**Ohio Department of Medicaid**

Choose an item.

**Medicaid Addendum**

This Addendum supplements the Base Contract or Agreement between Choose an item. and Click or tap here to enter text. effective Click or tap to enter a date. and runs concurrently with the terms of the Base Contract or Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

The provider will provide services to the following eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement (select all that apply):

All Medicaid Managed Care members (non-duals)

All MyCare Ohio members (dual eligible)

Medicaid Managed Care Single Case Agreement

MyCare Ohio Single Case Agreement

The provider agrees to provide services to the Managed Care Organization’s (MCO’s) member(s) within the MCO’s designated service area(s) as specified below (select all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| **Medicaid Managed Care Service Areas** | **MyCare Ohio Service Areas** | | |
| Central/Southeast Region  Northeast Region  West Region | Central  Northwest  East Central | West Central  Northeast | Southwest  Northeast Central |

*Not applicable (out-of-state provider)*

With the exception of single case agreements, the provider must either be currently enrolled as a Medicaid provider and meet the qualifications specified in OAC rule 5160-26-05(C) or be in the process of enrolling as an ODM provider. A MyCare Ohio waiver provider must be currently enrolled as an ODM provider with an active status in accordance with OAC rule 5160-58-04.

**ADDENDUM SECTIONS**

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| --- | --- |
| **Section A** | Provisions applicable to contracted network providers and single case agreements |
| **Section B** | Provisions only applicable to contracted network providers |
| **Section C** | Provisions applicable to contracted network providers and single case agreements depending on the service being provided |
| **Section D** | Provisions applicable to managed care organizations |

**ADDENDUM DEFINITIONS**

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| --- | --- |
| **Agreement/Base Contract** | The contract or single case agreement between the managed care organization and the provider (hereinafter referred to as Base Contract). |
| **Managed Care Organization (MCO)** | A health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. For the purposes of this Addendum, references to an MCO include MyCare Ohio plans. |
| **Medicaid** | The program of medical assistance established by Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq., including any medical assistance provided under the Medicaid state plan or a federal Medicaid waiver granted by the United States secretary of health and human services |
| **Member** | A Medicaid recipient who has selected MCO membership or has been assigned to an MCO for the purpose of receiving health care services. |
| **OAC** | Ohio Administrative Code. |
| **ORC** | Ohio Revised Code. |
| **Provider** | A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed, certified, appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCO’s member. |

