

Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 4: Provider Enrollment

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.
2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.
3. Agree to furnish required documentation of the provider's business transactions per 42 C.F.R. § 455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.
4. Agree to abide by the requirements of 42 C.F.R., PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following:
 - a) Provider Screening Procedures (42 C.F.R. § 424.518) which based on the category of the provider type can include license verifications; database checks of eligible professionals, owners, managing employees etc.; fingerprinting and criminal background checks; unscheduled or unannounced site visits based on required screening rules.
 - b) Provider Application Fees (42 C.F.R. § 424.514).
 - c) Temporary Moratorium (42 C.F.R. § 424.570).
 - d) Provider Termination (42 C.F.R. § 455.416).
 - e) Payment Suspensions (42 C.F.R. § 455.23).
5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 C.F.R. § 455.414.
6. All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of six (6) years in order to comply with all federal and state regulations and laws. When there is a change

of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3: Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information; and (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XX services program. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.
8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.
9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.
10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306 Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, age or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these two (2) Acts.
12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.
13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.
14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.
15. 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.
16. The provider must verify with the NET Broker that all non-emergency transportation (NET) services are for a Medicaid covered service only. The provider is only required to verify the date, time, beneficiary's Medicaid number, and provide confirmation that a

Medicaid covered service will be provided at the appointment.

17. Participating providers must comply with all requirements delineated in Miss. Admin. Code Part 200, Chapter 4, Rule 4.8, Requirements for All Providers.

B. Out of State Providers –

1. The Division of Medicaid may enroll an out-of-state provider to cover medical services if one (1) of the following conditions is met:
 - a) Services are needed because of an emergency medical condition as defined in Miss. Admin. Code Title 23, Part 201, Rule 1.2.G.
 - b) Services are needed because the beneficiary's health would be endangered if they were required to travel to their state of residence.
 - c) The Division of Medicaid has determined, on the basis of medical advice, services are needed and more readily available in the other state.
 - d) The location of services provided is within:
 - 1) Thirty (30) miles of the Mississippi state border for a pharmacy, or
 - 2) Sixty (60) miles from the Mississippi state border for certain other provider types.
 - e) Or as determined by the Division of Medicaid.
2. The Division of Medicaid may use the results of the provider screenings performed by another state's Medicaid or Children's Health Insurance Program (CHIP) agency in the state in which the out-of-state provider is located or by a Medicare Contractor.
3. An out-of-state provider that has not billed the Division of Medicaid within a three (3) year period will be disenrolled except for certain providers, as determined by the Division of Medicaid, that are necessary to maintain access to covered services not available in Mississippi. Once disenrolled, the out-of-state provider may reapply in accordance with the out-of-state enrollment policy.
4. Out-of-state providers must adhere to the Division of Medicaid's policies and procedures.

Source: 42 C.F.R. Part 455, Subpart E; 42 C.F.R. §§ 431.52, 431.107; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised eff. 09/01/2020; Revised Miss. Admin. Code Part 200, Rule 4.2.B. eff. 01/01/2020; Revised eff. 12/01/2019.

Rule 4.3: Change of Ownership

- A. A change of ownership of a provider/facility as defined by the Division of Medicaid includes, but is not limited to: inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions 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.
- B. The new ownership agreement shall be subject to any restrictions, conditions, penalties, sanctions or other remedial actions taken by the Division of Medicaid, the state agency or the federal agency against the prior owner of the facility.
- C. The agreement will also remain subject to all applicable statutes and regulations, including, but not limited to:
 - 1. Any statement of deficiencies cited by the State Agency that are not in substantial compliance, including any existing plan of correction,
 - 2. Any expiration date,
 - 3. Compliance with applicable health and safety standards,
 - 4. Compliance with ownership and financial disclosure requirements, and
 - 5. Compliance with civil rights and the rights of individuals with developmental disability requirements.
- D. A provider/facility that undergoes a change of ownership must:
 - 1. Notify the Division of Medicaid within thirty-five (35) days after any change in ownership through the submission of:
 - a) A complete Mississippi Medicaid Provider Application Packet, and
 - b) Proof of change of ownership such as a bill-of-sale or Medicare Tie-In Notice.
 - 2. Receive a new taxpayer identification segment for the new owner with the provider number remaining unchanged.
 - 3. Comply with all applicable Mississippi Department of Health requirements for changes of ownership [Refer to 15 Miss. Admin. Code. Pt 16, Subpart 1, Rule 49.2.6 and 15 Miss. Admin. Code Pt. 9, Subpart 91, Appendices.]
- E. When there is a change of ownership or retirement/closure, a provider must continue to maintain all Medicaid beneficiary records for at least six (6) years, unless an alternative method for maintaining the records has been established in writing, and approved by the Division of Medicaid as required by Health Insurance Portability and Accountability Act of

1996 (HIPAA). [Refer to Part 200, Chapter 1, Rule 1.3, Maintenance of Records.]

F. The following are examples of changes of ownership. This list is not exhaustive. Providers who are unsure of whether a transaction constitutes a change of ownership should contact the Division of Medicaid's Office of Provider Enrollment. Examples include:

1. Changes in type of organization (ex. Partnership to limited liability company, or single proprietorship to organization),
2. Mergers, when a new organization is formed and the merging companies are non-surviving,
3. Consolidation of two or more corporations resulting in a new corporate entity,
4. Changes in partnership, including the removal, addition, or substitution of one or more individuals as partners (under Mississippi law, these actions result in dissolution of an older partnership and creation of a new one),
5. Transfers between different levels of government, such as city to county, state to county, etc., and
6. Transfer (sale, gift, exchange of stock) that results in a fifty (50) percent or more change.

Source: 42 C.F.R. §§ 455.104, 489.18; Miss. Code Ann. §§ 41-7-173, 43-13-121.

History: Revised eff. 09/01/2020.

Rule 4.8: Requirements for All Providers

A. All providers are required to submit the following documentation:

1. Mississippi Medicaid Provider Enrollment Application
 - a) Individuals and Sole Proprietor applications must be signed by the individual provider.
 - b) Business/Entity applications must be signed by the Authorized Official.
2. Medical Assistance Participation Agreement (Provider Agreement)
3. Direct Deposit Authorization/Agreement Form
 - a) Include a copy of a voided check, deposit slip, or letter from the bank noting the account number and transit routing number.
 - b) Starter checks and counter deposit slips are not acceptable.

4. W-9

- a) Name on the W-9 should match the written confirmation from the IRS confirming your Tax Identification Number with the legal business name/legal name as noted in Section 1 of the Mississippi Medicaid Provider Enrollment Application. Note: This information is needed if enrolling as a professional corporation or limited liability company, or enrolling as a sole proprietor using the Employer Identification Number.
- b) Name on the W-9 should match the documentation to confirm the social security number verification for any provider enrolling as an individual sole proprietor.

5. EDI Provider Agreement and Enrollment Form is required if the intent is to submit electronically.

6. Civil Rights Compliance Information Request Packet including the following:

- a) A copy of the provider's Nondiscrimination Policy.
- b) A copy of the provider's Limited English Proficiency Policy.
- c) A copy of the provider's Sensory and Speech Impairment Policy.
- d) A copy of the provider's Notice of Program Accessibility Policy.
- e) Statement of compliance, signature required. A copy of the DHHS Office of Civil Rights letter of compliance may be submitted in lieu of completing the Division of Medicaid's compliance packet.
- f) A copy of the provider's published newspaper article stating the provider's non-discrimination policy, required only for healthcare facilities.

7. Providers who have changes of information which are not considered a CHOW must submit the following forms, if applicable:

- a) W9 form for a provider name change,
- b) Change of Address form for provider mailing and/or business addresses, e-mail contact information or telephone number changes,
- c) Electronic Funds Transfer (EFT) form for provider banking information changes, and/or
- d) Provider Disclosure Form for any other applicable changes.

8. Certain disclosures are required for participation as a provider in the Mississippi Division of Medicaid.

a) The Division of Medicaid requires use of the Mississippi Medicaid Provider Disclosure Form in the following instances:

- 1) Upon the provider's submission of the provider enrollment application,
- 2) Upon request of the Division of Medicaid during the re-validation of enrollment process, and
- 3) Within thirty-five (35) days after any change in ownership of the provider.

b) Required disclosures include:

- 1) The name and address of any individual or corporation with an ownership or control interest in the provider. The address for corporate entities must include an applicable primary business address, every business location, every P. O. Box address, and/or other mailing address.
- 2) Date of birth and Social Security Number (in the case of an individual).
- 3) Other tax identification number (in the case of an organization) with an ownership or control interest in the provider or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest.
- 4) Whether the person (individual or corporation) with an ownership or control interest in the provider is related to another person with ownership or control interest in the provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more ownership interest is related to another person with ownership or control interest in the provider as a spouse, parent, or sibling.
- 5) The name of any other provider in which the ownership of the provider has an ownership or control interest.
- 6) The name address, date of birth, and Social Security Number of any managing employee, authorized official, and delegated official of the provider.
- 7) Any additional disclosures as required and enumerated by state and/or federal law.

B. Failure to comply with the terms of this rule may result in rejection of the Provider Enrollment Application, revocation of provider enrollment, or a suspension in the payment of claims.

Source: 42 C.F.R. §§ 455.104, 455.414; Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2020.