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Green Mountain Care

Instructions for Enrollment & Revalidation

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS
dvha.vermont.gov/

DXC.technology
vtmedicaid.com/#/home

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Green Mountain Care

Instructions for Enrollment & Revalidation

Thank you for your interest in becoming a Green Mountain Care health care professional. Provider participation is vital to the successful delivery of services to our Medicaid members. We welcome your application. All forms and packets discussed in these instructions may be found on the Vermont Medicaid Portal at: http://www.vtmedicaid.com/#/provEnrollAppPackets. For more information, please see our Frequently Asked Questions document.

Overview & Federal Requirements

Affordable Care Act

In accordance with Section 6401 of the Affordable Care Act of 2010 (ACA), all enrolled and newly enrolling providers will be subject to federal screening requirements. State Medicaid Agency requirements are available for review at http://www.cms.gov/Medicare/ Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/ProviderEnrollmentRegulation.html

Provider Screening, Risk Categories & Change in Risk Level

Title 42 Code of Federal Regulations (CFR) §§455.410 and §455.450 require that all participating providers be screened upon initial enrollment and revalidation of enrollment. Health care providers are categorized by screening levels established by the Centers for Medicare & Medicaid Services (CMS) utilized by Department of Vermont Health Access (DVHA). The defined risk levels of limited, moderate, and high are based on an assessment of potential fraud, waste, and abuse for each provider/supplier type. Providers will be screened according to their risk level. Risk level assignments may be increased at any time at the discretion of DVHA and the new risk level will apply to all enrollment-related transactions.

1. Limited categorical risk: Providers/suppliers in the limited risk category include: physicians, non-physician practitioners other than physical therapists, medical groups or clinics, ambulatory surgical centers, competitive acquisition program part B vendor, end-stage renal disease facilities, federally-qualified health centers, histocompatibility laboratories, hospitals (including critical access hospitals, department of Veterans Affairs hospitals, and other federally-owned hospital facilities), health programs operated by an Indian Health Program (as defined in section 4(12) of the Indian Health Care Improvement Act) or an urban Indian organization (as defined in section 4(29) of the Indian Health Care Improvement Act) that receives funding from the Indian Health Service pursuant to Title V of the Indian Health Care Improvement Act, mammography screening centers, mass immunization roster billers, organ procurement organizations, pharmacies that are newly enrolling or revalidating, radiation therapy centers, religious non-medical health care institutions, rural health clinics and skilled nursing facilities. **Screening Requirements for Limited Risk:** Verify that the provider or supplier meets all applicable federal regulations and state requirements for the provider or supplier type prior to making an enrollment determination. Conduct license verifications, including licensure verifications across state lines for physicians, non-physician practitioners, providers and suppliers. Conduct database checks on a pre-and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.
2. Moderate categorical risk: Providers/suppliers in the moderate risk category include: ambulance service suppliers, community mental health centers (CMHCs), comprehensive outpatient rehabilitation facilities (CORFs), hospice organizations, independent clinical laboratories, independent diagnostic testing facilities (IDTFs), physical therapists enrolling as individuals or as group practices, portable x-ray suppliers (PXRS), revalidating home health agencies (HHA) and revalidating DMEPOS suppliers. **Screening Requirement for Moderate Risk:** Perform the limited risk screening requirements and conduct on-site visits.

3. High categorical risk: Providers/suppliers in the high risk category include: newly-enrolling durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and newly-enrolling home health agencies (HHAs).
   Screening Requirements for High Risk: Perform the limited and moderate risk screening requirements and, no later than June 1, 2016, a fingerprint-based criminal background check will be required.

Change in Risk Level

Providers and suppliers may have their risk level reassessed due to:

- Imposition of a payment suspension within the previous 10 years
- A provider or supplier has been terminated or is otherwise precluded from billing Medicaid
- Exclusion by the OIG
- A provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location
- A provider or supplier has been excluded from any federal health care program
- A provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years
- Instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted

Provider Revalidation

In compliance with 42 CFR §455.414, all providers are required to revalidate their enrollment at least every three to five years depending on provider type and assigned risk level. Providers will be notified that they are required to revalidate prior to the revalidation deadline. Screening criteria applies during revalidation. Providers that do not revalidate their enrollment by the designated date will no longer be enrolled and will not receive reimbursement from Vermont Medicaid.