**ADDENDUM PROVISIONS**

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

1. All providers providing health care services to Choose an item.’s Medicaid managed care and/or MyCare Ohio members, including providers operating under a single case agreement, agree to abide by all of the following specific terms:
   1. The provider, acting within their scope of practice, will provide services as enumerated in Attachment D of this Addendum. For single case agreements, Attachment D only needs to be completed if the Base Contract does not specify the service being provided. Any amendment to Attachment D must be agreed to by both parties.
   2. 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.
   3. The Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCO.
      1. ODM will notify the MCO and the MCO shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCO.
      2. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.
      3. The MCO shall notify the provider of all applicable contractual obligations.
   4. The procedures specified in the Base Contract to be employed upon the ending, nonrenewal, or termination of the Base Contract apply to this Addendum, including an agreement to promptly supply all records necessary for the settlement of outstanding medical claims.
   5. The provider will serve members through the last day the Base Contract is in effect.
   6. The provider shall be compensated pursuant to the method and in the amounts specified in the Base Contract.
   7. The 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 that the provider and all employees of the provider are not excluded from participating in federally funded health care programs.
   8. The 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.
   9. The 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.
   10. The provider will abide by the MCO’s written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.
   11. The 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.
   12. With the exception of any member co-payments the MCO has elected to implement in accordance with OAC rule 5160-26-12, the MCO’s payment constitutes payment in full for any covered service and the provider 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 or home and community-based waiver providers from collecting patient liability payments from members as specified in OAC rules 5160:1-6-07 and 5160:1-6-07.1, or Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payments to ODM as specified in OAC Chapter 5160-28.
2. The MCO shall notify the provider whether the MCO 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.
3. The provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.
   1. The provider will not to hold liable ODM or any member(s) in the event the MCO cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exceptions that:
4. FQHCs and RHCs may be reimbursed by ODM in the event of MCO insolvency pursuant to Section 1902(bb) of the Social Security Act.
5. The provider may bill the member when the MCO denied prior authorization or referral for the services and the following conditions are met:
6. The provider notified the member of the financial liability in advance of service delivery;
7. 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
8. The notification is dated and signed by the member.
   1. The provider will not bill members for missed appointments.
   2. In accordance with OAC rule 5160-26-05, the provider agrees to identify, and where indicated arrange, for the following at no cost to the member:
9. Sign language services; and
10. Oral interpretation and oral translation services.  
    1. The provider shall be bound by the standards of confidentiality outlined in OAC rule 5160-1-32 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).
11. The provider will not identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.
12. The provider will immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, to the MCO for processing.
13. The provider will release to the MCO, ODM, or ODM’s designee(s) any information necessary for the MCO to perform any of its obligations under the ODM provider agreement, including but not limited to, compliance with reporting and quality assurance requirements.
14. The provider will supply, upon request, the business transaction information required under 42 CFR. 455.105.
15. The provider will contact the MCO’s designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC rule 5160-26-03.
16. All of the provider’s applicable facilities and records will be open to inspection by the MCO, ODM, or ODM’s designee(s), or other entities as specified in OAC rule 5160-26-06.
17. The Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.
18. The provider will retain and allow the MCO 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.
19. The provider will make medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.
    * + 1. All participating providers providing health care services to Choose an item.’s Medicaid managed care and/or MyCare Ohio members, not including providers operating under a single case agreement, agree to abide by all of the following specific terms:
20. Notwithstanding item A.2 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:
    1. The provider gives the MCO at least 60 days prior notice in writing for the nonrenewal or termination of the Base Contract, or the termination of any services for which the provider is contracted. The effective date for the nonrenewal or termination of the Base Contract or any contracted services must be the last day of the month; or
    2. 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 written notice must be received by the MCO within 15 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.
21. The provider will cooperate with the MCO’s quality assessment and performance improvement (QAPI) program in all the MCO’s provider subcontracts and employment agreements for physician and nonphysician providers.
22. The provider will cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, and on-site audits, as deemed necessary based on ODM’s periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160, including rule 5160-26-07.
    * + 1. If applicable based on the service(s) being provided to the Medicaid managed care and/or MyCare Ohio member, the provider agrees to abide by the following specific terms:
23. If the provider is a primary care provider (PCP), the provider will participate in the care coordination requirements outlined in OAC rule 5160-26-03.1.
24. If the provider is a hospital or hospital system, Attachment C (ODM Hospital Services Form) must be completed and included with this Addendum, which specifies which services of the hospital are included in the Base Contract.
25. Notwithstanding Items B.1 and C.4 of this Addendum, in the event of a hospital provider’s proposed non-renewal or termination of the Base Contract, the hospital provider will 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 MCO, 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.
26. 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.
27. If the provider is a home health provider, the provider 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.
28. Any third party administrator (TPA) will include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontracted providers will forward information to ODM as requested.
    * + 1. The MCO agrees to abide by the following specific terms:
29. The MCO shall disseminate written policies including 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 MCO’s policies and procedures for detecting and preventing fraud, waste and abuse.
30. The MCO will 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 MCO’s denial of payment of a Medicaid service, as specified in OAC rule 5160-26-08.4 and 5160-58-08.4, utilizing the procedures and forms as specified in OAC Chapter 5101:6-2.
31. The MCO will not 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:  
    1. The member’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    2. Any information the member needs in order to decide among all relevant treatment options.
    3. The risks, benefits, and consequences of treatment versus non-treatment.
    4. 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.
32. Notwithstanding item A.2 of this Addendum, and with the exception of single case agreements, the MCO must give the provider at least sixty days prior notice in writing 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 or when the Base Contract is temporary in accordance with 42 CFR 438.602 and the provider fails to enroll as an ODM provider within 120 calendar days.

Any changes to Attachments A, B, C, and/or D may be made without renegotiation of the Base Contract or this Addendum.

**SIGNATURES**

|  |  |
| --- | --- |
| MCO Name:  Choose an item. | Provider Name:  Click or tap here to enter text. |
| Signature:  Click or tap here to enter text. | Signature:  Click or tap here to enter text. |
| Printed Name:  Click or tap here to enter text. | Printed Name:  Click or tap here to enter text. |
| Title:  Click or tap here to enter text. | Title:  Click or tap here to enter text. |
| Date:  Click or tap to enter a date. | Date:  Click or tap to enter a date. |