Ohio Department of Medicaid

Anthem Blue Cross and Blue Sheild

MEDICAID ADDENDUM

This Addendum supplements the Base Contract or Agreement between Anthem Blue Cross and Blue Sheild 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 Anthem Blue Cross and Blue Sheild 's Provider Agreement or contract with the Ohio Department of Medicaid **(select all that apply)**

- ☑ All Managed Care Organization (MCO) members
- ☐ All MyCare Ohio plan (MCOP) members
- ☐ All OhioRise members
- ☐ All Single Pharmacy Benefit Manager (SPBM) members
- ☐ Medicaid Managed Care Single Case Agreement
- ☐ MyCare Ohio Single Case Agreement
- ☐ OhioRISE Single Case Agreement

The provider agrees to provide services to the managed care entity's *(MCE's)* member(s) within the designated service 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 Anthem Blue Cross and Blue Sheild '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 Anthem Blue Cross and Blue Sheild ▼ '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

2. 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. The provider will cooperate with the MCE's quality assessment and performance improvement (QAPI) program in all the MCE's provider subcontracts and employment agreements for physician and non-physician providers.

D. The provider will cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, ad on-site audits, as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160.

C. If applicable based on the service(s) being provided to Anthem Blue Cross and Blue Sheild ▼ '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. ☐ 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.

3. ☐ 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.

4. ☐ 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.

5. ☐ 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.

6. ☐ 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. Anthem Blue Cross and Blue Sheild 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 and/or C may be made without renegotiation of the Base Contract or this Addendum.

SIGNATURES

MCE Name	Provider Name
Signature	Signature
Printed Name	Printed Name
Title	Title
Date	Date