Application Fee

Under 42 CFR §455.460, institutional providers and certain other providers are subject to an application fee at time of application. This includes: initial applications for enrollment, applications for the addition of a new practice location, and applications received in response to revalidation notification. Note: The application fee is NOT required for providers that have already paid the fee to Medicare, another state's Medicaid program, or another Vermont state agency. Providers are required to provide proof of payment to DVHA when application is made. CMS sets the application fee amount, which may be adjusted annually. CMS may agree to waive the application fee based on proof of financial hardship for a provider. To request a waiver, providers must submit, at the time of application, a letter that supports the request for the financial hardship waiver. The final decision to waive the application fee will be made by CMS. DVHA will inform you of CMS's determination, and if an application fee is due.

Instructions Are Included for the Following Forms

Please read the descriptions below and click the link to be directed to the instructions for your application type.

- **Vermont Medicaid Provider Enrollment & Revalidation - Billing & Servicing Providers** - This application applies to practitioners wishing to provide medical services to Green Mountain Care members and submit claims for those services for reimbursement.
- **Vermont Medicaid Provider Enrollment & Revalidation Form - Non Billing (OPRA Providers and Residents)** - This application is limited to practitioners seeking to enroll in Vermont Medicaid as an ordering, prescribing, referring, attending provider (OPRA), including residents. Practitioners who complete this application are not eligible for reimbursement. Attending providers are only to use this form when their name and NPI is to appear on a hospital claim and reimbursement is not anticipated.
- **Vermont Medicaid Provider Enrollment & Revalidation Form - Medicare Crossover Providers Only** - This application is limited to practitioners who render services to Medicare dual-eligible beneficiaries and who are not enrolled in Vermont Medicaid. A provider would fill out this application if they are requesting authorization to bill Vermont Medicaid solely for Medicare cost sharing amounts.
- **Vermont Medicaid Disclosure Form** - In compliance with 42 CFR §457.935, 42 CFR §1001. §1001, 42 USCS §1395cc(j)(5), 42 CFR §455.104, §455.105, and §455.106, providers are required to disclose including, but not limited to, information regarding (1) the identity of all persons with an ownership or control interest in the provider, or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent or more including the identity of managing employees, agents, and other disclosing entities; (2) certain business transactions between the provider and subcontractors/wholly owned suppliers; and (3) the identity of any person with an ownership or control interest in the provider or disclosing entity, or who is an agent or managing employee of the provider or disclosing entity that has ever been convicted of any crime related to that person's involvement in any program under the Medicaid, Medicare, or Title XX program (Social Services Block Grants), or XXI (State Children's Health Insurance Program) of the Social Security Act since the inception of those programs.

Contact Information

For information/questions about Vermont Medicaid provider requirements or the status of your enrollment, please contact DXC Technology Provider Enrollment at (802)878-7871 or 1-800-925-1706 (Toll free if you are calling in Vermont).

Return all completed forms to:
DXC Technology, Enrollment Unit, P.O. BOX 888, Williston, VT 05495-0888

If confirmation of delivery is requested, please return to:
DXC Technology, 312 Hurricane Ln., Suite 101, Williston, VT 05495-0888

Instructions for Completing Enrollment & Revalidation Forms

For Billing & Servicing Providers

Type or print clearly in ink. To make corrections please line through, date, and initial in ink. Do not use correction fluid. Do not leave any questions, boxes, or lines blank; please use the provided options.

All sections/fields indicated by an asterisk* must be completed in their entirety or partially. Please review thoroughly, as failure to provide the information applicable to the service(s) to be provided within the applicant's scope of licensure will result in the application being returned.

