PCA Provider Agreement for Personal Care Attendant (PCA) Program

PCA Provider Agreement

Instructions and Important Information

1. All Personal Care Attendants (PCAs) in the MassHealth PCA Program must read, sign, and return this form to their PCA Consumer-employer before they can begin providing PCA services.
2. The PCA's employer (the Consumer-employer) must submit this form to the fiscal intermediary (FI), along with all other paperwork required by the FI and MassHealth.
3. The PCA Provider must complete and return all required New Hire Paperwork and be issued a Unique Identification Number (ID) before being paid for providing payment as part of the PCA Program.
4. PCA Providers must be eligible to work in the United States to work as a PCA, and that neither MassHealth nor the FI will pay me if I am not authorized to work in the United States.
5. MassHealth does not cover PCA services when:
   - The Consumer-employer is in an inpatient facility, such as a hospital or nursing facility;
   - The Consumer-employer is enrolled in an adult foster care or a group adult foster care program;
   - The Consumer-employer does not have a prior authorization for PCA services;
   - The PCA is providing a non-covered service as outlined in 130 CMR 422.412;
   - The PCA is providing other MassHealth covered services; or
   - The number of hours that has been authorized by MassHealth has been exhausted
   - The PCA works in excess of the maximum weekly hour limit established as outlined in 130 CMR 422.413(K)

The PCA must read, sign, and return this agreement before working and receiving payment as part of the PCA Program.

By signing below, I understand that:

1. As a MassHealth PCA provider, I must comply with the PCA provider's eligibility requirements at 130 CMR 422.404(A)(1) and in accordance with the PCA provider scope of services at 130 CMR 422.404(B)(1) and 422.419(C).
2. **My employer is the Consumer-employer. My employer is NOT MassHealth, the Personal Care Management Agency (PCM) or the Fiscal Intermediary (FI).**
3. My Consumer-employer is responsible for hiring, firing, training, and scheduling PCA providers. My employer may select another person (a surrogate or administrative proxy) to help manage their personal care services. I must notify my employer and the surrogate or administrative proxy (if any), of any changes in my circumstances that would affect my ability to perform my duties as a PCA provider.
4. A Consumer-employer cannot hire, MassHealth cannot authorize, and the FI cannot pay a PCA, that is on the List of Excluded Individuals and Entities (LEIE) maintained by the U.S. Department of Health and Human Services Office of Inspector General (OIG) or the MassHealth List of Suspended/Excluded Providers.
5. My new hire paperwork must be completed and processed before I will be issued a PCA Identification

Number (PCA ID) and before I can receive payment as part of the PCA Program.

6. I must be eligible to work in the United States, and I must complete the Form I-9 Employment Eligibility Verification and provide copies of a valid form of photo identification and employment authorization documentation to my Consumer-employer. The above referenced documents must demonstrate that I am authorized to work in the United States, as required by the Department of Homeland Security (DHS). I understand that the Fiscal Intermediary (FI) will confirm my employment eligibility using E-Verify on my Consumer-employer's behalf. I understand I will not be paid if I am not authorized to work in the United States.
7. I must be at least sixteen (16) years of age or older.
8. MassHealth and the FI cannot pay me if I am on the List of Excluded Individuals and Entities (LEIE) maintained by the U.S. Department of Health and Human Services Office of Inspector General (OIG) and the MassHealth List of Suspended/Excluded Providers.
9. My Consumer-employer has the right to perform a CORI or SORI background check as a condition of my employment and will make a hiring determination based on the information obtained.
10. My Consumer-employer determines the number of hours I am scheduled to work each week. I understand that the number of hours I am scheduled to work may be less than the total number of hours authorized by my Consumer-employer's prior authorization (PA).
11. My wages are established through a collective bargaining agreement (CBA) between the PCA Quality Home Care Workforce Council (the Council) which represents PCA Consumers, and SEIU Local 1199 (the Union), which represents PCAs.
12. I am not eligible to receive any pay differentials, including seniority rate or complex care differentials, until I have completed New Hire Orientation (NHO) or have been exempted from the NHO requirement.
13. I must comply with MassHealth regulations and federal requirements regarding the use of EVV submission of Activity Forms (also known as "timesheets"), including the use of Electronic Visit Verification (EVV) system, as required by federal law and by MassHealth.
14. The FI will process payroll for my Consumer-employer. I understand that I must enroll in Direct Deposit or have the option to enroll in payroll debit card, unless I have applied for and received an exemption from this requirement. If I receive my payment by paper check, I acknowledge that the FI will issue a check in my name and send it to my Consumer-employer.
15. It is my responsibility to immediately notify the FI and my Consumer-employer if any of my contact information changes, such as my name, address, email, phone number, or other information. I must immediately provide my updated contact information to my Consumer-employer and the FI any time this information changes.
16. The MassHealth PCA program pays for personal care services provided by a PCA only when the PCA provider provides physical assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to an eligible PCA Consumer-employer who has obtained prior authorization from MassHealth for PCA services. PCA services must be provided in accordance with MassHealth regulations at 130 CMR 422.410, the PCA Consumer-employer Prior Authorization, as well as the authorized PCA evaluation or re-evaluation, service agreement.
17. My Consumer-employer will tell me which tasks on the Prior Authorization they require for me to provide physical assistance with.
18. I understand that ADLs may include providing physical assistance to the PCA Consumer-employer with transferring, walking, using medical equipment, taking medications, bathing and grooming,

dressing and undressing, passive range-of-motion exercises, eating, and toileting. I understand that IADLs may include household services that are instrumental to the PCA consumer's PCA care needs such as laundry, shopping, housekeeping, meal preparation and cleanup, transportation to medical appointments, activities such as maintenance of wheelchairs or other medical equipment, completing the paperwork required for receiving PCA services, and other activities approved by MassHealth as being instrumental to the health care needs of the PCA consumer.

19. I understand that I must adhere to PCA Program weekly hour limits, which limit the number of hours I may work each week to maximum weekly hour limit as outlined in 130 CMR 422.413(K) inclusive of all Consumer-employers I work for.
20. I understand that should I work overtime, I must adhere to PCA Program overtime rules and may not work more than 50 hours per week in total across all of my Consumer-employers without an overtime authorization; and that I may not work more than the maximum weekly hour limit as outlined in total across employers for any reason. I must inform my Consumer-employer(s) when I work additional hours for other Consumer-employers, and that all of my Consumer-employers to must obtain authorization in order for a PCA to work over 50 hours (but no more than the maximum weekly hour limit).
21. I understand that I may be subject to sanction, such as suspension or termination as a PCA provider, for failure to comply with the MassHealth PCA program regulations at 130 CMR 422.000 and other applicable MassHealth regulations, including, but not limited to, failure to provide services covered by the MassHealth PCA provider, repeated failure to work within the weekly hour limit or authorized overtime hours, provider eligibility requirements, or other program requirements.
22. I understand that I cannot be paid as a PCA provider if I am a spouse, parent (if the PCA Consumer-employer is a minor child), surrogate or administrative proxy, foster parent, or legally responsible relative of the PCA Consumer-employer (including a relative who is a legal guardian).

In providing MassHealth covered PCA services to my employer (the PCA Consumer), I understand and agree to the following:

23. If my employer has an advance directive concerning the provision of care in the event that he or she becomes incapacitated, I agree to respect the terms of the advance directive, unless, as a matter of conscience, I cannot implement an advance directive. I agree not to condition the provision of care or otherwise discriminate against my employer based on whether or not the individual has executed an advance directive. I understand that I am not required to provide care that conflicts with an advanced directive.
24. I agree to keep any records that are necessary to show the extent of the services I provide to my Consumer-employer, including Activity Forms (also called "timesheets") and I agree to furnish, upon request, copies of records in my possession and any information regarding payments I claimed for furnishing PCA services to my Consumer-employer, to the Medicaid agency, the Secretary of the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

I agree to comply with the disclosure requirements contained in 42 CFR Part 455, Subpart B, as follows:

25. Pursuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A "MassHealth provider entity could include any provider type enrolled with MassHealth, including a Home Health agency, an Adult Foster Care agency, or any other provider type. Please complete this information on Page 3, below.
26. If requested by MassHealth, I agree to provide information about business transactions in accordance with 42 CFR 455.105.

27. In accordance with state statute M.G.L. c.118E, § 36, and federal requirement, 42 CFR 455.106, by signing this form, I am stating that I have not been convicted of a criminal offense related to my involvement in any program under Medicare, Medicaid, or the title XX services program.

28. I understand that certain relationships between me and my Consumer-employer may affect my tax exemption status. I understand that any tax exemption status resulting from my relationship with my employer is mandatory, based on applicable Federal and State tax rules. I understand that the FI is required to follow all Federal and State rules regarding tax withholding, and MassHealth or the FI cannot change such rules.

Provider Information and Attestation

Please check one option:

The following describes my relationship to my employer (the PCA consumer). Select only one option.
◯ I am not related to my Consumer-employer
◯ I am my Consumer-employer's daughter or son
◯ I am my Consumer-employer's parent
◯ I am related to my consumer in a different way (please explain): **Explanation of Consumer Relationship** **(only required if I am related to my consumer in a different way is selected)**

Please check one option:

Pursuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A "MassHealth provider entity could include any provider type enrolled with MassHealth, including a Home Health agency, an Adult Foster Care agency, or any other provider type. Please check one:

◯ I DO NOT have ownership or control of any other MassHealth provider entity

◯ I DO have ownership or control of any other MassHealth provider entity. The information for such entity/entities is as follows: **Entity/Entities Information you have ownership or control (only required if you I DO is selected)**

Please complete and attest to the following information:

I certify under pains and penalties of perjury that the information on this signature form, and any accompanying statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also certify that I understand my duties, rights, and responsibilities as a PCA and that all the information I have provided to my employer (the PCA Consumer), to the fiscal intermediary, to the personal care management agency, or to MassHealth is true and accurate to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

I attest to all the above information, and agree to accept the position of personal care attendant (PCA) provider for:

Consumer Printed Name: Printed Name of the Consumer

PCA Provider Signature: PCA Provider Signature

PCA Provider Printed Name: Printed Name of the PCA Provider

Date Signed: Date Signed