Agenda Item #: **3E-5**

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: February 6, 2007 **(X) Consent** **( ) Regular**
( ) Ordinance **( ) Public Hearing**

Department
Submitted By: **Community Services**

Submitted For: **Division of Senior Services**

I. EXECUTIVE BRIEF

Motion and Title: Staff recommends motion to approve: Non-Institutional Medicaid Provider Agreement renewals for the Home and Community Base Medicaid Waiver program with the State of Florida Agency for Health Care Administration (AHCA) for a period of ten (10) years from the effective date of eligibility.

Summary: The Division of Senior Services (DOSS) administers the Home and Community Base Medicaid Waiver program, which provides a variety of services to low-income eligible seniors at risk of nursing home placement. The Non-Institutional Medicaid Provider Agreements will allow DOSS the ability to continue to utilize the Medicaid Program in providing services to seniors. DOSS bills Medicaid directly for Case Management services on a contracted unit rate basis and receive payments via Electronic Funds Transfers (EFT). No County funding is required. (DOSS) Countywide except for portions of Districts 3, 4, 5, and 7 south of Hypoluxo Road (TKF)

Background and Justification: The AHCA is a State administered program and requires a valid agreement on file in order for services to be billed through the program. DOSS is a Medicaid Waiver provider and the renewal agreement must be executed for the Division to continue to access the Medicaid program.

Attachments:
Non-Institutional Medicaid Provider Agreements for Florida Medicaid Identification No. 670732701 and No. 670732700

Recommended by: _____ 1-17-2007
Department Director **Date**

Approved By: _____ 1/29/07
Assistant County Administrator **Date**

II. FISCAL ANALYSIS IMPACT

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2007	2008	2009	2010	2011
Capital Expenditures					
Operating Costs					
External Revenue					
Program Income (County)					
In-Kind Match (County)					
NET FISCAL IMPACT					
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included in Current Budget: Yes _____ No
Budget Account No.: Fund_____ Dept_____ Unit____ Obj._____
Program Code ____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

Departmental Fiscal Review: _____

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Administration Comments:

1-23-07
OFMB

1/18/07 1-18-07

1/26/07
Contract Administration

This item complies with current County policies.

B. Legal Sufficiency:

1/28/07
Assistant County Attorney

C. Other Department Review:

_____
Department Director

This summary is not to be used as a basis for payment.

ACS Provider Enrollment
P.O. Box 13800
Tallahassee, FL 32317-3800

FLORIDA MEDICAID

JEB BUSH, GOVERNOR

CHRISTA CALAMAS, SECRETARY

004296
PALM BEACH CO DIV OF SENIOR SVCS
810 DATURA ST
STE. 300
WEST PALM BCH, FL 33401

RE: Medicaid Provider Agreement Renewal
Provider Number: 670732701 & 670732700

Dear Medicaid Provider:

A routine review of Medicaid provider files indicates that your Non-Institutional Medicaid provider agreement has either expired, or will expire in the near future. Enclosed is your new Non-institutional Medicaid Provider Agreement to sign and return. If you have more than one Medicaid provider number, you will receive a separate agreement for each number. You must complete a separate provider agreement for each provider number you hold.

Please review the enclosed agreement and verify that the name and provider id pre-printed on page three are correct. Sign and submit the completed agreement within 30 days to:

For Regular Mail:
ACS State Healthcare
Provider Enrollment
P.O. Box 13800
Tallahassee, FL 32317-3800

For Overnight or Express Delivery:
ACS State Healthcare
Provider Enrollment
2308 Killearn Center Blvd STE 100
Tallahassee, FL 32309

Medicaid policy requires a valid agreement on file before payment for services may be issued. In compliance with this policy the Agency will terminate your provider number if you do not return the requested information within 30 days of the date of this letter,

If you have any questions, please call the ACS Provider Enrollment Unit at 1-800-377-8216 for assistance. Please have your Medicaid provider number ready. We look forward to continuing our work together and appreciate your attention to this issue

Sincerely,

Alan Strowd, Chief
Medicaid Contract Management

Enclosures

NON-INSTITUTIONAL MEDICAID PROVIDER AGREEMENT

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:

(1) Discrimination. The parties agree that the Agency for Health Care Administration (AHCA) may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with AHCA; who is performing services or supplying goods in accordance with federal, state, and local law; and who agrees that no person shall, on the grounds of sex, handicap, race, color, national origin, other insurance, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from AHCA.

(2) Quality of Service. The provider agrees that services or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with AHCA. The services or goods must have been actually provided to eligible Medicaid recipients by the provider prior to submitting the claim.

(3) Compliance. The provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA.

(4) Term and signatures. The parties agree that this is a voluntary agreement between AHCA and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. Provided that all requirements for enrollment have been met, this agreement shall remain in effect for ten (10) years from the effective date of the provider's eligibility unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no AHCA signature is required to make this agreement valid and enforceable

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of the signing of the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional, occupational, facility or other license appropriate to the services or goods being provided, as required by law.

(b) Keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records as AHCA requires for a period of at least five (5) years.

(c) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients as required by law.

(d) Send, at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees, including their agents, access to all Medicaid patient records and to other information that can not be separated from Medicaid-related records.

(e) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.

(f) Within 90 days of receipt, refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program.

(g) To the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation, be liable for and indemnify, defend, and hold AHCA harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(h) Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except, and only to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. This includes situations in which the provider's Medicare coinsurance claims are denied in accordance with Medicaid's payment.

(i) Agrees to submit claims to AHCA electronically and to abide by the terms of the Electronic Claims Submission Agreement.

(j) Agrees to receive payment from AHCA by Electronic Funds Transfer (EFT). In the event that AHCA erroneously deposits funds to the provider's account, then the provider agrees that AHCA may withdraw the funds from the account.

(6) AHCA Responsibilities. The agency shall:

(a) Make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim.

(b) Not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the state's determination of eligibility of a recipient.

(7) Termination For Convenience. This agreement may be terminated without cause upon thirty (30) days written notice by either party.

(8) Ownership. The provider agrees to give AHCA sixty (60) days written notice before making any change in ownership of the entity named in the provider agreement as the provider. The provider is required to maintain and make available to AHCA Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(9) Complete Information. All statements and information furnished by the prospective provider before signing the provider agreement shall be true and complete. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the option of AHCA and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(10) Interpretation. This agreement shall not be construed against either party on the basis of this agreement having been prepared by one of the parties.

(11) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida.

(12) Amendment. This agreement, the application and other documents being executed and delivered pursuant hereto constitute the full and entire agreement and understanding between the parties hereto with respect to the subject matter hereof. No amendment shall be effective unless it is in writing and signed by each party.

(13) Severability. If one or more of the provisions contained in this agreement or application shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired.

(14) Agreement Retention. The parties agree that AHCA may only retain the signature page of this agreement, and that a copy of this standard provider agreement will be maintained by the Director of Medicaid, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

(15) Funding. This contract is contingent upon the availability of funds.

The parties concur that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The signatories hereto represent and warrant that they have read the agreement, understand it, and are authorized to execute it on behalf of their respective principals or co-owners. This agreement becomes null and void upon transfer of assets; change of ownership; or upon discovery by ahca of the submission of a materially incomplete, misleading or false provider application unless subsequently ratified or approved by ahca.

All shareholders (with five percent or greater ownership interest), principals, partners and financial custodians are required to sign this agreement or, a chief executive officer (CEO) or president of an organization may sign this agreement in lieu of the above. Failure to sign the agreement will make this application, agreement and provider number voidable by AHCA.

IN WITNESS WHEREOF, the undersigned have caused this agreement to be duly executed under the penalties of perjury, swear or affirm that the foregoing is true and correct.

Addie L. Greene	Chairperson		
(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date

(USE ADDITIONAL PAGES IF NECESSARY

Provider's Name: PALM BEACH CO DIV OF SENIOR SVCS

DBA Name:

Tax Identification Number: 59-6000785

National Provider Identifier:

Florida Medicaid Identification Number:
(For new applicants this block will be completed by the fiscal agent.) 670732700

APPROVED AS TO TERMS AND CONDITIONS
BY:

The parties concur that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The signatories hereto represent and warrant that they have read the agreement, understand it, and are authorized to execute it on behalf of their respective principals or co-owners. This agreement becomes null and void upon transfer of assets; change of ownership; or upon discovery by ahca of the submission of a materially incomplete, misleading or false provider application unless subsequently ratified or approved by ahca.

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DBA Name:

Tax Identification Number: 59-6000785

National Provider Identifier:

Florida Medicaid Identification Number:
(For new applicants this block will be completed by the fiscal agent.) 670732701

APPROVED AS TO TERMS AND CONDITIONS
BY: DEPARTMENT HEAD