

ADVANTAGE *Care Select* Program Addendum to the Indiana Health Coverage Programs/Medicaid Provider Agreement

This is an addendum to the Indiana Health Coverage Programs/Medicaid (IHCP/Medicaid) Provider Agreement ("the Agreement"). All other matters previously agreed to and set forth in the Agreement, and not affected by this addendum, shall remain in full force and effect.

By execution of this addendum, to the IHCP/Medicaid Provider Agreement, the undersigned physician requests enrollment as a Primary Medical Provider (PMP) in the above-referenced Care Management Organization's (CMO) provider network for the *Care Select* Program ("*Care Select* Program").

Enrollment Requirements

1. The provider is a physician in the field of General Practice, Family Practice, General Pediatrics, General Internal Medicine or Obstetrics/Gynecology and operates a primary care mode of practice OR a physician in any specialty who agrees to the responsibilities and requirements of a *Care Select* Program *PMP*.
2. For group practices and clinics, the qualified physician agrees to act as the primary care provider for each member assigned to him/her. It is preferred that each physician in a group or clinic enroll as a PMP in the *Care Select* Program. However, not all physicians in the group have to enroll as PMPs for other group members to participate in the program.
3. The PMP agrees to submit, as a prerequisite to the effectiveness of this addendum, the information set out in the PMP Enrollment Form (Schedule A) and the PMP must be approved as a PMP by the *Care Select* Program.
4. The PMP shall update any changes in the information listed in the Enrollment Form of this addendum at least 30 days prior to the effective date of the changes. The most recent copy of the addendum and Enrollment Form submitted by the PMP shall supersede (unless noted to the contrary) the current addendum and Enrollment Form as applicable.
5. The PMP must also notify IHCP Provider Enrollment of all provider file changes, using the appropriate group or provider number.
6. Each PMP must designate a panel size on the Enrollment Form, i.e., the number of *Care Select* Program members he/she is willing to accept

General Responsibilities of the Provider

7. The provider's PMP activities will be governed by the guidelines and policies set forth in the *Care Select* Program *Provider Manual* (*Care Select* Manual), as amended from time to time, as well as all PMP bulletins and notices. This includes, but is not limited to, full participation and cooperation with the *Care Select* Program quality improvement and utilization management requirements as outlined in

the *Care Select* Manual. Adherence to these requirements shall be binding upon receipt of this addendum. Any amendments to the *Care Select* Manual, as well as provider bulletins and notices, communicated to the PMP shall be binding upon receipt. Receipt of amendments, bulletins, and notices by the PMP shall be presumed when mailed to the PMP's current "mail to" address on file with the Office of Medicaid Policy and Planning (OMPP) or its fiscal agent.

8. The provider agrees to be listed as a PMP in the *Care Select* Program provider listing.
9. Hospital Privileges. The PMP shall have admitting privileges at a local accredited hospital. PMPs without such privileges must make arrangements for admissions with a physician of similar specialty who does have admitting privileges. These arrangements must be documented in writing and are subject to approval of the *Care Select* Program. PMPs who provide prenatal services must also have delivery privileges. PMPs who withdraw from or lose their hospital admitting or delivery privileges must notify the *Care Select* Program within seven (7) days.
10. Non-Emergency Admissions. Non-emergency inpatient admissions require approval from the PMP. The PMP shall not refuse to approve any appropriate, medically necessary inpatient admissions.
11. Multiple Office Locations. A physician may select multiple office locations at which he/she will serve as a PMP, i.e., accept assignments to his/her practice panel. Physicians are not restricted as to where they can provide medical care; however, the provider must be enrolled in IHCP at each of the service locations he/she chooses as his/her location.
12. Minimum Office Hours. A PMP in private practice must be available to see patients for a minimum of 20 hours per week, 3 days per week. A PMP with multiple locations may meet this minimum requirement between both locations. In group practice or clinic settings, one or more appropriate on-site physicians of the same scope of practice may meet this minimum requirement.
13. 24-Hour Availability. The PMP must provide reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions. The PMP agrees to be available 24 hours per day, seven days per week, via telephone to a live voice or a paging system. The live voice must be the PMP, an employee or designee of the PMP, or an answering service. The pager system must immediately page an on-call medical professional and the on-call professional shall respond to the page within one hour of being paged.
14. The PMP will, from time to time and with reasonable notice, permit and make arrangements for the OMPP or its contractors and the *Care Select* Program to review medical records of *Care Select* Program members for quality of care studies.
15. The PMP agrees to participate in access to care monitoring audits.
16. The PMP agrees to have specific written policies allowing members to receive information on available treatment options or alternative courses of care, regardless of whether or not the benefits are covered by the *Care Select* Program.
17. The PMP may not discriminate in enrollment, disenrollment, re-enrollment, or the provision of covered services, based on the member's age, sex, race, color, national origin, ancestry, religion, income level, physical or mental disability, health status or need for health services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs, except when continued enrollment with the PMP seriously impairs the PMP's ability to furnish

services to this particular member or other members or when that illness or condition can be better treated by another provider type.

18. The PMP agrees to provide *Care Select* Program covered services to members in the same manner as services are provided to all other patients, that is, according to the severity of medical need and availability of personnel, equipment, and/or necessary facilities. Members shall not be discriminated against on the basis on an adverse change in health status, utilization of medical services, or on being a member of the *Care Select* Program.
19. The PMP agrees to accept members as assigned by the *Care Select* Program, except as modified herein, up to the limit specified by the PMP on the Enrollment Form. A patient/physician relationship for this program is initiated by a member's selection of a PMP or assignment by the program if the member fails to choose. PMPs cannot designate their practice as open to his/her current patients only.
20. Once the PMP's panel size has reached the designated limit, the PMP will not be assigned members by default. The PMP understands that the actual number of members on the panel roster may exceed the designated limit, under the following circumstances:
 - a. if the member had a previous relationship with the PMP;
 - b. if a family member with the same Case ID number is already assigned to the PMP; or
 - c. if the PMP requests, in accordance with the procedure outlined in the *Care Select* Manual, that the member be added to his/her panel, and such request is approved by the program.
21. A physician who has reason to believe that a child under eighteen years of age is a victim of child abuse or neglect shall make a report to the local child protection service or local law enforcement agency as required by Indiana law (I.C. 31-33-5-1). If the reporting physician is part of a public or private facility or agency, then that person must also notify the individual in charge of the public or private facility or agency of the report (I.C. 31-33-5-2). Failure to comply with these provisions is a Class B Misdemeanor (I.C. 31-33-22-1).
22. PMPs will maintain a comprehensive medical record for each patient enrolled in the *Care Select* Program in accordance with 405 IAC 1-5-1. The PMP shall retain all records relating to the provision of services under this addendum for at least 7 years from the date of creation.
23. The PMP will transfer, at no cost to the member, a summary or copy of the member's medical records to another PMP or to the *Care Select* Program if the member is reassigned, or to the OMPP or its designee upon request.
24. The PMP must have specific written policies and procedures to allow members to have access to his or her medical records in accordance with applicable Federal and State laws.

Delivery of Services

25. The provider agrees to function in the role of PMP, as an authorized provider for the *Care Select* Program's provider network. In this role, the PMP will provide, or will arrange for the provision of, routine comprehensive preventive services, medically necessary primary care treatment and urgent care services, in keeping with the universally accepted standards as defined by Paragraph 29 of this addendum.
26. In particular, the PMP will provide, coordinate or seek referrals for the following services:
 - a. physician services;

- b. hospital inpatient and outpatient services; and
 - c. ancillary services including but not limited to: laboratory and radiology; orthotics/prosthetics; HealthWatch/EPSTD; audiology; and durable medical equipment and supplies specified in the *Care Select* Manual and any services added in Provider bulletins amending the *Care Select* Manual.
27. The PMP agrees to provide patient management services in accordance with the *Care Select* Manual and on a timely basis. The PMP agrees to work with the *Care Select Program* nurse care managers and other related health care professionals as needed based on the member's care plan.
28. HealthWatch/EPSTD Services. The PMP will promote and provide HealthWatch services for members under age 21 or refer members to other appropriate providers, in accordance with the IHCP EPSTD/HealthWatch Provider Manual.
29. Adherence to Universally Accepted Standards of Care. The PMP agrees to adhere to universally accepted standards or periodicity schedules, of preventive care for pregnant women, infants, children, adolescents and adults. These standards or periodicity schedules are endorsed by the Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, and the American Society of Internal Medicine, as listed in the *Care Select* Manual.
30. Advance Directives. The PMP must comply with requirements of Federal and State law with respect to advance directives.

Referrals

31. The PMP must make referrals to appropriate physicians and other practitioners who are IHCP providers to ensure that services are furnished to members promptly and without compromise to quality of care.
32. The PMP may refer a member under his/her care to another IHCP participating provider for any medically necessary service. Referrals may be given in writing or by telephone. Referrals must be documented in the medical record by the PMP. The PMP must specify which services are covered by the referral and may cover one or multiple visits to complete a plan of care. An optional sample referral form is included in the *Care Select* Manual.
33. The PMP shall refer a member to his/her selected specialist if the member is already an established patient of that physician, and the physician is an IHCP provider.
34. If, at the time of assignment, a member has an established relationship with another provider from whom the member requires immediate medical attention, the PMP shall make a referral to that provider in order to maintain continuity of care for the member. Examples of this situation include members who enroll in the *Care Select* Program during late stages of pregnancy or have previously scheduled surgery with a physician other than the PMP.
35. The PMP shall make a referral to an IHCP provider for a second opinion if requested by the member. This referral shall apply only to the consultation. Any subsequent treatment by the second opinion provider, if necessary, shall require a separate referral.
36. The following services do not require a PMP referral:
- a. Emergency services, as defined in the *Care Select* Manual
 - b. Eye Care (except eye surgical services)

- c. Family Planning Services
- d. Dental Care
- e. Chiropractic Care
- f. Pharmacy
- g. HIV/AIDS Targeted Case Management Services
- h. Podiatry Services
- i. Behavioral Health Care, including mental health, substance abuse and chemical dependency services, provided by behavioral health provider specialty
- j. Disease/Case Management Services.

The above list may be amended in the future via provider bulletins.

Responsibilities to *Care Select* CMO

37. Subject to Network Requirements. Provider participation in the CMO provider network is subject to review and approval by the CMO. Acceptance of provider participation by the CMO is dependent upon CMO provider network and member access needs.
38. Provider Credentialing.
- a. Provider will submit to and abide by the CMO's Credentialing programs with respect to Provider's application for and continued participation in the CMO provider network. To the extent Provider operates a facility that provides services subject to review and accreditation by a recognized accrediting body under the CMO's then-current credentialing requirements, Provider shall obtain and maintain such accreditation at all times during the term of this addendum.
 - b. Provider shall notify the CMO within ten (10) business days following Provider's receipt of any notice regarding an adverse action related to any restrictions upon, or any suspension, loss or surrender of, any professional license, certification or registration; privileges; Drug Enforcement Administration provider number; or any other action that impacts Provider's ability to render Covered Services. In the case of a Provider who operates a facility, this requirement shall apply to any adverse action related to any restrictions upon, or any suspension or loss of, the provider's accreditation as required under the CMO's then-current credentialing requirements.
 - c. Subject to applicable law, State Contract, and the *Care Select* Program requirements, this addendum shall immediately terminate upon any such expiration, surrender, revocation, restriction, or suspension as described in this section.
39. Coordinated Care. Provider shall participate in the CMO's programs designed to facilitate the coordination of all medically necessary Covered Services, including both physical and behavioral health healthcare services, as well as other non-medical services that a Member may be receiving or be in need of receiving. Subject to medical judgment, patient care interests, and a patient's express instructions, and recognizing that the level of Covered Services provided by Provider may be affected by the Provider's scope of services, Provider shall abide by all applicable laws and regulations, the State Contract and all *Care Select* Program and CMO requirements governing the referral of Members. For Members requiring hospitalization, Provider shall abide by all applicable CMO policies and procedures and all State Contract, Program and CMO utilization review requirements.
40. Responsibility for Medical Care Decisions. Provider shall be solely responsible for all medical advice and services provided by Provider to Members, and acknowledges and agrees that the CMO will neither be responsible nor liable for the manner or method by which Provider provides services to Members.

