PRODUCT ATTACHMENT
OHIO MEDICAID PRODUCT

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between _____ ("***Health Plan***") and _____ ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "Participating Providers" in the Product described in this Attachment; and

WHEREAS, Health Plan has contracted with the Ohio Department of Medicaid ("ODM") to be a Managed Care Organization ("MCO") to provide Covered Services to Covered Persons in the State's Medicaid managed care program ("Program") and such other programs (hereafter referred to as "Medicaid Product") as may be awarded to Health Plan by ODM.

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Program Participation. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the Medicaid Product. The Medicaid Product includes those programs and health benefit arrangements offered by Health Plan or other Company pursuant to a contract (the "***State Contract***" sometimes abbreviated as "***SC***" in citations) with the Ohio Department of Medicaid, or any successor thereto, to provide specified services and goods to covered beneficiaries under the Programs (or additional, ancillary or successor State Medicaid programs thereto), and to meet certain performance standards while doing so. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

Where Company is not the Payor, the rights and responsibilities assigned under this Attachment to Company, Payor, or "Company or Payor" shall be understood to apply to either Company or Payor as applicable under the circumstances and as determined by the terms of the Payor Contract, Regulatory Requirements and/or Company policies and procedures. The phrase "Company or Payor" is not intended to nor shall result in the expansion of any rights on the part of Provider or Contracted Providers or any liabilities on the part of Company or Payor. Nothing in this Attachment shall be construed as conferring any financial or legal liabilities of Payor under any Regulatory Requirements or the Payor Contract to Company or Health Plan. Nothing in this Attachment shall be construed as altering the terms of the Payor Contract, or in a manner that is inconsistent with Regulatory Requirements. The rights and responsibilities that arise under a Payor Contract (including a Governmental Contract) and that are assigned under this Attachment to Health Plan are understood to be assigned to Company (and references to "Health Plan" will be understood to be references to Company) where Company is a party to the Payor Contract.

2.2 Participation. Unless otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicaid Product as "***Providers***," and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment for the Medicaid Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company. To the extent any provision of this Attachment, or any provision of the Agreement as it relates to this Attachment, (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment. Notwithstanding the above, Health Plan may immediately terminate this Attachment upon notice to Provider in the event that the State Contract is terminated or the Program (or any aspect thereof) is no longer authorized by law (i.e., has been vacated by a court of law, CMS has withdrawn federal authority for the program, or the program is the subject of a legislative repeal).

4. Governmental Contract/Regulatory Requirements. **Schedule A** to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under the State Contract and the provisions that are required by the State Contract to be included in the Agreement with respect to the Medicaid Product. **Schedule B** to this Attachment ("Model Medicaid Addendum"), which is incorporated herein by this reference, shall be completed and executed by Health Plan and Provider and sets forth terms that are applicable to the Medicaid Product under State laws and regulations, and that are required under such laws and regulations (and Appendix F. Section 3.b.ii of the State Contract) to be included in the Agreement with respect to the Medicaid Product. To the extent that a Coverage Agreement is subject to the law cited in the **Schedule B**, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement. Provider shall expressly impose these terms and obligations, in writing, on each of its Contracted Providers, as such term is defined in the Agreement. Health Plan is and shall be a third-party beneficiary of any agreement between Provider and its Contracted Providers with the right to directly enforce these terms and condition upon Contracted Providers. Applicable State agencies have the right to modify, supplement, amend and add to the terms, conditions and obligations set forth in **Schedule A**, and Provider shall be bound by such changes.

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule A sets forth the special provisions that are specific to the Ohio Medicaid and CHIP Product under the applicable State Contract.

A. Definitions and Acronyms. For purposes of this Attachment, the following terms have the meanings set forth below. Terms used in this Attachment and not defined below will have the same meaning set forth in the Agreement, or, if not defined there, in the State Contract (as defined below). Terms used in this Attachment that are not otherwise explicitly defined shall be understood to have the definition laid out in applicable State and federal rules and regulations, including but not limited to 42 C.F.R. Chapter IV and 45 C.F.R. Parts 160 and 164.

1. **Abuse** – As defined in OAC rule 5160-26-01, Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care. Abuse also includes Member practices that result in unnecessary cost to the Medicaid program.

2. **Advance Directive** – As defined in OAC rule 5160-26-01, written instructions such as a living will or durable power of attorney for health care relating to the provision of health care when an adult is incapacitated.

3. **Business Day** – Monday through Friday, except for state of Ohio holidays.

4. **Calendar Day** – All seven days of the week, including state of Ohio holidays.

5. **Care Coordination** – A strategy to deliberately organize and support an individual with addressing needs to achieve better health outcomes.

6. **Child and Adolescent Needs and Strengths (CANS)** – A multiple purpose information integration tool developed for children's services to support decision-making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS is designed to be the output of an assessment process.

7. **Claim** – A bill from a Provider for health care services assigned a unique identifier. A Claim does not include an encounter form. A Claim can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one Member within a bill.

8. **Covered Services** – As defined in OAC rule 5160-26-01, the medical services set forth in OAC rule 516026-03 or a subset of those services.

9. **Date of Payment** – The date of the check or date of electronic payment transmission.

10. **Emergency Medical Condition** – As defined in OAC rule 5160-26-01, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

11. **Emergency Services** – As defined in OAC rule 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified Provider and are needed to evaluate, treat, or stabilize an Emergency Medical Condition. Providers of Emergency Services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with an MCO.

12. **External Medical Review** –The review process conducted by an ODM-identified, independent, External Medical Review entity that is initiated by a Provider that disagrees with the MCO's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of Medical Necessity.

13. **Fraud** – As defined in OAC rule 5160-26-01, any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes Fraud under federal or state law. Member Fraud means the altering of information or documents in order to fraudulently receive unauthorized benefits or to knowingly permit others to use the Member's identification card to obtain services or supplies.

14. **Health Information Exchange (HIE)** – As defined in ORC chapter 3798, any person or governmental entity that provides in this state a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information. Health Information Exchange excludes health care Providers engaged in direct exchange, including direct exchange through the use of a health information service Provider.

15. **Healthchek** – As defined in OAC rule 5160-1-14, comprehensive preventive health services available to individuals under 21 years of age who are enrolled in Medicaid, otherwise known as early and periodic screening, diagnostic, and treatment (EPSDT) services.

16. **Institution for Mental Disease (IMD)** – As defined in 42 CFR 435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an IMD.

17. **Limited English Proficiency (LEP)** – Eligible individual or Member who does not speak English as their primary language and who has a limited ability to read, write, speak, or understand English.

18. **Managed Care Organization (MCO)** – An entity that meets the requirements of 42 CFR 438.2 and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care Provider Agreement with ODM. Health Plan is an MCO. The terms Health Plan and MCO may sometimes be used interchangeably.

19. **Marketing** – Any communication from the MCO to an eligible individual who is not a Member of the MCO that can reasonably be interpreted as intended to influence the individual to select Membership in the MCO, or to not select membership in or to terminate membership from another MCO.

20. **Marketing Materials** – Items produced in any medium, by or on behalf of the MCO, including gifts of nominal value (i.e., items worth no more than $15), which can reasonably be interpreted as intended to market to eligible individuals.

21. **Medicaid** – As defined in OAC rule 5160-26-01, medical assistance as defined in ORC section 5162.01 and OAC rule 5160-26-01.

22. **Medicaid Fraud Control Unit (MFCU)** – Consistent with OAC rule 5160-26-01, the unit of the Ohio Attorney General's Office responsible for the investigation and prosecution of Fraud and related offenses within Medicaid.

23. **Medically Necessary or Medical Necessity** – Has the same meaning as OAC rule 5160-1-01:

    a. Medical Necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition

such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

b. Medical Necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

c. Conditions of Medical Necessity are met if all the following apply:

   i. Meets generally accepted standards of medical practice;

   ii. Clinically appropriate in its type, frequency, extent, duration, and delivery setting;

   iii. Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;

   iv. Is the lowest cost alternative that effectively addresses and treats the medical problem;

   v. Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and

   vi. Not provided primarily for the economic benefit of the Provider nor for the convenience of the Provider or anyone else other than the recipient.

d. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a Claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service Medically Necessary and does not guarantee payment for it.

e. The definition and conditions of Medical Necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of Medical Necessity for particular categories of service may be set forth within ODM coverage policies or rules.

24. **Medicare** – As defined in OAC rule 5160-26-01, the federally financed medical assistance program defined in 42 USC Subchapter XVIII.

25. **Medication Therapy Management** – A process that promotes safe and effective use of medications, including prescription and over-the-counter drugs, vitamins, and herbal supplements.

26. **Member** – As defined in OAC rule 5160-26-01, a Medicaid-eligible individual who has selected MCO membership or has been assigned to an MCO for the purpose of receiving health care services. For clarity, **Covered Person** is a **Member** assigned to Health Plan and the two are sometimes used interchangeably.

27. **Member Materials** - Items developed by or on behalf of Health Plan to fulfill Health Plan program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a source other than Health Plan and which do not include any reference to Health Plan are not considered to be member materials

28. **Mobile Response and Stabilization Services (MRSS)** – As provided in OAC rule 5160-27-13, MRSS is a mobile response stabilization service for young people who are experiencing significant behavioral or emotional challenges and their families. The service may be delivered through a face-to-face mobile response to the young person's home, school,

a local emergency department (ED), or another location in the community, including a location preferred by the family. MRSS is available 24 hours a day, 365 days a year.

The purpose of MRSS is to provide rapid community-based crisis assessment and stabilization to young people and their families and to build the skills needed to help maintain young people in their homes and communities whenever safe and possible. In addition to the direct provision of crisis intervention and stabilization services, MRSS Providers link young people and their families to ongoing clinical and natural supports and services through a facilitated child and family team planning process.

MRSS consists of a series of four phases of services including: triage and initial mobile response; assessment and planning; stabilization; and service transition. MRSS provides young people and their caregivers with short-term, flexible services to assist in stabilizing young people in their community setting. Interventions are designed to maintain the young person in their current living arrangement and to stabilize behavioral health needs to improve functioning in all life domains.

29. **Provider** – As defined in OAC rule 5160-26-01, a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care services rendered to an MCO's Member.

30. **Provider Agreement** – As defined in OAC rule 2160-26-01, a formal agreement between ODM and an MCO for the provision of Medically Necessary services to Medicaid Members.

31. **Provider Claim Dispute Resolution** – Established process for MCO Network and out-of-Network Providers to challenge MCO Claim payments or denials.

32. **Provider Network or Network** – Consistent with "Provider Panel" as defined in OAC rule 5160-26-01, the MCO's contracted Providers available to the MCO's Members.

33. **Provider-Preventable Condition** – As defined in 42 CFR 447.26, a condition that meets the definition of a "health care-acquired condition" (a condition occurring in any inpatient hospital setting, identified as a health care-acquired condition by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the Ohio Medicaid state plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients) or an "other Provider-Preventable Condition" (a condition occurring in any health care setting) that meets the following criteria:

    a. Is identified in the Ohio Medicaid state plan;

    b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

    c. Has a negative consequence for the beneficiary;

    d. Is auditable;

    e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

34. **Subcontract** – As defined in OAC rule 5160-26-01, a written contract between an MCO and a third party, including the MCO's parent company or any subsidiary corporation owned by the MCO's parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the MCO's Provider Agreement with ODM.

35. **Subcontractor** – As defined in OAC rule 5160-26-01, any party that has entered into a Subcontract to perform a specific part of the obligations specified under the MCO's Provider Agreement with ODM. A Network Provider is not a Subcontractor by virtue of the Network Provider contract with the MCO.

36. **Waste** – As defined in OAC rule 5160-26-01, payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.

Acronyms:

APP	Appendix (to State Contract)
CANS	Child and Adolescent Needs and Strengths
CCE	Care Coordination Entity
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
EDI	Electronic Data Interchange
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EVV	Electronic Visit Verification
FFS	Fee-for-Service
HIE	Health Information Exchange
IMD	Institution for Mental Disease
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MRSS	Mobile Response and Stabilization Services
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODM	Ohio Department of Medicaid
ORC	Ohio Revised Code
SC	State Contract
TPL	Third Party Liability
UM	Utilization Management
USC	United States Code

B. Requirements.

1. **Fiscal Intermediary and Centralized Credentialing.** Provider acknowledges as follows: (¶2.c. Introduction to "The Ohio Department of Medicaid; Ohio Medicaid Provider Agreement for Managed Care Organization")

   a. ODM's fiscal intermediary will serve as a single clearinghouse for all medical (non-pharmacy) Claims. All medical Claims will be submitted to ODM's fiscal intermediary, ODM's electronic data interchange (EDI) vendor will apply specified Strategic National Implementation Process (SNIP) level edits, and ODM's fiscal intermediary will send the Claim to Health Plan for Claims processing and payment.

   b. ODM's fiscal intermediary will also serve as the single, centralized location for Provider submissions of prior authorization requests for all medical (non-pharmacy) services. The fiscal intermediary will streamline the prior authorization process and reduce Provider burden by systemically standardizing prior authorization forms and the necessary clinical documentation to support the request. Provider shall cooperate and comply with ODM, ODM's fiscal intermediary and Health Plan's Service Authorization policies and procedures in such regard, including, but not limited to submission requirements. (SC App. B, §7)

   c. ODM has adopted a centralized credentialing approach, creating efficiencies through a system-level consolidation of Provider screening, enrollment, and credentialing activities. Provider will submit an application for Medicaid enrollment

and credentialing materials using a single, electronic application. This streamlined process will eliminate the need for Provider to submit credentialing and re-credentialing materials to multiple MCOs. Provider shall cooperate and comply with ODM, ODM's fiscal intermediary and Health Plan's Credentialing policies and procedures in such regard, including, but not limited to submission requirements. Provider shall promptly provide Health Plan with any changes to its organization and practice which might reasonably affect its credentialing, including, but not limited to changes in the information described in State Contract, Appendix F, Section 3.d.viii. (SC App. F, §3.d.) Provider shall comply with all changes to the credentialing process adopted by ODM over the term of the State Contract.

2. **Compliance with ODM Instructions.** ODM may, as it deems appropriate, communicate specific instructions and requests to Health Plan concerning the performance of the services described in the State Contract. To the extent such instructions and requests relate to Provider's performance under the Agreement, Health Plan will communicate same to Provider and Provider must comply with such instructions and fulfill such requests within the timeframe designated by ODM and to the satisfaction of ODM. It is expressly understood that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in the State Contract and are not intended to amend or alter this Agreement or any part thereof. (SC Art. I, §D.)

3. **Compliance with Applicable Laws**. Provider shall comply with all applicable federal, state, and local laws in the conduct of the work under the Agreement. (SC Art. IV, §B.)

4. **Conflicts of Interest.** Provider shall maintain adequate internal control to detect and prevent conflicts of interest from occurring at all levels of its organization. Moreover, Provider shall comply with the following: (SC Art. V, §E.)

   a. In accordance with 42 CFR 438.58, the safeguards specified in Section 27 of the Office of Federal Procurement Policy Act (41 USC 423), and other applicable federal requirements, an officer, member, or employee of Provider must not, prior to the completion of its obligations or reimbursement therefor, acquire any interest, personal or otherwise, direct or indirect that is incompatible or in conflict with or would compromise in any manner or degree the discharge and fulfillment of their functions and responsibilities with respect to carrying out of such services.

   b. Provider represents, warrants, and certifies that Provider and its employees engaged in the administration or performance of this Agreement are knowledgeable of and understand the Ohio Ethics and Conflicts of Interest laws, including those provisions found in ORC Chapters 102 and 2921, and Executive Order 201911D. Provider further represents, warrants, and certifies that neither Provider nor any of its employees will perform, cause, or omit any action in any way that is inconsistent with such laws and Executive Order. The Governor's Executive Orders may be found by accessing the following website: https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders.

   c. Provider hereby covenants that Provider, its officers, members, and employees must not, prior to the completion of the work under this Agreement, voluntarily acquire any interest, personal or otherwise, direct or indirect that is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of their functions and responsibilities under this Agreement. Provider must periodically inquire of its officers, members, and employees concerning such interests.

   d. Provider must ensure that any such person who acquires an incompatible, compromising, or conflicting personal or business interest, on or after the effective date of this Agreement, or who involuntarily acquires any such incompatible or conflicting personal interest, immediately discloses their interest to Health Plan and ODM in writing. Thereafter, Provider must ensure that they must not participate in any action affecting the services under this Agreement unless ODM

determines in its sole discretion that, in the light of the personal interest disclosed, their participation in any such action would not be contrary to the public interest. Provider must provide written disclosure of such interest to Health Plan and ODM.

5. **Non-Discrimination.** In addition to compliance with OAC Chapter 5160-26, Provider shall adhere to the following requirements: (SC Art. VI, §D.)

   a. Provider must not discriminate in the performance or employment under this Agreement of an individual who is qualified and available to perform the Covered Services under this Agreement on the basis of race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, veteran status, military status, health status, genetic information, or ancestry. For purposes of this article, "Members" does not include individuals whose sole connection with Provider is the receipt of Covered Services through a health care program offered by Health Plan. Provider, its officers, employees, Members, and Subcontractors hereby affirm current and ongoing compliance with all federal civil rights laws, including: (i) Title VII of the Civil Rights Act of 1964 (Pub. L. 88-352); (ii) Title VI of the Civil Rights Act of 1964 (42 USC 2000d, et seq.); (iii) The Americans with Disabilities Act of 1990 (42 USC 12101, et seq.) and Section 504 of the Rehabilitation Act of 1973; and (iv) The Age Discrimination Act of 1975 (42 USC 6101, et seq.).

   b. Provider must not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance of Covered Services under this Agreement based upon race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, veteran status, health status, genetic information, or ancestry.

   c. Provider must not participate in, condone, or tolerate any form of sexual harassment against any employee, subcontractor, or other person or entity with which it is associated in performance of this Agreement that is considered a form of sex discrimination prohibited by Title VII of the Civil Rights Act of 1964, ORC section 4112.02, OAC 123:1-49, the Anti-Discrimination Policy in State Government Executive Order 2019-05D, or state agency policy.

6. **Records, Documents, and Data.** Provider must ensure that all records, documents, data, or other information produced or used by Provider under this Agreement are treated in accordance with OAC rule 5160-26-06 and must be provided to ODM or its designee at no cost if requested. The records, documents, data, and information must be provided by Provider in a format solely determined by ODM, which may include the analysis of any data and documentation Provider is required to maintain. Provider must maintain an appropriate record system for Covered Services provided to Members. Provider must retain all records in accordance with 42 CFR 438.3(u) and comply with the audit and inspection rights of those records in accordance with 42 CFR 438.3(h). Provider acknowledges that these records, may be a part of any audit conducted by Ohio Auditor of State pursuant to ORC Chapter 117. (SC Art. VII, §A.)

7. **Use of Information and Confidentiality.** Provider must not use any information, systems, or records made available to it under the Agreement for any purpose other than to fulfill the duties specified in this Agreement. Provider must be bound by the same standards of confidentiality that apply to the employees of ODM and the state of Ohio, including without limitation the confidentiality requirements found in 42 CFR Part 431 Subpart F and ORC section 5160.45, as well as 42 CFR Part 2 and ORC section 5119.27 as applicable. Provider must implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements cited above, as well as those set forth in 45 CFR Part 160 and 164. Provider must allow ODM, CMS, the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General, the Ohio Auditor of State, the Ohio Inspector General, or any of designees of any of the foregoing to inspect and audit, at any time, any records or documents of Provider or its subcontractors, and/or to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this article shall survive the termination

of this Agreement and remain in effect for ten years from the termination or expiration of this Agreement or from the date of completion of any audit, whichever is later. (SC Art. VII, §D.)

8. **Record Retention.** Provider must retain all records relating to performance under or pertaining to this Agreement in accordance with the appropriate records retention schedule. Pursuant to 42 CFR 438.3(u) and 42 CFR 438.3(h), the appropriate records retention schedule for this Agreement is for a total period of ten years as are the audit and inspection rights for those records. For the initial three years of the retention period, Provider must store records in a manner and place that provides readily available access. (SC Art. VII, §E.)

9. **Litigation Holds.** Provider must retain all records in accordance with ODM's notification of any litigation holds and actively participate in the discovery process if required to do so at no additional charge. Litigation holds may require Provider to keep the records longer than the approved records retention schedule. ODM will notify the MCO and MCO will notify Provider when the litigation hold ends, and retention can resume based on the approved records retention schedule. (SC Art. VII, §F.)

10. **Lobbying.** Provider certifies that no federal funds paid to Provider through this Agreement will be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement, or loan. Provider further certifies its continuing compliance with applicable lobbying restrictions contained in 31 USC 1352 and 45 CFR Part 93. If this Agreement exceeds $100,000, Provider has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. (SC Art. XIII, §B.)

11. **Debarment and Suspension**. Provider certifies that neither Provider nor any principals of Provider (e.g., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCO's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any federal agency. Provider also certifies that it is not debarred from consideration for contract awards by the Director of the Department of Administrative Services, pursuant to either ORC section 153.02 or ORC section 125.25. This certification is a material representation of fact upon which reliance was placed when this Agreement was entered into. Federal financial participation (FFP) is not available for amounts expended for Providers excluded by Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP), except for Emergency Services. Provider shall promptly notify Health Plan in the event it learns of the inaccuracy or incompleteness of any assertion herein. (SC Art. XIII, §C.)

12. **Required Disclosures**. Provider shall timely disclose information pertaining to its owners, principals, affiliations, business interests and investments as may be required by Health Plan and/or ODM in accordance with federal and state law, including, but not limited to, 42 CFR 455.105 and .106. (SC App. G. §4).

13. **Smoke & Drug Free Workplace.** Provider shall comply with all state and federal laws regarding a smoke-free and drug-free workplace. Provider and its employees shall not purchase, transfer, use, or possess illegal drugs or alcohol, or Abuse prescribed drug in any way while performing their duties under this Agreement. (SC Art. XIII, §I.)

14. **Offshoring.** Consistent with Executive Order 2019-12D (A copy of Executive Order 2019-12D can be found at https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-12d.) Provider may not perform services under the Agreement outside of the United States except under certain circumstances. Such services include the use of offshore programming or call centers. Additionally, Provider shall not maintain PHI outside the United States or its territories. (SC Art. XIII, §M.)

15. **Communication with ODM.** Provider shall communicate with ODM as requested by ODM. ODM may meet with Provider at any time and does not need to have approval of the MCO to do so. (SC App. A., §1.g.ii.1.c.)

16. **Equitable Access.** In accordance with 42 CFR 438.206(c), Provider will provide equitable access to and the delivery of Covered Services to all Covered Persons, including those with Limited English Proficiency, diverse cultural and ethnic backgrounds, or disabilities, and regardless of gender, sexual orientation, or gender identity. "Equitable access" for purposes of this Agreement means meeting the standards as defined by the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (https://www.thinkculturalhealth.hhs.gov/clas). In accordance with 42 CFR 438.206(c)(3), Provider must provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. (SC App. A., §4.a and App. F §1.b.)

17. **Marketing.** All Marketing Materials and Member Materials proposed to be issued by Provider relating to the Provider's participation in the Program as a Provider for Health Plan must be pre-approved by Health Plan. (SC App. A., §4.b. and App. E.)

18. **Covered Person's Rights.** Provider shall adhere to federal and state laws pertaining to Covered Persons' rights when providing Covered Services to Covered Persons. (SC App. A., §4.d.ii)

19. **Advance Directives.** If and when Provider becomes aware that a Covered Person has an Advance Directive, Provider shall document such fact in the Covered Person's medical record. Provider shall comply with Health Plan's policies and procedures regarding Advance Directives. Moreover, Provider may not condition the provision of care or otherwise discriminate against a Covered Person based upon whether the Covered Person has executed an Advance Directive. (SC App. A., §4.f)

20. **Training.** Provider shall participate in Health Plan-sponsored training on applicable Program requirements and all necessary Health Plan operational requirements. Provider shall also participate in ODM-delivered Provider-training, as mandated by ODM. (SC App. A., §6.a.v.)

21. **Claims Disputes.** Provider shall utilize Health Plan's Provider Claim Dispute Resolution process to dispute adverse Claims payment decisions made by Health Plan. "Provider Claim Disputes" do not include Provider disagreements with Health Plan's decision to deny, limit, reduce, suspend, or terminate a Covered Service or lack of Medical Necessity which are subject to External Medical Review. (SC App. A. §6.f.i.)

22. **External Medical Review.** Provider shall utilize Health Plan's External Medical Review if and when Provider is dissatisfied with Health Plan decisions to deny, limit, reduce, suspend, or terminate a Covered Service for lack of Medical Necessity. Covered Services denied for reasons other than lack of Medical Necessity are not subject to External Medical Review. (SC App. A.§6.g.i)

23. **Provider Website.** Provider shall utilize Health Plan's online Provider website through which Provider may, among other things, access relevant Covered Person information (e.g., eligibility and enrollment); confirm Covered Person's primary language and other special communication needs; access Claims and utilization history; file and track status of pending Provider Claims disputes and External Medical Reviews. (SC App. A.§7.c.)

24. **Disclosure to ODM of Financial Terms.** Provider understands Health Plan may, upon ODM's request, disclose to ODM all financial terms and arrangements for payment of any kind that apply between Health Plan and Provider, except where federal and state law restricts disclosure. (SC App. A, §9.c.ii. and App. F, §3.b.v.)

25. **Disaster/Emergency Response.** Provider shall cooperate with Health Plan's Comprehensive Disaster/Emergency Response Plan. (SC App. A., §10)

26. **Covered Services.** Provider shall familiarize itself with those services which are Covered Services, and for which Provider is contracted, as described in OAC Chapter 5160 and OAC Rule 5160. Health Plan is not required to pay for services not covered by Ohio Medicaid, except as specified in OAC rule 5160-26-03 and the State Contract. (SC App. B., §1.a and b.)

27. **Provider Preventable Conditions.** Health Plan will not pay for a service resulting from a Provider-Preventable Condition, as defined in 42 CFR 447.26. Provider shall report all instances of Provider-Preventable Conditions. Provider shall not restrict care to a Covered Person because of Health Plan's refusal to pay for Provider-Preventable Conditions. (SC App. B., §1.c.)

28. **Healthchek.** Provider shall cooperate with Health Plan's written policies and procedures regarding Healthchek including, but not limited to EPSDT screenings and pregnancy-related services. Moreover, Provider shall participate in Health Plan's annual Healthchek training (SC App. B. §2.a.)

29. **MTM.** Provider shall cooperate with Health Plan's Medication Therapy Management Program. (SC App. B., §2.b.)

30. **Abortion and Sterilization.** Health Plan will not reimburse for abortion and sterilization services (or associated services – e.g., anesthesia, lab tests etc.) unless the specific criteria found in federal law and OAC rules 5160-17-01 and 5160-21-02.2 are met, and the applicable documentation/forms submitted including, but not limited to, appropriate certification and consent forms. (SC App. B., §2.c.)

31. **Moral/Religious Objections.** Provider shall promptly notify Health Plan should Provider fail or refuse to provide Covered Service due to an objection on moral or religious grounds. (SC App. B., §2.e.)

32. **Mental Health Inpatient Stays.** Health Plan will not pay for stays of more than fifteen (15) Calendar Days per calendar month for mental health, inpatient services at an Institution for Mental Disease, as defined in Section 1905(i) of the Social Security Act, for Covered Persons ages 21 through 64. (SC App. B., §2.h.)

33. **Transplants.** Coverage for all organ transplant services, except kidney transplants, is contingent upon, among other things, review and recommendation by the "Ohio Solid Organ Transplant Consortium." Coverage and for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC rule 3701-84-01, is contingent upon, among other things, review and recommendation by the "Ohio Hematopoietic Stem Cell Transplant Consortium." (SC App. B., §2.m.i.)

34. **Room and Board – Nursing Facility.** In accordance with Sections 1902(a)(13)(B) and 1905(o)(3)(C) of the Social Security Act, if a Covered Person resides in a nursing facility and is receiving hospice services, Health Plan will pay a Claim for room and board to the hospice Provider instead of the nursing facility. (SC App. B., §2.o.)

35. **Hospital Readmission.** Provider shall abide by Health Plan's hospital readmission policies and procedures when submitting Claims for readmission. Health Plan will follow the readmission policies and requirements pursuant to OAC rule. (SC App. B., §2.p.)

36. **PASRR.** For nursing facility stays, Provider shall provide Health Plan with all information necessary for Health Plan to complete a PASRR and to determine need for level of services consistent with OAC rules 5160-3-08, 5160-3-09, and 5160-101. (SC App. B., §2.s.)

37. **No Balance Billing.** Pursuant to OAC rule 5160-26-05, Provider shall not bill Covered Persons any amount greater than would be owed if the entity provided the Covered Services directly (i.e., no balance billing). (SC App. B., §4.h.)

38. **Utilization Management**. Provider shall cooperate with Health Plan's Utilization Management (UM) program. (SC App. B. §§5.a.,b., and c.)

39. **Medically Necessary Services.** Provider acknowledges and understands its compensation under the Agreement for providing Covered Services to Covered Persons does not, in any way, incentivize Provider to deny, limit, or discontinue Medically Necessary Covered Services to Covered Persons and Provider will not so deny, limit, or discontinue such Covered Services in light of the compensation amounts it receives from Health Plan. Covered Services shall not be arbitrarily denied or reduced in amount, duration, or scope solely because of a diagnosis, type of illness, or condition of the Covered Person. (SC App. B. §5.a.iv. and v.)

40. **Peer-to-Peer.** In the event Provider requests a "peer-to-peer" consultation following a service authorization denial, Provider shall provide Health Plan with the documentation reasonably requested by Health Plan. (SC App. B §7.f.iv.)

41. **Mental Health Parity.** Provider shall cooperate with Health Plan's Mental Health Parity and Addiction Equity (MHPAEA) policies and procedures and shall not discriminate against Covered Persons requiring mental health and/or addiction services. (SC App. B §8)

42. **Best Practice Guidelines.** Provider shall cooperate with Health Plan's clinical best practice guidelines (SC App. C. §4.d.)

43. **Care Coordination.** Provider shall cooperate with Health Plan's Care Coordination policies and procedures. (SC App. D)

44. **Pediatric Services.** If Provider provides pediatric services, unless otherwise approved by Health Plan, Provider must maintain a general pediatric practice and be listed as a pediatrician with the Ohio State Medical Board. If such information was not provided during the credentialing process, Provider shall promptly notify Health Plan if Provider is not certified by the American Board of Pediatrics. (SC App. F. §4.b.ii.)

45. **Specialty Physician.** If Provider is a specialty physician, unless otherwise approved by Health Plan, Provider must maintain a full-time practice (i.e., Provider is available to patients at Provider's practice site(s) for at least 25 hours a week) (SC App. F. §4.c.iii.)

46. **OB/GYN and Midwife.** If Provider provides OB/GYN, Gynecology, and/or certified nurse midwife services, unless otherwise approved by Health Plan, Provider must have current hospital privileges at a hospital under contract with Health Plan. (SC App. F. §4.d.iv.)

47. **CANS.** If Provider provides Child and Adolescent Needs and Strengths (CANS) assessments for eligibility for OhioRISE enrollment, Provider shall comply with ODM's standards and guidance and employ a standardized protocol as specified by ODM. Provider shall complete a CANS assessment within 10 Business Days after scheduling unless it is in the best interest of the Covered Person to allow for more than 10 Business Days as reasonably determined by Provider and Health Plan. (SC App. F. §4.g.i.)

48. **MRSS.** If Provider provides Mobile Response and Stabilization Services (MRSS), Provider shall comply with ODM's standards and guidance and employ a standardized protocol as specified by ODM. (SC App. F. §4.g.ii.)

49. **BHCCE.** If Provider is a Behavioral Health Coordination Entity (BHCCE), Provider shall comply with ODM's standards and guidance and employ a standardized protocol as specified by ODM. (SC App. F. §4.g.iii.)

