

**INTERAGENCY SUBGRANT/SUBRECIPIENT AGREEMENT
BETWEEN
THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
AND
THE OHIO DEPARTMENT OF MENTAL HEALTH**

A-1213-07-0279

RECITALS

This Subgrant of the federal grant identified in the following paragraph is awarded by the Ohio Department of Job and Family Services, State of Ohio (hereinafter referred to as "ODJFS") to the Ohio Department of Mental Health (hereinafter referred to as "ODMH"). ODJFS hereby awards this Subgrant and ODMH hereby accepts this Subgrant and agrees to comply with all the terms and conditions set forth in this Subgrant Agreement.

This Subgrant is made pursuant to the following federal awards: State Children's Health Insurance Award, CFDA# 93.767, Award #1105OH5021 for the 2011 FFY covering the period October 1, 2010 to September 30, 2011 and #1205OH5021 for the 2012 FFY covering the period October 1, 2011 to September 30, 2012, awarded by the United States Department of Health and Human Services; the Medicaid Cluster Award (Subsidy and Administration), CFDA #93.778, Award #1105OH5028 and 1105OH5048 for the 2011 FFY covering the period October 1, 2010 to September 30, 2011 and 1205OH5028 and 1205OH5048 for the 2012 FFY covering the period October 1, 2011 to September 30, 2012 #1305OH5028, awarded by the United States Department of Health and Human Services and the Money Follows the Person Rebalancing Demonstration Grant Award, CFDA# 93.791, Award #1LICMS300156, awarded by the United States Department of Health and Human Services. These Subgrants are not for research and development purposes.

ODJFS shall be the "Paying Agency" for purposes of this Interagency Subgrant/Subrecipient Agreement. The Director of ODJFS is Michael B Colbert, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43215-3414. The ODJFS Agreement Manager for purposes of this Agreement only is Daniel Arnold, Medicaid Health Systems Administrator, 50 West Town Street, Suite 400, 5th floor, Columbus, Ohio 43215, 614-752-3525, daniel.arnold@jfs.ohio.gov.

ODMH shall be the "Receiving Agency" for purposes of this Interagency Subgrant/Subrecipient Agreement. The Director of ODMH is Tracy J. Plouck, 30 East Broad Street, 8th Floor, Columbus, Ohio 43215. The ODMH Agreement Manager for purposes of this Agreement only is Angie Bergefurd, Assistant Deputy Director, 30 East Broad Street, 7th Floor, Columbus, Ohio 43215, 614-387-2799, angie.bergefurd@mh.ohio.gov.

PROGRAM SPECIFIC DEFINITIONS

ARRA	American Recovery and Reinvestment Act of 2009, H.R. 1.
CMH Boards	Community Mental Health Boards which, in addition to Alcohol, Drug Addiction and Mental Health (ADAMH) Services Boards established pursuant to ORC Chapter 340 have contracts with ODMH for Medicaid reimbursement of mental health services. For purposes of this agreement, CMH Boards are considered subrecipients to ODMH, unless determined otherwise by an appropriate authority.
CMS	The Centers for Medicare and Medicaid Services, United States Department of Health and Human Services.
CMH Agency	A Community Mental Health provider as defined in ORC 5122.01 which has been certified by ODMH in accordance with the requirements of ORC 5119.611. For purposes of this agreement, CMH Agencies are considered vendors, unless determined otherwise by an appropriate authority.

CMH Services	Community Mental Health Services, including the following medical, psychotherapeutic or rehabilitative services provided in accordance with OAC Chapters 5122-24 through 5122-29: Behavioral Health Counseling and Therapy Services as described in OAC 5122-29-03 and 5101:3-27-02; Mental Health Assessment Services as described in OAC 5122-29-04 and 5101:3-27-02; Pharmacologic Management Services as described in OAC 5122-29-05 and 5101:3-27-02; Partial Hospitalization Services as described in OAC 5122-29-06 and 5101:3-27-02; Crisis Intervention Mental Health Services as described in OAC 5122-29-10 and 5101:3-27-02; and Community Psychiatric Support Treatment Services as described in OAC 5122-29-17 and 5101:3-27-02.
CPE	Certified Public Expenditure, a certification by a Board that it has expended non-federal, public funds on items and services eligible for federal match under the Medicaid and SCHIP programs.
DSH	Disproportionate Share Hospital, special funding to hospitals which treat significant populations of indigent patients, as set forth in 42 CFR 412.106.
eFMAP	Temporary increase of Medicaid FMAP calculated quarterly per Section 5001 of the American Recovery and Reinvestment Act of 2009, H.R. 1.
FFP	Federal Financial Participation, providing for payments to states for a part of their federal medical expenditures, as set forth in 42 CFR 433.10.
FFS	Fee for service, where a provider who provides health care services to eligible Medicaid consumers bills and is paid by Medicaid for those services on a service claim basis.
FFY	Federal Fiscal Year. The Federal Fiscal Year runs from October 1 of a calendar year through September 30 of the following calendar year.
FMAP	Federal Medical Assistance Percentages and the enhanced federal medical assistance percentages. The percentages used by the U.S. Department of Health and Human Services (HHS) to determine the amount of federal matching funds for State medical assistance (Medicaid) and State Children's Health Insurance Program (SCHIP) expenditures.
HCBS	Medicaid Home and Community-Based Services.
IMD	Institution for Mental Disease, an institution that is primarily in providing care to persons with mental diseases, as defined in 42 USC 1396d(i).
Inpatient	Refers to psychiatric services provided in freestanding psychiatric hospitals where the patient is admitted and generally stays at least one night.
MACSIS	Multi-Agency Community Services Information System. The claim and encounter reporting system used by ODADAS, ODMH and Boards to process Medicaid and non-Medicaid claims and encounter data for community based alcohol or other drug (AoD) treatment and mental health services.
Medicaid	The health insurance program as set forth in Title XIX of the Social Security Act administered by Ohio through CFDA grant number 93.778.
MCPs	Managed Care Plan, a health care organization that makes arrangements for the provision of health care services to eligible individuals in Ohio's Covered Families and Children and Aged, Blind, and Disabled programs.
OAKS	The Ohio Administrative Knowledge System, an integrated computer system for performing some of the State's primary administrative tasks.

OBM	Ohio Office of Budget and Management
ODA	Ohio Department of Aging.
ODADAS	Ohio Department of Alcohol and Drug Addiction Services.
ODODD	Ohio Department of Developmental Disabilities.
OMB	Federal Office of Management and Budget
ORC	Ohio Revised Code
PASSPORT	Preadmission Screening System Providing Options and Resources Today (PASSPORT), an HCBS waiver program for individuals who are eligible for Medicaid, need at least an intermediate level of care, and are age 60 or older.
PASRR	Pre-Admission Screening and Resident Review provisions of OBRA '87, as amended, and as prescribed in Ohio Administrative Code 5101: 3-3-14, 5101: 3-3-15.1, 5101: 3-3-15.2, 5123: 2-14-01, and 5122-21-03.
Physician Services	Those services covered in accordance with Chapter 5101:3-4 of the OAC provided to Medicaid recipients receiving inpatient psychiatric hospital services covered in accordance with OAC 5101:3-2.
QIO	Quality Improvement Organization (formerly Peer Review Organization), a private contractor working under CMS which monitors quality of care provided to Medicare beneficiaries.
Retrospective Review	Utilization review of medical necessity that is conducted after health care services have been provided to a patient.
SCHIP	The State Children's Health Insurance Program as set forth in Title XXI of the Social Security Act and administered by Ohio through CFDA grant number 93.767.
SFY	State Fiscal Year
State Plan Amendment	The means by which a state changes its State Plan under Title XIX of the Social Security Act, the document that defines Ohio's Medicaid program.
Utilization Review	Process used to monitor or evaluate the clinical necessity, appropriateness, or efficiency of health care services, procedures, or settings.

ARTICLE I. PURPOSE

The purpose of this Agreement is to identify a subrecipient relationship between ODJFS and ODMH with regard to providing or assisting to provide, with ODJFS, statewide access for eligible individuals who are covered by the Medicaid program as set forth in Title XIX of the Social Security Act or the State Children's Health Insurance Program (SCHIP) Medicaid expansion as set forth in Title XXI of the Social Security Act for: providing access to community mental health (CMH) services and psychiatric hospital services for Medicaid eligible consumers; implementing a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of services and excess payments, assesses the quality, and provides for the control of the utilization of those services; developing strategies for managing the Medicaid behavioral health services, including responsibility that may transfer to ODMH; and establishing and maintaining an eligibility verification system which will be part of a claims and encounter system for managing behavioral health care services. This Agreement will also assure statewide access to medically necessary covered services comparable in amount, scope and duration, with the exception of PASRR, in accordance with federal compliance requirements, including Statewide, Recipient Free Choice of Provider, Comparability of Services, and Reasonable Promptness. This Agreement is to implement the provisions of 42 CFR 431 (Subpart M). This Agreement also authorizes the transfer of federal funds between ODJFS and ODMH for those Medicaid services under CFDA 93.767 and CFDA 93.778. Attachments

entitled "Community Medicaid Services Agreement" (Attachment 1) and "ODJFS Medicaid Provider Agreement" (Attachment 2), which are hereby incorporated into this Agreement.

ARTICLE II. RESPONSIBILITIES OF ODJFS/THE "PAYING AGENCY"

A. General Program Responsibilities.

1. ODJFS is the single state agency in Ohio responsible for the administration of the Medicaid and SCHIP Programs and has the full legal authority to administer or supervise the administration of the programs. Certain discrete functions may be delegated to ODMH; however, nothing in this Agreement can modify, impair, or hinder the authority of ODJFS to administer the Medicaid and SCHIP programs.
2. ODJFS shall assign to ODMH the authority for the day-to-day administration of the Medicaid and SCHIP programs directly relating to the provisions of this Agreement in accordance with federal program requirements.
3. ODJFS, in consultation with ODMH, shall promulgate rules pursuant to the Ohio Administrative Code, Ohio Revised Code language, and State Plan Amendments governing the Medicaid and SCHIP programs administered by ODMH pursuant to this Agreement.
4. ODJFS shall determine the eligibility of Medicaid applicants on a timely basis according to appropriate provisions of state and federal law, regulations and rules, the Medicaid Eligibility Manual, and the Medicaid state plan.
5. ODJFS shall monitor ODMH performance under this Agreement and ODMH compliance with applicable state and federal laws, rules, and regulations.
6. ODJFS shall serve as the final arbiter of Medicaid provider agreement disputes by conducting administrative hearings in connection with ORC Chapter 5111.031.
7. ODJFS will be responsible for processing ODJFS provider agreements submitted by ODMH. ODJFS will return signed or denied provider agreements to ODMH on a bi-weekly schedule. ODJFS will notify ODMH when a community mental health provider is contacted regarding the need to renew a Medicaid provider agreement or upon termination or non-renewal of an agreement. As stated in the ODJFS Medicaid Provider Agreement, providers are responsible for providing to ODJFS ownership and/or control information as well as any changes in this information within thirty days of the change.
8. ODJFS shall process provider enrollment applications for those hospitals which are determined to be eligible to participate in the Medicaid program in accordance with OAC Chapter 5101:3-2.
9. ODJFS shall provide ODMH all material which is distributed by ODJFS to hospital providers who participate in the Medicaid program. Such material will be provided to ODMH and Medicaid providers at the same time.
10. ODJFS shall provide to ODMH, eligibility data to support administration of the community mental health program, comply with reporting requirements related to Medicaid inpatient hospital utilization and payment, ensure accurate ODMH hospital reimbursements, and facilitate Medicaid eligibility reinstatement upon hospital discharge. Spend down information will be made available to ODMH in order for the Boards to facilitate spend down eligibility determinations.
11. ODJFS will notify ODMH of any situation involving a potential risk to the health or welfare of a Medicaid client receiving community mental health services.
12. ODJFS shall provide ODMH the following regarding Healthchek (Early Periodic Screening, Diagnosis, and Treatment): education and/or training, access to informing materials, and technical assistance upon request.

