Massachusetts Medicaid Program Provider Agreement and Acknowledgement of Terms of Participation
for
Frail Elder Waiver
Home- and Community-Based Services Waiver Providers

Completion of this form is required under federal law by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, under 42 CFR 431.107.

Name of Provider (Printed) _____

Telephone Number _____

Street Address _____

City _____ State _____ Zip Code _____ - _____

The above-referenced Provider of home- and community-based services waivers under the Massachusetts Medicaid program, hereinafter referred to as "the Provider," hereby agrees and acknowledges the following.

1. The Provider acknowledges it is subject to certain federal and state laws, regulations, and policies, including those relating to Title XIX of the Social Security Act, those pertinent to Massachusetts Medicaid program (MassHealth), official written policy as transmitted to the Provider in the applicable MassHealth program manuals and bulletins, the standards for the specific Medicaid waiver service that the provider will deliver, and other requirements related to the delivery of Medicaid waiver services under the Frail Elder waiver. The Provider acknowledges that it is responsible for knowing the provisions of federal and state laws, regulations, the Medicaid waiver requirements and policies that apply to it, and for complying with applicable federal and state law as a condition of its participation as a provider of home- and community-based services under the Massachusetts Medicaid program.
2. The Provider shall claim payment only for covered services to individual waiver participants who are authorized by the Executive Office of Health and Human Services (EOHHS) or its designee in the waiver participant's individual service plan. Claims for payment shall be submitted to the Aging Services Access Point (ASAP).
3. In accordance with 42 CFR 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to document the extent of services provided to members for a period of six years, and upon request, to furnish to EOHHS, the U.S. Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Medicaid Home- and Community-Based Services Waiver. For state policy related to record retention, see 130 CMR 450.205.
4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, the Provider shall furnish to the state waiver operating agency, and upon request, to EOHHS in writing:

   (a) the names and addresses of all vendors of drugs, medical supplies, or transportation, or other Medicaid providers in which it has a controlling interest or ownership;

   (b) the names and addresses of all persons who own or have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest, such as spouse, parent, child, or sibling;

(d) the names and addresses of any subcontractors who have had business transactions with the Provider; and

(e) the identity of any person, named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XIX services programs since the inception of those programs.

5. Within 35 days of a written request for such information from EOHHS or the U.S. Department of Health and Human Services, the Provider must disclose (i) updated information on ownership and control in accordance with 42 CFR 455.104; (ii) full and complete information on business transactions in accordance with 42 CFR 455.105; and (iii) the identity of any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider 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 programs since the inception of those programs, in accordance with 42 CFR Part 455.106.

6. The Provider hereby affirms that it and each person employed by or under contract with it for the purpose of providing services holds all licenses and/or similar certifications or meets the qualifications specified in the Medicaid Home- and Community-Based Services Waiver, or as required by federal or state statute, regulation, or rule for the provision of the service.

7. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the provider to the Medicaid program as a result of an investigation or audit conducted by EOHHS, the state Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

8. Unless earlier terminated as provided in paragraph 9 below, this agreement shall remain in full force and effect for a maximum of one year. In the absence of a notice of termination by either party, the agreement shall automatically be renewed and extended for a period of one year. Automatic annual extensions may not continue for more than three years or extend this agreement beyond the due date of the next provider standards credentialing. Provider standards credentialing is a state agency function, whereby the State Medicaid Agency or its designee must assess and ensure that the waiver service provider continues to meet all applicable waiver service standards.

9. This agreement may be terminated as follows:

   (a) by the Provider as provided at 130 CMR 450.223(D); or

   (b) by EOHHS upon grounds set forth at 130 CMR 450.213 or 130 CMR 450.227, or pursuant to terms set forth in the Medicaid Home- and Community-Based Services Waiver.

10. The Provider agrees to give the Massachusetts Medicaid program or any state waiver operating agency any information it requests to enable it to enroll providers, to authorize payment for Medicaid-covered services provided to eligible members and to assess the health and safety of any waiver participant served by the Provider. Failure to supply the information requested by the Massachusetts Medicaid program may result in denial of Medicaid payment or sanctions related to the Provider's continued participation in the program. For state policy related to sanctions, see 130 CMR 450.238.

11. The Provider acknowledges that any statement made in this document or in the provider application process constitutes a statement or representation of a material fact made in an application for a benefit or payment, or made for use in determining rights to such benefit or payment that is knowingly and willfully made or caused to be made by the Provider within the meaning of M.G.L. c. 118E, §40, which imposes criminal penalties for fraud committed in connection with the Massachusetts Medicaid program.

12. The Provider agrees to comply with the advance directive requirements specified under 42 CFR 431.107(b)(4), if it is a provider of home health or personal care services.

13. The Provider agrees to provide services to eligible members without regard to religion, race, color, or national origin in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq*. and its implementing regulations at 45 CFR Part 80, and without regard to handicap, in compliance with Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. §794 and its implementing regulations at 45 CFR Part 84).

Modifications to this agreement cannot and will not be agreed to. This agreement is not transferable or assignable.

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the Provider or, in the case of a legal entity, duly authorized to act on behalf of the Provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature

_____

(Signature and date stamps, or the signature of anyone other than the Provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of Provider _____

Printed legal name of individual signing (if Provider is a legal entity) _____

Date _____