50. **Vision Health.** If Provider provides vision health care Provider (ophthalmologists and optometrists), unless otherwise approved by Health Plan, Provider must maintain a full-time practice and perform routine eye exams. (SC App. F. §4.h.ii)

51. **Dental.** If Provider provides dental care, unless otherwise approved by Health Plan, Provider must maintain a full-time practice and serve all ages – adults and children. (SC App. F. §4.i.i.)

52. **Changes to Practice.** Provider acknowledges and understands that the physical location(s) of its practice, the types of services provided to Covered Persons, the number of practitioners/professionals, and the daily/weekly hours it provides Covered Services is a material factor in Health Plan's entering into this Agreement as such factors affect Health Plan's ability to comply with ODM's Network accessibility requirements. Provider shall immediately notify Health Plan in the event of any changes to the foregoing, the effective date of such changes, and the reasons for such changes. (SC App. F. §6.)

53. **Hours of Operation.** Provider must offer hours of operation no less than the hours of operation offered to commercial patients (or comparable to ODM Fee-For-Service, if Provider serves only Medicaid patients). (SC App. F. §7.a.ii.) Medically Necessary Covered Services shall be available 24 hours a day, seven days a week. (SC App. F. §7.a.iii) Provider shall be subject to corrective action in the event of noncompliance with the foregoing. (SC App. F. §7.a.iv)

54. **Appointment Availability.** Provider shall comply with the following minimum appointment availability standards for the Covered Services provided by Provider. Provider shall be subject to corrective action in the event of noncompliance with such standards. (SC App. F. §8)

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an Emergency Medical Condition.	24 hours, 7 days/week
Urgent Care (includes medical, behavioral health, and dental services)	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a Member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance Abuse treatment from behavioral health Providers.	Within 10 Business Days or 14 Calendar Days, whichever is earlier
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment and referral to treatment.	Within 48 hours of request

ASAM Medically Managed Intensive Inpatient Services – 4	Covered Services needed to treat and stabilize a Member's behavioral health condition.	24 hours, 7 days/week
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 6 weeks
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 Calendar Days
Prenatal Care – First or Second Trimester	Care provided to a Member while the Member is pregnant to help keep Member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 Calendar Days; follow up appointments no more than 14 Calendar Days after request
Prenatal Care – Third Trimester or High Risk Pregnancy		Within 3 Calendar Days
Specialty Care Appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

55. **Triage Assistance.** Provider shall cooperate with Health Plan's policies and procedures for triage to assist Health Plan staff and Provider in determining whether a Covered Person's need is emergent, behavioral health non-life-threatening emergent, urgent, or routine, and to support Member access to needed services based on the urgency of the Covered Person's need. (SC App. F §8.e.)

56. **Telehealth**. If Provider provides telehealth services, Provider shall comply with state requirements related thereto including, but not limited to, OAC rule 5160-1-18. (SC App. F §9.h.)

57. **Payment in Full.** As a condition of payment, Provider accepts the amount paid by Health Plan, or appropriate denial made by Health Plan (or, if applicable, payment by Health Plan that is supplementary to the Covered Person's third-party payor), and, in addition, any applicable co-payment or patient liability amount due from Covered Person as payment in full for the Covered Service. Covered Persons must be held harmless by Provider for the costs of Medically Necessary Covered Services and additional services offered by Health Plan, except for applicable co-payment or patient liability amounts. (SC App. F §12.a.iv. and v.)

58. **ODM Enrollment.** Health Plan will only pay Provider for Covered Services performed when Provider is enrolled with ODM and active in ODM's Provider Network management system, unless Provider is rendering service under a single case agreement or providing Emergency Services in accordance with 42 CFR 438.114. Except for Emergency Services, Health Plan will not pay Provider for Covered Services provided when Provider has been terminated or suspended by ODM, or has been terminated by Medicare, Medicaid, or the Children's Health Insurance Program. (SC App. F §12.a.vi. and App. G. §§5.a., 5.b. and 5.f))

59. **Nursing Facility Liability Offset.** If Provider is a nursing facility, Health Plan will offset patient liability against submitted Claims. If patient liability exceeds the amount Health Plan would pay for a Claim, Health Plan will process the Claim with a $0 payment. Moreover, Health Plan will not pay Claims for Covered Services rendered during a Covered Person's restricted Medicaid coverage period. (SC App. F §12.g.)

60. **Provider Directory.** Provider must provide Health Plan with all information necessary and required under the State Contract for its Provider Directory, in accordance with 42 CFR 438.10. (SC App. F §13)

61. **FWA Training.** Provider shall participate in Health Plan training and education programs relating to Fraud, Waste and Abuse. (SC App. G. §2.b.ix)

62. **Notice of Termination.** Provider must give Health Plan at least 50 Calendar Days prior to the termination/non-renewal of the Agreement. (SC App. G. §5.e)

63. **Provider Suspension.** Upon notification from ODM that Provider has been suspended, Health Plan will suspend Provider and payments to Provider until and unless it receives subsequent notice from ODM to lift the suspension. (SC App. G. §5.g.)

64. **Return of Payments.** Provider will return any episode, quality, or other value-based payments to Health Plan when Provider is convicted of Fraud and the time period of the fraudulent activity overlaps with the time period that the episode, quality, or other value-based payment is based. (SC App. G. §5.h.)

65. **Recovery of Payments.** Health Plan will recover any payment made to Provider for services provided after Provider is terminated pursuant to the requirements in the State Contract. (SC App. G. §5.i.)

66. **Audit.** ODM has the right to audit, review, investigate, and/or recover payment from Provider at any time and without notice and Provider shall participate in such reviews and audits, announced or unannounced, with ODM, as requested. (SC App. G.§10.f. and g.)

67. **Overpayment.** In accordance with 42 CFR 438.608, Provider shall report receipt of an overpayment (and the reason for such overpayment) and return the overpayment to Health Plan within 60 Calendar Days following discovery. Moreover, Health Plan retains the right to recover any overpayments identified arising out of Fraud, Waste, or Abuse, as defined by OAC rule 5160-26-01, under the following circumstances: (SC App. G. 11.b.)

    a. The MFCU has an open case, and Health Plan requested deconfliction and received leave to proceed since there was not a conflict with an active law enforcement investigation; or
    b. The date of the deconfliction request occurred prior to the date that the MFCU opened their case on the same Provider; and
    c. Health Plan submitted a referral regarding the same Provider after completion of its previously approved audit, investigation, or review.

