

**Mississippi Division of Medicaid
Medical Assistance Participation Agreement
Medicaid-Title XIX Program
Section C-1**

The Medicaid Provider Agrees:

1. To provide medical services to eligible Medicaid and/or CHIP 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 and/or CHIP program(s) to an individual who is eligible for such program(s) 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 and/or CHIP program(s).
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) 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 to Medicaid beneficiaries, 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 That in the event the Provider's license has been revoked by the appropriate Board or if the Provider is disqualified through a federal administrative action, this Agreement is automatically terminated.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 the Mississippi 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, and/or Medicaid administrative action, the Provider will not submit claims for payment to the Mississippi Division of Medicaid for services performed after the disqualification date.
9. To comply with all federal and state standards of practice, including licensure.
10. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of the 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

The Medicaid Provider Agrees Continued:

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 service or billing for beneficiaries. A searchable federal web site, updated monthly, exists at <http://exclusions.oig.hhs.gov/>.

11. That all Medicaid covered services have been administered and billed in accordance with Medicaid policy, to include but not limited to, disclosing the appropriate provider NPI in each applicable section of claim submission.

12. That claims for reimbursement will be submitted in accordance with the instructions from the Mississippi 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.

13. 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.

14. To authorize and agree to electronic direct deposit transfer payments for claims reimbursement by the Mississippi Division of Medicaid and to submit, in accordance with instructions from the Mississippi Division of Medicaid or its designated agent, the appropriate Direct Deposit Authorization/Agreement Form.

15. 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.

16. The Provider confirms that all information submitted in the provider enrollment packet is accurate at the time of submission and changes will be reported to the Mississippi Division of Medicaid in accordance with the Medicaid Administrative Code located at www.medicaid.ms.gov.

17. The Provider agrees to comply with advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs.

18. The Provider agrees to furnish to the Mississippi Division of Medicaid its National Provider Identifier (NPI) (if eligible for an NPI); and include its NPI on all claims under the Medicaid program.

19. The Provider agrees to respond to any request for information or documentation from the Mississippi Division of Medicaid or its designated agent thereof, in accordance with the specified timeframes of any such request and understands that failure to provide the requested information or documentation may result in termination of participation in the Medicaid program or denial of any such application or claim pending.

20. Pursuant to 42 C.F.R. Part 455, providers identified as high categorical risk upon request will submit fingerprints on the form and in the manner required by the Mississippi Division of Medicaid or their designees for the Provider and any person with five (5) percent or more direct or indirect ownership interest and authorizes the

Mississippi Division of Medicaid or their designee to complete criminal background checks.

21. Provider acknowledges and will grant access to the Mississippi Division of Medicaid or their designees, and/or Medicaid Fraud Control Unit (MFCU), and/or U.S. Department of Health & Human Services (HHS) for unannounced site visits for the purpose of meeting requirements of 42 C.F.R. § 455.432 and upholding the integrity of the Medicaid program.

22. To comply with the applicable provisions of Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), The Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), Sections 1303(b)(4), 1553, and 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. §§ 18023(b)(4), 18113, 18116), and any other relevant state and/or federal law.

23. To maintain policies and/or documents supporting compliance with the relevant Civil Rights laws which are substantially similar to the examples located at <https://medicaid.ms.gov/wp-content/uploads/2025/05/Civil-Rights-Compliance.pdf>

24. That compliance with the Civil Rights requirements agreed to herein is a material condition of continued participation in the Medicaid and/or CHIP program(s).

25. That Provider's assurances regarding Civil Rights requirements are binding upon Provider's successors, transferees, and assignees for as long as participation in the Medicaid and/or CHIP program(s) continues.

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 Mississippi 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 Mississippi Division of Medicaid or its designated agent, or on other terms approved by the Mississippi 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. A change of ownership of a provider/facility as defined by the Mississippi Division of Medicaid includes, but is not limited to: inter vivos gifts, purchases, transfers, lease arrangements, cash and/or other comparable arrangements whenever the person or entity acquires or controls a majority interest of the facility or service. 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 to the Medicaid program, and such amounts may be withheld from the payment of claims submitted when determined such is owed. An indemnification agreement between Provider and the previous provider shall not affect Medicaid's right to recovery.

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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. 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.

5. 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 Mississippi Division of Medicaid or its designated agent, and as may be applicable to the services under this Agreement.

6. 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 Mississippi Division of Medicaid.

The Division of Medicaid and the Provider Mutually Agree Continued:

7. This agreement is automatically terminated in the event the Provider's license has been revoked by the appropriate Board, the Provider is disqualified through a federal administrative action, or the Provider is convicted as set forth in Miss. Code Ann. Section 43-13-121 (l) (1972, as amended).

8. That the Provider has reviewed all documents related to participation in the Medicaid and CHIP programs to include but not limited to, the Administrative Code and Billing Manuals located at www.medicaid.ms.gov and agrees to be bound by the current versions as well as any amendments, revisions, etc. of such documents.

9. In the event litigation is had concerning any part of this Agreement, whether initiated by the Provider or the Mississippi Division of Medicaid, it is agreed that such litigation shall be had and conducted in either the Circuit or Chancery Courts of Hinds County, Mississippi, or the United States District Court for the Southern District of Mississippi, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

Printed Name of Provider

NPI (if applicable)

Provider Number (if assigned)

Provider Signature

Date