



North Carolina Department of Health and Human Services

PROVIDER ADMINISTRATIVE PARTICIPATION AGREEMENT

1. Parties to the Agreement

This Medicaid Provider Administrative Participation Agreement ("Agreement") is entered into by and between the North Carolina Department of Health and Human Services hereinafter referred to as the "Department", and the below identified provider, hereinafter referred to as the "Provider."

STATE/FISCAL AGENT USE ONLY

- Initial Enrollment
- Re-Enrollment
- CHOW
- Other Change

2. Agreement Document

The Agreement Documents shall consist of this Agreement, any addendum, and the Provider's application, incorporated herein by reference. Except for changes to DHHS medical coverage policies, or other guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent as referenced in Section 3, below, no alterations or modifications shall be made to the terms of the Agreement unless through a written amendment executed by both parties.

3. Governing Law and Venue

This Agreement is required by 42 CFR §431.107 and shall be governed by the following (hereinafter referred to as the "Controlling Authority"):

- (a) Title XIX of the Social Security Act and its implementing regulations, the North Carolina State Plan for Medical Assistance, and any Title XIX waivers authorized by the Centers for Medicare and Medicaid Services (CMS); and
- (b) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, including but not limited to the Standard for Privacy of Individually Identifiable Health Information and Health Insurance Reform: Security Standards; and
- (c) The Family Educational Rights and Privacy Act (FERPA); and
- (d) N.C.G.S §108A-80; and
- (e) The following that are consistent with and expressly or implicitly authorized by the authority in subdivision (a) herein: state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agent in effect at the time the service is rendered.

By execution of this Agreement, the Provider does not release, waive or modify in any way any procedural or substantive rights it may have pursuant to Controlling Authority related to its participation in the Medicaid program. In case of conflict between any provision of this Agreement and any current or future provision of Controlling Authority, the Controlling Authority shall govern and the terms of this Agreement shall be deemed to be modified so as to comply with Controlling Authority. In the event of a

lawsuit or administrative petition involving this Agreement, venue is proper in Wake County, North Carolina.

The Provider agrees to operate and provide services in accordance with the Controlling Authority. Unless otherwise required by this Agreement or Controlling Authority, the Department may publish notice of changes in policies, guidelines, or other procedures on its website within 30 days advance notice to provide for implementation thereof.

Nothing in this Agreement creates in the provider a property right or liberty right in continued participation in the North Carolina Medicaid program.

4. License

The Provider agrees to:

- a. Be licensed, certified, registered, accredited and/or endorsed as required by Controlling Authority or Department policy, as appropriate for the service provided by the Provider, at all times those services are provided.
- b. Notify the Department within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.

5. Billing and Payment

The Provider agrees:

- a. To submit claims for services rendered to eligible North Carolina Medicaid recipients (hereinafter "recipients") in accordance with rules and billing instructions in effect at the time the service is rendered. Provider agrees to be responsible for research and correction of all billing discrepancies in claims submitted by the Provider or its authorized agent.
- b. To accept as sole and complete remuneration the amount paid in accordance with the finally determined reimbursement rate for services covered by the Department, except for payments from legally liable third parties, and authorized co-payments, coinsurance and/or deductibles authorized by the Controlling Authority or the Department. A Provider may bill for goods, services, or supplies provided to a recipient if such are not covered under Medicaid and the recipient has been notified in advance that such services are not covered and that the recipient is financially responsible. By agreeing to this provision, the Provider does not waive any potential rights to challenge or appeal its reimbursement rate or payment calculation in accordance with Controlling Authority.
- c. That in no event shall the Department be liable or responsible, either directly or indirectly, to any subcontractor of the Provider or any other party that may provide services.
- d. To be held to all the terms of this Agreement even though a third party agent may be involved in billing claims to the Department. It is a breach of the Agreement to assign the right to payment under this Agreement to a third party in violation of 42 CFR §447.10.
- e. To inquire about other coverage and bill other insurers and third parties, including the Medicare program, if applicable, before billing the Department, when the recipient is eligible for payment for health care or related services from another insurer or person.
- f. To not bill the recipient or any other person for items and services covered by Medicaid and to refund payments made by the recipient or by a third party on behalf of the recipient for Medicaid covered services for any claims for which the recipient has been approved for payment by the Department, including retroactive authorization for payment. No refund is due by the Provider to the recipient or any

