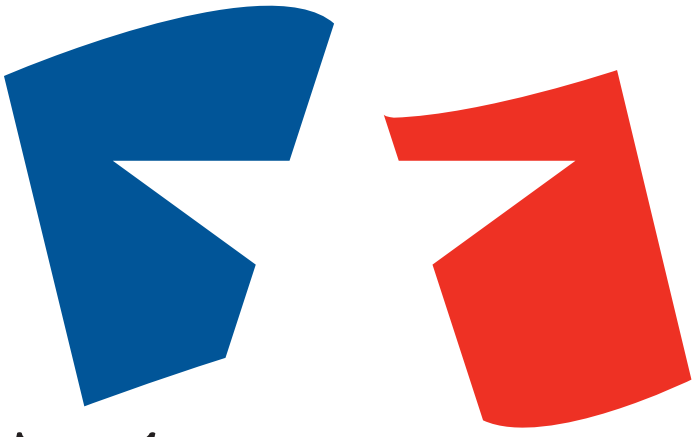
Children with Special Health Care Needs (CSHCN) Services Program Expedited Enrollment Application



TMHP

Texas Medicaid & Healthcare Partnership

A STATE MEDICAID CONTRACTOR

Rev. VIII

Introduction

Dear Health-care Professional:

Thank you for your interest in becoming a Children with Special Health Care Needs (CSHCN) Services Program provider. Participation by providers in the CSHCN Services Program is vital to the successful delivery of services to the clients of the CSHCN Services Program, and we welcome your application for enrollment.

This application must be completed in its entirety and will be reviewed by the Department of State Health Services (DSHS) and the claims contractor Texas Medicaid & Healthcare Partnership (TMHP).

Providers are encouraged to review the current CSHCN Services Program Provider Manual for information about provider responsibilities, claims filing procedures, filing deadlines, benefits and limitations, and much more. The provider manual is updated monthly, and the current and archived provider manuals can be accessed on the TMHP web site at www.tmhp.com. Select "Reference Materials" from the Providers-CSHCN page.

There is no guarantee your application will be approved for processing or you will be assigned a CSHCN Services Program Texas Provider Identifier (TPI) number. If you make the decision to provide services to a CSHCN Services Program client prior to approval of the application, you do so with the understanding that, if the application is denied, claims will not be payable by the CSHCN Services Program.

Affordable Care Act (ACA) Requirements

In compliance with the Affordable Care Act of 2010 (ACA), all Medicare and Medicaid providers are subject to ACA screening procedures for newly enrolling and re-enrolling providers. Providers that have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA compliant for all subsequent program enrollments. Providers who enroll only in the CSHCN Services Program (medical foods providers and hospice providers) are also required to undergo the ACA screening procedures, pursuant to 25 Texas Administrative Code (TAC) §38.6(a)(8) and are not eligible to use this expedited enrollment form.

Refer to: Code of Federal Regulations (CFR) Title 42 Ch. IV, Subpart E-Provider Screening and Enrollment; and TAC Title 1, Part 15, Chapter 352, for the statutory provisions for these requirements.

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested in the Contact Information section of this application.

Contact Information

For information about CSHCN Services Program provider identifier requirements, the status of your enrollment, or claims submission, call TMHP-CSHCN Services Program Contact Center toll-free at 1-800-568-2413.

Thank you for your applying to become a CSHCN Services Program provider.

Instructions

PREREQUISITE: With the exceptions of Medical Foods and hospice providers, all providers rendering Medicaid services must be enrolled with Texas Medicaid as a prerequisite to enrolling in the CSHCN Services Program. Call the TMHP Contact Center at 1-800-925-9126 for information about Texas Medicaid and provider enrollment criteria.

To avoid any delay of the enrollment process, use this sheet as a checklist. For assistance with completing this form, call the TMHP CSHCN Services Program Contact Center at 1-800-568-2413 and select option 2 to speak with a TMHP provider enrollment representative.

☐ **Deemed Enrollment.** Under certain circumstances, a provider who is actively enrolled in Medicaid in good standing may be deemed enrolled in the program without completing the usual application process. Providers applying for Deemed Enrollment should check the Deemed Enrollment box and submit this page, along with a signed Provider Agreement with the Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program, found on pages 4 through 8.

Important: *Retain a copy for your records of all documents submitted for enrollment.*

Mail your application to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

INSTRUCTIONS – Completing the Application and Other Forms

Complete this application using the following information:

Item	Instructions
Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program	Complete the required information at the beginning of the form, read the agreement information, and sign and date the agreement to indicate that you have read and agree with the terms of enrollment. **Note:** *If you are enrolling as a group you must also enroll at least one performing provider and submit an application for the group and an application for each performing provider.* Upon enrollment you will receive a Texas Provider Identifier (TPI) specific to your CSHCN Services Program enrollment.
Provider Type and Specialty	By completing this Deemed Enrollment form, you are requesting CSHCN Services Program enrollment under the same provider type and specialty with which you are enrolled in Texas Medicaid. If you want to enroll as a Custom Durable Medical Equipment (DME) Supplier or Supplier of Hemophilia Blood Factor Products, indicate your selection below: ☐ Custom Durable Medical Equipment (DME) Supplier - Custom DME is medical equipment made or modified specifically to address the individual client's needs: • Must be enrolled as a DME Supplier in Texas Medicaid. • Attach a copy of your RESNA certification to this application. ☐ Supplier of Hemophilia Blood Factor Products: • Must be enrolled as a Pharmacy in Texas Medicaid

CONTACT INFORMATION – Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address on this application.

Contact Name: *Last*	*First*	*Middle Initial*

Contact Telephone Number:	**Contact Fax** *(if applicable)*:

Email Address *(if applicable)*:

Address: *Number*	*Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Provider Agreement with the Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program

☐ **Application for Deemed (Expedited) Enrollment**

Name of provider enrolling:	
Medicaid TPI:	**CSHCN Services Program TPI (*if applicable*):**
Physical address: Number Street Suite City State ZIP	
Mailing address: *(if applicable)* Number Street Suite City State ZIP	

The provider agrees, in accordance with the state laws, rules and regulations pertaining to the Texas Health and Human Services Commission (HHSC), CSHCN Services Program, and as a condition for participation in this program, to the terms and conditions set forth below:

1. A copy of the current *CSHCN Services Program Provider Manual* may be accessed via the internet at www.tmhp.com. Provider has a duty to become familiar with the contents and procedures contained in the provider manual. Provider agrees to comply with all the requirements of the provider manual, as well as all state and federal laws and amendments, governing or regulating CSHCN Services Program. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the provider manual and all state and federal laws and amendments governing or regulating CSHCN Services Program.
2. To maintain and retain for a period of five years from the date of service, or until audit and all audit exceptions are resolved, whichever period is longer, such records as are necessary to fully disclose the extent of the services provided to the clients receiving assistance under the CSHCN Services Program and any information relating to payments claimed by the Provider. Providers must cooperate and assist HHSC or its designee, Office of Inspector General, and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their designees access to its premises. If litigation is involved, the records must be retained until litigation is ended or for five (5) years as cited above, whichever is longer.
3. To provide unconditionally, upon request, free copies of and access to all records pertaining to the services for which claims are submitted to CSHCN Services Program or its designees.
4. To accept CSHCN Services Program payment as payment in full for service. Provider may collect allowable insurance or health maintenance organization co–payments in accordance with those plan provisions.
5. Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes and provides such information, on request, to HHSC, Office of the Inspector General, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the CSHCN Services Program current by informing HHSC or its designee in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, within 30 days of the change. Provider also agrees to notify HHSC or its designee within 30 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must submit to HHSC complete information related to any such suspension or restriction.

