MEDICAID PROGRAM PROVIDER AGREEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 615 (Rev. 6-2023)

Clear Fields

Agreement between the Department of Health and Human Services, hereinafter referred to as "the Department" and:

Provider:	NPI:	Medicaid Provider Number	
Mailing Address:	City:	State:	ZIP Code:

hereinafter referred to as "Provider".

1. Participation. As a condition of participation in the North Dakota Medicaid Program, the Provider agrees to submit true, accurate and complete claims for payment in the manner prescribed by the Department. The Department agrees to pay the Provider for services rendered to persons who are eligible for such services under the rules and regulations for the North Dakota Medicaid Program with payment to be in accordance with the payment structure established by the Department and other programs for which payments are made through the same system.

I wish to participate in (check all that apply):

☐ Medicaid Fee For Service ☐ PACE ☐ Medicaid Expansion MCO

Selecting any of the above managed care organization (MCO) boxes (PACE or Medicaid Expansion) does not automatically enroll a provider to render or bill services for the MCO. As all benefits and claims are administrated by the MCO, in order to provide and bill these MCO services, all providers must be contracted directly with the applicable MCO.

2. Compliance. As a condition of participation in the North Dakota Medicaid Program, the Provider agrees to comply with all applicable provisions of statute, rules, and federal regulations governing the providing of healthcare and reimbursement of services and items under Medicaid in North Dakota, including the current applicable General information for Providers Manual and any instructions contained in provider information releases or other program notices and applicable manuals. The Provider specifically agrees that it is required to comply with:

Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed thereunder by regulation of the Department of Health and Human Services (45 CFR Part 80) to the end that no person shall on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the provider receives federal financial participation from the state agency; and hereby gives assurance that it will immediately take any measures necessary to effectuate this agreement;

The Health Insurance Portability and Accountability Act of 1996, 45 CFR parts 160 and 164;
The Age Discrimination Act of 1975, 45 CFR parts 90 and 91;
The Americans with Disabilities Act of 1990, 42 USC section 1201 et. seq.;
The North Dakota Human Rights Act of 1983, NDCC Chapter 14-02.4;
The Social Security Act, section 1902(a)68);

Section 504 of the Rehabilitation Act of 1973 as amended, to the end that no otherwise qualified disabled individual shall, solely by reason of his or her disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial participation; and

Sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) and all requirements imposed there under by regulations of the Department of Health and Human Services (42 CFR Parts 431 and 455) including but not limited to, the maintenance and disclosure of records identifying those persons holding an ownership or control interest in the provider.

If additional beds are added at this facility, it is the responsibility of the provider to notify the Department immediately. If the facility does not currently operate residential or inpatient beds but decides to add beds in the future, it is the responsibility of the provider to notify the Department immediately.

3. Contact. The Provider must advise the Department of its current address or change in ownership. The address must include a physical street address. If a P.O. Box is used, the owner's home address and phone number must be included. All Medicaid correspondence shall be sent to the mailing address on file with the Department and shall be deemed to be received by the Provider.

4. Professionalism. The Provider agrees to be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally-supervised paraprofessionals where their use is authorized. The Provider agrees to screen all employees and contractors to determine whether any of them have been excluded. Compliance with this obligation is a condition of enrollment. The Provider needs to immediately report any exclusion information discovered to the Department.

(Continued next page...)

5. Recordkeeping. The Provider agrees to document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of the Department, applicable rules, and this agreement. Such records shall be maintained according to 42 CFR 424.516 (f) for at least seven years after the date of service or as required by rule. Upon reasonable request, the Department, the U.S. Department of Health and Human Services (DHHS) or their agencies, shall be given immediate access to, and permitted to review and copy all records relied on by the Provider in support of services billed to Medicaid. Copies will be furnished at the Provider's expense. The Provider agrees to follow all applicable state and federal laws and regulations related to maintaining confidentiality of records.

6. Accurate Billing. The provider agrees that all original Medicaid primary claims must be received by the Department within 180 days from the date the service was provided, all original Medicare crossover claims must be received by the Department within 180 days from the date of the Medicare Explanation of Benefits (EOB), and all original Medicaid secondary/tertiary claims (excludes Medicare crossovers) must be received by the Department within 365 days from the date the service was provided. The provider agrees that all requests for replacements, resubmissions, and voids of an adjudicated claim must be received by the Department within 365 days from the date the service was provided. The provider agrees that claims not submitted for payment within these timeframes may not be billed to the client.

7. Overpayment. The Provider agrees that in any event it receives payment for services or goods in an amount in excess of payment permitted by the Department, that such overpayments may be deducted from future payments otherwise payable to the Provider. The Provider acknowledges that such remedy is not the only or exclusive remedy available to the Department. It is the Provider's responsibility to inform the Department of any Medicaid overpayments discovered.

8. Secondary Payer. The Provider acknowledges that Medicaid is a secondary payer and agrees to first seek payment from other sources as required by statute, rule, or regulation.

9. Full Payment. The Provider agrees to accept Medicaid payment for any item or service as payment in full and agrees to make no additional charge. The Provider further agrees:

If Medicaid requires a prior authorization, screening, or an assessment before the item or service is provided, the Provider may not bill Medicaid or the client when any of the before mentioned items were not submitted in a timely manner.