    Provider shall cooperate with Health Plan's fraud referral policies and procedures and shall further make referrals to Health Plan should Provider identify potential fraud. All program integrity responsibilities of Provider shall be imposed upon Provider's subcontractors and/or delegated entities.

68. **Recovery by Health Plan of Governmental Collections.** Absent any restrictions on recovery, Health Plan may otherwise recover from Provider any amount collected from Health Plan by ODM, the Ohio Auditor of State, the federal government, any other regulatory agency, or their designees, relating to an improper payment to Provider by Health Plan that resulted from an audit, review, or investigation of the Provider. Health Plan retains recovery rights to any amount paid to ODM when a Provider self-reports an overpayment arising from a payment made by Health Plan to Provider or other reason. (SC App. G. 11.b.v)

69. **Time for Recovery of Overpayments**. Health Plan may recover overpayments made Provider if the overpayment is identified and Provider is notified within two years of the date Health Plan improperly paid Provider, within 6 months of

the MFCU returning a Fraud referral to Health Plan, within any applicable statute limitations for Fraud, or if ODM recovers the payment to Provider from Health Plan, whichever is later. (SC App. G. 11.b.vi.)

70. **Response of Provider to Overpayment Claims**. Provider will have 30 Calendar Days from receipt of the notice to submit a written response disputing the overpayment or requesting an extended payment arrangement or settlement. If Provider fails to submit a written response within the time period provided, Health Plan may execute the recovery as specified in the notice. (SC App. G. 11.d.i) Upon receipt of a written response disputing the overpayment, Health Plan will, within 30 Calendar Days from the date the written response is received, consider the response, including any pertinent additional information submitted by Provider, together with any other material bearing upon the matter, and determine whether the facts justify recovery. (SC App. G. 11.d.ii) Health Plan will provide a written notice of determination that includes the rationale for the determination. If Health Plan determines the facts justify the recovery, Health Plan may execute the recovery within three Business Days of sending the notice of determination. (SC App. G. 11.d.iii.)

71. **Payment Extension Arrangement.** Upon receipt of a written response from Provider requesting an extended payment arrangement or settlement, the MCO will, within 30 Calendar Days from the date the written response is received, consider the response, including any pertinent additional information submitted by Provider, and determine whether to allow an extended payment arrangement or enter into settlement discussions. Health Plan will provide a written notice of determination and, as applicable, the proposed extended payment arrangement or settlement terms. However, Health Plan will not settle for less than the amount specified in the notice of intent to recover and any extended payment arrangement or settlement must be approved by ODM. Moreover, any extended payment arrangement or settlement must be finalized within 120 Calendar Days of the sending of the notice of intent to recover. (SC App. G. §11.e)

72. **Offsetting of Overpayments.** Outstanding Claims to Provider will be adjusted or voided, as applicable, to reflect identified overpayments to Provider, regardless of whether they have been recovered. (SC App. G. §11.g.)

73. **ODM Identification of Overpayments.** If ODM identifies a Provider overpayment, ODM will notify Health Plan, and Health Plan will be responsible for recovering the payment from Provider. (SC App. G. §11.h.)

74. **Federal False Claims Act.** In accordance with 42 CFR 438.608, provisions regarding treatment of recoveries of overpayments made by Health Plan do not apply to any amount of a recovery to be retained under the federal False Claims Act cases or through other investigations. (SC App. G. §11.i)

75. **Recovery of Payments for Disenrolled Members.** Health Plan may recover payments made to Provider for Covered Services rendered to a Covered Person who was retroactively disenrolled from Health Plan in accordance with the following (SC App. G. §12):

    a. Health Plan will initiate such recovery within 30 Calendar Days of notice of the capitation recovery.

    b. If the recovery is for payments made more than two years from the Date of Payment of Provider, Health Plan must notify ODM and receive permission to proceed with the recovery.

    c. Health Plan's recovery process will comply with the requirements for recovery of overpayments as described in the State Contract. In addition, Health Plan must notify Provider of the option to submit a Claim to ODM for services rendered to a Covered Person who was retroactively disenrolled from Health Plan.

    d. Health Plan will not recover payments from Provider beyond two years from the Date of Payment of the Claim due to a Covered Person's retroactive disenrollment from Health Plan, unless Health Plan is directed to do so by CMS or ODM.

76. **Timing of Identification of Overpayments**. Health Plan may recover overpayments to Provider if the overpayment is identified and Provider is notified within two years of the date Health Plan improperly paid Provider, within six months of the MFCU returning a Fraud referral to Health Plan, or if ODM recovers the payment made to Provider from the Health Plan, whichever is later. Moreover, Provider shall allow ODM to audit payments made to Provider by Health Plan and to recover overpayments under the time limits set forth in ORC section 5164.57. (SC App. O §2.a.xi)

77. **Data Available to Governmental Authorities**. Upon request, Provider must make available to state and federal authorities all administrative, financial, and medical data, documentation, and other information relating to the delivery of items or services under this Agreement. Provider must provide such data, documentation, and other information at no cost to the requesting entity. (SC App. G. §13.f)

78. **VBP.** To the extent Provider participates in Health Plan's value-based payment program, Provider shall cooperate and comply with Health Plan's VBP policies and procedures. Moreover, Health Plan will implement episode based payments pursuant to OAC rule 5160-19-4 and patient centered medical home payments pursuant to OAC rules 5160-19-01 and 5160-19-02 pursuant to its value based initiative program. (SC App. H)

79. **Accuracy and Completeness of Data.** Health Plan is required to ensure data received from Provider is accurate and complete by verifying the accuracy and timeliness of reported data, screening the data for completeness, logic, and consistency, and collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for ODM's quality improvement and care coordination efforts. Accordingly, Provider shall ensure all submitted data is accurate and complete and Provider shall undertake such efforts to ensure such accuracy and completeness as may be required by law. (SC App. K §1.a.i.4.)

80. **Third Party Liability.** Provider shall use third party liability (TPL) data maintained by ODM's fiscal intermediary for Provider's TPL activities and Provider shall cooperate with Health Plan's TPL policies and procedures. (SC App. K §5.b.viii and App L. §10)

81. **EVV**. In order to validate Claims during the Claims adjudication process, Provider must use ODM's electronic visit verification (EVV) system, or an alternative EVV system that has been certified by ODM's EVV vendor, for the following services, or as otherwise specified by ODM: Home Health Aide G0156, Nursing RN G0299, Nursing LPN G0300, PDN/Independent Nursing T1000, RN Assessment T1001, Nursing RN T1002, Nursing LPN T1003, Home Care Attendant S5125, Personal Care Aide T1019, Waiver services not otherwise specified T2025, Physical Therapy G0151, Occupational Therapy G0152, and Speech Language Pathology G0153. (SC App. K. §5.e.)

82. **ADT Data.** Moreover, Provider shall provide admission, discharge, and transfer data to both Ohio Health Information Exchanges (HIEs). Provider shall cooperate with Health Plan's utilization of HIEs. (SC App. K §10)

83. **Physician Incentive Plans.** In accordance with 42 CFR 422.208, in the event Provider participates in a physician incentive plan with Health Plan and Provider is at substantial financial risk for services that Provider does not furnish itself, Provider shall have either aggregate or per-patient stop-loss protection. (SC App. L §9.c.)

84. **NPI.** Provider shall have and, where required by Health Plan, provide its National Provider Identifier (NPI) (SC App N, Table N.1, Box 64)

85. **Termination of State Contract.** The Agreement will terminate if and when the State Contract is terminated. (SC App. O §1) Upon expiration or termination of the Agreement, Provider shall comply with all obligations under the Program relating to transition of Covered Persons and Provider shall cooperate with Health Plan's Transition Plan. (SC App. O §2)

SCHEDULE B

Ohio Department of Medicaid
Buckeye Community Health Plan
MEDICAID ADDENDUM

This Addendum supplements the Base Contract or Agreement between **Buckeye Community Health Plan** and _____ effective _____ and runs concurrently with the terms of the Base Contract or Agreement *(hereinafter referred to as "Base Contract").* 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 **Buckeye Community Health Plan**'s Provider Agreement or contract with the Ohio Department of Medicaid **(select all that apply)**

☐ All Managed Care Organization (MCO) members ☐ Medicaid Managed Care Single Case Agreement ☐ All MyCare Ohio plan (MCOP) members ☐ MyCare Ohio Single Case Agreement

☐ All OhioRise members ☐ OhioRISE Single Case Agreement

☐ All Single Pharmacy Benefit Manager (SPBM) members

The provider agrees to provide services to the managed care entity's *(MCE's)* member(s) within the designated services area(s) as specified below **(select all that apply)**

MCO Service Area	**SPBM Service Area**	**OhioRISE Service Area**
☐ Statewide	☐ Statewide	☐ Statewide
MCOP Service Areas ☐ Central ☐ West Central ☐ East Central ☐ Northeast ☐ Northwest ☐ Southwest ☐ Northeast Central		

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

The provider must either be currently enrolled as a Medicaid provider and meet the qualifications specified in Ohio Administrative Code (OAC) rule 5160-26-05(C) or be in the process of enrolling as an Ohio Department of Medicaid (ODM) provider. ODM administered home and community based services (HCBS) waiver providers must be currently enrolled as an ODM provider with an active status in accordance with Agency 5160 of the Ohio Administrative Code.

ADDENDUM PROVISIONS

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

A. All providers providing health care services to **Buckeye Community Health Plan**'s members as specified above, 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 all specialties as identified in their ODM enrollment or the specialties as enumerated in Attachment C of this Addendum. Any amendment to Attachment C must be agreed to by both parties.

   i. Attachment C is not required for pharmacy providers when contracting with the SPBM.

   ii. For single case agreements, Attachment C only needs to be completed if the Base Contract does not specify the service being provided.

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 Managed Care Entity (MCE).
   i. ODM will notify the MCE and the MCE shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCE.

   ii. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

iii. The MCE 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 MCE'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 MCE has elected to implement in accordance with OAC rule 5160-26-12, the MCE'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.

    i. The MCE shall notify the provider whether the MCE 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.

    ii. The provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

    iii. In accordance with OAC rule 5160-26-12, members who are under the age of twenty-one are excluded from co-payment obligations.

13. The provider will not hold liable ODM or any member(s) in the event the MCE cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exceptions that:

    i. FQHCs and RHCs may be reimbursed by ODM in the event of MCE insolvency.

    ii. The provider may bill the member when the MCE denied prior authorization or referral for the services and the conditions described in OAC rule 5160-1-13.1 are met.

14. The provider will not bill members for missed appointments.

15. 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:

    i. Sign language services; and

    ii. Oral interpretation and oral translation services.

16. 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).

17. The provider will not identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

18. 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 MCE for processing.

19. The provider will release to the MCE, ODM, or ODM's designee(s) any information necessary for the MCE to perform any of its obligations under the MCE's provider agreement or contract with ODM, including but not limited to, compliance with reporting and quality assurance requirements.

20. The provider will supply, upon request, the business transaction information required under 42 CFR. 455.105.

21. The provider will contact the MCE'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 or OAC rule 5160-59-03.

22. All of the provider's applicable facilities and records will be open to inspection by the MCE, ODM, or ODM's designee(s), or other entities as specified in OAC rule 5160-26-06.

23. The provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

24. The provider will retain and allow the MCE access to all member medical records for a period of not fewer than ten years from the date of service or until any audit initiated within the ten 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 ten year-period of documentation must be readily available.

25. The provider will make medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.

B. All participating providers providing health care services to **Buckeye Community Health Plan**'s members as specified above, not including providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. Notwithstanding item A.2 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

    i. The provider gives the MCE 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

    ii. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10, regardless whether the action is appealed. The provider's nonrenewal or termination written notice must be received by the MCE 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.

C. If applicable based on the service(s) being provided to **Buckeye Community Health Plan**'s member(s) as specified above, the provider agrees to abide by the following specific terms:

1. ☐ 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 or OAC rule 5160-59-03.2

2. ☐ If the provider is a hospital or hospital system, Attachment B (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.

3. ☐ 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 MCE, 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.

4. ☐ 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.

5. ☐ 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.

6. ☐ 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.

7. ☐ Institutional providers will assure discharge planning begins upon the member's admission to the facility and discharge will not occur until there is a safe discharge plan in place, including identification of and arrangement for necessary community supports.

D. **Buckeye Community Health Plan** agrees to abide by the following specific terms:

1. The MCE 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 MCE's policies and procedures for detecting and preventing fraud, waste and abuse.

2. The MCE 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 MCE'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.

3. The MCE 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:

    i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

    ii. Any information the member needs in order to decide among all relevant treatment options.

iii. The risks, benefits, and consequences of treatment versus non-treatment.

iv. 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.

4. Not with standing item A.2 of this Addendum, and with the exception of single case agreements, the MCE 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, and/or C may be made without renegotiation of the Base Contract or this Addendum.

SIGNATURES

Buckeye Community Health Plan	Provider Name
Signature	Signature
Printed Name	Printed Name
Title	Title
Date	Date