- other person until payment to the Provider is final and has been made in full by Medicaid to the Provider.
- g. To accept assignment of Medicare payment in order to receive payment from the Department for amounts not covered by Medicare for dually eligible recipients.
 - h. To refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents.
 - i. That payment for covered services by the Department is limited to those services that are medically necessary. Medical necessity and appeals of medical necessity determinations will be determined in accordance with the Controlling Authority.
 - j. That items or services provided under arrangements or contracts between the Provider and outside entities and professionals shall meet the same professional standards and principles as herein agreed to by the Provider.
 - k. That payment and satisfaction of claims will be from federal and state funds.
 - l. That claims are subject to the Medical Assistance Provider False Claims Act (Part 7, Article 2, Chapter 108A of the General Statutes), the North Carolina False Claims Act, Chapter 1, Article 51 of the North Carolina General Statutes (N.C.G.S §§1-605 through 617), and the federal False Claims Act.
 - m. That the Department may withhold payments because of irregularity without regard to cause until such irregularity is resolved, or may recoup or recover overpayments, penalties or invalid payments due to error of the Provider and/or the Department and their agents. The Department shall provide timely notice to the Provider that states the Department's reasons for withholding payments, the conditions that must be met to resolve the irregularity and the Provider's right to appeal. This withhold shall be subject to adjustment in accordance with Controlling Authority as a result of any contrary final determination in any challenge or appeal brought by the Provider. The Department may also withhold or suspend payments to a Provider as authorized by Controlling Authority. A Provider that is subject to a withhold recoupment, recovery, suspension, or penalty initiated by the Department shall not directly or indirectly bill through a different provider number for the purpose of evading the action.
 - n. Any Providers that share the same IRS Employee Identification Number are equally subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until any overpayment, penalty, or invalid payment incurred by such Provider(s) is resolved, either by payment in full or final agency decision. Any Provider that does not share the same Employee Identification Number but that is more than fifty percent (50%) owned, in whole or in part, by an individual or entity that has more than fifty percent (50%) ownership interest in a separate provider entity that owes an outstanding overpayment, penalty, or invalid payment to the Department shall also be subject to the withholding, recoupment or recovery referred to and in accordance with subsection "m" above until such overpayment, penalty, or invalid payment is resolved, either by payment in full or final agency decision.
 - o. That billings and reports related to services rendered shall be submitted in the format and frequency specified by the Department, any of its divisions and/or its fiscal agent. Failure to file mandatory reports or required disclosures within the time frames established by Department rule or policy may result in suspension of payments and/or other enforcement actions.
 - p. That claims shall be received by the Department within 365 calendar days of the date of service except as otherwise provided by Controlling Authority.
 - q. That electronic and non-electronic Medicaid claims may be submitted without signature and same is binding upon Provider, its employees, or its agents who provide services to recipients or who file claims under the Provider name and identification number.
 - r. That all claims shall be true, accurate, and complete and that services billed shall be personally furnished by Provider, its employees, or persons with whom the Provider has contracted to render services, under its direction.
 - s. That, except for hospital services as set forth in 42 CFR §413.65 the assigned Medicaid Provider Number

is specific to the Provider name and site location identified on the signature page of this Agreement, and that Provider shall not bill for services provided at or from other site locations using Medicaid Provider Number assigned to the site location identified on the signature page of this Agreement.

- t. That any change of ownership of Provider shall not be approved unless and until the new owner/entity agrees in writing to assume all liability, including but not limited to cost report settlements, health care assessment settlements, or recoupment actions, that have arisen or that may arise in connection with claims billed by Provider.
- u. To not bill the Department for services that were rendered during any period in which the institutional or professional license, certification, registration, accreditation and/or endorsement required of the individual or entity providing the service has become invalid due to suspension or termination by the issuing agency.