A complete enrollment/revalidation application packet includes the original signed Enrollment & Revalidation Application (Billing & Servicing Providers), Vermont Medicaid Disclosure form(s) if applicable, executed Provider General Agreement and applicable Special Provisions. Include copies of the following documents, when applicable:

- Proof of Professional Liability Insurance – attach a copy of the face page of Malpractice Certificate
- CLIA Certificate or copy of agreement/contract to use another facility's lab to render laboratory services.
- IRS W-9 Form
- CMS swing bed certification letter
- All professional licenses, accreditations or certifications. If a professional license/certification has been revoked or suspended, include a copy of the licensing authority's decision(s) and written confirmation from them that privileges have been restored.
- IRS Letter 147C and, if needed, any applicable tax documents to validate SSN and/or EIN

Section 1: *Request Type

Specify action requested; indicate type of individual provider or group.

Section 2: *Provider/Applicant Information

Provide all applicable information and submit copies of documentation to validate your entry, for example, valid CLIA Certificate, and W-9. Please also include all applicable taxonomy numbers.

Section 3: *Legal Address

Enter your complete legal address (your tax forms will be sent here).

Section 4: *Licensing Information

List current licenses. Include copies of all professional licenses, accreditations or certifications. If a professional license/ certification has been revoked or suspended, include a copy of the licensing authority's decision(s) and written confirmation from them confirming that privileges have been restored.

Section 5:* Type of Business

Indicate type of business; information must match what is indicated on IRS Form W-9.

Section 6: *Type of Services to be Provided

List the types of services or supplies you or your agency will provide.

Section 7: *Proof of Professional Liability Insurance

Provide the name of liability insurance carrier/company, address, telephone number, insurance policy number date issued and expiration date. Must supply proof of Professional Liability Insurance – attach a copy of the face page of Malpractice Certificate.

Section 8: Medical/Dental/Clinical Specialties *

Indicate specialty and if board certified. **Note: This field is <u>required</u> for the following provider types: physicians, nurse practitioners, dentists, doctoral-level psychologists & social workers and individual DME providers (includes prosthetics).

Section 9: Hospital Privileges

List all hospitals that have granted hospital privileges, including the hospital name, complete address and contact information.

Section 10: *Group Affiliation

Indicate if you are affiliated with other individuals or groups and list all providers and medical entities to include their name, the effective date of your affiliation, their Medicaid Provider Number, NPI, Medicare Number, DEA and CLIA Numbers (if applicable), complete address and the specialty of the practice. For group applications, please list providers that are enrolled with Vermont Medicaid and are affiliated with your group.

Section 11: *Applicant/Provider Accommodations & Addresses

Provide the physical service address where health care services are provided; specify what patient accommodations are available and the pay to, mail to and prior authorization addresses relevant to the service address. Use one sheet per service address. Copy and attach an additional sheet for each additional service address.

Section 12: *Conviction/Sanction/Disclosure and Suspension/Debarment

All questions must be answered. If Yes, fully explain details and include all supporting documentation from the licensing board or agency taking action. If you are not in good standing with respect to (or in full compliance with a plan to pay) any and all overdue taxes, specify why.

Section 13: *Disclosure of Information -Ownership & Control

A completed *Vermont Medicaid Disclosure Form* must be submitted for each person/entity, managing individual/employee and subcontractor reported on the Vermont Medicaid Provider Enrollment & Revalidation Form, as defined below.

Entity is defined as follows:

- All owners with a direct or indirect ownership or a controlling interest of 5 percent or more
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company)
- All companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider
- An agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients
- An agency, or organization with which a provider has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement

Person is defined as follows:

- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations
- All individuals who are able to act on behalf of the provider because their authority is apparent.

Section 13A: Direct or Indirect Ownership

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in:

a. The capital, the stock or the profits of the entity, or
b. Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

Person with an ownership or control interest means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e. Is an officer or director of a disclosing entity that is organized as a corporation; or

f. Is a partner in a disclosing entity that is organized as a partnership.

How to Determine Ownership or Control Percentages (42 CFR§455.102)

a. **Indirect ownership interest**. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

b. **Person with an ownership or control interest.** In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Section 13B: Managing individuals/Employees

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

Section 13C: Definition of a Subcontractor and Significant Business Transactions

- *Subcontractor* means an individual, agency or organization to which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies to its patients And with whom an applicant or provider has entered into a contract, agreement, purchase order, lease or leases of real property, to obtain space, supplies, equipment, or services provided under the Vermont Medicaid Program.
- *Significant business transaction* means, any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Green Mountain Care members that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or 5% of provider's total operating expenses.

Section 14: *Applicant/Provider Self Disclosure of person(s) or entities

A. *Convictions/Financial*: Complete this section in its entirety. If Yes, specify the date and details.
B. *Bed Capacity*: Hospitals are required to complete this section. Must specify current bed capacity and answer all other questions
that apply.

Section 15: *Contact Information

Provide the name and contact information of the individual to contact regarding the enrollment/revalidation application.

Section 16: Backdating Enrollment Start Date

This section is for NEW or RE-ENROLLING provider who are currently Medicare-enrolled only. New and Re-Enrollment effective dates are based on the day the complete packet is received by DXC. If you wish your effective date to be up to a year earlier and you are Medicare enrolled, please complete section 16 of this application by indicating the date you wish your enrollment to begin. For requests that are more than a year or for non-Medicare enrolled providers, please complete the Enrollment Backdate Form located here: http://www.vtmedicaid.com/#/provEnrollDataMaint. Note: You must be enrolled with Vermont Medicaid prior to submitting this form. Please check the Provider Look-Up:

(http://www.vtmedicaid.com/#/providerLookup) to verify you're enrolled. Requests made prior to enrollment with Vermont Medicaid will be returned to the provider.

If, upon verification of Medicare enrollment, we find your Medicare enrollment has lapsed, your effective will be the date of receipt of your complete application, not your requested effective date.

Section 17: * Declaration and Signature

All applicants or providers must complete this section. Legal name of applicant/provider must match name listed on associated application packet. The signature must be from the individual provider/applicant, or those who have the authorized or delegated authority to legally bind the applicant or provider (i.e. the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization). **See Title 22, CCR Section 51000.30(a)(2)(B).** An original signature (must be signed in blue ink, as it denotes authenticity) is required. Stamped, faxed, and/or photocopied signatures are not acceptable; application will be returned.

**Asterisked sections must be completed. Failure to provide information will result in application being returned.*

Provider General Agreement and Special Provisions

All Applicants or providers must review, sign and return the Provider General Agreement as part of the enrollment application. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. The Department of Vermont Health Access advises that this contract, including the Special Provisions, contain important contractual obligations. A copy should be retained by the provider. Signatures must be in blue ink (as it denotes authenticity).

Non-Billing Enrollment Privileges: Ordering, Prescribing, Referring & Attending (OPRA) Providers and Residents

The Affordable Care Act (ACA) requires that physicians or other eligible providers enroll in Medicaid to order, prescribe, refer or attend items or services for Medicaid beneficiaries, even when they do not submit claims to Medicaid. The Provider Enrollment and Revalidation Form for OPRA Providers is an abbreviated enrollment application for those OPRA providers and Residents that do not intend to submit claims. Enrolling ensures that physician, other practitioners and facilities that provide services and bill based on your order referral, or prescription, will be paid for such items or services.

Enrolling in Vermont Medicaid as an OPRA Provider:

- Does not obligate you to see Medicaid patients;
- Does not mean you will be listed as a Medicaid provider for patient assignment or referral;
- Helps ensure that your orders, prescriptions and referrals for Medicaid patients are accepted and processed appropriately

A complete OPRA packet includes the original signed Non-Billing OPRA application, Provider Agreement, applicable Special Provisions and copies of the following documents, when applicable:

- Proof of Professional Liability Insurance – attach a copy of the face page of Malpractice Certificate
- CLIA Certificate or copy of agreement/contract to use another facility's lab to render laboratory services.
- All professional licenses, accreditations or certifications. If a professional license/certification has been revoked or suspended, include a copy of the licensing authority's decision(s) and written confirmation from them that privileges have been restored.

Type or print clearly in ink. If applicant/provider must make corrections, please line through, date, and initial in ink. Do not use correction fluid. Do not leave any questions, boxes, or lines, blank, please use the provided options.

All sections/fields indicated by an asterisk* must be completed in their entirety or partially. Please review thoroughly, as failure to provide the information applicable to the service(s) to be provided within the applicant's scope of licensure will result in application being returned.

Section 1: *Request Type

Specify action requested; indicate type of individual provider or group.

Section 2: *Provider/Applicant Information

Provide all applicable information and submit copies of documentation to validate your enrollment.

Section 3: *Licensing Information

List current licenses held. Include copies of all professional licenses, accreditations or certifications. If a professional license/ certification has been revoked or suspended, include a copy of the licensing authority's decision(s) and written confirmation from them confirming that privileges have been restored.

Section 4: Medical/Dental/Clinical Specialties **

Indicate specialty and if board certified. **Note: This field is required for the following provider types: physicians, nurse practitioners, dentists, doctoral-level psychologists & social workers and individual DME providers (includes prosthetics).

Section 5: *Proof of Professional Liability Insurance

Provide the name of liability insurance carrier/company, address, telephone number, insurance policy number date issued and expiration date. Must supply proof of Professional Liability Insurance – attach a copy of the face page of Malpractice Certificate.

Section 6: Hospital Privileges

List all hospitals that have granted hospital privileges. List hospital name, complete address and contact information.

Section 7:*Applicant/Provider Accommodations & Addresses

Provide the physical service address where health care services are to be provided, as well as the mail to address.

Section 8: *Conviction/Sanction/Disclosure and Suspension/Debarment

All questions must be answered. If **Yes**, fully explain details and include all supporting documentation from the licensing board or agency taking action. If you are not in good standing with respect to (or in full compliance with a plan to pay) any and all overdue taxes, specify why.

Section 9: *Contact Information

Provider the name and contact information of the individual to contact regarding the enrollment/revalidation application. Correspondence may be required to complete your application.

Section 10: Backdating Enrollment Start Date

This section is for NEW or RE-ENROLLING provider who are currently Medicare-enrolled only. New and Re-Enrollment effective dates are based on the day the complete packet is received by DXC. If you wish your effective date to be up to a year earlier and you are Medicare enrolled, please complete section 16 of this application by indicating the date you wish your enrollment to begin. For requests that are more than a year or for non-Medicare enrolled providers, please complete the Enrollment Backdate Form located here: http://www.vtmedicaid.com/#/provEnrollDataMaint. Note: You must be enrolled with Vermont Medicaid prior to submitting this form. Please check the Provider Look-Up: (http://www.vtmedicaid.com/#/providerLookup) to verify you're enrolled. Requests made prior to enrollment with Vermont Medicaid will be returned to the provider.

If, upon verification of Medicare enrollment, we find your Medicare enrollment has lapsed, your effective will be the date of receipt of your complete application, not your requested effective date.

Section 11: *Declaration and Signature

All applicants or providers must complete this section. Legal name of applicant/provider must match name listed on associated application packet. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a
governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider.

An original signature, signed in blue ink (which denotes authenticity) is required. Stamped, faxed, and/or photocopied signatures are *not* acceptable; application will be returned.

**Asterisked sections must be completed. Failure to provide information will result in application being returned. Applications without complete information and/or original signature (blue ink denotes authenticity) will be returned.*

Provider General Agreement and Special Provisions

All applicants or providers must review, sign and return the Provider General Agreement as part of the OPRA enrollment application. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to

legally bind the applicant or provider. The Department of Vermont Health Access advises that this contract, including the Special Provisions, contain important contractual obligations of DVHA. A copy should be retained by the provider.

Medicare Crossover Providers Only

Completion of this form is limited to providers who render services to Medicare dual-eligible beneficiaries. A dual-eligible beneficiary is eligible for both Medicare and Vermont Medicaid. A provider would fill out this form if seeking payment for cost sharing amounts.

In order to use this form, the provider must meet all of the following conditions:

- The provider must be Medicare enrolled.
- The provider must have provided services to a dual-eligible beneficiary.
- The provider is requesting a **new enrollment or revalidation** to submit claims for reimbursement for services provided to a dual-eligible beneficiary or the provider would like to **change to previously submitted information**.

Unless all the above statements apply, a provider is not eligible to use the Crossover form.

A dual-eligible beneficiary is defined as a Vermont Medicaid beneficiary that may be entitled to Medicare and eligible for some form of Medicaid benefit. There are various categories: Qualified Medicaid Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs) and
Qualifying Individuals (QI-1s).
Type or print clearly in ink. If applicant/provider must make corrections, please line through, date, and initial in ink. Do not use correction fluid. Do not leave any questions, boxes, or lines, blank, please use the provided options.

All sections/fields indicated by an asterisk must be completed in their entirety or partially. Please review thoroughly, as failure to provide the information applicable to the service(s) to be provided within the applicant's scope of licensure will result in application being returned.*

All applicable documents include: the Crossover enrollment form and a legible copy of the Centers for Medicare & Medicaid (CMS) Approval Letter.

Section 1: *Request Type

Specify action requested (new enrollment, revalidation or change).

Section 2: *Provider/Applicant Information

Provide all applicable information and submit copies of documentation to validate your request.

Section 3:*Applicant/Provider Accommodations & Addresses

Mail-To Address: Provide address at which provider wants to receive information, including Remittance Advice from Green Mountain Care.
Service Address: Provide the physical address at which health care services are provided.

Section 4: *Contact Information

Provider the name and contact information of the individual to contact regarding the cross-over enrollment/revalidation application.

Section 5: *Declaration and Signature

All applicants or providers must complete this section. Legal name of applicant/provider must match name listed on associated application packet. *The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. Signatures must be in blue ink (which denotes authenticity).*

Overview of the Disclosure Form

Federal law requires Vermont Medicaid have applicants and providers complete and submit a current Vermont Medicaid Disclosure Form as part of a complete application packet for enrollment, revalidation and to report a change in an entity or person, as defined below. For more information on federal disclosure requirements, please see 42 CFR §§ 455.100 – 106, 42 CFR 455.436, and 42 CFR §1002.3.

Completion is required for any person or entity that meets the below definitions. A separate copy of this disclosure form must be completed in full for each entity or person.

Medicaid Disclosure Form Definitions (42 CFR 455.101) and (42 CFR 1001.1001)

1) **Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).
2) **Disclosing entity** means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.
3) **Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.
4) **Group of practitioner(s)** health care practitioner(s) who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).
5) **Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. It also means an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue (42 CFR 1001.1001). (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)
6) **Immediate family member** means a person's husband or wife; natural or adoptive parent; child or sibling; step-parent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild (42 CFR 1001.1001).
7) **Length of exclusion means**
    a) Except as provided in § 1001.3002(c), exclusions under this section will be for the same period as that of the individual whose relationship with the entity is the basis for this exclusion, if the individual has been or is being excluded
    b) If the individual was not excluded, the length of the entity's exclusion will be determined by considering the factors that would have been considered if the individual had been excluded.
    c) An entity excluded under this section may apply for reinstatement at any time in accordance with the procedures set forth in §1001.3001(a) (2).
8) ***Managed care entity*** *(MCE)* means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs. These terms are defined in 42 CFR § 438.2.
9) **Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.
10) **Member of household** means, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household (42 CFR 1001.1001).
11) **Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
b) Any Medicare intermediary or carrier; and
c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of,
health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

12) **Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity. It also means an interest in:
a) The capital, the stock or the profits of the entity, or
b) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

13) **Person with an ownership or control interest** means a person or corporation that:
a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e) Is an officer or director of a disclosing entity that is organized as a corporation; or
f) Is a partner in a disclosing entity that is organized as a partnership.

14) **Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $ 25,000 and 5 percent of a provider's total operating expenses.

15) **Subcontractor** means:
a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

16) **Supplier** means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

17) **Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

18) **Termination** means -
(1) For a-- (i). Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and (ii). Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. (2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. (3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to-- (i) Fraud; (ii) Integrity; or (iii) Quality.

Additional Definitions

1. **Federal health care program** means-- (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code [5 USCS §§ 8901 et seq.]); or (2) any State health care program, as defined in section 1128(h) [42 USCS § 1320a-7(h)].
2. [**42 USCS § 1320a-7b(f)] State health care program** means—
   (1) a State plan approved under title XIX [42 USCS §§ 1396 et seq.],
   (2) any program receiving funds under title V [42 USCS §§ 701 et seq.] or from an allotment to a State under such title,
   (3) any program receiving funds under subtitle 1 of title XX [42 USCS §§ 1397 et seq.] or from an allotment to a State under such
   subtitle, or
   (4) a State child health plan approved under title XXI [42 USCS § 1397aa et seq.].
3. **[42 USCS § 1320a-7(h)]**
   Affiliate or affiliated person means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another. It also includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve: (i) A compensation arrangement; (ii) An ownership arrangement; (iii) Managerial authority over any member of the affiliation; (iv) The ability of one member of the affiliation to control any other; (v) The ability of a third party to control any member of the affiliation; or (vi) any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a Medicaid/SCHIP provider, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.
4. **Affiliates** also means associated business concerns or individuals if, directly or indirectly -- (1) Either one controls or can control the other; or (2) A third party controls or can control both. **48 CFR 2.101**

How to Determine Ownership or Control Percentages (42 CFR §455.102)

(a) **Indirect ownership interest.** The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

(b) **Person with an ownership or control interest**. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Instructions for Completing the Vermont Medicaid Disclosure Form

Type or print clearly in ink. If applicant/provider must make corrections, please line through, date, and initial in ink. Do not use correction fluid. Do not leave any questions, boxes, or lines, blank, please use the provided options.

All sections/fields indicated by an asterisk* must be completed in their entirety. Please review thoroughly. Failure to provide the information required on this form will result in application packet being returned.

Section 1: *Provider Information

Provide information for currently enrolled provider if a change in ownership, managing employee or subcontractor occurs (must be within 35 days change). If a new provider, please indicate provider information from the Enrollment & Revalidation Enrollment Form (Billing Providers). Indicate if you are an Entity (Company, Firm or Corporation or if a Person [individual]).

Section 2: *Entity Information

If Entity selected in Section 1, please complete with applicable information.

Section 3: *Individual/Person Information

If Person is selected in Section 1, please complete with applicable information.

Section 4: *Contractual Relations

Indicate all applicable information regarding affiliation with provider.

Section 5: *Conviction/Sanction/Disclosure and Suspension/Debarment

All questions must be answered by either the Entity or Person. If **Yes,** fully explain details and include all supporting documentation from the licensing board or agency taking action. If you are not in good standing with respect to (or in full compliance with a plan to pay) any and all overdue taxes, specify why.

Section 6: *Declaration and Signature

All Entity or Person completing the form must complete this Section.

An original signature, in blue ink (which denotes authenticity) is required. Stamped, faxed, and/or photocopied signatures are *not* acceptable; application will be returned

**Asterisked sections must be completed. Failure to provide information and/or original signature, signed in blue ink (which denotes authenticity) will result in application being returned.*

A complete disclosure packet includes the following documents, when applicable:

- The Disclosure Form
- CLIA Certificate or copy of agreement/contract to use another facilities lab to render laboratory services
- All professional licenses, accreditations or certifications. If a professional license/certification has been revoked or suspended, include a copy of the licensing authority's decision(s) and written confirmation from them that privileges have been restored.
- All applicable documents include: the Enrollment & Revalidation form (Billing & Servicing Providers), if applicable.