DEPARTMENT OF HEALTH CARE FINANCE
MEDICAID PROVIDER AGREEMENT

Name of Provider
_____

Address
_____

Title XIX Provider Number (if applicable):_____

National Provider Number:
_____

This Agreement made and entered into this _____ day of _____, 20 ___, by and between the District of Columbia Department of Health Care Finance, hereinafter designated as the Department, and the above-named, a Provider of Medicaid Services, whose address is, as stated above, hereinafter designated as the Provider.

Witnesseth:

WHEREAS, persons receiving public assistance payments from the Department and other persons eligible for care under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care;

WHEREAS, Section 1902(a) (27) of Title XIX of the Social Security Act requires the District of Columbia to enter into written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX), or under a Waiver of the Plan;

WHEREAS, pursuant to the "Department of Health Care Finance Establishment Act of 2007," effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code §7-771.01 et seq.), the Department is the single State agency responsible for administering the Medical Assistance Program (Title XIX) in the District of Columbia, and authorizes the Department to take all necessary steps for the proper

and efficient administration of the District of Columbia Medical Assistance Program;

WHEREAS, to participate in the District of Columbia Medical Assistance Program, the provider when applicable, must: (1) be licensed in the jurisdiction where located and/or the District of Columbia; (2) be currently in compliance with standards for licensure; (3) ensure that services be administered by a licensed or certified practitioner; and, (4) comply with applicable Federal and District standards for participation in Title XIX of the Social Security Act, and;

WHEREAS, prospective provider has filed an application with the Department to provide medical services to persons eligible under the Medical Assistance Program operated under Title XIX of the Social Security Act and said application is incorporated by reference into this Agreement and made a part hereof the same as if it were written herein.

The Provider agrees:

I. GENERAL PROVISIONS

A. To provide to Medicaid beneficiaries, services as covered in Title XIX of the Social Security Act and the State Plan for Medical Assistance (State Plan), or a Waiver of the Plan.

B. To adhere to the requirements, as listed below, for accepting payment when delivering services in accordance with the State Plan, or a Waiver of the Plan:
    1. The provider's payment shall be accepted as payment in full for the care of a beneficiary; and
    2. No additional charge shall be imposed on a beneficiary, member of his or her family or to another source for payment of services provided to a beneficiary.

C. To satisfy all applicable requirements of the Social Security Act, as amended, and be in full compliance with the State Plan, or a Waiver of the Plan, and standards prescribed by Federal and State statute and regulations.

D. To accept such amendments, modifications or changes in the program made necessary by amendments, modifications or changes in the Federal or State standards for participation.

E. To comply with any amendments thereto and the rules and regulations there under including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, 42 CFR Parts 80, 84 and 90 and the Americans with Disabilities Act, P.L. 101-336.

F. To maintain all records relevant to this Agreement at his/her cost, for a period of ten (10) years or until all audits are completed, whichever is longer. Such records shall include all records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to Medicaid beneficiaries.

G. To provide full access to these records to authorized personnel of the Department, District of Columbia Office of the Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives for audit purposes.

H. To expeditiously comply with a beneficiary's request to transfer his/her medical records when switching providers.

I. To furnish upon request to the Department, the Federal Government or their agents, information related to business transactions in accordance with 42 CFR § 455.105(b);

J. To identify and disclose information about any person, corporation or entity with or ownership or control interest in the provider, to the Department in accordance with 42 CFR § 455.104(b);

K. To disclose the identity of any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program in accordance with 42 C.F.R. § 455.106(a);

L. To comply with the provider screening and enrollment requirements, including criminal background checks and fingerprinting, as set forth in 42 C.F.R. Part 455 Subpart E.

M. To hold harmless the District of Columbia Government, the Department and Medicaid beneficiaries against any loss, damage, expense, and liability of any kind arising out of any action of the provider or its subcontractors arising out of the performance of this agreement.

N. To indemnify and hold harmless the District of Columbia Government, its officers, agents and employees, from any and all claims and/or lawsuits arising from the care provided by the Medicaid provider, and its officers, agents and employees. This indemnification also extends to and includes any independent acts by the District in hiring, training, or supervising the Medicaid provider so long as the claim or lawsuit arises from or is related to the underlying acts or omissions of the Medicaid provider.

O. To comply with the advance directive requirements contained in 42 CFR, Part 489, Subpart I, as appropriate.

P. To complete and sign a Provider Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the understanding that the application becomes a part of this agreement and that each succeeding change in the application constitutes an amendment to the Agreement and failure to keep the information current constitutes a breach of the Agreement.

Q. To conduct a quarterly comparison of employees against the Medicare Exclusion Database (the MED), HHS/OIG List of Excluded Individuals/Entities (LEIE) or the General Services Administration's Excluded Parties List System (EPLS).

R. To provide assurances of compliance with:

1. The Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002, (D.C. Laws 12-238 and 14-98), D.C. Official Code § 44-551 et seq., which prohibits Medicaid providers from offering employment or contracting with any person who is not a licensed healthcare professional until a criminal background check has been conducted for the person and also prohibits any facility from employing or contracting with any person who has been convicted
of certain criminal offenses specified in the law which should be checked no less than once per year; 49 USC § 31306 and 49 CFR 382 which requires employers of commercial drivers to conduct pre-employment, reasonable suspicion, and post-accident testing for controlled substances;

2. The Drug-Free Work Place Act of 1988 (41 USC § 8101 et seq.), which requires the implementation of an alcohol and drug-testing program; and

3. Title VI of the Civil Rights Act of 1964 and 45 CFR 84.52(5)(d) requires that all patients receive the same level of care and service regardless of limited or no English proficiency (LEP) or limited or no hearing ability. All providers serving Medicaid beneficiaries are responsible for ensuring interpreter services are available for patients who need them. Federally Qualified Health Centers (FQHCs), hospitals, and other inpatient facilities

must have their own interpreter services available for LEP or hearing impaired/deaf patients. Smaller, independent providers with no direct affiliation with such facilities may be eligible to request an interpreter through the Department.

S. That any breach or violation of any term of this Agreement shall make the entire Agreement, at the Department's option, subject to suspension and termination or imposition of enforcement remedies in conformance with Federal and District laws and regulations.

II. REQUIRED INFORMATION:

A. The address of all sites at which services will be provided to Medicaid beneficiaries including email address(es) and phone number(s);

B. A completed provider application including submission of the W9 form;

C. A copy of the professional or business license (if individual or group);

D. A copy of the hospital license (if a hospital);

E. Proof of liability insurance;

F. Disclosure of ownership and control form; and

G. The submission of any other documentation deemed necessary by the Department for the approval process as a Medicaid provider.

III. CONTRACTS AND SUBCONTRACTS

A. The Department or the provider may terminate this Agreement for convenience by giving ninety
(90) days written notice of intent to terminate the Agreement to the party.

B. The provider shall be legally responsible for all activities of its contractor and subcontractors and for requiring that they conform to the provisions of this Agreement. Subject to such conditions any service or function required by the provider pursuant to this Agreement may be subcontracted to any person or organization who/which meets all Federal and District requirements for participation in Medicaid, whether or not they are enrolled as Medicaid providers.

C. Sub-contractual agreement with providers who have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act is prohibited. Services

provided to Medicaid beneficiaries, who qualify also as Medicare crossover beneficiaries, through such subcontracts shall not be eligible for reimbursement by the Department.

D. The Department reserves the right to require the provider to furnish information relating to the ownership of the subcontractor, the subcontractor's ability to carry out the proposed obligations, assurances that the subcontractor shall comply with all applicable provisions of Federal and District law, and regulations pertaining to Title XIX of the Social Security Act and the State Plan for Medical Assistance and with all Federal and District laws and regulations applicable to the service or activity covered by the contract; the procedures to be followed by the provider in monitoring or coordinating the subcontractor's activities and such other provisions as the Department or the Federal Government may reasonably require.

E. Each subcontract shall contain a provision that the subcontractor shall look solely to the provider for payment of covered services rendered.

F. Effective October 1, 2020 each hospital including the hospital affiliated physician group located in the District of Columbia shall contract with each DC Medicaid Managed Care Organization (MCO) to provide inpatient and outpatient services to all eligible beneficiaries. DHCF reserves the right to terminate this Provider Agreement in accordance with the requirements set forth in Section VI, if it determines the hospital has refused in good faith to negotiate a contract with each DC Medicaid MCO within ninety (90) days of the effective date of this agreement.

G. Effective October 1, 2020, each federally qualified health center (FQHC) located in the District of Columbia shall contract with each DC MCO to provide services to all eligible beneficiaries. DHCF reserves the right to terminate this Provider Agreement in accordance with the requirements set forth in Section VI, if it determines the FQHC has refused in good faith to negotiate a contract with each DC Medicaid MCO within ninety (90) days of the effective date of this agreement.

IV. PAYMENT TO PROVIDER

A. The Department shall reimburse providers for services to Medicaid beneficiaries in accordance with the State Plan or any applicable waiver from the State Plan.

B. The provider shall submit claims for payment according to the Department's requirements.

C. The provider shall furnish to the Department its National Provider Identifier (NPI) and include the NPI on all claims submitted to the Department.

D. The Department shall make payments to the provider in accordance with applicable laws, as promptly as is feasible after a proper claim is submitted and approved.

E. The Department shall notify the provider of any major changes in Title XIX rules and regulations and in the State Plan. Publication in the D.C. Register may satisfy this notice requirement.

F. The provider shall not bill the beneficiary for any part of care or treatment.

V. THIRD PARTY LIABILITY RECOVERY

A. The provider shall utilize and require its subcontractors to utilize, when available, covered medical and hospital services or payments from other public or private sources, including Medicare.

B. The provider shall attempt to recover, and shall require its subcontractors to attempt to recover, monies from third party liability cases involving workers' compensation, accidental injury insurance and other subrogation of benefit settlements.

C. The Department shall notify the provider of any reported third party payment sources.

D. The provider shall verify third party payment sources directly, when appropriate.

E. Payment of Federal and District funds under the State Plan to the provider shall be conditional upon the utilization of all benefits available from such payment sources.

F. Each third party collection by a provider for a Medicaid beneficiary shall be reported to the Department and all recovered monies shall be returned to the Department immediately upon recovery.

VI. SANCTIONS FOR NON-COMPLIANCE

A. If the Department determines that a provider has failed to comply with any applicable Federal or District law or regulation, or any law or order that prohibits discrimination on the basis of race, age, sex, national origin, marital status or physical or mental handicap, the Department may:

1. Take any of the administrative actions described in Chapter 13 of Title 29 of the District of Columbia Municipal Regulations (DCMR). The Department shall comply with the requirements set forth in Chapter 13. These actions

include but are not limited to exclusion, termination and/or suspension of the provider from the Medicaid program;

2. If the provider's compliance failure amounts to a credible allegation of fraud, suspend Medicaid payments in accordance with federal law and rules (See 42 CFR §455.23 etc.); or

3. Take any other enforcement action consistent with any applicable District or Federal law, rule, or regulation.

B. The termination of the Agreement shall not discharge the responsibilities of either party with respect to services or items furnished prior to termination, including retention of records and verification of overpayment or underpayment.

C. Upon termination, the provider shall submit to the Department all outstanding claims for allowable services rendered prior to the date of termination in the form prescribed by the Department. Claims submitted not later than thirty (30) days following the termination date shall be adjudicated.

D. The provider also shall submit to the Department all financial performance and other reports required as a condition to this Agreement within ninety (90) days of the termination date.

E. The Department reserves the right to terminate this Agreement immediately if:

1. The United States Department of Health and Human Services withdraws Federal financing participation in all or part for the cost of covered services;
2. District funds are unavailable for the continuation of the Agreement; or
3. Any owner, officer, manager, agent or contractor of the provider is indicted by the U.S. Attorney for fraud or any misconduct related to the provision and reimbursement of services provided by the Medicaid program pursuant to this Provider Agreement.

F. Upon termination of the Agreement for reasons stated in VI. E., the Department will issue a notice stating the basis and reason for the termination and the effective date of the termination. The notice shall also include the procedures and timeframes for filing an appeal. Termination pursuant to VI.E. may not be stayed pending appeal.

G. The following shall trigger use of an enforcement action against a provider:

1. Inability of the provider to provide the services described in this Agreement;
2. Insolvency of the provider;
3. Failure of the provider to maintain its licensure or accreditation;
4. Conviction of the owner, officer, manager or other person with a five percent or greater direct or indirect ownership of certain crimes or the imposition of certain sanctions as specified in Section 1128 of the Social Security Act; or
5. Violation of any provision of applicable Federal or District laws.

H. The provider shall be responsible for providing written notice to beneficiaries prior to the effective date of any termination in a form and manner prescribed by the Department and shall be responsible for notifying the Department of those beneficiaries who are undergoing treatment of an acute condition.

VII. ASSIGNMENT OF RIGHTS

The rights, benefits and duties included under this Agreement shall not be assignable by the provider without receiving the written approval of the Department. The Department, as a condition of granting such approval, shall require that such assignees be subject to all conditions and provisions of this Agreement and all Federal laws and regulations governing the assigned Agreement.

VIII. TERMINATION OR REDUCTION OF THE DEPARTMENT'S SOURCE OF FUNDING

The Department's obligation to pay funds for the purpose of this Agreement is limited solely to availability of Federal and District funds for such purposes. No commitment is made by the Department to continue or expand such activities.

IX. CONFIDENTIALITY OF INFORMATION

A. The provider and its employees, contractors, and authorized agent shall use appropriate administrative, physical, and technical safeguards requirements described at 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 to maintain the security of the protected information and to prevent use or disclosure of such protected information other than for purposes directly related to the administration of the Medicaid program and to ensure the confidentiality, integrity, and availability of any protected information that it creates, receives, maintains, or transmits on behalf of DHCF.

B. The provider and its employees, contractors, and authorized agent shall not use or further disclose protected information created, collected, received, stored, used,

maintained or disseminated relating to eligible Medicaid beneficiaries other than as necessary to perform their obligations for purposes directly related to the administration of the Medicaid program, or as required by law, either during the period of this agreement or after (45 C.F.R. §§ 164.502(b) and 164.514(d)).

C. For the purposes of this agreement, protected information shall include information listed in 42 C.F.R. § 431.305 and information subject to any of the laws identified in Section IX.E of this agreement.

D. Purpose directly related to the administration of the Medicaid program shall include the following:

1. Establishing eligibility;
2. Determining the amount of medical assistance;
3. Providing services; and
4. Conducting or assisting in an investigation, prosecution, civil, or criminal proceeding relating to the administration of the Medicaid program

E. The provider shall ensure that its employees and agents comply with and are properly trained about:

1. The Data-Sharing and Information Coordination Amendment Act of 2010 (D.C. Law 18-273, D.C. Official Code §§7-241 et seq.), as amended, and corresponding regulations at 29 DCMR §§ 3000, et seq. (the Data-Sharing Act);
2. The District of Columbia Mental Health Information Act of 1978, (D.C. Law 2-136; D.C. Code § 7-1201.01 et seq.), as amended;
3. The federal Health Insurance Portability and Accountability Act (HIPAA), including but not limited to the requirements of the Privacy Rule and Security Regulations, 45 C.F.R. §§ 160, 162, and 164;
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records (42 C.F.R. Part 2); and
5. Any other applicable District and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider obtains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I agree that the receipt by the District of Columbia Medicaid program of the first and each succeeding claim for payment from me will be the Medicaid program's understanding of my declaration that the provisions of this Agreement and supplemental provider's manuals and instructions have been understood and complied with:

_____ _____

Provider's Signature Date

_____

_

Address

_____ _____

Phone Number Business Email Address

_____

_

Signature of individuals responsible to enforce compliance with these conditions

_____ _____

Chief Executive Officer (if applicable) Date

_____ _____

Chief Medical Officer (if applicable) Date

_____ _____

Principal Corporate Officer (if applicable) Date

DO NOT WRITE BELOW THIS LINE

Accepted by:

_____ _____

Authorized Signature by: Date
Department of Health Care Finance

For Official Use Only
D.C. Medicaid Provider Number Assigned: _____