MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 57 NURSING FACILITY

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **9am – 5pm.**

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

Please visit health.maryland.gov/ePREP for more information about ePREP

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Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

Section I:
Please upload the following (attached) document to ePREP :

- Completed Nursing Facility Title XIX Provider Agreement (attached)

Section II:

- Is this application being submitted for a new enrollment or for an ownership change?

☐ YES ☐ NO

If yes, please include the completed Private Daily Room Rate form in your upload and provide the point of contact information.

- Private Daily Room Rate form (attached)
  - Private Daily Room Rate Contact Information

Private Daily Room Rate Contact:	
Name:	Position/Title:
Phone:	Email:
Additional Private Daily Room Rate Contact (if applicable):	
Name:	Position/Title:
Phone:	Email:

  -
- If you are submitting this for an ownership change, please provide the buyers point of contact information

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- Buyer Point of Contact Information;

Buyer's Contact Information (if submitting for an ownership change):	
Name:	Position/Title:
Phone:	Email:
Additional Buyer's Contact (if applicable):	
Name:	Position/Title:
Phone:	Email:

Next Steps: Once your enrollment application for a new enrollment or for an ownership change is submitted and within the review process, the contact person listed above will receive an email from the MDH Long Term Care Resolution Unit (LTCRU) for the patient roster.

The Long Term Care facility (LTCF) Rate/Change form(s) is **required** when an LTCF receives a new E&E Vendor ID and MMIS provider ID numbers and when necessary, reports changes of the private daily room (PDR) rate(s). The private daily room rate is used in the Long Term Care (LTC) Eligibility Determination process in E&E. Without this information, Long Term Care cases will not properly accept in the E&E system to render an accurate and final eligibility decision.

***Note**: As a reminder, you must submit a Certificate of Assurance or Letter of Credit to the MDH Office of Finance. Failure to submit this information will result in a pended enrollment status with Maryland Medicaid and will not be made active until submitted.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
AGREEMENT FOR NURSING FACILITY
PARTICIPATION IN THE TITLE XIX PROGRAM

Name of Facility:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Fiscal Year End Date: _____ Nursing Facility License No._____ Title XIX Vendor No. _____

This Contract, made and entered into this _____ day of _____ , _____, by and between the Maryland Department of Health, hereinafter designated as the Department, and the above-named provider of service, hereinafter designated as the Facility

Witnesseth:

WHEREAS, the Department is designated as the single State agency to administer all aspects of the Maryland Medical Assistance Plan prescribed under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., and whereas the Facility purposes to provide Nursing Facility services and, if approved by the federal Centers for Medicare and Medicaid Services for participation under Title XVIII of the Act, Nursing Facility services covered by the Maryland Medical Assistance Program to eligible participants of the Program.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained, the parties hereto agree as follows:

I. THE FACILITY AGREES:

A. That at all times during which this Agreement is in effect the Facility will:

1. Be licensed by the Department, pursuant to Health-General Article Title 19, Subtitle 3, §19-301 et seq., Annotated Code of Maryland, as a Comprehensive Care Facility,

2. Comply with the requirements of COMAR 10.07.02 as issued by the Department, and such guidelines as may be promulgated thereunder by the Office of Health Care Quality and

3. Comply with the requirements and follow the procedures set forth in COMAR 10.09.10 and 10.09.36, as appropriate, and in guidelines promulgated thereunder by the Maryland Medical Assistance Program;

B. To accept for payment for supplying the services covered by the Medical Assistance Program, the Department's provider payment now in effect, or as hereinafter modified;

1. The provider payment as determined according to COMAR 10.09.10 plus the Recipient's available resource, if any, as determined by the Local Department of Social Services, will be accepted as payment in full for all services covered by the Medical Assistance Program, and

2. No additional charge will be made to the patient, any member of his family, or to any other source for any supplementation or for any item except as allowed within the Title XIX, regulations issued pursuant thereto, and COMAR 10.09.10, 10.09.36 and guidelines issued pursuant thereto;

C. To submit, within 35 days of the date on a request by the Secretary of the Department, or the Medicaid agency, full and complete information about:

1. The ownership of any subcontractor[1] 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, and

2. Any significant business transactions[2] between the provider and any wholly owned supplier[3], or between the provider and any subcontractor, during the 6-year period ending on the date of the request;

D. To disclose to the Department at the time this agreement is executed or at any time upon written request by the Department the identity of any person who:

1. Has ownership or control interest[4] in the provider, or is an agent or managing employee of the provider, and

2. Has been convicted[5] of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;

[1]"Subcontractor" means: (a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

[2]"Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expenses of a provider,

[3]"Supplier" means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

"Wholly owned supplier" means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

[4]"Ownership interest" means the possession of equity in the capital of, of stock in, or of any interest in the profits of the disclosing entity.

"Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in the disclosing entity.

"Person with an ownership or control interest" means a person or corporation that: (a) Has an ownership interest totaling 5 percent or more in a disclosing entity; (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) Is an officer or director of a disclosing entity that is organized as a corporation; or (f) Is a partner in a disclosing entity that is organized as a partnership.

"Disclosing entity" means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

[5]"Convicted" means that a judgment of conviction has been entered by a federal, State, or local court, irrespective of whether an appeal from that judgment is pending.

E. To respect the observance of religious beliefs of all Title XIX patients;

F. To have satisfactory written policies and procedures for:

1. Maintaining all medical records on each patient in the Facility,

2. Obtaining, dispensing and administering drugs and biologicals,

3. Assuring that each patient is under the care of a physician, and

4. Making adequate provision for medical attention to any patient during emergencies;

G. To have arrangements with one or more general hospitals under which such hospital or hospitals will provide needed diagnostic and other services to patients of such Facility and under which such hospital or hospitals agree to timely acceptance, as patients thereof, or acutely ill patients of such Facility who are in need of hospital care, in accordance with the provisions of 42 CFR 483.75(n);

H. To allow regular medical reviews of each patient covered under the Title XIX program, including a medical evaluation of the patient's need for the level of care provided;

I. To cooperate with local, State and federal personnel, or their designees, who make periodic inspections, medical reviews, and audits;

J. To promptly inform the Department, according to Departmental procedures, when individuals covered under the Title XIX program enter and leave the Facility;

K. To maintain all records for a period of 6 years and to make available, in Maryland, to the appropriate State and federal personnel, or their designees, at all reasonable times all records necessary to justify medical services rendered and charges made; all records as may be required to be kept by federal or State laws or regulations; and all financial records of the Facility;

L. To comply with Title VI of the "Civil Rights Act of 1964," and any amendments thereto, and the rules and regulations thereunder, said law providing in part as follows:

"No person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.";

M. To assure that the services are provided and facilities are operated without regard to political or religious opinion or affiliation, age, physical or mental handicap, sex or marital status;

N. To submit invoices for care provided in accordance with the regulations and guidelines of the Department;

O. That if the Recipient has insurance, or if any other person is obligated, either legally or contractually, to pay for or to reimburse the Recipient for any services provided by the Program, to bill the other source prior to billing the Program;

P. That if funds become identified after the invoice has been submitted to the Department, the Facility will collect such funds and refund to the Department the lesser of the Department's payment or the sums collected, unless otherwise provided for by the Program's regulations or guidelines; and

Q. That any material breach or violation of any one of the above provisions shall make this entire Agreement, at the Department's option, subject to cancellation.

II. THE DEPARTMENT AGREES:

A. To pay the Facility for services provided to Recipients and covered by the Medical Assistance Program in accordance with, and at rates prescribed by, the regulations and guidelines of the Program, or other applicable State law;

B. To give to the Facility reasonable notice of any impending change in its status or change in payment formula as a participating Nursing Facility; and

C. To provide a fair hearing to the Facility in the event the Department suspends or cancels the Facility's participation in the Title XIX program.

III. THE DEPARTMENT AND FACILITY MUTUALLY AGREE:

A. That the terms and conditions of the Agreement shall be modified, when necessary, in accordance with any changes in the regulations of the Department, or to bring the Agreement into conformity with any applicable State or federal law;

B. That in the event the federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this Agreement on the part of either party infeasible or impossible or if the parties to this Agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX program as the result of amendments or judicial interpretations, then, and in that event, both the Facility and the Department shall be discharged from further obligation created under the terms of this Agreement, except for equitable settlement of the respective accrued interests up to the date of the termination;

C. That this Agreement shall be effective: _____

1. For Nursing Facility services, as long as the Facility remains in compliance with federal requirements as specified in sections 1919(b), (c) and (d) of the Act, and applicable State requirements, and

2. For Nursing Facility services, as long as the Facility remains in compliance with federal requirements as specified in sections 1819(b), (c) and (d) of the Act, and applicable State requirements;

D. That this Agreement shall terminate when the federal government ceases to participate in the cost of the Department's payments made to the Facility, or by mutual consent of the Department and the Facility, or, if not by such mutual consent, either party to this Agreement may consider it cancelled by giving 30 days notice in writing to the other party;

E. That any provision of this Agreement may be waived in writing; however, such waiver shall extend to the particular case, time and manner specified, and shall not constitute a waiver of any other term or clause;

F. That no employee of the State of Maryland shall be paid of the funds provided in this Agreement, nor shall any employee of the State, or any department, commission, agency or branch thereof, whose duties as such employee include matters relating to or affecting the subject matter of this Agreement, while such an employee, become or be an employee of the party or parties hereby contracting with the State of Maryland; and

G. That this Agreement shall not be transferable or assignable.

_____

NAME OF NURSING FACILITY

BY_____

AUTHORIZED SIGNATURE

_____ _____

TITLE DATE

MARYLAND DEPARTMENT OF HEALTH

BY_____

AUTHORIZED SIGNATURE

Chief, Division of Long Term Care Services _____

TITLE DATE

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

_____ _____

NAME DATE

Assistant Attorney General_____

TITLE

Maryland
DEPARTMENT OF HEALTH

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

Office of Medicaid Provider Services
MEDICAL ASSISTANCE PROVIDER RESOLUTION DIVISION
LONG TERM CARE PROVIDER RESOLUTION UNIT

LONG TERM CARE/CHRONIC FACILITY RATE FORM

LTC Facility Administrator/personnel must complete sections II-III (items 1-5) below only when submitting a rate update/change; otherwise, complete section III (items 4-5) below only for new provider/new rate submission. Retain a copy and return the completed signed form via fax, mail, or email.

SECTION – I

☐ **New Provider /Vendor ID# and New Private Daily Room Rate**

SECTION – II

☐ **Private Daily Room Rate Update/Change** Pay to Provider Name: _____

Address: _____ City/State/Zip: _____

DHMH MMIS Provider #: _____

SECTION - III
CARES Vendor ID #/ LEVEL OF CARE (LOC):

(1.) Check the applicable corresponding LOC box/boxes below:

☐ Skilled Care (081-SC) --
☐ Intermediate Care (082-IC) --
☐ Chronic Care (072-CC) --
☐ Psychiatric (073-PSYC) --

(2.) Vendor ID#	*(3.) Daily Room rate Effective Date (mm/yy):*	*(4.) Daily Room Rate Amount $*
	/	
	/	
	/	
	/	

(5.) _____
SIGNATURE, LTC FACILITY ADMINISTRATOR/ PERSONNEL **DATE** **PHONE**

(REV.7/17)