Provider acknowledges and agrees that payment may be denied for provider services rendered to a Member that it determines are not Medically Necessary, are not Covered Services pursuant to the State Contract, or are not otherwise provided in accordance with this Agreement, the State Contract and all *Care Select* Program and CMO requirements. Neither such a denial nor any other action taken by the *Care Select* Program pursuant to a utilization review, referral or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Member under applicable law and any applicable code of professional responsibility.

41. Noninterference with Medical Care. Provider agrees to provide treatment to Members in a manner consistent with sound medical judgment and practice. Nothing in this Agreement shall be construed to require Provider to take any action inconsistent with Provider's professional judgment concerning the medical treatment to be provided to Members. The CMO shall not prohibit or restrict Provider from advising a Member about his or her health status, medical care or treatment options, regardless of whether benefits for such care are provided under the Program, as long as Provider is acting within his or her scope of practice. However, the CMO reserves the right to make coverage decisions when a dispute exists regarding the Medical Necessity of a Covered Service. Provider will maintain the relationship of physician and patient with Member, without intervention in any manner by the CMO or its agents or employees, and Provider will be solely responsible for all medical advice to and treatment of his or her patients and for the performance of all medical services in accordance with accepted professional standards and practice.
42. Quality and Utilization Management. Provider agrees to participate in quality improvement activities, care coordination activities, grievance procedures, continuing medical education requirements and other policies and programs of the CMO as may be required from time to time. Provider shall cooperate with the CMO in satisfying the accreditation standards of NCQA and OMPP, among others. Provider agrees to participate in and cooperate with the decision, rules and regulations established by the CMO's medical management and disease management programs. Provider also agrees to abide by the terms of the CMO's *Care Select* quality improvement incentive plan, if applicable.
43. Provider agrees to request and encourage members to sign a consent that permits release of substance abuse treatment information to the CMO and to the PMP or behavioral health provider, if appropriate. The disclosure of mental health records by the provider to the CMO and to the PMP is permissible under HIPAA and State law (IC 16-39-2-6(a)) without consent of the patient because it is for treatment.
44. Adherence to Policies and Procedures. Provider shall adhere to such reasonable policies and procedures as may be developed and implemented by the CMO from time to time during the term(s) of this addendum. The CMO will provide Provider with any revised or new policies and procedures with thirty (30) days prior notice unless otherwise required by the *Care Select* Program.
45. Proprietary Information. All information and materials provided, directly or indirectly, by the CMO to Provider (including without limitation, contracts, procedures, manuals, operations manuals and or software) shall remain proprietary to the CMO or OMPP, as the case may be. Provider shall not disclose or permit the disclosure of any such information or materials or use them except as provided in this addendum.
46. Provider Listing. Provider acknowledges and agrees that the CMO shall be entitled to use (i) the name(s), business address(es), and phone number(s) of Provider and (ii) in addition to the foregoing,

information about education, specialty, subspecialty, licensure, certification, hospital affiliation, office hours, languages spoken, and any other demographic information for any individual Participating Provider employed by or under contract with Provider to provide services under this addendum, for the purposes of enrolling and referring Members, marketing, complying with *Care Select* Program and CMO program requirements, reporting, and otherwise carrying out the terms and conditions of this addendum.