   Provider agrees to disclose all convictions of Provider and Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in Title 42, Code of Federal Regulations (CFR) §1001.2. All principals of the Provider include an owner with a direct or indirect ownership or control interest of 5% or more, is an agent or managing employee of the Provider, is a corporate officer or director, general or limited partner, agent, managing employee (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof.

6. The Office of Inspector General, internal and external auditors for the state/federal government, and/or HHSC may conduct interviews of the Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, subcontractors and their employees, witnesses, and clients must not be coerced by the Provider or Provider's representative, to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control, cooperate fully in any investigation conducted by the Office of Inspector General. Subcontractors are those persons or entities that provide medical goods or services for which the Provider bills the CSHCN Services Program or who provide billing, administrative, or management services in connection with CSHCN Services Program covered services.

7. Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or their designee, including electronic claims. Provider certifies that information submitted regarding claims will be true, accurate, and complete, and that the Provider's records and documents are accessible and validates the services and the need for services billed and represented as provided. Further, Providers understand that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

8. Provider agrees to accept payments established by Texas Medicaid as payment in full for Medicaid covered services for those clients who are assisted by this resource. The provider acknowledges that CSHCN Services Program does not pay a provider for any services that could have been reimbursed by Texas Medicaid.

9. To utilize CSHCN Services Program as a resource for payment when clients are eligible for program assistance.

10. Provider acknowledges that it/they have executed an HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts, unless the provider is enrolling only in CSHCN Services Program and is not eligible to enroll in Medicaid. All of the provisions of the HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts are hereby incorporated by reference in this Provider Agreement for participation in the Children with Special Health Care Needs (CSHCN) Services Program.

11. To utilize Texas Medicaid, Medicare, Children's Health Insurance Program (CHIP), and/or private insurance (including HMO coverage) and the United States Department of Defense or Department of Veterans Affairs benefit plans as sources for reimbursement because they are primary to CSHCN Services Program payments.

12. To not bill the client/family for the cost of any charges not paid for by CSHCN Services Program due to the provider's failure to request the required authorization and/or failure to submit a claim for reimbursement within the appropriate submission deadline.

13. To not charge the client/family any pre–admission or pretreatment charges or deposits if services are reimbursable by CSHCN Services Program.

14. To refund the client/family any pre–admission or pretreatment charges when services are authorized and collection occurred prior to program application and eligibility determination.

15. To request authorization from CSHCN Services Program, before the date of service, for all services requiring prior authorization.

16. To request authorization from CSHCN Services Program for all services requiring authorization before the date of service or up to 95 days after the date of service.

17. That claims submitted by the provider, or on behalf of the provider, for payment by the CSHCN Services Program shall be for services or items actually provided by the provider or under his/her personal supervision to the eligible client for which the provider is entitled to payment. Claims must be submitted in the manner and in the form set forth in the CSHCN Services Program Provider Manual and within the time limits established by HHSC for submission of claims. The provider understands that payment and satisfaction of such claims will be from federal and/or state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and /or state laws. Fraud is a felony, which can result in fines and imprisonment.

18. Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Provider's failure to provide timely notice.

    Provider must have a written contract with any person or entity for the purpose of billing Provider's claims, unless the person or entity is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on the person. The contract must be signed and dated by the Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according to the CSHCN Services Program records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

    - Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the CSHCN Services Program.
    - Biller understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings.
    - Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to clients. Provider understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings directly or indirectly, to the Biller or to the CSHCN Services Program or its contractor.

- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the CSHCN Services Program.
- Biller agrees to enroll and be approved by the CSHCN Services Program as a Third Party Billing Vendor prior to submitting claims to the CSHCN Services Program on behalf of the Provider.
- Biller and Provider agree to notify the CSHCN Services Program within 5 working days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

19. Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct, are received by HHSC or its designee within CSHCN Services Program deadlines, and to implement an effective method to track submitted claims against payments made by HHSC or its designee.

20. Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund to CSHCN Services Program any overpayments, duplicate payments, and or erroneous payments to which entitlement is not authorized under CSHCN Services Program rules and regulations that are paid to Provider by CSHCN Services Program or its designee as soon as the payment error is discovered.

21. To comply with Title VI of the Civil Rights Act of 1964 (Public Law 88–352), Sections 504 of the Rehabilitation Act of 1973 (Public Law 93–112), the Americans with Disabilities Act of 1990 (Public Law 101–336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the provider agrees to comply with Title 40, Chapter 73, of the TAC. These provide, in part, that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination. To comply with Texas Health and Safety Code, Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).

22. Provider agrees to not discriminate against the individual on the basis the person is a CSHCN Services Program client by means of pricing differentials or other means of discriminatory treatment. Provider must not exclude or deny aid, care, service, or other benefits available under CSHCN Services Program or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to CSHCN Services Program clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to apply to CSHCN Services Program clients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the CSHCN Services Program for CSHCN Services Program clients and discounted services to the general public must not be billed to CSHCN Services Program for a CSHCN Services Program client as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

23. To provide language assistance that may be required for effective communication with CSHCN Services Program clients who demonstrate limited English proficiency to insure they have equal access to services.

24. To comply with all requirements of CSHCN Services Program regulations, rules, standards, and guidelines published by CSHCN Services Program or its designee. The CSHCN Services Program laws, regulations, and program instructions are available through the claims contractor. Provider understands that payment of a claim by the CSHCN Services Program is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in the CSHCN Services Program.

25. To maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

26. To promptly (within 30 calendar days) report change of address and/or change in status, including but not limited to change in name, loss of license, change in certification status, or change in Medicaid provider status.

27. To maintain provider enrollment and participation in Texas Medicaid, unless the provider is not eligible to enroll in Medicaid, as a condition to participate in the CSHCN Services Program. Should Texas Medicaid status be terminated, participation in CSHCN Services Program shall be terminated effective the date of Medicaid termination.

28. That this agreement may be terminated by either party upon thirty (30) days written notice to the other party, except that termination may be earlier for submitting false or fraudulent claims, failing to provide and maintain quality services or medically acceptable standards, failure to comply with the provider agreement signed at the time of application or renewal for CSHCN Services Program participation, disenrollment as a Medicaid provider or violation of the standards of CSHCN Services Program rules and regulations or parts thereof. Provider specifically agrees to the sections of this Agreement concerning client record retention, access by HHSC to records pertaining to CSHCN Services Program services, and confidentiality of client records and information shall remain in effect and binding upon provider if the remainder of this Agreement is terminated for any reason.

29. HHSC and the CSHCN Services Program expect providers to comply with the provisions of State law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

30. **PRIVACY, SECURITY, AND BREACH NOTIFICATION.** "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

    (a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);

    (b) Sensitive Personal Information (as defined in Texas Business and Commerce Code section 521.002);

    (c) Federal Tax Information (as defined in IRS Publication 1075);

(d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);

(e) Social Security Administration data;

(f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

31. Any Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation the following:

(a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(f) OMB Memorandum M-07-16;

(g) Texas Business and Commerce Code Chapter 521;

(h) Texas Health and Safety Code, Chapters 181 and 611;

(i) Texas Government Code, Chapter 552, a applicable; and

(j) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

32. The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

33. Provider will ensure that any subcontractor of Provider who has access to Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider, and Provider will submit a copy of that Business Associate Agreement upon request by HHSC, the CSHCN Services Program, or its designee.

34. Provider understands and agrees that any signature on a submitted document certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).

35. Provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

I certify that the information I have supplied in this provider enrollment application constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Name of Applicant: _____

Applicant's Signature: _____ Date: _____

For applicants that are entities, facilities, groups, or organizations, and an authorized representative is completing this application with authority to sign on the applicant's behalf, the authorized representative must sign above and print their name and title where indicated below.

Representative's Name: _____

Representative's Position/Title: _____

IT IS RECOMMENDED THAT YOU RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS.