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OF COUNTY COMMISSIONERS
MIAMI-DADE COUNTY, FLORIDA

Memorandum

MIAMI-DADE COUNTY

Agenda Item No. 3(B)(3)

Date: April 5, 2016

To: Honorable Chairman Jean Monestime
and Members, Board of County Commissioners

From: Carlos A. Gimenez
Mayor

Subject: Resolution Retroactively Authorizing the County Mayor Execution of the Non-Institutional Medicaid Provider Agreement with the Florida Agency for Health Care Administration

Resolution No. R-250-16

RECOMMENDATION

It is recommended that the Board of County Commissioners (Board) approve the attached resolution retroactively authorizing the County Mayor or the County Mayor's designee's execution of the Non-Institutional Medicaid Provider Agreement (Agreement) with the Florida Agency for Health Care Administration (AHCA), and authorizing the County Mayor or County Mayor's designee to enter into future Medicaid reimbursement agreements with the AHCA in substantially the same form as the attached Agreement, after approval by the County Attorney's Office, as to legal sufficiency. This item is retroactive because there was insufficient time to submit the resolution to the Board for approval prior to execution of the Agreement. This program does not require matching funds.

SCOPE

The impact of this item is countywide.

FISCAL IMPACT/FUNDING SOURCE

Miami Dade Fire Rescue (MDFR) is expected to receive approximately $2.2 million annually from collection of Medicaid remittances resulting from the medical transport of Medicaid recipients.

TRACK RECORD/MONITOR

Medicaid remittances will be monitored by Scott Mendelsberg, Assistant Director of Finance and Budget for MDFR.

BACKGROUND

MDFR responds to almost 200,000 emergency medical incidents annually, of which about 80,000 require a patient to be medically transported to the closest appropriate medical facility. In Fiscal Year 2014-15, MDFR transported more than 15,000 Medicaid recipients and collected approximately $2.168 million. The AHCA only reimburses the cost of medical assistance and related services, including medical transports, rendered to Medicaid recipients to entities who have executed a provider agreement with the agency and who are performing services in accordance with applicable federal, state, and local law. This Agreement allows MDFR to bill and be reimbursed for medical transports and other medical services provided to Medicaid recipients.

Russell Benford
Deputy Mayor

MEMORANDUM

(Revised)

TO: Honorable Chairman Jean Monestime
and Members, Board of County Commissioners

DATE: April 5, 2016

FROM: Abigail Price-Williams
County Attorney

SUBJECT: Agenda Item No. 3(B)(3)

Please note any items checked.

_____ **"3-Day Rule" for committees applicable if raised**

_____ **6 weeks required between first reading and public hearing**

_____ **4 weeks notification to municipal officials required prior to public hearing**

_____ **Decreases revenues or increases expenditures without balancing budget**

_____ **Budget required**

_____ **Statement of fiscal impact required**

_____ **Statement of social equity required**

_____ **Ordinance creating a new board requires detailed County Mayor's report for public hearing**

√ **No committee review**

_____ **Applicable legislation requires more than a majority vote (i.e., 2/3's ____, 3/5's ____, unanimous _____) to approve**

_____ **Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required**

Approved _____ Mayor
Veto _____
Override _____

Agenda Item No. 3(B)(3)
4-5-16

RESOLUTION NO. R-250-16

RESOLUTION RETROACTIVELY AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE'S EXECUTION OF A NON-INSTITUTIONAL MEDICAID PROVIDER AGREEMENT WITH THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION TO REIMBURSE MIAMI-DADE COUNTY FOR MEDICAL ASSISTANCE AND RELATED SERVICES PROVIDED TO MEDICAID RECIPIENTS AND AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO ENTER INTO FUTURE MEDICAID REIMBURSEMENT AGREEMENTS WITH THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

WHEREAS, this Board desires to accomplish the purposes outlined in the accompanying memorandum, a copy of which is incorporated herein by reference,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that this Board retroactively authorizes the County Mayor or County Mayor's designee's execution of the attached Non-Institutional Medicaid Provider Agreement with the Florida Agency for Health Care Administration to reimburse Miami-Dade County for medical assistance and related services provided to Medicaid recipients and authorizes the County Mayor or County Mayor's designee to enter into future Medicaid reimbursement agreements with the Florida Agency of Health Care Administration in substantially the same form as the attached Agreement after approval by the County Attorney's office as to legal sufficiency.

The foregoing resolution was offered by Commissioner **Rebeca Sosa**, who moved its adoption. The motion was seconded by Commissioner **Xavier L. Suarez** and upon being put to a vote, the vote was as follows:

Jean Monestime, Chairman	**aye**		
Esteban L. Bovo, Jr., Vice Chairman	**aye**		
Bruno A. Barreiro	**absent**	Daniella Levine Cava	**aye**
Jose "Pepe" Diaz	**aye**	Audrey M. Edmonson	**aye**
Sally A. Heyman	**aye**	Barbara J. Jordan	**aye**
Dennis C. Moss	**absent**	Rebeca Sosa	**aye**
Sen. Javier D. Souto	**absent**	Xavier L. Suarez	**aye**
Juan C. Zapata	**absent**		

The Chairperson thereupon declared the resolution duly passed and adopted this 5th day of April, 2016. This resolution shall become effective upon the earlier of (1) 10 days after the date of its adoption unless vetoed by the County Mayor, and if vetoed, shall become effective only upon an override by this Board, or (2) approval by the County Mayor of this Resolution and the filing of this approval with the Clerk of the Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

HARVEY RUVIN, CLERK

By: Christopher Agrippa
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency. DF

Daniel Frastai

NON-INSTITUTIONAL MEDICAID PROVIDER AGREEMENT

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 (agency) may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, 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, or 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 the agency.

(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 the agency. 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 fully with all state and federal laws, rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by the agency, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts.

(4) Term and signatures. The parties agree that this is a voluntary agreement between the agency 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 five (5) years from the effective date of the provider's eligibility for initial enrollment unless otherwise terminated. With respect to reenrolling providers, the agreement shall remain in effect for five (5) years from either the date the most recent agreement expires or the date the provider signs the renewal agreement, which ever date is earlier, unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no agency signature is required to make this agreement valid and enforceable.

(5) Provider Responsibilities. The Medicaid provider shall:

(a) Possess at the time of 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 pertinent to the services or goods being provided, as required by the state or locality in which the provider is located, and the Federal Government, if applicable.

(b) Maintain in a systematic and orderly manner all medical and Medicaid-related records the agency requires and determines are relevant to the services or goods being provided.

(c) Retain all medical and Medicaid-related records for a period of five (5) years to satisfy all necessary inquiries by the agency.

(d) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients and comply with all state and federal laws pertaining to confidentiality of patient information.

(e) Send, at the provider's expense, all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and other information pertaining to services or goods billed to the Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records to the Attorney General, the Federal Government, and the authorized agents of each of these entities.

(f) 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 and comply with all other state and federal requirements in this regard.

(g) Report and refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program within 90 days of receipt.

(h) Be liable for and indemnify, defend, and hold the agency 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 to the extent allowed by in and accordance with section 768.28, F.S. (2001), and any successor legislation.

(i) Provide proof of liability insurance at the option of the agency and maintain such insurance in effect for any period during which services of goods are furnished to Medicaid recipients.

(j) 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 the agency 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 policy.

(k) Comply with all of the requirements of Section 6032 (Employee Education About False Claims Recovery) of the Deficit Reduction Act of 2005, if the provider receives or earns five million dollars or greater annually under the State plan.

(l) Submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, 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; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(m) Employ only individuals who may legally work in the United States, either U.S. citizens or foreign citizens who are authorized to work in the U.S, in compliance with the Immigration Reform and Control Act of 1986 which prohibits employers from knowingly hiring illegal workers.

(n) Utilize the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system to verify the employment eligibility of all persons employed by the provider during the term of this Contract to perform employment duties within Florida and all persons (including subcontractors) assigned by the provider to perform work pursuant to this Contract. The provider shall include this provision in all subcontracts it enters into for the performance of work under this Contract.

(o) Attest that 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 the agency and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(p) Agree to notify the agency of any changes to the information furnished on the Florida Medicaid Provider Enrollment Application, including but not limited to changes of address, tax identification number, group affiliation, or depository bank account. The provider shall report a change in any principal of the provider, including any officer, director, agent, managing employee, or affiliated person, or any partner or shareholder who has an ownership interest equal to five (5) percent or more in the provider to the agency in writing within thirty (30) days after the change occurs. For a hospital licensed under chapter 395, F.S., or a nursing home licensed under part II of chapter 400, F.S., a principal of the provider is one who meets the definition of a controlling interest under s. 408.803, F.S.

(q) Agree to notify the agency within 5 business days after suspension or disenrollment from Medicare. Failure to notify may result in sanctions imposed pursuant s. 409.908 (24) and the provider may be required to return funds paid to the provider during the period of time that the provider was suspended or disenrolled as a Medicare provider.

(r) Search the List of Excluded Individuals/Entities (LEIE), located at http://www.oig.hhs.gov/fraud/exclusions.asp, and the Agency's final order database, located at http://apps.ahca.myflorida.com/dm_web, monthly to determine whether any employee or contractor has been excluded. Providers will notify the Agency immediately any exclusion information discovered. Civil monetary penalties may be imposed against Medicaid providers and managed care entities who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

(6) Agency 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 to error of the agency in the determination of eligibility of a recipient.

(7) Change of Ownership. A Medicaid provider agreement may be revoked, at the option of the agency, as the result of a change of ownership of any facility, association, partnership, or other entity named as the provider in the provider agreement.

(a) If the provider sells or transfers a business interest or practice that substantially constitutes the entity named as the provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the provider in the provider agreement, the provider is required to maintain and make available to the agency 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.

(b) If there is a change of ownership, the transferor remains liable for all outstanding overpayments, administrative fines, and any other moneys owed to the agency before the effective date of the change. The transferee is also liable to the agency for all outstanding overpayments identified by the agency on or before the effective date of the change of ownership. In the event of a change of ownership for a skilled nursing facility or intermediate care facility, the Medicaid provider agreement shall be assigned to the transferee if the transferee meets all other Medicaid provider qualifications. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179, F.S.

(c) At least 60 days before the anticipated date of the change of ownership, the transferor shall notify the agency of the intended change of ownership and the transferee shall submit to the agency a Medicaid provider enrollment application. If a change of ownership occurs without compliance with the notice requirements of this subsection, the transferor and transferee shall be jointly and severally liable for all overpayments, administrative fines, and other moneys due to the agency, regardless of whether the agency identified the overpayments, administrative fines, or other moneys before or after the effective date of the change of ownership. The agency may not approve a transferee's Medicaid provider enrollment application if the transferee or transferor has not paid or agreed in writing to a payment plan for all outstanding overpayments, administrative fines, and other moneys due to the agency. This subsection does not preclude the agency from seeking any other legal or equitable remedies available to the agency for the recovery of moneys owed to the Medicaid program. In the event of a change of ownership involving a skilled nursing facility licensed under part II of chapter 400, liability for all outstanding overpayments, administrative fines, and any moneys owed to the agency before the effective date of the change of ownership shall be determined in accordance with s. 400.179 if the Medicaid provider enrollment application for change of ownership is submitted before the change of ownership.

(d) As used in this subsection, the term:

(1.) "Administrative fines" includes any amount identified in a notice of a monetary penalty or fine which has been issued by the agency or other regulatory or licensing agency that governs the provider.

(2.) "Outstanding overpayment" includes any amount identified in a preliminary audit report issued to the transferor by the agency on or before the effective date of a change of ownership.

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

(9) Interpretation. When interpreting this agreement, it shall be neither construed against either party nor considered which party prepared the agreement.

(10) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida. Both parties concur that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. Any legal action involving this agreement will be brought in the appropriate court in Leon County, Florida, and the parties submit to exclusive venue and personal jurisdiction in that court.

(11) Amendment. This agreement, application and supporting documents constitute the full and entire agreement and understanding between the parties with respect to their relationship. No amendment is effective unless it is in writing and signed by each party.

(12) 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.

(13) Agreement Retention. The parties agree that the agency 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.

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

(15) Assignability. The parties agree that neither may assign their rights under this agreement without the express written consent of the other.

The provider, or each principal of the provider if the provider is a corporation, partnership, association, or other entity, is required to sign this agreement. For this purpose, principals includes partners or shareholders of five (5) percent or more, officers, directors, managers, financial records custodian, medical records custodian, subcontractors, and individuals holding signing privileges on the depository account, and other affiliated person. A chief executive officer (CEO) or president may sign this agreement in lieu of all principals. Failure to sign the agreement will make the agreement and provider number voidable by the agency.

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 the agency of the submission of a materially incomplete, misleading or false provider application unless subsequently ratified or approved by the agency.

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

(legibly print name of signatory)	Title	Signature	Date
(legibly print name of signatory)	Title	Signature	Date

(ATTACH ADDITIONAL SIGNATURE PAGES IF NECESSARY)

Please complete the following information:

Provider's Name: County of Dade Board of County Commissioners

DBA Name: Miami-Dade County Fire Rescue Department

Tax Identification Number: 596000573

National Provider Identifier: 1588768279

Florida Medicaid Identification Number: 083899301

(For new applicants, the Medicaid ID will be entered by the fiscal agent upon approval of the application.)