adult General Medical/Surgical Services	<input type="checkbox"/> Midwife Services
<input type="checkbox"/> Pediatric General Medical/Surgical Services	<input type="checkbox"/> Outpatient Surgery
<input type="checkbox"/> Obstetrical Services	<input type="checkbox"/> Pediatric Intensive Care
<input type="checkbox"/> Nursery Services	<input type="checkbox"/> Special Care
<input type="checkbox"/> Nursery Services Level 1 & 2	<input type="checkbox"/> Psychiatric Services
<input type="checkbox"/> Neonatal Intensive Care -- Level 3	<input type="checkbox"/> Practitioner Services
<input type="checkbox"/> Adult Intensive Care	<input type="checkbox"/> Other

3. Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds. List Services :

Signatures	
MCP Name: Choose an item.	Provider Name:
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

Attachment D: Services Provided

Provider agrees to provide services as enumerated below (specify below):

<input type="checkbox"/> Ambulance transportation	<input type="checkbox"/> Mental health and/or substance abuse services
<input type="checkbox"/> Ambulette transportation	<input type="checkbox"/> Nursing facility services
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Obstetrical and/or gynecological services
<input type="checkbox"/> Advanced practice nurse services specify: _____	<input type="checkbox"/> Ophthalmology services
<input type="checkbox"/> Chiropractic services	<input type="checkbox"/> Outpatient hospital services
<input type="checkbox"/> Dental services	<input type="checkbox"/> Physical and occupational therapy
<input type="checkbox"/> Durable medical equipment (DME)	<input type="checkbox"/> Podiatry services
<input type="checkbox"/> Emergency Services	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Family planning services and supplies	<input type="checkbox"/> Physician services
<input type="checkbox"/> Federally Qualified Health Center services	<input type="checkbox"/> Primary care provider services
<input type="checkbox"/> Home health services/Private Duty Nursing	<input type="checkbox"/> Renal dialysis
<input type="checkbox"/> Hospice care	<input type="checkbox"/> Rural Health Clinic services
<input type="checkbox"/> Medical Imaging	<input type="checkbox"/> Specialty physician services, Specify (e.g., cardiology, allergy, etc): _____
<input type="checkbox"/> Inpatient hospital services	<input type="checkbox"/> Speech and hearing services
<input type="checkbox"/> Laboratory services	<input type="checkbox"/> Vision (optical) services, including eyeglasses
<input type="checkbox"/> Other Click here to enter text.	

Community Behavioral Health Services (included only in the MyCare Ohio benefit package)

<input type="checkbox"/> Pharmacological Management	<input type="checkbox"/> Ambulatory Detox
<input type="checkbox"/> Behavioral Health Assessment	<input type="checkbox"/> Targeted Case Management for AOD
<input type="checkbox"/> Behavioral Health Counseling and Therapy	<input type="checkbox"/> Intensive Outpatient
<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Laboratory urinalysis
<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Med –Somatic
<input type="checkbox"/> Community Psychiatric Support Treatment	<input type="checkbox"/> Methadone Administration

Home and Community Based Services (included only in the MyCare Ohio benefit package)

** indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.*

<input type="checkbox"/> Out of Home Respite Services	<input type="checkbox"/> Waiver Nursing Services
<input type="checkbox"/> Adult Day Health Services	<input type="checkbox"/> Home Delivered Meals*
<input type="checkbox"/> Waiver Transportation*	<input type="checkbox"/> Assisted Living Services
<input type="checkbox"/> Chore Services*	<input type="checkbox"/> Home Care Attendant
<input type="checkbox"/> Social Work Counseling	<input type="checkbox"/> Choices Home Care Attendant
<input type="checkbox"/> Emergency Response Services*	<input type="checkbox"/> Enhanced Community Living Services
<input type="checkbox"/> Home Modification Maintenance and Repair*	<input type="checkbox"/> Nutritional Consultation
<input type="checkbox"/> Personal Care Services	<input type="checkbox"/> Independent Living Assistance
<input type="checkbox"/> Homemaker Services	<input type="checkbox"/> Community Transition Services
<input type="checkbox"/> Pest Control*	<input type="checkbox"/> Alternative Meals Service
<input type="checkbox"/> Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*	

Signatures	
MCP Name: <u>Choose an item.</u>	Provider Name:
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date: