

HIPAA BUSINESS ASSOCIATE ADDENDUM
DEPARTMENT OF HEALTH AND HOSPITALS
ELIGIBILITY FIELD OPERATIONS

APPLICATION CENTER:

ACID#

This Business Associate Addendum is hereby made a part of the above referenced contract in its entirety as an attachment to the contract.

1. The U.S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the “HIPAA Privacy Rule”). The Department of Health and Hospitals, (“DHH”), as a “Covered Entity” as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.

2. “Protected Health Information” (“PHI”) means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.

“*Electronic protected health information*” means PHI that is transmitted by electronic media or maintained in electronic media.

“*Security incident*” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.

4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.

5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.

6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor will extend the confidentiality protections of the contract to the information and limit further use and disclosure to those purposes that make the return or destruction of the information infeasible.

Section Eight: Administrator/CEO Confidentiality Statement

- I, _____, understand my organization as a designated state approved Application Center must adhere to the following regulations regarding confidentiality responsibilities.
- ◆ Federal Regulations 42 CFR 431.300 restricts the use or disclosure of information concerning applicants/recipients to purposes directly connected with the administration of Medicaid. Federal Regulations 45 CFR Part 160 and 164 governs the privacy of individually identifiable health information. (HIPAA Privacy Rule)
 - ◆ Purposes directly related to Medicaid include:
Establishing Medicaid eligibility and determining the type and amount of medical assistance.
 - ◆ Confidential information includes, at a minimum, the following:
Name and address of applicant/recipient, medical services provided, social and economic conditions or circumstances, evaluation of personal information and medical data, including diagnosis and past history of disease or disability.
 - ◆ It shall be unlawful for any person to solicit, disclose, receive, make use of, or to authorize, knowingly permit, participate in, or acquiesce in the use of applications or client information or the information contained therein for any purpose not directly connected with the administration of the Medicaid Program.
 - ◆ Publications of lists of names of applicants/enrollees is prohibited.
 - ◆ Any person who violates any provisions of confidentiality is subject to a fine not more than two thousand five hundred dollars (\$2,500) or imprisonment for not more than **two (2) years** in the parish jail or both, not less than five hundred dollars (\$500) or **ninety (90) days** on each count. In addition to these criminal penalties, violation of confidentiality requirements shall result in the termination of certification to complete Medicaid applications.
 - ◆ **I acknowledge that staff will adhere to all confidentiality provisions set forth in this agreement.**

Signature of Application Center Administrator/CEO

Date

Section Nine: Agreements and Responsibilities

- ◆ I do hereby agree to adhere to published regulations of the Secretary and **DHH/MVA**. I agree to any rules governing my participation as an Application Center.
- ◆ I understand that I have the right to terminate this agreement for any reason in writing with **thirty (30) days** advance notice to DHH. I understand that DHH has the right to terminate this agreement with **ten (10) days** notice for violation of any of the stated agreements and responsibilities as set forth in this agreement.
- ◆ I hereby agree to keep such records as are identified in the *Application Center Handbook* to disclose fully the extent of services provided to Medicaid individuals.
- ◆ I agree to maintain information regarding such records and regarding any payments claimed for providing such services that Louisiana's Medicaid Agency, the DHH Secretary, the Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services may request for **five (5) years** from the date of service. I further agree that any record being reviewed or under litigation must be maintained until completion and/or finalization of the audit or lawsuit.
- ◆ I understand that to qualify for certification training, employees must agree to be bound by Federal and State requirements on client confidentiality, non-discrimination, and quality standards.
- ◆ I agree to sign the above confidentiality statement on behalf of my facility.
- ◆ I agree to periodic monitoring by State officials without prior notice given. I further agree that state officials will have access to the premises to inspect and evaluate work being performed and to audit compliance with the Application Center Agreement requirements. I understand that decertification may result if non-compliance with policy is found.
- ◆ I agree that only persons who have successfully completed certification training with a passing grade will be allowed to take Medicaid Applications and agree to any additional follow-up training. I agree that any changes in certified staff will be reported to DHH within **ten (10) calendar days** and recorded in the facility's AC profile.
- ◆ I further agree to maintain training certificates, certification letters and letters of regret on file and understand that each certified representative is required to take a minimum of **two (2)** applications per month to remain certified.
- ◆ I understand that the *Medicaid Application Center Handbook* will be furnished to my facility (replacement or additional manuals must be purchased). I understand that all copies of the *Application Center Handbook* must be maintained and updated by a representative of my facility as revisions to policy and forms are issued.
- ◆ I understand that application and/or packets to be used will be distributed by the DHH Office which will maintain a record of quantities issued to each Center.
- ◆ In the event this agreement is terminated by either party, I am responsible for returning all unused application packets within **ten (10) days** of the termination of the agreement.
- ◆ I understand that all Medicaid application interviews must be scheduled and completed within **five (5) working days** from the initial date of contact.
- ◆ Furthermore, I understand that all non-electronic Medicaid Applications must be signed and dated by the applicant, the AC Representative, and hand-delivered, sent by courier service, or **mailed daily**, to the designated Medicaid Office.

Signature of Application Center Administrator/CEO

Date