B. Utilization Review.

1. Community Mental Health.

- a. All provider utilization review activities will be conducted under the authority of the ODJFS Office of Fiscal and Monitoring Services (OFMS). OFMS must approve the inclusion or exclusion of any information contained in the Surveillance and Utilization Review System audit or limited review report
- b. Using the agreed upon risk factors, OFMS will conduct data analysis using the OFMS analytic tool. The risk factors may be refined and/or adjusted as necessary.
- c. ODJFS will consult with ODADAS and ODMH to identify providers needing examination for utilization review. Based on materiality or as otherwise required, OFMS reserves the right to examine additional providers above and beyond those chosen by aforementioned consultation.
- d. In the instance where a limited review or audit determines that an overpayment exists, ODJFS will notify the provider and offer reconsideration or hearing rights under ORC Chapter 119. If necessary, the dollar finding will be turned over to the Office of the Attorney General for collection, following established protocol.
- e. ODJFS will refer all Board requests regarding provider UR activities to ODMH.
- f. ODJFS delegates to ODMH or its contractual designee the authority to make prior authorization decisions on its behalf. ODJFS reserves the right to review and override any prior authorization decision made by ODMH or its contractual designee which impacts a Medicaid covered service.
- g. ODJFS shall administer the consumer appeals process for prior authorization functions in accordance with requirements stated in OAC rule 5101:6-2-31.

2. Inpatient Psychiatric Services.

- a. For inpatient psychiatric services, ODJFS delegates responsibility for implementing, managing, and paying for a statewide utilization control program to ODMH. ODJFS reserves the right to review and override any inpatient admission precertification determination decision made by ODMH or its contractual designee which impacts an inpatient Medicaid covered service.
- b. ODJFS shall administer the State hearing process for recipients who wish to contest a pre-admission certification determination. Recipients have a right to state hearing in accordance with OAC 5101:6-1 through 5101:6-9.

3. Medicaid Overpayment Recoveries. ODJFS Medicaid overpayment recoveries of ODMH providers, including any recoveries made by the Collections Enforcement Section of the Office of the Ohio Attorney General, will be disbursed in the following manner:

- a. Recoup and apply the entire federal share percentage to the corresponding account receivable.
- b. Apply the non-federal share amount to ODMH using OAKS ODMH financial coding.
- c. If ODJFS recovers less than 100% of the overpayment, it shall remit to ODMH only amounts in excess of the federal share recovered.

C. Monitoring and Oversight.

1. ODJFS shall monitor ODMH to ensure that it submits quarterly, adjusted two-year budget projections of anticipated expenditures for Medicaid services for the next four (4) consecutive quarters.
2. ODJFS authorizes ODMH to enter into contracts with the CMH Boards in order to implement specific policies and actions that ODMH deems necessary to assure the accuracy and compliance of Boards' payments to providers or to otherwise assure the integrity of Medicaid and SCHIP programs administered on a day-to-day basis by ODMH. ODJFS shall review budget reports submitted by ODMH on a quarterly basis. If the budget report indicates that current ODJFS allocations designated for transfers of FFP to ODMH are not adequate to support the projected reimbursement, ODJFS shall initiate actions to increase the ODJFS allocations, including submitting a request to OBM when an increase in ODJFS appropriation is also required. Any increase in the allocation above the amounts in ARTICLE V would require an amendment to this Agreement.
3. ODJFS shall assist ODMH to assure the compliance of a CMH Board with the requirements of this Agreement and/or the ODMH/Board contract.
4. When a Board fails to reasonably comply with requirements described in this Agreement and/or its ODMH contract, ODJFS may require ODMH to suspend submission of Board specific claims to ODJFS for pursuit of FFP reimbursement. ODJFS shall monitor any action taken by ODMH to suspend the submission of claims.
5. If ODJFS determines that ODMH is not adequately enforcing requirements of any Board described in this agreement, or any other requirement necessary to assure the integrity of the Medicaid and SCHIP programs administered on a day-to-day basis by ODMH, ODJFS shall request a corrective action plan, in writing, and require ODMH to submit the plan within thirty (30) days of the date of the ODJFS written request. ODJFS shall approve or disapprove the plan, in writing, within ten (10) days from the date ODMH sends ODJFS the plan. If ODJFS disapproves the plan, it shall identify to ODMH elements of the plan that must be revised in order to be approved.
6. If ODMH fails to implement the plan of correction within ninety (90) days from the date ODJFS approves the corrective action plan, or ODJFS otherwise determines that ODMH enforcement remains inadequate, ODJFS may withhold all FFP reimbursement for claims for Medicaid services to ODMH until ODMH enforces the requirements.
7. ODJFS shall promptly notify ODMH when it takes any action to revoke or suspend a Medicaid provider's authorization to provide or be reimbursed for Medicaid services.
8. ODJFS and ODMH will collaborate to support the compliance with Section 1915(a) of the Social Security Act.
9. ODJFS shall provide general monitoring and oversight to assure ODMH meets applicable requirements as set forth in OMB Circular A-133.

D. PASRR.

1. ODJFS shall be responsible for oversight of the applicable PASRR provisions of OBRA '87, as amended.
2. ODJFS shall conduct program reviews of ODMH's performance of PASRR Level II determinations, in accordance with OAC 5101:3-3-14, 5101: 3-3-15.1, 5101: 3-3-15.2, 5123: 2-14-01 and 5122-21-03.
3. ODJFS shall allow ODMH access to records and exchange information with ODMH as necessary in order to implement PASRR.

4. ODJFS shall participate in joint planning with all agencies involved in implementing PASRR.
5. ODJFS shall compile data from ODMH, ODA and ODMRDD to monitor compliance with PASRR requirements and shall submit reports to CMS, as required by Section 1919(e)(7)(E) of the Social Security Act. Such reports shall include at least the following data components: hospital exemptions, PASRR determinations, timeliness, placement options, and instances of a lack of level II records.
6. ODJFS shall work with other state agencies, involved in the implementation of PASRR, to develop curriculum and schedule routine PASRR-related training for at least the following: nursing facilities, mental health agencies, community mental health boards, hospital discharge planners and hearing officers/supervisors.

E. ODJFS: General Fiscal Responsibilities.

1. Community Mental Health.
 - a. ODJFS shall transfer to ODMH FFP for appropriately adjudicated CMH service claims. Any claim submitted with a service date of at least 365 days prior will be rejected as a non-reimbursable service unless the provisions of OAC 5101:3-1-19.3(E) apply. The transfer of FFP under this provision is not subject to the interest provisions of ORC 126.30.
 - b. ODJFS may suspend payment of claims upon thirty (30) days notice if it reasonably believes ODMH and/or any Boards are not in material compliance with the requirements of this Agreement or with state or federal laws or rules which govern the Medicaid and SCHIP program.
 - c. ODJFS may receive a notice of a disallowance or deferral under 42 CFR 433.300 of a claim, including any penalties, assessed for mental health services furnished pursuant to this Agreement. If appropriate, ODJFS will reduce, by an amount equal to the amount disallowed or deferred, from payments requested in ODMH's monthly invoices until such time as the full amount is recovered.
 - d. ODJFS shall cooperate with ODMH in preparing appeals of adverse federal audit exceptions when ODJFS and ODMH consider an appeal is warranted. If, subsequently, ODJFS' or ODMH's position is upheld on appeal, funds withheld from deferral or audit exceptions shall be restored to ODMH upon availability of FFP.
 - e. ODJFS shall comply with the provision of ORC 5111.101 to meet Medicaid obligations under the False Claims Act and Section 6032 of the Deficit Reduction Act of 2005.
 - f. In accordance with the provisions of OAC 5101:3-1-27.2, ODJFS may require ODMH to initiate or participate in a hold and review process for mental health services paid through ODMH. After ODJFS sends ODMH a request to initiate a hold and review process, ODJFS will allow ODMH three (3) business days from ODMH's receipt of the request to implement the hold and review process. No federal reimbursement will be withheld during this period.
 - g. On a quarterly basis, ODJFS will prepare an ISTV and submit it to ODMH in order to recoup the value of federal funds to be repaid to CMS for overpayments reported to ODJFS by ODMH in a previous quarter. The amount of the ISTV will be reduced by the amounts of federal funds for overpayments already remitted to ODJFS by ODMH and by the amounts of federal funds for overpayments that have not been finalized due to pending hearings and/or final adjudications.

2. Inpatient Psychiatric Hospital.
 - a. ODJFS shall process all claims (invoices) for hospital services provided by psychiatric hospitals, including Medicaid claims and crossover claims for Medicare Part A and Part B services provided by private and public psychiatric hospitals.
 - b. ODJFS will determine the applicable Medicaid reimbursement amount for hospital services in accordance with OAC Chapter 5101:3-2, and will generate and make available to ODMH a provider-specific remittance advice for all hospital claims processed for services provided by psychiatric hospitals.
 - c. ODJFS will transfer to ODMH the FFP for hospital claims (including Medicare crossover claims) for services provided by public and private psychiatric hospitals, and will ensure that the ODJFS claims processing system does not make payments directly to psychiatric hospitals for these claims.
 - d. ODJFS shall process claims (invoices) for physician services provided to Medicaid recipients in public psychiatric hospitals, generate and transmit a remittance advice, and transfer to ODMH the applicable FFP.
 - e. ODJFS shall transfer funds to ODMH the total IMD-DSH payment(s) that must be made to private psychiatric hospitals that qualify for IMD-DSH adjustments in accordance with OAC 5101:3-2-10.
 - f. ODJFS shall reimburse administrative costs allowed by CMS for the inpatient psychiatric utilization review program at seventy-five percent (75%), which is the allowable FFP if ODMH enters into a contract with a Medicare QIO or an organization deemed QIO-like; or ODJFS will reimburse such costs at fifty percent (50%), which is the allowable FFP if ODMH contracts with a non-Medicare QIO.
 - g. ODJFS shall transfer to ODMH inpatient hospital upper limit payments for state psychiatric hospitals in accordance with OAC 5101: 3-2-51.
3. Money Follows the Person

Upon receipt of a valid ISTV from ODMH, ODJFS shall transfer up to Fifty Thousand and 00/100 Dollars (\$50,000.00) in SFY 2012 in Federal Funds for the ODMH MFP responsibility outlined in ARTICLE III, Section F, Paragraph 3.

ARTICLE III. RESPONSIBILITIES OF ODMH/THE "RECEIVING AGENCY"

- A. General Program Responsibilities.
 1. ODMH shall assist ODJFS in the development of Ohio Administrative Code rules, Ohio Revised Code language, and State Plan Amendments governing the Medicaid and SCHIP programs administered by ODMH pursuant to this Agreement.
 2. ODMH shall ensure that all responsibilities identified in this Agreement are implemented in accordance with the approved Medicaid State Plan and Amendments thereto, and in accordance with applicable Ohio Administrative Code and Ohio Revised Code provisions, and shall abide by official ODJFS policies and procedures that ensure the integrity and efficient and effective administration of the Medicaid and SCHIP programs.
 3. ODMH shall conduct monitoring and oversight of Boards and providers that participate in the Medicaid and SCHIP program per the responsibilities outlined in this ARTICLE III, Section D of this Agreement.
 4. ODMH shall carry out its responsibilities specified in this Interagency Agreement as a subrecipient.

5. ODMH shall establish mandatory requirements for Boards and CMH agencies which provide mental health services covered under this Agreement to ensure compliance with the provisions of this Agreement and all the requirements of federal or state law or rules governing the Medicaid and SCHIP programs. Such requirements may be implemented through the "Community Medicaid Services Agreement" (Attachment 1) executed between ADAMH/CMH Boards and CMH agencies. With the implementation of an ODJFS OAC rule or rules implementing a change in Ohio's community mental health treatment component of Ohio's Medicaid program, any reference in an already executed open ended "Community Medicaid Services Agreement" relating to the change is amended as the requirements of the OAC prevail.
6. ODMH shall assure that CMH service providers under this Agreement are certified by ODMH in accordance with OAC Chapter 5122-29 and ORC 5119.611.
7. ODMH will assure that each new CMH agency opting to participate in the Medicaid program completes the ODJFS Medicaid provider agreement. For agencies that meet ODMH's certification requirements, ODMH will forward the application to ODJFS stating that the agency has met its certification requirements. Upon review of the application, ODJFS will either approve or deny the application. If denied, the application will be returned to ODMH. ODMH will deliver agreements to ODJFS on a biweekly schedule. ODMH will not authorize new providers for billing through MACSIS until a properly executed ODJFS Medicaid provider agreement, including the assignment of an ODJFS Medicaid provider number, is received from ODJFS.
8. ODMH shall ensure that a Board-contracted provider opting to participate in the Medicaid program meets all applicable eligibility requirements as defined in OAC Chapter 5101: 3-27 for participation in the Medicaid program.
9. ODMH shall notify ODJFS in the event that a CMH agency loses its ODMH certification due to termination, failure to renew, or failure to meet recertification requirements.
10. ODMH shall ensure that fundamental Medicaid requirements are stipulated and adhered to in Medicaid agreements between ODMH and Boards and between Boards and providers of CMH services.
11. ODMH, using procedures appropriate to the situation, will address any situation identified by ODJFS involving a potential risk to the health or welfare of a Medicaid client receiving community mental health services.
12. ODMH shall provide for disclosure of survey information as required in 42 CFR 431.115.
13. ODMH shall comply with its responsibilities in such a manner as to comply with Healthchek (Early Periodic Screening, Diagnosis, and Treatment) requirements as applicable to its responsibilities as stated in this ARTICLE III.

B. Inpatient Psychiatric Hospitals.

1. ODMH shall advise and assist ODJFS in verifying that applicants meet requirements for participation in the Medicaid and SCHIP programs and forward completed application to ODJFS for assignment of a Medicaid provider number.
2. ODMH shall advise and assist ODJFS in determining if out-of-state hospitals are qualified psychiatric hospitals, if services they provide are available in Ohio, and if patients' needs are of an emergency nature.
3. ODMH shall assure that private psychiatric hospitals meet licensure requirements to provide inpatient psychiatric care in Ohio.

C. Utilization Review.

1. Community Mental Health.

- a. All CMH agency utilization review activities will be conducted under the authority of OFMS.
- b. In order to fully support OFMS utilization review activities, ODMH will provide ODJFS with provider specific claims information, including provider identification numbers and accurate numbers of service units, as well provider demographics, all rendered in a format acceptable to ODJFS.
- c. ODMH, with ODADAS and ODJFS, will convene a behavioral health utilization review quality council, which will consist of representatives from all levels of the behavioral health system, consumers, providers, Boards, and state departments. The council will be responsible for ongoing monitoring of the Medicaid utilization review process to assure it continues to meet the needs of the behavioral health system. Additionally, the council may provide recommendations to the directors of ODADAS, ODJFS, and ODMH on improvements to the utilization review process and ways to improve the quality of services and the effectiveness and efficiency of service delivery, based on the outcomes of the utilization review process.
- d. ODMH will serve as a consultant to ODJFS when ODJFS identifies providers through the utilization review process.
- e. ODMH will consult with ODADAS and ODJFS to identify providers needing examination for utilization review. Based on materiality or as otherwise required, OFMS reserves the right to examine additional providers above and beyond those chosen by the aforementioned consultation.
- f. ODMH will serve as a medical technical advisor and will, when necessary, participate in field staff reviews with ODJFS staff. ODMH will provide clinical advice and support to OFMS while the latter is responsible for the financial review component and all audit/review findings and reports. The results of any medical technical review conducted by ODMH staff will be provided to ODJFS in writing and shall include an indication as to whether inappropriate payment for services possibly occurred.
- g. ODMH will provide feedback on utilization review activities to the Boards.
- h. A County Board request for OFMS conducted review activity will be reviewed and screened by ODMH prior to its possible submission to OFMS.
- i. ODMH shall perform the prior authorization function for those services subject to prior authorization as defined in OAC 5101: 3-27-02.

2. Inpatient Psychiatric Hospital.

- a. ODMH shall, as part of its utilization review activities, share Medicaid information with ODJFS for the purpose of evaluating the treatment patterns of inpatient psychiatric hospital patients. Information shared concerning Medicaid recipients will include reports as required in an ODMH contract with a utilization review contractor.
- b. ODMH shall perform utilization review (retrospective/post-payment review) functions for providers of inpatient psychiatric hospital services according to the terms of this Agreement. Reviews may include services rendered in general hospital psychiatric units and psychiatric hospitals.
- c. ODMH shall perform pre-admission certification functions for psychiatric admissions as described in this Agreement.

- d. ODMH shall administer the provider appeals process for pre-admission certification and post-payment review in accordance with ODJFS requirements.
- e. At the request of ODJFS, ODMH (or its contractual designee's) physician reviewers and other staff will provide assistance by telephone or in writing for state fair hearing and pre-hearing activities. ODMH will make all reasonable attempts to provide ODJFS staff with the information necessary to conduct a hearing and provide for the appropriate presentation of the information which resulted in the denial of services or payment. In addition, ODMH physician reviewers or other staff may be available by telephone or in person when considered appropriate by ODJFS.
- f. ODMH, or its contractual designee, will provide ODJFS assistance by telephone or in writing for any appeals by Medicaid eligible clients.

D. Monitoring and Oversight.

1. ODMH shall assure any mental health provider is fully responsible for the performance of its subcontractors for the provision of services herein. Those subcontractors who are not currently Medicaid providers must not have been terminated from the Medicaid program for abuse or fraud, proven or suspected.
2. ODMH shall require each Board to contract with all willing providers of Medicaid community mental health services to persons the Boards serve and to use the "Community Medicaid Services Agreement" (Attachment 1) as the contract.
3. ODMH may enter into contracts with Boards to require specific policies or actions that ODMH deems necessary to assure the accuracy and compliance of the Board's payments to providers or to otherwise assure the integrity of the Medicaid and SCHIP programs as administered on a day-to-day basis by ODMH.
4. When a Board fails to reasonably comply with any ODMH requirement described in this Agreement or an ODMH contract, ODMH may suspend the submission of claims by ODMH on behalf of the Board for pursuit, by ODJFS, of FFP reimbursement.
5. ODMH shall prepare and submit corrective action plans to ODJFS within thirty (30) days from the date of request from ODJFS. ODMH shall implement corrective action plans approved by ODJFS within ninety (90) days from the date of ODJFS approval.
6. When efforts by ODMH fail to result in a Board's compliance with a requirement, ODMH may request assistance for ODJFS to enforce the Board's compliance.
7. ODMH shall monitor Board expenditures and, on a quarterly basis, ODMH shall submit to ODJFS a one-year estimate of ODMH anticipated Medicaid expenditures broken down by the next four (4) quarters. This report is due at least thirty (30) days prior to the start of a quarter. ODMH, with the support of ODJFS, shall monitor each Board's expenditures to ensure the accuracy of the quarterly, adjusted one-year budget projection of anticipated expenditures for Medicaid services for the next four (4) consecutive quarters.
8. ODMH shall assist ODFJS to assure continued compliance with federal requirements in the Deficit Reduction Act of 2005, including assuring that Medicaid providers are apprised of prompt reporting requirements for suspected fraud, the means to report, and protections afforded reporters under the law.
9. Biannually, by February 1 and August 1, ODMH shall submit to ODJFS a listing of all ODMH certified community mental health centers.
10. ODMH shall promptly notify ODJFS when it takes any action to revoke or suspend a provider's ODMH certification. When a provider is also participating in Ohio's Medicaid and SCHIP programs as a provider of mental health services, ODMH shall terminate a provider's rates and/or Medicaid

contract in MACSIS effective the date of revocation or suspension, or as soon after the date of revocation or suspension as is reasonably and operationally possible.

11. ODMH shall terminate a provider's Medicaid contract effective the date the provider voluntarily returns its ODMH certification to ODMH. ODMH is also authorized to terminate a provider's rates and/or Medicaid contract in MACSIS effective the date ODMH is notified by ODJFS that an ODMH certified community mental health agency's ODJFS Medicaid provider agreement has been terminated or not renewed per ARTICLE II, Section A, Paragraph 7 of this Agreement.
12. Upon receipt of a request from ODMH, ODJFS may delegate to ODMH the authority to perform review activities which would enable ODMH to identify Medicaid overpayments. Once identified, ODMH may pursue such overpayments under ORC 5111.914. Upon request, ODMH shall report to ODJFS any information associated with pursuit or collection of overpayments, or the overpayment recovery process, required for compliance with or the implementation of OAC 5111.914.
13. ODMH shall initiate meetings with ODJFS, at least once in the second and fourth quarters of the fiscal year, to report and discuss findings of ODMH certification and licensure processes of providers that participate in the Medicaid program, including aggregate and provider specific information on license or certification revocation and suspensions, other findings related to providers failures to meet minimum Medicaid standards or requirements and description and status of corrective actions.
14. ODMH and ODJFS shall collaborate to assure the compliance of ODMH contracts with private vendors to conduct utilization reviews of psychiatric hospital admissions.
15. ODMH and ODJFS shall collaborate to support the compliance of Section 1915(a) of the Social Security Act.

E. PASRR.

1. ODMH, through its relationships with ADAMH/CMH Boards and Agencies, shall assure the provision of specialized services for Medicaid recipients who are determined, pursuant to PASRR rules, to need specialized services.
2. ODMH shall procure PASRR evaluations from independent third parties who shall not be nursing facilities (NFs) or entities having direct or indirect affiliation or relationship with NFs.
3. ODMH, as the state mental health authority, shall make final NF and specialized services determinations for individuals with indications of Severe Mental Illness (SMI) that have applied for admission to a NF or for enrollment onto the PASSPORT waiver.
4. ODMH shall record, report and exchange medical and social information with ODJFS as necessary to implement the PASRR provisions of OBRA '87, as amended in accordance with 42 C.F.R. 431.621, and to comply with CMS required reports. ODMH shall participate in joint planning with all agencies involved in implementing PASRR.
5. ODMH shall assure that PASRR evaluations and determinations are made in accordance with the specifications and time lines found in OAC 5122-21- 03, 5123:2-14-01, 5101:3-3-15.1, and 5101:3-3-15.2.
6. ODMH shall assure that all individuals evaluated as part of PASRR have the right to appeal any determination they consider adverse by utilizing the ODJFS state fair hearing process. ODMH will provide notice, hearing summaries and defend their determinations at hearings conducted by ODJFS hearing officers in compliance with OAC Chapter 5101:6.
7. ODMH shall monitor the PASRR process by conducting periodic quality reviews and provide ODJFS with reports outlining the findings of the reviews. Such reports shall include at least the following data components; hospital exemptions, PASRR determinations, timeliness, placement

options, instances of a lack of level II records, and any problems and solutions that are the responsibility of ODMR/DD to remedy.

8. ODMH shall retain evaluation and determination records for not less than three years in order to support determinations and protect appeal rights.
9. ODMH shall notify ODJFS whenever they become aware of instances of PASRR non-compliance on the part of NFs.

F. ODMH General Fiscal Responsibilities.

1. Community Mental Health.

- a. ODMH shall submit claims to ODJFS in an agreed upon format.
- b. ODMH shall assure that Boards are certifying payments to providers using appropriate funds for the Medicaid and SCHIP programs through the CPE process. ODMH shall also assure that payments for services to the Boards are on a reimbursement basis.
- c. ODMH shall assure that lack of local non-federal public funds does not result in lowering the amount, scope and duration of Medicaid and SCHIP services.
- d. ODMH shall assure that Boards make payment in full for Medicaid claims submitted prior to claiming FFP. This shall be accomplished through the use of the modified CPE application.
- e. ODMH shall assure cost reconciliation of reimbursed services is performed in accordance with OAC Chapter 5101:3-27-07.
- f. ODMH shall recover Medicaid provider overpayments in accordance with ORC 5111.914 and any rules promulgated to implement that section.
- g. ODMH Medicaid overpayment recoveries of ODMH providers, including any recoveries made by the Collections Enforcement Section of the Office of the Ohio Attorney General, or through the provider reconciliation process will be disbursed in the following manner:
 1. Remit only the federal share to ODJFS; or
 2. If ODMH recovers less than one hundred percent (100%) of the federal share, ODMH shall remit to ODJFS the entire amount that was recovered.
 3. Any amounts recovered under this agreement that are not reimbursement of the federal share shall no longer be considered Medicaid funds subject to governance of laws or regulations of the Medicaid program.
- h. ODMH shall provide a quarterly report by July 15, October 15, January 15, and April 15, to ODJFS, Office of Fiscal Services, Bureau of Cash and Cost Reporting Services, Medicaid Federal Reporting Unit, that lists, by provider number, current findings made under authority of ORC 5111.914, date of provider notification, the status of the recovery and the status of reimbursement of the FFP to ODJFS, and the status of any collections made for amounts certified by ODMH and turned over to the Attorney General's Office. The reports shall be in a form specified by ODJFS and agreed to by ODMH.
- i. ODMH shall comply with the provision of ORC 5111.101 to meet Medicaid obligations under the False Claims Act and Section 6032 of the Deficit Reduction Act of 2005.
- j. ODMH shall require each Board to use the web-based modified CPE application.
- k. ODMH will submit to ODJFS, no later than June 1, 2012, a summary Medicaid provider

cost report that includes at least the following data: provider, each service rendered, total units of each service, total costs of each service, and actual rate paid for each service.

2. Inpatient Psychiatric Hospital.

- a. ODMH shall submit Medicaid claims to ODJFS for inpatient hospital services provided by public psychiatric hospitals and physician services provided in public psychiatric hospitals. Claims shall be submitted within 365 days of the service date.
- b. ODMH shall make payments to private psychiatric hospitals for hospital services (including Medicare crossover claims for Part A and Part B hospital services) at one hundred percent (100%) of the Medicaid reimbursement amount as determined by ODJFS in accordance with OAC Chapter 5101:3-2.
- c. ODMH shall make IMD-DSH payments to private psychiatric hospitals that qualify for IMD-DSH adjustments in accordance with OAC 5101:3-2-10.

3. Money Follows the Person

ODMH shall be reimbursed up to Fifty Thousand and 00/100 Dollars (\$50,000.00) in personnel costs for the MFP Liaison position for performing authorized activities as outlined in the MFP Operational Protocol.

G. Data Sharing.

1. ODMH and ODJFS agree to share electronic data on a continual basis, as is feasible and agreeable to each agency. Such access shall be provided to ODJFS by ODMH according to the conditions agreed to by both state agencies in such a way as to ensure the integrity and effective and efficient administration of the Medicaid and SCHIP Programs.
2. ODMH shall provide necessary data that ODJFS needs in order to conduct oversight activities. This data shall include, but not be limited to:
 - a. Within forty-five (45) days of completion, quarterly and annual reports of licensed facilities and certified provider reviews, terms of licensure or certification provided, revocation proceedings, date of licensure or certification renewal and provider terminations
 - b. Ongoing notifications pertaining to facility or provider specific information associated with licensure terminations, suspensions and revocations including information that describes corrective measures initiated by ODMH.

ARTICLE IV. EFFECTIVE DATE OF THE SUBGRANT

A. This Agreement is in effect from July 1, 2011, through June 30, 2012, unless this Agreement is suspended or terminated pursuant to the provisions of this Agreement prior to the termination date.

B. Termination.

1. This Agreement may be terminated at the convenience of either party without cause upon thirty (30) days written notice of termination to the other party. Notice of termination shall be sent or otherwise delivered to the persons signing this Agreement.
2. This Agreement may be terminated immediately in the event there is a loss of funding, disapproval by a federal administrative agency, or upon discovery of non-compliance with any federal or state law, rule, or regulation. In the event of termination pursuant to this Section, a notice specifying the reason for termination shall be sent as soon as possible after the termination to the non-terminating party.

3. Notwithstanding Paragraph 1 above, this Agreement may not be terminated at the convenience of either party if the performance under this Agreement is compelled by state or federal statute or executive order.

ARTICLE V. AMOUNT OF AWARD/AMOUNT OF SUBGRANT

- A. The total amount of the federal award is Three Hundred Ninety Million, Six Hundred Twenty-Five Thousand, Two Hundred Seventy-Six Dollars and 00/100 Dollars (\$390,625,276.00). ODJFS agrees to transfer up to Three Hundred Ninety Million, Six Hundred Twenty-Five Thousand, Two Hundred Seventy-Six Dollars and 00/100 Dollars (\$390,625,276.00) to ODMH in SFY 2012. Additionally, ODJFS shall transfer non-federal Disproportionate Share Hospital (DSH) payments referenced in ARTICLE II, Section E, Paragraph 2 to ODMH. The total transfer of DSH payments shall not exceed Three Million, Six Hundred Twenty-Four and 00/100 Dollars (\$3,000,624.00) for State Fiscal Year (SFY) 2012. It is expressly understood by ODJFS and ODMH that the terms of this Agreement do not allow total compensation in excess of Three Hundred Ninety-Three Million, Six Hundred Twenty-Five Thousand, Nine Hundred and 00/100 Dollars (\$393,625,900.00) for the period set forth in ARTICLE IV.

All obligations under this Agreement are subject to the requirements of ORC 126.07.

- B. ODMH shall prepare proper invoices and Intra-State Transfer Vouchers (hereinafter "ISTVs") for reimbursement on at least a quarterly basis for actual allowable expenditures incurred and paid pursuant to responsibilities outlined in ARTICLE III. The parties agree that no further reimbursement will be sought hereunder.
- C. Subject to the provisions of ORC 126.07 and 131.33, which shall at all times govern this Agreement, ODJFS represents: (1) that it has adequate funds to meet its obligations under this Agreement; (2) that it intends to maintain this Agreement for the full period set forth herein and has no reason to believe that it will not have sufficient funds to enable it to make all payments due hereunder during such period; and (3) that it will use its best effort to obtain the appropriation of any necessary funds during the term of this Agreement. However, it is understood by ODMH that availability of funds is contingent on appropriations made by the Ohio General Assembly. If the Ohio General Assembly fails at any time to continue funding ODJFS for the payments due hereunder, this Agreement is terminated as of the date funding expires without further obligation of the State of Ohio.
- D. It is further understood by ODMH that compensation under this Agreement may be based in whole or in part upon funding sources external to the State of Ohio (e.g., federal funding). Should the external source of the funding be terminated or reduced for reasons beyond the control of ODJFS or the State of Ohio, this Agreement shall terminate as of the date the funding expires without further obligation of the State of Ohio.

ARTICLE VI. COMPLIANCE WITH FEDERAL REGULATIONS

- A. Definitions.
 1. For purposes of this Agreement, the terms "auditee", "auditor", "audit finding", "Catalog of Federal Domestic Assistance Number," "Federal award," "Federal awarding agency," "Federal program," "internal control," "management decision," "non-profit organization," "Office of Management and Budget," (hereinafter "OMB"), "pass-through entity," "single audit," "state," and "subrecipient" have the same meanings as provided in §___.105 of OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations.
 2. For purposes of this Agreement, the terms "awarding agency," "equipment," "real property," "subgrant," "subgrantee," "supplies," "suspension," and "termination" have the same meanings as provided in 45 CFR 92.3.
- B. ODMH shall be deemed the subrecipient of the federal grant received by ODJFS. Any subcontractor or subgrantee who receives funds from ODMH under this Agreement is also considered a subrecipient of federal funds and must meet the requirements of OMB Circular A-133. ODMH is required to conduct monitoring activities consistent with OMB Circular A-133 for any subcontractor or subgrantee who receives funds from ODMH under this Agreement.

- C. As a subrecipient of federal funds, ODMH hereby specifically acknowledges its obligations relative to the funds provided under this Agreement pursuant to the following federal rules:
1. Standards for Financial Management Systems. ODMH and its subgrantee(s) shall comply with the requirements of 45 CFR 92.20, Standards for Financial Management Systems, including, but not limited to:
 - a. Financial Reporting;
 - b. Accounting records;
 - c. Internal control over cash, real and personal property, and other assets;
 - d. Budgetary control to compare actual expenditures or outlays to budgeted amounts;
 - e. Allowable Costs;
 - f. Source documentation; and
 - g. Cash management.
 2. Period of Availability of Funds. Pursuant to 45 CFR 92.23, ODMH and its subgrantee(s) may charge to the award only costs resulting from obligations of the funding period specified in ARTICLE IV unless carryover of unobligated balances is permitted.
 3. Matching or Cost Sharing. Matching or cost sharing requirements applicable to the federal program must be satisfied by allowable costs incurred or third-party in-kind contributions, as provided in 45 CFR 92.24, and subject to the qualifications, exceptions, and requirements of that section.
 4. Program Income. Program income must be used as defined and specified in 45 CFR 92.25.
 5. Real Property. If ODMH is authorized to use Subgrant funds for the acquisition of real property, then title, use, and disposition of the real property shall be governed by the provisions of 45 CFR 92.31.
 6. Equipment. Title, use, management (including record keeping, internal control, and maintenance), and disposition of equipment acquired by ODMH or its subgrantee(s) with Subgrant funds, shall be governed by the provisions of 45 CFR 92.32.
 7. Supplies. Title and disposition of supplies acquired by ODMH or its subgrantee(s) with Subgrant funds shall be governed by the provisions of 45 CFR 92.33.
- D. Subject to the threshold requirements of 45 CFR 92.26, ODMH must have an entity-wide single audit as specified in that section. One copy of every audit report must be sent to Al Hammond in the ODJFS Office of Fiscal Services at 30 East Broad Street, 38th Floor, Columbus, Ohio 43215-3414, within two (2) weeks of ODMH's receipt of any such audit report.
- E. Responsibilities of ODMH as an auditee under OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations, include, but are not limited to:
1. Proper identification of federal awards received;
 2. Maintenance of required internal controls;
 3. Compliance with laws, regulations, and the provisions of contracts, grants, or subgrant agreements related to each of its federal programs;
 4. Preparation of appropriate financial statements, including a schedule of expenditures of federal awards;
 5. Ensuring that the required A-133 Single Audit is properly performed and submitted when due; and
 6. Following up and taking corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan.

F. Subgrants.

1. Subgrants. Any subgrants by ODMH will be made in accordance with 45 CFR 92.37 and 45 CFR 74.5.
2. Debarment and Suspension. As provided in 45 CFR 92.35, ODMH and its subgrantees must not make any award or permit any award at any tier to any party that is debarred or suspended or is otherwise excluded from or ineligible for participation in federal assistance programs under 45 CFR Part 76.
3. Procurement. While ODMH and its subgrantees may use their own procurement procedures, the procedures must conform to all applicable federal laws, including 45 CFR 92.36. In the event of conflict between federal, state, and local requirements, the most restrictive must be used.
4. Monitoring. ODMH must manage and monitor the routine operations of Subgrant supported activities, including each project, program, subaward, and function supported by the Subgrant, to ensure compliance with all applicable federal requirements, including 45 CFR 92.40.

G. Duties as Pass-through Entity. In the event that ODMH subgrants federal funds received under this Agreement to another government or to a non-profit organization, ODMH, as a pass-through entity, must:

1. Identify the federal awards made by informing each subrecipient of CFDA title and number, award name and number, award year, whether the award is for research and development, and the name of federal awarding agency. When some of this information is not available, the pass-through entity will provide the best information available to describe the federal award.
2. Advise subrecipients of requirements imposed on them by federal laws, regulations, and the provisions of contracts or subgrant agreements as well as any supplemental requirements imposed by ODJFS and any subsequent pass-through entity.
3. Monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with all applicable federal and state laws and regulations and the provisions of contracts or subgrant agreements, and that all performance goals are achieved.
4. Ensure that subrecipients expending Five Hundred Thousand and 00/100 Dollars (\$500,000.00) or more in federal awards during the subrecipient's fiscal year have met the audit requirements of this Agreement for that fiscal year. One copy of every audit report must be sent to Al Hammond in the ODJFS Office of Fiscal Services at 30 East Broad Street, 38th Floor, Columbus, Ohio 43215, within two (2) weeks of the subrecipient's receipt of any such audit report.
5. Determine whether its subrecipients spent federal assistance funds provided in accordance with applicable laws and regulations;
6. Issue a management decision on audit findings within six (6) months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
7. Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
8. Require each subrecipient to permit ODJFS, any other state or government entity, and federal and state auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this Section G.

H. ODMH ("The Receiving Agency") agrees to comply with the applicable financial and administrative requirements set forth by the U.S. Department of Labor as found at: <http://www.dol.gov>.

ARTICLE VII. REQUIREMENTS UNDER HIPAA

- A. The definitions contained in this Section are derived from federal law. Should there be any conflict between the meanings assigned in this Contract and the meanings defined in applicable federal law, even in the event of future amendments to law that create such conflict, the definitions found in federal law shall prevail.
1. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.
 2. "Protected Health Information" ("PHI") means information received from or on behalf of a Covered Entity that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 164.501 and any amendments thereto.
- B. ODMH acknowledges that ODJFS through its Office of Ohio Health Plans is the single state agency for the administration of the Medicaid program. ODMH further acknowledges that it is administering a component of the Medicaid program on behalf of ODJFS, and, in carrying out the work described in this Contract, the ODMH agrees to comply with all of the following provisions:
1. Permitted Uses and Disclosures. ODMH shall not use or disclose PHI except as provided in this Contract or as otherwise required under HIPAA regulations or other applicable law.
 2. Safeguards. ODMH shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the ODJFS against use or disclosure not provided for by this Contract.
 3. Reporting of Disclosures. ODMH shall promptly report to ODJFS any knowledge of uses or disclosures of PHI that are not in accordance with this Contract or applicable law. In addition, ODMH shall mitigate any adverse effects of such a breach of confidentiality to the greatest extent possible.
 4. Agents and Subcontractors. ODMH shall ensure that all its agents and subcontractors that receive PHI from or on behalf of ODMH and/or ODJFS agree to the same restrictions and conditions that apply to ODMH with respect to the use or disclosure of PHI.
 5. Accessibility of Information. ODMH shall make available to ODJFS such information as ODJFS may require to fulfill its obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services.
 6. Amendment of Information. ODMH shall make PHI available to ODJFS so that ODJFS may fulfill its obligations pursuant to HIPAA to amend the information. As directed by ODJFS, ODMH shall also incorporate any amendments into the information held by ODMH and shall ensure incorporation of any such amendments into information held by ODMH's agents or subgrantees.
 7. Disclosure. ODMH shall make available to ODJFS and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODJFS, or created or received by ODMH on behalf of ODJFS. Such access is for the purpose of determining ODJFS' compliance with HIPAA, regulations promulgated by the United States Department of Health and Human Services, and any amendment thereto.
 8. Material Breach. In the event of material breach of ODMH obligations under this Article, ODJFS may immediately terminate this Contract as set forth in ARTICLE IV. Termination of this Contract shall not affect any provision of this Contract which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.

9. Return or Destruction of Information. Upon termination of this Contract and at the request of ODJFS, ODMH shall return to ODJFS or destroy all PHI in ODMH's possession stemming from this CONTRACT, and shall not keep copies of the PHI except as requested by ODJFS or required by law. If ODMH, its agent(s), or subcontractor(s) destroy any PHI, then CONTRACTOR will provide to ODJFS documentation evidencing such destruction. Any PHI retained by ODMH shall continue to be extended the same protections set forth in this Section and HIPAA regulations for as long as it is maintained.

ARTICLE VIII. GENERAL PROVISIONS

- A. Entirety of Agreement. All terms and conditions of this Agreement are embodied herein. No other terms and conditions will be considered a part of this Agreement unless expressly agreed upon in writing and signed by both parties.
- B. Amendments. This Agreement may be modified or amended provided that any such modification or amendment is in writing and is signed by the directors of the parties. It is agreed, however, that any amendments to laws, rules, or regulations cited herein will result in the correlative modification of this Agreement, without the necessity for executing written amendments.
- C. Partial Invalidity. This Agreement shall be governed, construed, and enforced in accordance with the laws of the State of Ohio. Should any portion of this Agreement be unenforceable by operation of statute or by administrative or judicial decision, the operation of the balance of this Agreement is not affected thereby provided, however, the absence of the illegal provision does not render the performance of the remainder of the Agreement impossible. Should the removal of such an unenforceable provision render the intended performance under this Agreement difficult or nonsensical, but not impossible, the parties shall negotiate, in good faith, replacement provision(s) in keeping with the objectives of this Agreement and the budgetary and statutory constraints of the parties.
- D. Audit Exceptions.
1. ODJFS shall be responsible for receiving, replying to, and arranging compliance with any audit exception(s) found as a result of any state or federal audit of this Agreement as it pertains to federal or ODJFS funding of the Agreement. ODJFS shall promptly notify ODMH of any adverse findings which allegedly are the fault of ODMH. Upon receipt of notification by ODJFS, ODMH shall fully cooperate with ODJFS and timely prepare and send to ODJFS its written response to the audit exception(s).
 2. ODMH shall be liable for any audit exception(s) that result(s) solely from its acts or omissions in the performance of this Agreement. ODJFS shall be liable for any audit exception(s) that result(s) solely from its acts or omissions in the performance of this Agreement. In the event that any audit exception(s) result(s) from the acts or omissions of both ODJFS and ODMH, the financial liability for the audit exception(s) shall be shared by the parties in proportion to their relative fault. In the event of a dispute concerning the allocation of financial liability for audit exceptions, the parties agree that the dispute shall be referred to the Office of the Governor for a final, binding determination allocating financial liability.
 3. For the purpose of this section, the term "audit exception" shall include federal disallowance and deferrals.
- E. Liability Requirements (other than audit). To the extent allowable by law, ODMH agrees to be responsible for any liability, suits, losses, judgments, damages, or other demands brought as a result of its actions or omissions in the performance of this Agreement. ODJFS agrees to be responsible for any liability, suits, losses, judgments, damages or other demands brought as a result of its actions or omissions in performance of this Agreement.
- F. Resolution of Disputes. The parties agree that the directors of ODJFS and ODMH shall resolve any disputes between the parties concerning responsibilities under, or performance of, any of the terms of this Agreement. In the event the directors cannot agree to an appropriate resolution to a dispute, they shall be referred to the Office of the Governor for a final, binding determination resolving the dispute.

- G. Breach and Default. Upon breach or default of any of the provisions, obligations, or duties embodied in this Agreement, the parties may exercise any administrative, contractual, equitable, or legal remedies available, without limitation. The waiver of any occurrence of breach or default does not constitute waiver of subsequent occurrences, and the parties retain the right to exercise all remedies mentioned herein.
- H. Confidentiality of Information.
1. The parties agree that they shall not use any information, systems, or records made available to either party for any purpose other than to fulfill the obligations specified herein. The parties specifically agree to be bound by the same standards of confidentiality that apply to the employees of both ODJFS and ODMH and the State of Ohio. The terms of this Section shall be included in any subcontracts executed by either party for work under this Agreement. The parties specifically agree to comply with state and federal confidentiality laws and regulations applicable to the programs under which this Agreement is funded. The parties are responsible for obtaining copies of all applicable rules governing confidentiality and for assuring compliance with the rules by employees and contractors of both ODJFS and ODMH. The parties agree to current and ongoing compliance with 42 USC 1320d through 1320d-8 and the implementing regulations found at 45 CFR 164.502 (e) and 164.504 (e) regarding disclosure of protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
 2. The parties agree and acknowledge that the information provided by one or both parties may be considered confidential or proprietary under the laws of the State of Ohio or under federal law. If either party to this Agreement, as public entities, receives a public records request for information related to this document, the party receiving the request (Party "A") will promptly notify the other agency (Party "B") of the request. If Party "B" believes there is information that is confidential or proprietary and should not be released, Party "A" will provide a reasonable period of time for Party "B" to seek to have the confidential or proprietary information withheld from the document prior to releasing the information.
- I. Records Retention. All records relating to costs, work performed, and supporting documentation for invoices submitted to ODJFS by ODMH along with copies of all materials produced under or pertaining to this Agreement shall be retained and made available by ODMH for audit by the State of Ohio (including, but not limited to, ODJFS, the Auditor of the State of Ohio, the Inspector General, or any duly authorized law enforcement officials) and agencies of the United States government for a minimum of three (3) years after final payment under this Agreement. If an audit is initiated during this time period, ODMH shall retain such records until the audit is concluded and all issues resolved or three (3) years after final payment, whichever is longer. If applicable, ODMH must meet the requirements of federal OMB Circulars A-87, A-110, A-122, or A-133.
- J. Ethics. ODMH certifies that by executing this Agreement, it has reviewed, knows, and understands the State of Ohio's ethics and conflict of interest laws, which includes the Governor's Executive Order 2011-03K pertaining to ethics. ODMH further agrees that it will not engage in any action(s) inconsistent with Ohio ethics laws or the aforementioned Executive Order.
- K. Fair Labor Standards and Employment Practices.
- a. ODMH certifies that it is in compliance with all applicable federal and state laws, rules, and regulations governing fair labor and employment practices.
 - b. In carrying out this Agreement, ODMH will not discriminate against any employee or applicant for employment because of race, color, religion, gender, national origin, military status, disability, age, genetic information, or sexual orientation, in making any of the following employment decisions: hiring, layoff, termination, transfer, promotion demotion, rate of compensation, and eligibility for in-service training programs.
 - c. ODMH agrees to post notices affirming compliance with all applicable federal and state non-discrimination laws in conspicuous places accessible to all employees and applicants for employment.

- d. ODMH will incorporate the foregoing requirements of this Section in all of its subgrants or subcontracts for any of the work prescribed herein.
- L. MBE/EDGE. Pursuant to the Governor's Executive Order 2008-13S, ODMH agrees to purchase goods and services under this Agreement from certified Minority Business Enterprise ("MBE") and Encouraging Diversity, Growth, and Equity ("EDGE") vendors whenever possible. ODMH agrees to encourage any of its subgrantees or subcontractors to purchase goods and services from certified MBE and EDGE vendors.
- M. Certification of Compliance. ODMH certifies that it is in compliance with all other applicable federal and state laws, regulations, and rules and will require the same certification from its subgrantees or subcontractors.

*Signature Page Follows
Remainder of Page Intentionally Left Blank*

**INTERAGENCY SUBGRANT/SUBRECIPIENT AGREEMENT
BETWEEN
THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
AND
THE OHIO DEPARTMENT OF MENTAL HEALTH**

A-1213-07-0279

SIGNATURE PAGE

IN WITNESS WHEREOF, THE PARTIES HAVE EXECUTED THIS AGREEMENT AS OF THE DATE OF THE SIGNATURE OF THE DIRECTOR OF THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES.

APPROVED BY:

Ohio Department of Mental Health Services

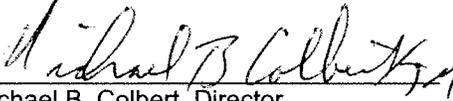


Tracy J. Prouck, Director

30 East Broad Street, 7th Floor
Columbus, Ohio 43215

7/19/11
Date

Ohio Department of Job and Family Services



Michael B. Colbert, Director

30 East Broad Street, 32nd Floor
Columbus, Ohio 43215

7/25/11
Date

COMMUNITY MEDICAID SERVICES AGREEMENT

Between
ADAMH/CMH BOARDS
And
Community Mental Health Agencies

MC _____ - _____

This Agreement is made and effective by and between the

("Board") and _____, ("CMH
AGENCY") for the provision of Community Mental Health ("CMH") Medicaid services to eligible
individuals pursuant to Title XIX of the Social Security Act. This agreement shall be effective July
1, 2007 and automatically renews every July 1 thereafter.

A. GENERAL AGREEMENT TERMS

1. This Agreement is entered into pursuant to the intent and effect of the Interagency Agreement effective September 27, 2005 and its Amendments, or its successor, between the Ohio Department of Mental Health (Department) and the Ohio Department of Job and Family Services (ODJFS). The interagency agreement gives the Department the responsibility to establish requirements for Boards and CMH agencies which provide CMH services to ensure compliance with the provisions of the Interagency Agreement as well as all the requirements of federal or state law or rules governing the Medicaid program.
2. A copy of the Interagency Agreement is posted as Exhibit A on the Department website at <http://www.mh.state.oh.us/medicaid/general/medicaid.index.html> . The Interagency Agreement is incorporated into this Agreement by reference as if fully set out herein. In case of conflict between any provision of this Agreement and Exhibit A, the posted Exhibit A shall be controlling.
3. This Agreement is subject to the provisions of Chapter 5101:3-27, "Community Mental Health Agency Services," and all other applicable Ohio Administrative Code rules. In case of conflict between any provision of this Agreement and Chapter 5101:3-27, as it may be amended, the provisions of OAC Chapter 5101:3-27 shall be controlling.
4. If ODJFS, the Ohio General Assembly, the federal government, or any other source at any time disapproves or ceases to continue funding to the Department for payments due hereunder, this agreement is terminated as of the date funding expires without notice or further obligation.

B. CMH AGENCY RESPONSIBILITIES

1. The CMH agency shall be subject to all requirements of all Exhibits posted at <http://www.mh.state.oh.us/medicaid/general/medicaid.index.html> and/or referenced herein (and any amendments to said Exhibits) and all of these Exhibits and amendments thereto are made part of this agreement as if fully set forth herein. These include:

- FY 06 Interagency Agreement between ODJFS and ODMH A-67-07-0524 – Exhibit A
 - FY 06 Interagency Agreement between ODJFS and ODMH A-67-0524 – Amendment No. 1 – Exhibit A
 - FY07 Interagency Agreement between ODJFS and ODMH A-67-07-0524 Amendment No. 2 – Exhibit A
 - FY 04-05 Community Medicaid Rate Ceilings – Exhibit D
 - Ohio Health Plans Provider Enrollment Application, W-9 and The Declaration Regarding Material Assistance/Non Assistance to a Terrorist Organization (DMA) – Exhibit E
2. The CMH agency agrees to ensure the provision of an independent audit. This audit must be conducted in accordance with OAC 5122-1-5-01.
 3. The CMH agency agrees to provide the medical assistance services covered under this Agreement (provided on or after July 1, 2007). The services will be reimbursed at the prospective cost based unit rate as submitted to the Department on the most current Community Medicaid Mental Health Services Rate Sheet and established in accordance with O.A.C. 5101:3-27-05.
 4. The CMH agency shall submit claims for payment using the electronic 837 Professional Claim Format as required by HIPAA and adhering to the technical specifications contained in the most recent version of the Guidelines Pertaining to Implementation of MACSIS under HIPAA.
 5. The CMH agency shall be responsible for receiving, replying to, and/or complying with any audit exception by appropriate Board, State, Federal, or independent audit directly related to the provision of this Agreement. The CMH agency agrees to pay the full amount of any liability resulting from said audit exceptions unless the audit was the direct result of actions or omissions of either the Department or the Board.
 6. The CMH agency shall not knowingly alter, falsify, destroy, conceal, or remove any records that are necessary to fully disclose the nature of all goods and services claimed and all income and expenditures upon which the rates of reimbursement are received under the Medicaid Program.
 7. The CMH agency shall file cost reports with the Department in accordance with the requirements of OAC 5122-26-19. The CMH agency must keep all actual Uniform Cost Reports and supporting documentation necessary to fully disclose the extent of services provided and costs associated with providing those services for a period of seven SFYs from the date a service is rendered, or until all financial reporting obligations which include data contained in the UCR have been completed, whichever is longer. If an audit is initiated during this time period, the CMH agency shall retain all records until the audit is concluded and all issues are resolved. All records shall be made available by the CMH agency for audit by the Board and the State of Ohio (including but not limited to ODJFS, the Auditor of the State of Ohio, Inspector General, the Department, or duly authorized law enforcement officials) and agencies of the United States government for the minimum of six years after final payment of the agreement.
 8. The records shall document the service type and in the case of partial hospitalization, shall document the service as separate, identifiable, organized units. All records shall contain the documentation requirements defined in O.A.C. 5101:3-27-02 and O.A.C. 5122-27. The duration of the service must be exact when noted in the Individualized Client Record. For billing purposes, agencies must use the Service

Units Rounding Conventions as stated in the Guidelines Pertaining to Implementation of MACSIS under HIPAA for each type of billing unit.

9. The CMH agency shall maintain at all times an updated list of the individuals providing services by service type.
10. The CMH agency agrees to cooperate with the Board in the Board's annual Medicaid Compliance Reviews and Medical Necessity Documentation Reviews pursuant to O.A.C. 5101:3-27-06 for each fiscal year of this Agreement.
11. In cases where a CMH agency serves residents of more than one (1) Board service district, the CMH agency may choose to have an Agreement with only one Board.

C. BOARD RESPONSIBILITIES

1. The Board agrees to pay participating CMH agencies, for the medical assistance services covered under this Agreement (provided on or after July 1, 2007). The services will be reimbursed at the prospective cost based unit rate as submitted to ODMH on the most current Community Medicaid Mental Health Services Rate Sheet and established in accordance with O.A.C. 5101:3-27-05.
2. The Board shall pay at 100%, valid Medicaid and SCHIP claims for reimbursable services provided to residents of the Board's service district by any provider organization which has a Community Mental Health Medicaid agreement with any ADAMH/CMHS Board. All provider organizations which currently have Community Mental Health Agreements are referenced in the document titled List of Community Medicaid Contract Agencies- Exhibit I which is posted at <http://www.mh.state.oh.us/medicaid/general/medicaid.index.html> and incorporated by reference into this agreement.
3. The Board shall cooperate with ODMH, and with governmental entities which receive nonfederal public funds and are certified by the Department, by entering into direct agreements with such governmental entities. Such governmental entities must certify that sufficient state and/or local public funds not otherwise encumbered are committed to match Title XIX funds.
4. The board shall review the number of cases required by OAC 5101:3-27-06 of residents of its service district in each agency holding a medicaid agreement with the board, except for agencies identified by the Department as serving a large number of residents outside the board service districts in which the agencies are located. For each of those specially designated agencies, the board which has the medicaid agreement shall conduct the review. In circumstances where the agency has medicaid agreements with more than one board, the board which has the largest number of board residents receiving services from the agency shall conduct the review. The Board conducting the compliance review pursuant to OAC 5101:3-27-06 shall ensure that services to residents outside of the service district are included in the review.

D. ASSURANCES

1. The undersigned, duly authorized by the CMH agency hereby assures that: In the performance of this agreement and in the hiring of any employees for the performance of work under this agreement, the CMH agency shall not by reason of race, color, religion, sex, sexual preference, age, handicap, national origin, Vietnam-era veteran's status, or ancestry discriminate against any citizen of this State in the employment of a person qualified and available to perform the work to which the agreement relates.

2. The CMH agency agrees to comply with all federal and state laws, rules, regulations and auditing standards which are applicable to the performance of this agreement.
3. The CMH agency agrees that it shall not use any information, systems, or records made available to either party for any purpose other than to fulfill the obligations specified herein. The confidentiality of all records and patient identification information shall be maintained in accordance with federal and state laws and regulations.
4. The CMH agency further recognizes that no member or employee of the Board shall serve as a member of the Board of any CMH agency with which the Board has entered into an Agreement for the provision of services or facilities. No member of a Community Board shall be an employee of any CMH agency with which the Board has entered into an agreement for the provision of services or facilities. No person shall serve as a member of the Community Board whose spouse, child, parent, brother, sister, grandchild, step-parent, step-child, step-brother, step-sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law serves as the member of the Board of any CMH agency with which the Board has entered into such an agreement.
5. This agreement constitutes the entire Agreement between the parties pertaining to community mental health services and no other prior oral or written communication shall have any force or effect.

Alcohol, Drug Addiction and Mental Health Services/Community Mental Health Board

By: _____ Title: _____

Date: _____

Print name and title

Community Mental Health Agency

By: _____ Title: _____

Date: _____

Print name and title

Submit completed signed application/agreement with required attachments to:
Provider Network Management Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43216-1461
Call the Interactive Voice Response (IVR) System at 1-800-686-1516

(For State Use Only)

Ohio Department of Job and Family Services
**OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT
FOR ORGANIZATIONS**

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

Organizational Provider Types: - Required Mark the **ONE** appropriate type

- | | | |
|---|--|--|
| <input type="checkbox"/> Ambulance (82) | <input type="checkbox"/> Home Health Agency (JC/CHAPS) (16) | <input type="checkbox"/> PACE (08) |
| <input type="checkbox"/> Ambulatory Surgery Center (46) | <input type="checkbox"/> Hospice (44) | <input type="checkbox"/> Pharmacy (70) |
| <input type="checkbox"/> Ambulette (83) | <input type="checkbox"/> Independent Diagnostic Testing Facility (IDTF) (79) | <input type="checkbox"/> Portable X-ray Laboratory (81) |
| <input type="checkbox"/> Assisted Living Waiver Provider (74) | <input type="checkbox"/> Independent Laboratory (80) | <input type="checkbox"/> Primary Care Clinic (50) |
| <input type="checkbox"/> Durable Medical Equipment (76) | <input type="checkbox"/> Medicaid School Program (28) | <input type="checkbox"/> Professional Dental School Clinic (56) |
| <input type="checkbox"/> End-Stage Renal Disease Dialysis Clinic (59) | <input type="checkbox"/> Mental Health Clinic (51) | <input type="checkbox"/> Professional Optometry School Clinic (55) |
| <input type="checkbox"/> Family Planning Clinic (54) | <input type="checkbox"/> Mental Hospital (02) | <input type="checkbox"/> Public Health Department Clinic (52) |
| <input type="checkbox"/> Federally Qualified Health Center (12) | <input type="checkbox"/> Optician (75) | <input type="checkbox"/> Rural Health Clinic (05) |
| <input type="checkbox"/> General Hospital (01) | <input type="checkbox"/> Outpatient Health Facility (04) | <input type="checkbox"/> Targeted Case Management (85) |
| <input type="checkbox"/> Hearing and Speech Clinic (58) | <input type="checkbox"/> Outpatient Rehabilitation Clinic (53) | <input type="checkbox"/> Waiver Service Provider (45) |
| <input type="checkbox"/> Home Health Agency (Medicare Cert.) (80) | <input type="checkbox"/> ODADAS Certified/Licensed Treatment Program | <input type="checkbox"/> ODMH Certified Comm Mental Hlth Agency |

Provider Identification: - Required (Print or type entries)

Organization Name	
Abbreviated Organization Name (If your name exceeds 30 spaces, indicate preferred abbreviation.)	
Employer Identification Number	You must attach a signed W-9 form

Address Information: - Required

Physical Location of Business (Applicants: If more than one location, list Primary. Required field)

Building Name / OR / Department / OR / In care of			
Business Address (Number, Street, Avenue, Route, etc. P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if possible)
Telephone Number			

"Pay to" Address (Name & Address to which Payment and/or Remittance Advice is to be mailed)

Building Name / OR / Department / OR / In care of			
Address			Suite Number
City	State	Zip Code (Zip +4, if possible)	

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

Building Name / OR / Department / OR / In care of			
Address			Suite Number
City	State	Zip Code (Zip +4, if possible)	

(For State Use Only)

National Provider Identifier:

If you have received your National Provider Identifier (NPI) number, please report it here:	If you had a previous NPI number, please report it here:
NPI number **	NPI number
** You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.	

Medicare Identification Information: - Required if applicable

* You must attach copy of CLIA Certificate

PIN number*	PIN number*	DMERC number*
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*You must attach copy of Department of Health and Human Services Approval Letter.

Clinical Laboratory Improvement Act Information - REQUIRED FOR ALL HOSPITALS AND ALL LABORATORIES

CLIA number*	CLIA number*	CLIA number*
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* You must attach copy of CLIA Certificate

* You must attach copy of CLIA Certificate

Optional Categories of Service:

Check your Provider Type, and any other Categories of Service you are licensed and/or authorized to provide.

Provider Type	Optional Category of Service	Provider Type	Optional Category of Service
<input type="checkbox"/> Ambulance (82)	<input type="checkbox"/> Ambulette Services (38)	<input type="checkbox"/> Outpatient Rehabilitation Clinic (53)	<input type="checkbox"/> Supplies & Med Equip (32)
<input type="checkbox"/> End-Stage Renal Disease Dialysis Clinic (59)	<input type="checkbox"/> Prescribed Drugs (30) <input type="checkbox"/> Supplies & Med Equip (32)	<input type="checkbox"/> Primary Care Clinic (50)	<input type="checkbox"/> Dental Services (45) <input type="checkbox"/> Optometric Services (47) <input type="checkbox"/> Advanced Practice Nurse (21) <input type="checkbox"/> Supplies and Medical Equip (32) <input type="checkbox"/> Physician Services (43) <input type="checkbox"/> EPSDT Services (40)
<input type="checkbox"/> Family Planning Clinic (54)	<input type="checkbox"/> Supplies & Med Equip (32)	<input type="checkbox"/> Professional Optometry School Clinic (55)	<input type="checkbox"/> Supplies & Med Equip (32)
<input type="checkbox"/> General Hospital (01)	<input type="checkbox"/> Ambulance Services (37) <input type="checkbox"/> Ambulette Services (38)	<input type="checkbox"/> Public Health Department Clinic (52)	<input type="checkbox"/> Dental Services (45) <input type="checkbox"/> Optometric Services (47) <input type="checkbox"/> Supplies & Medical Equip (32)
<input type="checkbox"/> Mental Health Clinic(51)	<input type="checkbox"/> Supplies & Medical Equip(32)		

Federally Qualified Health Centers, Rural Health Facilities, Outpatient Health Facilities

Providers may be enrolled as only one type of alternative payment clinic. An "alternative payment clinic" shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF). Check the appropriate box:

Section 330 of Public Health Service Act grants – recipient or under a contract with the recipient
(include documentation from CMS that identifies the specific service site(s) included in the 330 public health services project)

Health and Human Services Certification as a Federally Qualified Health Center
(include documentation from US secretary of health and human services confirmation letter that the service site(s) is/are considered an FQHC look-alike with respect to Medicaid coverage)

(For State Use Only)

Medicaid School Program

Medicaid School Program	
<p>A Medicaid School Program Provider must document effort to coordinate with an eligible child's medical home. The documentation must indicate effort made to obtain a release of information that would allow notation of the eligible child's primary healthcare provider's contact information and/or Medicaid managed care plan in the child's special education record. The release must allow the Medicaid School Program Provider to share health informational records with a child's primary healthcare provider and/or Medicaid managed care plan. Documentation must also include the efforts made to establish protocol for a bilateral exchange of information with the primary healthcare provider or managed care plan consistent with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, as applicable. These efforts should facilitate the coordination and non-duplication of screening, diagnostic, and treatment services for the eligible child.</p>	
<p>Ohio Department of Education Internal Retrieval Number (IRN):</p>	<p>internal Retrieval Number (IRN)*</p>
<p>Type of School District (check one only):</p> <p> <input type="checkbox"/> City School <input type="checkbox"/> Exempted Village <input type="checkbox"/> Community School <input type="checkbox"/> Local School <input type="checkbox"/> State School for the Deaf <input type="checkbox"/> State School for the Blind </p>	

Clinics Check the applicable Clinic Provider Type, and attach a copy of the required documentation as indicated for your Provider Type

Provider Type	Required documentation (to be submitted with application)
<input type="checkbox"/> 59 - End-Stage Renal Dialysis Clinic	<input type="checkbox"/> Medicare Certification as a Dialysis Clinic <input type="checkbox"/> Licensure by the Ohio Department of Health as a dialysis provider
<input type="checkbox"/> 54 - Family Planning Clinic	<input type="checkbox"/> Affiliation with the Planned Parenthood Federation of America (PPFA) <input type="checkbox"/> Grant award for the provision of family planning services under Title X of the Public Health Services Act <input type="checkbox"/> Grant award through the Ohio Department of Health for family planning services under the Child and Family Health Services program <input type="checkbox"/> Grant award through the Ohio Department of Health's Women's Health Services, in accordance with rule 3701-68-01 of the Administrative Code
<input type="checkbox"/> 58 - Hearing and Speech Clinic	<input type="checkbox"/> Specialize in either speech language/audiology services or diagnostic imaging services
<input type="checkbox"/> 51 - Mental Health Clinic	<input type="checkbox"/> Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care Services Program. <input type="checkbox"/> Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
<input type="checkbox"/> 53 - Outpatient Rehabilitation Clinic	<input type="checkbox"/> Medicare Certification as an Outpatient Rehabilitation Clinic OR <input type="checkbox"/> Medicare Certification a Comprehensive Outpatient Rehabilitation Clinic
<input type="checkbox"/> 50 - Primary Care Clinic	<input type="checkbox"/> Joint Commission Accreditation <input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC) <input type="checkbox"/> Healthcare Facilities Accreditation Program of the American Osteopathic Association <input type="checkbox"/> Community Health Accreditation Program (CHAP) <input type="checkbox"/> Receipt of state or federal grant funds for the provision of health services
<input type="checkbox"/> 56 - Professional Dental Dental Clinic	<input type="checkbox"/> Accreditation by the Council on Dental Education (CODA) of the American Dental Association (ADA)
<input type="checkbox"/> 55 - Professional Optometry School Clinic	<input type="checkbox"/> Accreditation by the Council on Optometry Education (ACOE) of the American Optometric Association
<input type="checkbox"/> 52 - Public Health Department Clinic	<input type="checkbox"/> Legal Status as a County Health Department, City Health Department, or Combined Health District

(For State Use Only)

Hospitals - Required

Hospital License Registry Number*	License Registry Date (mm/dd/yyyy)	Current License Registry Expiration Date* (mm/dd/yyyy)
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*You must attach copy of License

Hospital Beds - You must attach a copy of the letter from Department of Health with Your Bed Certification.

TOTAL HOSPITAL BEDS _____

Please check all that apply and attach supporting documentation for each block checked

- | | |
|---|---|
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Rehabilitation Hospital |
| <input type="checkbox"/> Hospital has a Distinct Part Psychiatric Unit | <input type="checkbox"/> Long Term Acute Care Hospital |
| <input type="checkbox"/> Major Teaching Hospital
(Submit intern to bed ratio from fiscal intermediary) | <input type="checkbox"/> Cancer Hospital |
| <input type="checkbox"/> Rural Referral Center | <input type="checkbox"/> HMO owned Hospital |
| <input type="checkbox"/> For hospitals in Ohio, please specify Nursery Level <input type="checkbox"/> Level 1 | <input type="checkbox"/> Specialty Hospital
(Please Specify) _____ |
| <input type="checkbox"/> (Submit documentation from Ohio Dept. of Health) <input type="checkbox"/> Level 2 | |
| <input type="checkbox"/> Level 3 | |

If you provide Pharmacy and/or Ambulance/Ambulette services you must also complete the Pharmacy and Transportation sections of this application

National Provider Identifier: Secondary NPIs

Psychiatric Unit NPI	Rehabilitation Unit NPI
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Hospital Cost Report Contact- Required

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

Hospital Care Assurance Program (HCAP) Contact

(If contact is not different from "Hospital Cost Report Contact," leave blank.)

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

Upper Payment Limit (UPL) Program Contact

(If contact is not different from "Hospital Cost Report Contact," leave blank.)

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

(For State Use Only)

Pharmacies - Required

State Pharmacy Board License Number*	DEA Registration Number*
*You must attach a copy of license.	
*You must attach a copy of Controlled Substance Registration Certificate	
Name of Licensed, Registered Pharmacist (in full and actual charge of the Pharmacy)(print or type)	
Pharmacist's License Number*	Pharmacist's Signature
Date of Signature (mm/dd/yyyy)	
*You must attach a copy of license	

Medical Suppliers - Required

State Vendor's License Number*	or	Orthotics / Prosthetics License Number*	or	State Tax Exemption Certificate Number*
*You must attach a copy of license.		*You must attach a copy of license.		*You must attach a copy of Certificate.
Do you have a Respiratory Board license? <input type="checkbox"/> YES <input type="checkbox"/> NO (This is required to bill for respiratory services)				
State Respiratory Board License Number*	Date license was issued (mm/dd/yyyy)	Date license expires (mm/dd/yyyy)		
*You must attach a copy of license.		*You must attach a copy of license.		
Are you dispensing hearing aids? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please enter the appropriate License Number below.				
Hearing Aid Dispenser License Number*	or	Audiologist License Number*		
*You must attach a copy of license.		*You must attach a copy of license.		

Independent Diagnostic Testing Facilities - Required

Physician's Certification: I certify that (check one):

I own or partially own the facility and employ the operating personnel.

I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality control manuals, observing the operator's or technician's performance, verifying that the equipment and personnel meet applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.

Physician's Name (print)	Physician's Signature	Date of Signature (mm/dd/yyyy)
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Eligible Medicaid providers of Independent Diagnostic Testing Facility services must meet the following criteria:

- Possess a current unrevoked or unsuspended Medicare Provider Number as an Independent Diagnostic Testing Facility.
- Be in conformity with all applicable federal, state, and local laws and regulations.
- Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of diagnostic testing procedures.
- Provide radiological services under the following conditions:
 - The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
 - The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
 - The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
 - All operators of the x-ray equipment must meet the following requirements:
 - Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
 - For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
- Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment. X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

(For State Use Only)

Ambulance/Ambulette Transportation Services

Are you publicly owned and operated? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, enter your <i>State Medical Transportation Board Service Number</i> * here	Medicare Certification Number (Ambulance Provider Applicants only)*
* You must attach a copy of the State Medical Transportation Board Certificate of Licensure	* You must attach a copy of the Medicare Certification

Ambulance/Ambulette Personnel

(This page may be copied as needed to list all drivers.)

Ambulance providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application)
 A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application.

Ambulette providers:

Each driver and each attendant must have a current card as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification

Each card must be signed and a copy of each driver's card, front and back, must be included with the application

OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application)

List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant. Please print or type all responses.

Driver/Attendant's Name	EMT Card Number Required for Ambulance Drivers	American Red Cross Basic/Community First Aid and CPR	EMT Expiration Date or Completed Date of American Red Cross Basic/Community First Aid Training/CPR (mm/dd/yyyy)
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date

(For State Use Only)

**Requirements for Ambulette Vehicle Providers
Documents to be included with the application**

You must include, with your application, copies of documents for each item listed on this page. In addition, all ambulette vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

Check each block to certify compliance and include required documentation

<input type="checkbox"/> Currently, the ambulette service is operating _____ vehicles. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.
<input type="checkbox"/> Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.
<input type="checkbox"/> The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.
<input type="checkbox"/> The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulette vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.
<input type="checkbox"/> Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.
<input type="checkbox"/> Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.
<input type="checkbox"/> Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Include a copy of each driver's driving record with the application.
<input type="checkbox"/> The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.

(For State Use Only)

Requirements for Ambulette Vehicle Providers

All ambulette providers must certify that they operate vehicles that meet the following standards and have documentation to verify compliance that is available upon request.

Check each block to certify compliance

<input type="checkbox"/>	Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.
<input type="checkbox"/>	Each vehicle has a minimum ceiling to floor height of fifty-six inches.
<input type="checkbox"/>	Each vehicle is equipped with a communication system capable of two-way communication.
<input type="checkbox"/>	Each vehicle is equipped with a stable access ramp or hydraulic lift.
<input type="checkbox"/>	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.
<input type="checkbox"/>	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.
<input type="checkbox"/>	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.
<input type="checkbox"/>	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.
<input type="checkbox"/>	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.
<input type="checkbox"/>	Each ambulette driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.
<input type="checkbox"/>	The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.
<input type="checkbox"/>	Each ambulette driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.
<input type="checkbox"/>	Each ambulette and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

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Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?
 YES NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

1. B. Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?
 YES NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

2. A. List names, addresses, and SSNs for individuals, and the names, addresses, and Employer Identification Numbers (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled Related for all names listed who are related to each other.

Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN

2. B. Type of Entity or Practice: Sole Proprietorship Partnership Corporation Unincorporated Associations
 Other (specify) _____

2. C. If the disclosing entity or practice is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN

2. D. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?
 YES NO If, YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number
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(For State Use Only)

2.E. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.

YES NO

Name	Address	Provider (Title XIX Vendor) Number

3.A. Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)

YES NO ATTACH EXPLANATION

B. Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)

YES NO ATTACH EXPLANATION

4. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations. (mm/dd/yyyy)

YES NO

5. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?

YES NO

6. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)

YES NO

Name	Address	EIN

7. Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?

YES NO

Name	Type of offense?	When, give date? (mm/dd/yyyy)	SSN/EIN

Hospitals, only:

8. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? if yes, give year of change. Current Beds Prior Beds

YES NO

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Disclosure statement: Additional Names, Addresses, and Numbers by section.

Section: 1.A.

Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN

Section: 1.B.

Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name	When? Give date (mm/dd/yyyy)	SSN/EIN

Section: 2.A.

Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN
Name	Related <input type="checkbox"/>	Address	SSN/EIN

Section: 2.C.

Name	Address	SSN/EIN

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All providers must read the statements below, print name, initial, and date

In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

A copy of Executive Order 2007-01S can be found at: <http://www.dot.state.oh.us/clc/governor.asp>

Authorized Representative Name and Title *(please print)*

Authorized Representative Initials

Date

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Authorized Representative Name and Title *(please print)*

Authorized Representative Initials

Date

For all Ambulatory Health Care Clinics Only

All Ambulatory Health Care Clinics must provide documentation indicating the facility:

- * Is Free Standing – no administrative, organizational, financial, or other connection with a hospital or long term care facility;
- * Furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist;
- * Has a fixed location or specifically designed mobile unit;
- * Does not provide overnight accommodations;
- * Is not eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors enrolled as a Medicare provider.

(For State Use Only)

OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Medicaid Managed Care Plans and Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.
2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.
3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.
6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;
7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.
8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.
9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.
10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".
11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid. **If you meet this provision, please check this box.**
A failure to check this box shall be taken by ODJFS to mean that you waive your rights to a retroactive period of up to 12 months prior to the date ODJFS approves your application.

Authorized Representative Name and Title <i>(please print)</i>	
Authorized Representative Signature	Date
Signature of Authorized Agent <i>(For State Use Only)</i>	
	Date

(For State Use Only)

For help completing the application, please call the Provider Enrollment Customer Service Line. You can reach the Provider enrollment Unit through the Interactive Voice Response Unit.

The telephone number is:

800-686-1516

Our business hours are 8:00 am to 4:30 pm Monday through Friday.

For State Use Only

Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Data Processed	Effective Date	Provider Number
Operator's Number		Ticket Number