Not to bill the client unless the item or service is not covered or approved for payment by the Department and the client has agreed to be responsible for payment prior to receiving the item or service.

If a third party pays the client, the client may be billed for that amount, and Medicaid may not be billed. The Provider agrees not to bill Medicaid or the client if a third party payment is made to the provider unless the third party payment is less than the amount Medicaid would pay. The Provider shall not refuse to furnish services on account of a third party's potential liability for the services (42 CFR § 447.20).

To sign up for and receive electronic funds transfers from the Department for their Medicaid payments. Any provider exempt from this requirement will have it noted on their provider checklists.

10. Ownership. The Provider agrees to comply with the disclosure of ownership requirements of 42 CFR Part 455, Subpart B and to notify the Department thirty (35) days prior to any change of ownership. This Provider agreement is nontransferrable. The Provider agrees to provide the Department with the information described below:

a. The name and address of each person directly or indirectly owning a five percent or more interest in the Provider's business;
b. Whether any of the persons identified in are related as spouse, parent, child, or sibling; and
c. The name of any other Medicaid provider entity in which a person identified in has indirect or direct ownership of five percent or more.

The provider agrees to furnish to the Department, or the U.S. Deptartment of Health and Human Services or their agencies on request, disclosure by providers of 42 CFR § 455.105 information related to business transactions in accordance with paragraph (b) of the section below.

"(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about:

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(Continued next page...)

11. Advance Directives. The Provider agrees to maintain written policies and procedures with respect to all adult individuals receiving care; to provide written information to each such individual regarding the individuals rights to make decisions concerning such care, including the right to accept or refuse medical or surgical treatment, the individuals right to formulate advance directives, and the Provider's written policies respecting the implementation of those rights; to document in the individuals medical record whether or not the individual has executed an advance directive; not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive; to ensure compliance with state law respecting advance directives; and to provide for education for staff and the community on issues concerning advance directives. "Advance directive" means a written instruction prepared in accordance with N.D.C.C. Chapter 23-06.5, relating to the provision of health care when the individual is incapacitated. The written information must be provided at the time of the individual's admission to a hospital or nursing home; in advance of the individual coming under the care of the provider, in the case of home health care or personal care; at the time of initial receipt of hospice care by the individual from the hospice program and; at the time of enrollment of the individual with a managed care organization.

12. Provider Screening. All current providers and providers applying to participate in the Medicaid program agree to screen their employees and contractors per Federal Regulations under 42 CFR 455.436. To ensure that employees and contractors meet program standards and are not excluded as an individual or an entity, the provider will:

- Upon hire:
  - Confirm the identity of the employee or contractor and determine their exclusion status
  - Search the HHS-OIG website by names of any individual or entity
  - Immediately report any exclusion information discovered to the Department
- Ongoing:
  - Continue to screen employees/contractors on a routine basis and immediately report any findings to the Department.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2)).

13. Enrollment. The Provider agrees that each individual provider who is eligible to enroll and is performing services (except allowed services performed under the supervision of an enrolled provider, with supervision meaning the physician or other supervising provider must direct and oversee the service according to professional requirements in state law, rules, or guidelines of a regulating/licensing board or organization) must be individually enrolled as a provider and that if individual providers within a group fail to enroll separately, payment to the group for services rendered to a Medicaid recipient by the non-enrolled provider will be denied or, if paid in error, recovered.

Practitioners rendering behavioral health rehabilitative services may not bill for services under a supervising practitioner's NPI.

As a condition of enrollment, the provider must consent to a criminal background check including fingerprinting when required to do so under state law or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.

The Provider agrees that if the enrollment date precedes the effective date of this agreement that all terms and conditions of this agreement apply to the period between the enrollment date and the effective date.

Providers that are able to enroll with North Dakota Medicaid are required to enroll and are not able to bill for services under a supervising or peer provider's NPI. Individual or Group provider types eligible to enroll with North Dakota Medicaid are listed on the website.

14. Duration and Termination of Agreement. This Agreement shall remain in effect until terminated in writing except the Department may terminate this agreement without notice if no service has been rendered by the Provider within two (2) calendar years. In the event of termination by the Department, the Departments sole obligation shall be to pay for services provided prior to the effective date of termination. This agreement may be terminated by either party without cause by giving thirty (30) days notice in writing to the other party.

This Agreement shall be terminated immediately and without notice if the Provider's license or certification required by law is suspended, not renewed, denied, or is otherwise not in effect at the time service is provided.

The Department may immediately terminate this Agreement in writing when the Provider fails to comply with any applicable statute, rule, regulation, term or provision of this Agreement. The Provider also understands and agrees that its conduct may be subject to additional penalties or sanctions. The Provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this Agreement.

15. Certification. By signing this Agreement, the Provider certifies that neither the Provider nor its principles, are presently debarred, declared ineligible, or voluntarily excluded from participation in transactions with the State or Federal Government by any Department Agency of the Federal Government or the State of North Dakota.

16. Effective Date of Agreement. This Agreement is effective when signed by the Provider. It supersedes all prior agreements. Any variation to the effective date must be approved by the Department.

I have read this Agreement, understand it, and agree to abide by its terms and conditions. I also agree that violation of any of the terms or conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action.

Provider Name/Printed Name	Title	Date
Provider Signature		