

**Division of Medicaid
In the Office of the Governor
Medical Assistance Participation Agreement
(Medicaid – Title XIX Program)
Section C –**



The Medicaid Provider Agrees:

1. To provide medical services to eligible Medicaid beneficiaries without regard to race, color, religion, sex, national origin, handicap, or limited English proficiency.
2. To abide by federal and state laws and regulations affecting delivery of services.
3. Not to refuse to furnish services covered under the Medicaid program to an individual who is eligible for Medicaid because of potential third party liability for the services, or to discriminate as to recipients served or services provided because of Medicaid eligibility or potential third party liability.
4. To take no action or adopt any procedure that would circumvent or deny freedom of choice to any eligible recipient of medical assistance under the Medicaid program.
5. To refrain from offering or purporting to give any reimbursement, premium, or other free merchandise as a trade inducement to an eligible recipient.
6. To make available to appropriate state and federal personnel, during regular business hours, 8:00 a.m. to 5:00 p.m. Monday-Friday, and all other hours when employees of the provider are normally available and conducting the business of the provider in the office of the provider, all records relating to services performed by the Provider including, but not limited to, the following:
 - a. Medical records required by Section 1902(a)(27) of Title XIX of the federal Social Security Act and any amendments adopted thereto, Miss. Code Ann. Sections 43-13- 118 and 43-13-121 (4) (1972, as amended), including the implementing of federal and state regulatory requirements.
 - b. Documentation in office records regarding services rendered by the Provider in substantiation of its claims for services rendered Medicaid. Documentation must be in accordance with Medicaid policy.
 - c. Documentation in office records regarding claims filed with third party sources for Medicaid covered services furnished to eligible recipients which will enable Medicaid to verify that third party policy has been followed. "Documentation" means portions of patient's file that show third party resource information, evidence of claims filed with third parties and financial records such as accounts receivable listing receipts of third party payments.
7. That in the event the Provider's license has been revoked by the appropriate Board or if the Provider is disqualified through a federal administrative action, this Agreement is automatically terminated. If the provider is disqualified through state action or Division of Medicaid administrative action, the agreement will terminate upon the effective date of that action.
8. That upon receipt of notification that the Provider is disqualified through any federal, state, an/or Medicaid administrative action, the Provider will not submit claims for payment to the Division of Medicaid for services performed after the disqualification date.
9. To comply with all federal and state standards of practice, including licensure.

Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries. A searchable federal web site, updated monthly, exists at <http://exclusions.oig.hhs.gov>.

The Medicaid Provider Agrees Continued:

10. That all Medicaid covered services have been administered and billed in accordance with Medicaid policy.
11. That claims for reimbursement will be submitted in accordance with the instructions from the Division of Medicaid or its designated agent and will conform with the provider billing certification requirements of Medicaid. Provider is responsible for validity and accuracy of claims submitted on paper, electronically or through a billing service.
12. To accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments.
13. To authorize and agree to electronic direct deposit transfer payments for claims reimbursement by the Division of Medicaid and to submit, in accordance with instructions from the Division of Medicaid or its agent, the appropriate Direct Deposit Authorization/Agreement Form.
14. To send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of state and federal laws and regulations.

The Division of Medicaid Agrees:

1. To pay for Medicaid covered services rendered by the Provider in accordance with the fee schedules and/or payment methodologies as prescribed by the Division of Medicaid for reimbursement of such services.
2. To make appropriate disposition as soon as possible of all claims submitted in accordance with the applicable laws and regulations.

The Division of Medicaid and the Provider mutually agree:

1. That payment may be withheld, if necessary, because of irregularity for whatever cause until such irregularity can be adjusted.
2. In the event funds have been overpaid or disallowed, the Provider shall repay within 30 days of discovery by the Provider or notification by the Division or its agent, or on other terms approved by the Division of Medicaid to the parties to this agreement. Failure to pay or make arrangements to repay any amount determined above may result in suspension from the Medicaid program as a Provider of medical services and legal action by the Division to recover such funds, including the legal rate of interest.
3. In case of institutional providers, when there is a change of ownership of the facility, the new owner, upon consummation of the transaction effecting the change of ownership, shall as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due or become due to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined.
4. That this agreement is subject to availability of state and federal funds, the cessation or reduction of which will constitute the voidance of this Agreement.
5. That this agreement becomes effective in accordance with applicable federal and state law and regulation and Medicaid policy and shall remain in force and effect until terminated by either party as set out herein above.
6. To abide by and to comply with the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Provider and the Division of Medicaid or its designated Fiscal Agent, and as may be applicable to the services under this Agreement.
7. That this agreement is not transferable or assignable by the Provider and may be terminated by thirty (30) days written notice by either party, with the exception of paragraph 3 of this section. Changes in ownership, corporate entity, and servicing location shall be reported immediately to the Division of Medicaid.
8. This agreement is automatically terminated in the event Provider's license has been revoked by the appropriate Board, Provider is disqualified through a federal administrative action or Provider is convicted as set forth in Miss. Code Ann. Section 43-13-121 (l) (1972, as amended).
9. That the applicable manual has been or will be furnished to the Provider and is adopted herein as if written in this Agreement.

Provider Name (Type or Print)

Provider Signature

Date

Provider Number

DOM REP. Signature

Date