6. Disclosure

- a. At any time during the course of this Agreement, the Provider agrees to notify the Department at the North Carolina Department of Health and Human Services, Division of Medical Assistance, Provider Services Section, of any material and/or substantial change in information contained in the enrollment application given to the Department by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial change includes, but is not limited to, a change in:
 - i. ownership;
 - ii. licensure;
 - iii. federal tax identification number;
 - iv. bankruptcy;
 - v. additions, deletions, or replacements in group membership; and
 - vi. any change in address or telephone number.
- b. The Provider agrees to submit to the Department upon request professional, business, and personal information concerning the Provider, any person with an ownership interest in the Provider, and any authorized agent of the Provider in accordance with the disclosure requirements set forth in 42 CFR Chapter IV, part 455, Subpart B. Such submittal shall include:
 - i. Proof of a valid license, operating certificate, and/or certification if required by Controlling Authority or policy, or rule of a local jurisdiction in which the Provider is located and that is consistent with Controlling Authority.
 - ii. Any prior or current violation, recoupment, fine, suspension, termination, or other administrative action taken relative to medical or behavioral health care benefit programs under (a) federal or State law, policy, or rule; or (b) Department policy(ies) or (c) the laws or rules of any other state, Medicare, or any regulatory body.
 - iii. Full and accurate disclosure of any financial or ownership interest that the Provider, or a person with an ownership interest in the Provider, may hold in any other medical or behavioral health care provider or medical or behavioral health care related entity or any other entity with whom the Provider conducts business or any other entity that is licensed by the state to provide medical or behavioral health care services.
- c. The Provider agrees to furnish on request, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
- d. The Provider agrees to submit to a criminal background check before or anytime after approval of this agreement.

- e. The Provider agrees to screen all its employees and contractors regularly using the List of Excluded Individuals/Entities (LEIE) database to determine whether any of its employees or contractors is excluded from participation in Medicare, Medicaid, or other federal health care programs. The LEIE database is maintained by the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG) and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Provider shall promptly notify the Department upon discovery that any employee or contractor is on the LEIE. Provider understands and acknowledges that employment of or contractual arrangements with persons listed in the LEIE will subject the Provider, in accordance with Controlling Authority, to recoupment of funds paid to the Provider during the period in which the employment or contract was in effect.
- f. The Provider agrees to 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 Chapter IV, part 489, subpart I and 42 CFR §417.436(d).

7. Inspection; Maintenance of Records; Filing Reports

- a. For a minimum of six years from the date of services, or longer if required specifically by Controlling Authority, the Provider shall:
 - i. Promptly furnish upon request copies of any and all documentation set forth below in subpart ii of this paragraph, whether in the possession of contractors, agents, or subcontractors, for review by the Department, its agents and/or assigns. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for medical or behavioral health care services not adequately documented, and may result in the termination or suspension of the Provider from participation in the Medicaid program. The Provider further understands that it is the Department's position that failure to promptly furnish records upon request creates a presumption that the records do not exist.
 - ii. Keep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department. For providers who are required to submit annual cost reports, fiscal records shall include invoices, checks, ledgers, contracts, personnel records, worksheets, schedules, and such other records as may be required by Controlling Authority or Department policy.
- b. Post payment audits or investigation may be conducted to determine compliance with the rules and regulations of the Department. If the Provider is notified that an audit or investigation has been initiated, the Provider shall retain all original records and supportive materials until the audit or investigation is completed and all issues are resolved if the period of retention extends beyond the minimum required 6-year period.
- c. Federal and State officials, employees and their agents may visit Provider facilities to make certification and compliance surveys, inspections, medical and professional reviews, and audits of costs and data relating to services to recipients. Such visits including unannounced visits must be allowed at any time during normal hours of operation. Failure to grant immediate access upon reasonable request may result in suspension of the Provider and/or of reimbursements.

8. Termination

Subject to applicable provisions of Controlling Authority:

- a. Either the Department or the Provider may terminate this Agreement with or without cause at any time upon 30 days written notification to the other;

- b. The Department may summarily terminate without giving 30 days written notice under the following circumstances:
- i. The Provider does not meet conditions for participation, including necessary licensure, certification, or endorsement requirements or other terms and conditions stated in this Agreement; or
 - ii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense set forth in 42 CFR §1001.101 or 42 CFR §1001.201; or
 - iii. Any person with ownership or controlling interest in the Provider, or managing employee of the Provider, has been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct, or crime of moral turpitude; or
 - iv. The Provider fails to disclose information required under 42 CFR §1002.3; or
 - v. Any person with ownership or controlling interest in the Provider, or an agent as that term is defined in accordance with 42 CFR §1001.1001 or managing employee of the Provider, has been excluded by the United States Department of Health and Human Services from participation in the Medicare or Medicaid programs; or
 - vi. The Provider poses an imminent health or safety risk to a patient; or
 - vii. The Provider has been found by the Department to be in breach or violation of any law, rule, or policy for which summary termination is authorized by Controlling Authority or by a rule authorized by and consistent with the Controlling Authority and adopted pursuant to Chapter 150B of the General Statutes; or

The Provider's right to appeal or otherwise contest any termination shall be determined in accordance with Controlling Authority.

9. Assignment

The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement to a third party except as allowed by federal law.

10. Release of Liability

The Provider agrees to fully release and discharge the State of North Carolina, the Department and any of their officers, agents and employees, from any and all liability, claims and causes of action that may be brought by third parties against the Provider arising out of this Agreement. This is a complete and irrevocable release and waiver of liability. The State of North Carolina, the Department, and any of their officers, agents and employees are not liable for claims and causes of action that may be brought by third parties arising out of any act or omission of the Provider or any subcontractor.

11. Severability

The provisions of this Agreement are severable. If any provision of the Agreement is held invalid by any court that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be modified to conform to existing law.

12. Independent Contractor

The Provider or its directors, officers, partners, employees and agents are not employees or agents of the Department.

13. Discrimination

The Provider agrees that the Department may make payments for medical or behavioral health care services rendered to Department recipients only to a person or entity who has a provider agreement in effect with the Department; who is performing services or supplying goods in accordance with all requirements under Title VI of the Civil Rights Act of 1964; Section 504 of the 1973 Rehabilitation Act; the 1975 Age Discrimination Act; the 1990 Americans With Disabilities Act; and all applicable federal and state statutes and regulations relating to the protection of human subjects of research. The authority of the Department and its Division of Medical Assistance to limit payment to the Provider under this Section or otherwise shall be restricted exclusively to payments for services rendered on specific dates as to which the above-referenced requirements were not met.

14. Waiver

No waiver of any term, right or condition of this Agreement shall be valid unless it is set forth in a writing duly executed by both parties. No delay or failure by either party to exercise or enforce at any time any right or provision of this Agreement will be considered a waiver thereof or of such party's right thereafter to exercise or enforce each and every right and provision of the Agreement. No single waiver will constitute a continuing or subsequent waiver.

15. Survival

All provisions of this Agreement which by their nature give rise to continuing obligations of the parties shall survive the expiration or termination of this Agreement, including without limitation the terms of paragraphs 3, 5, 7, 9, and 10.

16. Effective Date

This Agreement is effective on the date the Provider meets all requirements of participation as set forth in 42 CFR §431.108.

Required Fields are marked with an asterisk (*).

*Medicaid Provider Name (Last, First, Middle or Organization Name)

*Street Address Line 1 (Site/Physical Address; not a P.O. Box)

*Street Address Line 2

*Phone Number

*City

*State

*Zip Code + Four (Last 4 digits required)

*Correspondence Address Line 1 (Accounting)

*Correspondence Address Line 2

*City

*State

*Zip Code + Four (Last 4 digits required)

* Medicaid Provider Number (if applicable)

I certify that the responses in this attestation and information contained in the documents submitted with the application/enrollment documents/Administrative Participation Agreement are true, accurate, complete, and current as of the date this attestation is signed. I have not herein knowingly or willfully falsified, concealed or omitted any material fact that would constitute a false, fictitious or fraudulent statement or representation.

*Signature of Applicant or Authorized Agent

*Date

*Printed Name and Title

DHHS/DMA/FISCAL AGENT APPROVAL

*Signature

*Date