Miscellaneous Provisions

47. The provider agrees to provide PMP services for each *Care Select* member listed on the panel roster, unless the PMP can demonstrate just cause for terminating these responsibilities and requests that a member be assigned to another PMP. If a PMP wishes to terminate these responsibilities for a specific member, he/she must continue to perform PMP functions for the assigned member for up to 30 days or until the member has been linked to another PMP, whichever comes first. The PMP must notify the member of his/her intention to request removal of the member from his/her caseload prior to submitting the request to the *Care Select* Program. The PMP shall forward any correspondence requesting the removal of a member from his/her panel to the program, in accordance with the *Care Select* Manual. Requests will be considered for the following reasons only:
- a. Missed appointments
 - b. Member fraud
 - c. Threatening, abusive or hostile behavior
 - d. Medical needs better met by another PMP
 - e. Breakdown of the physician/patient relationship
 - f. Member accessing care from another provider
 - g. Previously approved reassignment
 - h. OB reassignments

For further information, please see the *Care Select* Manual.

48. *Care Select* Program members may request a PMP change at any time. If a change is approved by the program, the current PMP must continue to perform PMP functions for the assigned member for up to 30 days, or until the member has been linked to another PMP, whichever comes first.
49. PMPs enrolled in the *Care Select* Program will receive a six dollar (\$6.00) monthly administration fee for each member on the panel roster. Administration fees will not be paid for any month during which the PMP's license lapsed or was terminated for all or part of that month. Further, failure to comply with all *Care Select* Program guideline-based care may result in forfeiture of this fee, as appropriate and as approved by OMPP.
50. Reimbursement for services provided will follow the IHCP fee schedule. Fees for services provided will not be paid for any month during which the PMP's license lapsed or was terminated for all or part of that month.
51. Reimbursement under this Agreement shall immediately terminate with or without notice upon:
- a. the death or retirement of the PMP,
 - b. the sale of the PMP's practice; or
 - c. the termination of the PMP from participation in the IHCP Program and or the *Care Select* Program.
52. The PMP shall notify the *Care Select* Program if he/she is sued or receives any contact from a

member/patient or his/her attorney or other representative about a possible lawsuit or claim arising from the provision of services under this addendum.

53. The PMP authorizes the OMPP to intervene, at the OMPP's discretion, in any litigation arising from the provision of services under this addendum.
54. This addendum, including the rights, benefits or duties hereunder shall not be assigned in whole or in part either directly or indirectly by either party, unless documented in writing and agreed upon by both parties.
55. This addendum contains all the terms and conditions pertaining to the *Care Select* Program agreed upon by the parties. All other matters previously agreed to and set forth in the Agreement, and not affected by this addendum, shall remain in full force and effect. Where the terms of the addendum and the Agreement conflict, the terms of the addendum shall supersede those of the Agreement.
56. If any provision of this addendum is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; each provision not so affected shall be enforced to the fullest extent permitted by law.
57. Inconsistency or Ambiguity. Any inconsistency or ambiguity in this addendum shall be resolved by giving precedence in the following order:
 - a. the express terms of this addendum;
 - b. the *Care Select* Manual;
 - c. the IHCP/Medicaid Provider Agreement;
 - d. the IHCP/Medicaid Manual;
 - e. Exhibit 1 to this addendum;
 - f. any other document, standards, laws, rules or regulations incorporated by reference in the above materials, all of which are hereby incorporated by reference.

Sanctions

58. At the option of the OMPP and after appropriate review, OMPP may sanction any PMP who:
 - a. Fails substantially to provide medically necessary services that the PMP is required to provide, under law or under its agreement with the OMPP, to a member enrolled on his/her panel.
 - b. Imposes on members any co-pays or charges that are in excess of allowable co-pays or charges permitted under the program.
 - c. Acts to discriminate among members on the basis of their health status or need for health care services.
 - d. Misrepresents or falsifies information submitted to the OMPP or CMS.
 - e. Misrepresents or falsifies information that he/she furnishes to a member, potential member or health care provider.
 - f. Distributes, directly or indirectly, any marketing materials or information that has not been approved by the OMPP or that contains false or misleading information.
 - g. Violates any applicable requirements of federal or state laws, rules or regulations.

Sanctions may include, but are not limited to, panel size limitations, case management fee withdrawal, civil monetary penalties or termination of the addendum, as well as termination of the Medicaid Provider Agreement. Prior to imposing sanctions, the OMPP will provide written notification about the basis and nature of the sanctions as well as any due process protections that the OMPP provides.

Sanctions are further addressed in the *Care Select* Manual.

Term and Termination

59. This addendum shall be effective upon approval by CMS for the *Care Select* Program.
60. This addendum will expire concurrent with any termination or expiration of the Agreement. This addendum may also be terminated as follows:
 - a. By the OMPP for the PMP's breach of any provision of this addendum as determined by OMPP, or
 - b. By the OMPP upon 60 days written notice.
61. In the event the PMP desires to terminate his/her participation in the *Care Select* Program or in the IHCP Program, the PMP shall provide sixty (60) days advanced written notification including his/her reasons for seeking termination of this addendum and/or the Medicaid Provider Agreement to the OMPP, or its agent, and the *Care Select* CMO. Within thirty (30) days of OMPP, or its agent's, receipt of the PMP's written notice, the OMPP, or its agent, shall provide written confirmation of the PMP's request. The termination shall be effective forty-five (45) days from the date of OMPP, or its agent's, written confirmation. Termination effective dates shall not be granted retroactively.
 - a. The PMP shall notify each *Care Select* member under his/her care of the PMP's decision after confirmation from the OMPP and prior to the effective date of said termination. This notification must be made individually and in writing to members prior to the effective date of termination. The PMP must provide a copy of the notification to the OMPP, or its agent, by the effective date of termination.
 - b. In order to ensure continuity of care for members affected by the PMP's termination from the *Care Select* Program, whether that termination is initiated by the PMP, or the OMPP, or its agent, the PMP will continue to comply with all of the terms of this addendum and Agreement until the effective date of termination.
 - c. The *Care Select* CMO shall facilitate the transfer of *Care Select* Program members enrolled with the PMP to new PMPs in an expeditious manner. In no event shall any *Care Select* Program member remain assigned to the PMP after the effective date of the termination.
 - d. The OMPP shall continue payment of monthly case management fees for each *Care Select* Program member who continues to be assigned to the PMP up to the effective date of the termination, or until all *Care Select* Program members are reassigned, whichever comes first.
62. Termination of the *Care Select* Program or the termination of the CMO provider network contract will result in the termination of this addendum. Termination of the *Care Select* Program in the county or counties served by the PMP will also result in the termination of this addendum for the county or counties where the *Care Select* Program is terminated. Termination under this paragraph may be communicated to the PMP through a provider bulletin or notice, and will be effective forty-five (45) days after the date of the bulletin or notice, unless a later effective date is announced in the bulletin or notice.
63. Notwithstanding any other provision herein, this addendum shall become effective only upon the PMP's completion of the IHCP provider enrollment process and a determination by the OMPP or its designee that the PMP meets all of the requirements for participation in the *Care Select* Program. In the event that this condition precedent is not met, this addendum shall be null and void.

The undersigned, being the provider, or having the specific authority to bind the provider to the terms of this

agreement, and having read this agreement and understanding it in its entirety, hereby agrees, both individually and on behalf of the provider as a business entity, to abide by and comply with all the stipulations, conditions, and terms set forth herein

Signature

Date

PMP's Full Name or PMP Group Name (Typed or Printed)

PMP's IHCP Provider ID (if PMP Group, please attach list)

PMP's or PMP Group Practice Name (If Different)

County