INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS with INTELLECTUAL DISABILITIES (ICF-IID)
PROVIDER AGREEMENT
(MEDICAID)

MS-2005-ICF
REV. 1/2023

1. Person/Business to receive payment	**2. Address (Street, City, State, Zip)**
3. Federal tax ID number	**4. Facility name**
5. Facility Address (Street, City, State, Zip)	**6. Telephone number**
7. List all owners with 5% or more interest in the ICF-IID facility <u>premises</u>. If corporation(s), list states of incorporation. If unit(s) of government, specify the unit(s). If partnership(s), list all managing and general partners. Attach an additional sheet if necessary.	
8. List all owners with 5% or more interest in the ICF-IID facility <u>business</u> if different from owners of the premises. If corporation(s), list state(s) of incorporation. If unit(s) of government, specify the units. If partnership(s), list all managing and general partner(s). Attach an additional sheet if necessary.	
9. List all lessee(s) and sublessee(s) of the ICF-IID. (Place an "X" here if copies of executed leases and subleases are attached or have been submitted to the Kansas Department for Aging and Disability Services.)	
10. List the name and address of the management consultant or management services firm, if applicable. (Place an "X" here if a copy of the executed management agreement is attached or has been submitted to the Kansas Department for Aging and Disability Services.)	
11. Name(s) and address(es) of premises Owner(s).	
12. Name(s) and address(es) of all other individuals who control the operation or management of the ICF-IID Facility.	
13. Building is financed by industrial revenue bonds: YES ☐ or NO ☐ **Maturity date _____ Name & Address of govt. unit which issued the bonds:**	

Terms and Requirements

This **ICF-IID** facility provider herein agrees to participate in the Kansas Medicaid Program as administered by the Kansas Department for Aging and Disability Services. This **ICF-IID** facility provider agrees to comply with all requirements for participation and professional standards applicable to services and professional activities in the Kansas Medicaid Program as required by Federal and State laws, with program requirements as published in the Medicaid Provider Bulletins which can be found at https://portal.kmap-state-ks.us/PublicPage/Public/Bulletins and Manuals, which can be found at https://portal.kmap-state-ks.us/PublicPage/ProviderPricing/ProviderPublications, and with all terms and requirements of this agreement.

1. Disclosure of Ownership and Operating Information

This **ICF-IID** facility provider herein discloses all required ownership and operating information and certifies that all such information is true, accurate and appropriately entered or attached as of the effective date of this agreement. This **ICF-IID** facility provider agrees and accepts that this provision constitutes a duty to report and disclose the following ownership and operating information at the time of any change, and that any reported or unreported changes may affect the operation of this provider agreement. This notice must include the identity of the new individual. This requirement is in accordance with 42 C.F.R. §420.206 as amended by OBRA '87, as such, the following must be reported at the time of any change:

*Individuals with ownership or control interest;
*Officers, directors, agents, or managing employees;
*The corporation, association, or other company responsible for management of the facility; and
*The facility administrator.

2. Change of Ownership

This **ICF-IID** facility provider agrees that notice shall be given to the Kansas Department for Aging and Disability Services at least sixty (60) days in advance of the closing transaction date for any change of provider. This provider acknowledges and agrees that failure to give such timely notification shall result in the new provider assuming responsibility for any overpayments made to the present provider before transfer.

3. Transfer of program receivables

This **ICF-IID** facility provider and its present ownership acknowledges and agrees that no receivables of this provider and its present ownership for any payment related to these programs shall be transferred to any successive provider unless copies of all documentation of any such purchase of rights is promptly furnished to the Kansas Department for Aging and Disability Services at the time of the closing transaction for such change of ownership.

4. Assignment of provider agreement

This provider agreement, if in effect, shall be assigned to the new owner of this **ICF-IID** facility if a change of such ownership is applicable under the provisions of 42 C.F.R. §483 *et seq*., and its recognized state requirements.

5. License

This **ICF-IID** facility provider agrees to maintain a licensed status with the State of Kansas Department of Health and Environment.

6. Title XIX certification

This **ICF-IID** facility provider agrees to maintain standards of and to be at all times certified as being in compliance with all applicable requirements of Title XIX of the Social Security Act and all rules pursuant thereto by the Secretary of Health and Human Services.

7. Court order compliance

This **ICF-IID** facility provider agrees to comply with all court orders as entered by any court of competent and applicable jurisdiction as affecting it and/or the Kansas Medicaid Program.

8. Provider survey disclosure

This **ICF-IID** facility provider is hereby informed that 42 U.S.C. § 1396a and 42 C.F.R. § 483 *et seq*., provide that the state survey agency will make public all provider surveys performed by it, the Kansas Department for Aging and Disability Services. Residents' rights include examination of survey results. The results must be posted by the facility in a place readily accessible to residents.

9. Provider agreement effective date

This **ICF-IID** facility provider is hereby informed that provider agreements are effective on the date of the onsite health and safety survey if all Federal and State requirements are met. If all such requirements are not met, the effective date on which all such requirements are met or the date the provider submits an acceptable response to HCFA Form 2567 or waiver request, whichever date is later, will be the effective date of the provider agreement. This provider agreement does not include a specific date of expiration.

10. Resident Assessments required

This **ICF-IID** facility provider agrees to complete resident assessments of the residents in the provider's facility regardless of source of payment. The **ICF-IID** facility provider agrees to accept as residents only those individuals, regardless of payment, who have received a preadmission assessment in accordance with 42 C.F.R. § 483.20 subject to the exceptions therein.

11. Advance Directives

The **ICF-IID** facility provider agrees to provide written information to each adult resident, or, in the case of an incapacitated individual the family of, surrogate for, or other concerned person of the incapacitated individual, outlining their options as provided under the Kansas Natural Death Act, K.S.A. 65-28,101 *et seq.*, the Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A. 58-625 *et seq.*, and the Patient Self-Determination Act, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508. The provider agrees to maintain written policies, procedures and materials about advance directives as required by the above laws and statutes.

12. Record Keeping, Access and Confidentiality

This **ICF-IID** facility provider agrees to give full cooperation to the Kansas Department for Aging and Disability Services and its duly authorized agents in the administration of the program. Furthermore, this provider agrees to accurately maintain all records as required by Federal and State statutes and regulations and to allow and provide access to all such records as may be requested by the Kansas Department for Aging and Disability Services, and agents and designees of that department, and the Department of Health and Human Services.

This ICF-IID facility provider shall follow all applicable state and federal laws and regulations related to confidentiality.

13. Internal Revenue Services (IRS) reporting

This **ICF-IID** facility provider agrees that the Federal Employee Identification Number (FEIN) provided on the Provider Application Form is the correct number to report income to the IRS. This provider acknowledges that the Medicaid Program will report income to the IRS using only the FEIN of the provider.

14. Cost Reports

The **ICF-IID** facility provider agrees to retain responsibility for cost reports submitted to the Kansas Department for Aging and Disability Services and for information contained therein. The **ICF-IID** facility provider recognizes that the required cost reports will be used to determine the Medicaid rate of reimbursement and agrees to submit accurate, complete, and timely cost reports.

15. Resident liability

This **ICF-IID** facility provider agrees that the program designated resident liability for a recipient is to be collected by the provider for authorized care, services, and goods. This provider agrees not to bill and not to otherwise attempt to collect payments from the recipient's representative, relative of the recipient, recipient's estate, or others for any amounts for any care, services, or goods in excess of the applicable resident liability. If the resident chooses, the facility must manage the resident's funds. In managing the funds, the facility must keep them in separate accounts, maintain a system that assures a full and complete and separate accounting, and affords the resident or legal representative reasonable access to the record.

16. Payment

This **ICF-IID** facility provider agrees to accept as payment in full, subject to audit, the amount paid by the Medicaid Program, with the exception of authorized co-payment and resident liability. This **ICF-IID** facility provider acknowledges that if funds budgeted for the fiscal year prove inadequate to meet all Medicaid Program costs, payments may be pended or reduced, and a payment plan as determined by the Secretary of the Kansas Department for Aging and Disability Services will be developed within federal and state guidelines.

17. Billing for program services

This **ICF-IID** facility provider agrees to submit billings only for authorized care, services, and goods. Such billings shall be in accordance with form, contents, and amount as required by the Medicaid Program. Provisions of the Medicaid Program shall be in accordance with Federal statutes and regulations, State statutes and regulations, and from direct announcements, within the authorities of such statutes and regulations. Direct announcements of program and billing requirements shall be from the Kansas Department for Aging and Disability Services or its designee and shall be communicated in writing to this provider.

18. Timely filing of claims

This **ICF-IID** facility provider agrees that all claims must be received by the Financial & Information Services of the Kansas Department for Aging and Disability Services' fiscal agent within six (6) months from the date the service was provided and that claims which are originally received within six (6) months from the date of service but are not received before the six (6) month limitation expires, may be corrected and resubmitted up to twelve (12) months from the date of service.

19. Recovery of overpayment

This **ICF-IID** facility provider agrees that in any event that it receives payment for care, for service, for benefit, or for goods in an amount or amounts in excess of payment permitted by either Medicaid provisions as applicable that such excessive payments may be deducted from future payments otherwise payable under such program to this provider. This provider acknowledges that such remedy is not the only or exclusive remedy available to the Kansas Department for Aging and Disability Services in such instances. This provider acknowledges that it has rights to administrative review in such instances, and that deductions from future payments begin fifteen (15) days following the notification of excess payment or immediately following the administrative review decision.

20. Fraud

This **ICF-IID** facility provider agrees that payment of claims is from Federal and/or State funds and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws. This provider acknowledges that the submission of a false claim, cost report, document or other false information; charging the recipient for covered services except for authorized co-payment or resident liability; and giving or taking of a kickback or bribe in relationship to covered services are crimes which are prosecutable under applicable Federal and/or State laws.

21. <u>Civil Rights and 504 Compliance Assurances</u>

This **ICF-IID** facility provider agrees to abide by the Kansas Department for Aging and Disability Services' policy to comply with the nondiscrimination, equal opportunity and affirmative action provisions of various Federal and State laws, regulations, and executive orders, and to require individuals and firms with whom it does business to comply with these laws, regulations and orders. This **ICF-IID** facility provider understands that this compliance policy covers both employment policies and practices and service and benefit programs and activities. This **ICF-IID** facility provider understands that the Department will not do business with any individual or firm whose employment or service delivery practices discriminate against any person on the ground of race, color, national origin, ancestry, religion, age, sex, handicap, or political affiliation.

This **ICF-IID** facility provider agrees: (a) to observe the provisions of the Kansas Act Against Discrimination and shall not discriminate against any person in the performance of work under this agreement because of the race, religion, color, sex, physical handicap unrelated to such person's ability to engage in the particular work, national origin or ancestry; (b) in all solicitations or advertisement for employees, the contractor shall include the phrase, "equal opportunity employer," or a similar phrase to be approved by the Kansas Commission on Civil Rights; (c) if this provider fails to comply with the manner in which this provider reports to the commission in accordance with the provisions of Article 10 of Chapter 44 of the Kansas Statutes Annotated and corresponding regulations, this provider shall be deemed to have breached the present contract and it may be cancelled, terminated or suspended, in whole or in part, by the Kansas Department for Aging and Disability Services; (d) if this provider is found guilty of a violation of the Kansas Act Against Discrimination under a decision or order of the Kansas Commission on Civil Rights which has become final, this **ICF-IID** facility provider shall be deemed to have breached this agreement and it may be cancelled, terminated or suspended, in whole or in part, by the Kansas Department for Aging and Disability Services; and (e) this provider shall include the provisions of paragraphs (a) through (d) inclusively of this paragraph in every subcontract or purchase order so that such provisions will be binding upon such subcontractor or vendor. (The provisions of this paragraph shall not apply to an agreement with a provider: (a) who employs fewer than four (4) employees during the term of this agreement; or (b) whose contracts with the Kansas Department for Aging and Disability Services cumulatively total five thousand dollars ($5,000) or less during the fiscal year of the Kansas Department for Aging and Disability Services.)
This **ICF-IID** facility provider assures that all services will be provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the ground of race, color, or national origin. This provider further assures that the United States has a right to seek judicial enforcement of this assurance. (Specific regulations found at C.F.R. § 80.1 *et seq*.) The **ICF-IID** facility provider assures that in facilities employing fifteen (15) or more employees, an affirmative action plan is completed and in effect.

This **ICF-IID** facility provider assures that all services will be provided in compliance with the provisions of Section 504 of the Rehabilitation Act of 1973, which is designed to eliminate discrimination on the basis of handicap. (Specific regulations found at 45 C.F.R. § 84.1 *et seq*.) This provider further assures that all services will be provided in compliance with the Americans with Disabilities Act of 1990, codified at 42 U.S.C. § 12,101 *et seq*.

This **ICF-IID** facility provider assures that all services will be provided in compliance with the provisions of the Age Discrimination Act of 1975, which is designed to prohibit discrimination on the basis of age. (Specific regulations found at 45 C.F.R. § 90.1 *et seq*.)

22. **Requirements of DD Reform**

This **ICF-IID** provider agrees to comply with the tenets of the Developmental Disability Reform Act (K.S.A. 39-1801 *et seq*.).

23. Notice of termination of program participation

This **ICF-IID** facility provider and the Kansas Department for Aging and Disability Services mutually agree to give each other at least thirty (30) days (unless certification is terminated, then payment terminates at that time) prior notice in the event of termination of participation in the Medicaid Program. Such notice is required for cessation of business, election to no longer participate in the program, transfers of the ownership or ownership or operation of this **ICF-IID** Facility (this provision does not supersede the effects of requirements above), reduction in the types of care to be provided, and cancellation of this provider by the department.

This **ICF-IID** facility provider agrees that any notice of intent to terminate participation in the program shall state the date for such termination. Agreement to these provisions must be signed by the individual or by the officer of the business to be receiving payments for approved services.

24. Signature of ICF-IID Facility Provider

I certify by my signature, under penalty of perjury, that I am duly authorized to bind this ICF-IID to the terms of this Provider Agreement and that I have read and understood the Provider Agreement.

Signature of **ICF-IID** Facility Provider (Owner or Lessee)	
Name (type or print)	Date

For KDADS Internal Purposes Only

25. Acceptance by the Secretary of the Kansas Department for Aging & Disability Services
This **ICF-IID** facility agreement is for:

_____ ICF-IID Facility beds.
_____ Total

The assigned provider identification number is: _____

Signature:	
Name and title (type or print):	Date: