STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

21st Century Cures Act Application for NJ FamilyCare Health Plan Organizational Application (Institution or Group)

Application package consists of:

1. Application Fee Requirements (required) - FD-451
2. Application Cover Letter
3. Provider Application - FD-22B
4. Provider Agreement - FD-62
5. Notice to Enrollee (documentation required) - FD-462
6. Affirmative Action Survey (optional) - FD-450
7. Agreement of Understanding - FD-435
8. Disclosure of Ownership and Control Interest Statement - FD-452

If you are an individual provider, and a Social Security Number is the primary means of identity, you may be requested to submit a copy of your Social Security Card.

If all components are present and complete, the 21ST Century Cures Act (Institutional/Group) Application may be approved for participation by Gainwell Technologies. The effective date of approval will be the date of the Provider Agreement.

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

Application Fee Requirements

The Patient Protection Affordable Care Act (PPACA) of 2010 (42 CFR 455 Subpart E, Section 424.514) requires that new and re-enrolling provider applicants who are identified as 'institutional' providers by the federal Centers for Medicare and Medicaid Services (CMS), remit to the State of New Jersey an application fee. The application fee for **Calendar Year 2024 is $709.00**. Additional information, as well as a complete list of 'institutional' providers required to remit an application fee, is enclosed with this Notice.

Only if you are identified as an institutional provider (see page 2) as of June 1, 2013 forward, will you be required to submit an application fee to the State of New Jersey. Non-institutional applicants will send enrollment packets directly to Gainwell Technologies as usual. A signed check, with this signed notice, a completed Application Fee Form (FEE Form 11/04/2020); and your completed enrollment packet should be mailed to:

Division of Revenue
Lockbox 656
200 Woolverton Ave. Bldg. 20
Trenton, NJ 08646
Attention: Processing Bureau

Make Checks payable to the "Treasurer, State of New Jersey."

Please note that if you have already paid an application fee to Medicare or another State Medicaid Agency, you are **not required** to remit another fee. Please send your completed enrollment application **directly to Gainwell Technologies** (address provided in enrollment packet) for processing along with **proof** of a prior payment to Medicare or another State Medicaid Agency.

_____ _____
Signature Date

_____
Print Name

Application Fee Requirements

1. The following are institutional providers identified by CMS and are required to pay the application fee:

    - 21st Century
    - Ambulatory Care Clinics
    - Ambulatory Surgical Centers
    - Cystic Fibrosis Clinics
    - Dispensing Optical Appliance Providers
    - Federally Qualified Health Centers
    - Freestanding End Stage Renal Dialysis Centers
    - Independent Laboratories
    - Mental Health/ Substance Abuse Clinics
    - Medicare Certified Home Health Agencies **ONLY**
    - Hospice Agencies
    - Hospitals - General, Special or Rehabilitation
    - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
    - Long-Term Care Facilities
    - Medical Supplies/DME Providers
    - Pharmacies
    - Portable X-Ray Providers
    - Prosthetics & Orthotic Providers (P&O)
    - Psychiatric Hospitals - Extended Stay
    - Psychiatric Hospitals - Short Term Stay
    - Transportation Providers (Ambulance Only)
    - Work First

2. The application fee shall be assessed for newly-enrolled and re-enrolled institutional providers and suppliers
3. The application fee shall be assessed for each service location at initial enrollment or with a change of ownership.
4. The application fee shall not be assessed annually.
5. The application fee shall be assessed for the re-enrollment (revalidation) of providers when the State initiates a re-enrollment process.
6. Hardship Exception for Disaster Areas: CMS will assess on a case-by-case basis whether institutional providers enrolling in a geographic area that is a Presidentially-Declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 USC 5121-5206 (Stafford Act), should receive an exception to the application fee. A request for a hardship exception to the application fee must be filed at the time the provider enrollment application is submitted.

Failure to submit an application fee or a hardship exception request shall result in an enrollment application being denied and/or billing privileges of a currently enrolled provider being revoked.

Application Fee Form

Please place this completed Fee Form on the top of your enrollment packet with your check payable to: "Treasurer, State of New Jersey"

*** Checks sent regular mail, certified mail, courier or Fedex should be sent to:**

Division of Revenue
Lockbox 656
200 Woolverton Ave. Bldg. 20
Trenton, NJ 08646
Attention: Processing Bureau

Applicant's Name: _____

Address: _____

Address: _____

Tax ID #: _____

NPI #: _____

SS #: _____

Check #: _____

Signature: _____

Print Name: _____

Contact Phone #: _____

***** Please note that sending your enrollment packet to Gainwell Technologies will slow down the enrollment process.

FD-451 (Fee Form 11/04/2020)

Application Cover Letter

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Dear Provider:

Your request for a Provider Specific Enrollment Packet has been received and documented. We are mailing you the packet of forms needed to meet enrollment requirements for your provider type. Please complete the forms and make sure all questions are answered; where not applicable, just enter N/A. Otherwise, there will be a delay in the enrollment process.

Other attachments required for your provider type are listed on the preceding page.

Your promptly completed enrollment packet will ensure a speedy enrollment process. If you have not received any correspondence within a month, please write to:

Provider Enrollment
Gainwell Technologies
P.O. Box 4804
Trenton, NJ 08650

Provider Enrollment Unit
609-588-6036

For Fiscal Agent Internal Use Only

Provider Name: _____

Doc Type: _____ Provider Type: _____ Provider Specialty: _____

NPI Number: _____ Social Security No.: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

21st Century Cures Act Application for NJ FamilyCare Health Plan Organizational Providers (Institution or Group)

Type of Business or Facility: ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____

Provider Type: _____ Office Telephone Number/Ext. _____

Legal Name: _____ Employer/Tax ID Number _____

Business Name (if different from above) _____

Name, Birth Date, Social Security #s of any administrators, agents and employees in managing positions: (use separate sheet if necessary), if applicable

a) _____

b) _____

c) _____

Physical Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Email Address: _____ Fax Number: _____

Taxonomy Code: _____ (if available)

IF APPLICABLE, APPLICANTS MUST REPORT THE FOLLOWING INFORMATION

***NPI Number: _____**

***IMPORTANT NOTE: The NPI reported should match the NPI reported to the Managed Care Organization.**

Medicare Provider No.: _____ Lab-CLIA No.: _____

Certification No.: _____ Type: _____ Certifying Entity: _____

State of Certification: _____

NJDCA Home Improvement Registration No.: _____

21st Century Cures Act Application for NJ FamilyCare Health Plan Organizational Providers (Continued)

You must attach a copy of all current License(s), Registration(s) and Board Certification(s) and complete the conviction/exclusion information and the provider certification on Page 4

Applicants completing this application are under no obligation to accept NJ FamilyCare (NJFC) fee-for-service (FFS) beneficiaries into their professional practice.

In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title.

Applicants approved as 21st Century Cures Act providers are not authorized to bill or receive NJFC FFS reimbursement from the State of New Jersey. However, providers may submit a full FFS application to receive such authorization if they so choose.

21st Century Cures Act providers are required to comply with all applicable State and federal laws, rules and regulations in regard to providing a healthcare service(s) to a NJFC beneficiary.

Final Adverse Actions /Convictions

The section below defines the convictions and final adverse actions that must be reported in this application regardless of whether any records were expunged or any appeals are pending.

Convictions:

1. Within the last 10 years preceding this application for enrollment or revalidation of enrollment, conviction for a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare or NJFC program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.

2. Any misdemeanor conviction, under Federal or State law, related to (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.

21st Century Cures Act Application for NJ FamilyCare Health Plan Organizational Providers (Continued)

3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.

4. Any felony or misdemeanor conviction under Federal or State law relating to the interference with or obstruction of any investigation of any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

1. Any revocation or suspension of a license by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.

2. Any revocation or suspension of accreditation.

3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

4. Any current Medicare payment suspension under any Medicare Identification Number.

5. Any Medicare revocation of any Medicare Identification Number.

Have you, under any current or former name or business identity, ever had any final adverse legal action(s) listed above under **Convictions, Exclusions**, **Revocations, or Suspensions** in this application, imposed against you? Yes ☐ No ☐

If yes, on a separate sheet of paper report each final adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Attach a copy of the final adverse legal action documentation and resolution.

21st Century Cures Act Application for NJ FamilyCare Health Plan Organizational Providers (Continued)

Provider's Certification:

Do you, under any current or former business identity, have uncollected debt, are or have been subject to payment suspension under a Federal health care program, or have had your billing privileges denied or revoked?

Yes ☐ No ☐ **(If YES, attach a detailed explanation)**

Have you, under any current or former business identity, have a current or former affiliation (directly or indirectly) with a provider of medical or other items or services or supplies, that has uncollected debt, has been or is subject to payment suspension under a Federal health care program, or has had its billing privileges denied or revoked?

Yes ☐ No ☐ **(If YES, attach a detailed explanation)**

I certify that the foregoing information provided in this application is true, accurate and complete and I also acknowledge that I understand that providing any false statement, or false document, or concealing any material facts may subject me to penalties and/or prosecution under applicable federal or state laws.

Also, by signing this application, I consent to a civil and criminal background check by DMAHS and/or by the Medicaid Fraud Division of the Office of the State Comptroller. I understand that if the results of this background check are unsatisfactory, the Division of Medical Assistance and Health Services may refuse an applicant's participation in the NJFC FFS program and the applicant's provider contract with the health plan may be terminated.

Provider's Signature Original Signature Required - No Stamps	Print Name	Date
Signature of Person Completing Form	Print Name	Date

Thank you for taking the time to enroll as a 21st Century Cures Act provider in the NJFC program as required by Federal regulations. Please mail the signed application with required documentation to:

Gainwell Technologies Provider Enrollment
P.O. Box 4804
Trenton, NJ 08650

You can also fax the completed application with credentials to: 609-584-1192.

If you have any questions, Gainwell Technologies Provider Enrollment can be reached at 609-588-6036.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____

PROVIDER NAME

PROVIDER AGREES:

1. To comply with all applicable State and Federal laws, policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish the DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Sections of both the Division of Criminal Justice and the State's Comptroller Office with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 2428 which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.107.

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c., or otherwise permitted or required by State or Federal Law.

The provider or DMAHS may, on 60 days written notice to the other party, terminate this Agreement without cause.

_____ _____

DATE SIGNATURE OF PROVIDER

_____

PRINT NAME AND TITLE

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

Notice to Enrollee(s)

In an effort to properly set-up the identity of an individual or an entity as a NJ Medicaid provider the Division requires that when a social security number is the primary means of identity you may be requested to submit a copy of your social card.

If you are an entity, you are required to submit a copy of your 147C letter from the IRS or copy of the IRS CP-575 form.

PLEASE BE ADVISED THAT YOUR APPLICATION TO BECOME A NJ MEDICAID PROVIDER CANNOT BE COMPLETED UNTIL WE HAVE RECEIVED A COPY OF THESE DOCUMENTS.

AFFIRMATIVE ACTION SURVEY (OPTIONAL)

Dear Provider:

The Department of Human Services, Division of Medical Assistance and Health Services, which administers the New Jersey Medicaid Program, is conducting an Affirmative Action Survey of its participating providers.

This survey is being used as a tool to better understand the diversity of our provider network and the needs of our clients. The completion of this survey is voluntary. The statistical data from this survey will be used for Affirmative Action purposes only and will be maintained separately from all other types of information.

Please refer to definitions below and check or fill in appropriate responses in space indicated:

From N.J.A.C. 4A:7-1.1(D):

"White, Not of Hispanic Origin"	Means persons having origins in any of the original Peoples of Europe, North Africa or the Middle East
"Black, not of Hispanic Origin"	Means persons having origins in any of the Black Racial Groups of Africa
"Hispanic"	Means persons of Mexican, Puerto Rican, Cuban, Central or South America or other Spanish Culture or origin, regardless of race.
"American Indian or Alaskan Native"	Means persons having origins in any of the original Peoples of North America, and who Maintain cultural identification through Tribal Affiliation Community Recognition.
"Asian or Pacific Islander"	Means persons having origins in any of the original Peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

1. How many direct service providers are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

2. How many of your support staff are of the following racial or ethnic background?

_____White _____Black _____Hispanic _____American Indian

_____Asian

3. How many of service provider(s) speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____
_____ _____
_____ _____

4. How many of the support staff speak the following languages?

_____English _____Spanish Please list language & numbers

_____ _____
_____ _____
_____ _____

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

SARAH ADELMAN
Commissioner

JENNIFER LANGER JACOBS
Assistant Commissioner

*Agreement of Understanding

To the Person Submitting this Enrollment Packet:

I understand that upon receipt of this enrollment packet to Gainwell Technologies, it becomes property of the State of New Jersey. The enrollment packet and any documents that are generated as result of the submission of this application, such as but not limited to, an enrollment letter or a denial letter are subjected to the Open Public Records Act (OPRA see NJSA Section 47:1A).

Before any documents are sent to someone requesting this information, all personal information such as tax Id and social security numbers would be redacted.

It is the responsibility of the person signing this Agreement of Understanding to convey this information to all of individuals who are named in this application to become a New Jersey Medicaid provider. Although the request for enrollment information is uncommon, it does fall under the Open Public Records Act.

I have read this Agreement of Understanding and acknowledge that once I submit these documents for processing that they will become property of the State of New Jersey.

Sign

Print

_____
Date

*A signed Agreement of Understanding is required before an application can be processed.

09/12/2023

INSTRUCTIONS FOR COMPLETING DMAHS DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Completion and submission of this form is a condition of participation, certification, or recertification in the programs administered in whole or in part by the Division of Medical Assistance and Health Services (DMAHS). A full and accurate disclosure of ownership and financial interest is required. This form must be updated within 35 days for any changes in ownership. Failure to provide the required disclosures may result in payments to the disclosing entity being recovered by DMAHS, and may result in DMAHS not authorizing an individual/entity to be a provider in the Medicaid/NJ FamilyCare program.

General Instructions

Please answer all questions as of the current date. If the YES line for any item is checked, list requested additional information under the Remarks section on the last page, referencing the item number to be continued. If additional space is needed use an attached sheet. Return the original to DMAHS and keep a copy for your files. This form may be required to be completed annually and must be completed when there is a change in ownership or control greater than or equal to 5%. Any substantial delay in completing the form may result in the individual/entity not being authorized to participate in the Medicaid/NJ FamilyCare program.

Definitions:

An "**Affiliation**" exists when a provider, owner, or managing employee/organization of the provider has been or is in one of the following roles within the previous 5 years with a currently or formerly enrolled Medicare, Medicaid/NJ FamilyCare or Children's Health Insurance Program (CHIP) provider that had a disclosable event described below:

1. A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization; or
2. A general or limited partnership interest, regardless of the percentage, that an individual or entity has in another organization; or
3. An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including sole proprietorships) either under contract or through some other arrangements, regardless of whether or not the managing individual or entity is a W-2 employee of the organization; or
4. An interest in which an individual is acting as an officer or director of a corporation; or
5. Any payment assignment relationship under 42 CFR 447.10(g).

"**Disclosable event**" means any of the following:

1. Currently has an uncollected debt to Medicare, Medicaid/NJ FamilyCare or CHIP regardless of
   a. The amount of the debt;
   b. Whether the debt is currently being repaid (for example, as part of a repayment plan); or
   c. Whether the debt is currently being appealed; or
2. Has been or is subject to a payment suspension under a federal health care program regardless of when the payment suspension occurred or was imposed; or
3. Has been or is suspended or excluded by the Office of Inspector General (OIG) from participation in Medicare, Medicaid/NJ FamilyCare, or CHIP; regardless of whether the suspension or exclusion is currently being appealed or when the suspension or exclusion occurred or was imposed; or
4. Has had its Medicare, Medicaid/NJ FamilyCare or CHIP enrollment or participation suspended, denied, revoked or terminated, regardless of:
   a. The reason for the suspension, denial, revocation, or termination;
   b. Whether the suspension, denial, revocation, or termination is currently being appealed; or
   c. When the suspension, denial, revocation, or termination occurred or was imposed.

"Disclosing entity" means a provider including a managed care entity, individual practitioner, group of practitioners, or a fiscal agent under any of the programs administered in whole or in part by DMAHS.

"Federal health care program" is

(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 5 USCS §§ 89015 USCS §§ 89015 USCS §§ 8901 et seq.; or

(2) Any State health care program, as defined in 42 USCS § 1320a-7(h).

"Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership in the disclosing entity and must be reported.

A **"Management Company"** is any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the business.

"Managing employee" means a general manager, business manager, administrator, director, trustee, 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.

"**Ownership interest**" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

"**Person with an ownership or control interest**" includes an individual or entity that:

1. Has an ownership interest totaling 5 percent or more in a disclosing entity; or
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; or
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; or
4. 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; or
5. Is an officer, director or trustee of a disclosing entity that is organized as a for-profit or not-for- profit corporation; or
6. Is a partner in a disclosing entity that is organized as a partnership.

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

"**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 fraud, integrity or quality.

(4) For purposes of an affiliation, situations in which the provider or affiliated provider or supplier voluntarily terminated its Medicare, Medicaid/NJ FamilyCare enrollment to avoid a potential revocation or termination. Other terms that may be used include "revoked," "revocation," or "terminated".

"**Uncollected Debt**" applies to the following:

1. Medicare, Medicaid/NJ FamilyCare, or CHIP overpayments for which CMS, OIG, DMAHS or the Medicaid Fraud Division (MFD) has sent notice of the debt to the affiliated provider or supplier; or
2. Civil money penalties imposed under Titles XVIII, XIX, XX, or XXI; or
3. Assessments imposed under Titles XVIII, XIX, XX or XXI

"**Undue Risk**" DMAHS in consultation with CMS determines whether any of the disclosed affiliations pose an undue risk of fraud, waste or abuse by considering the following factors:

1. The duration of the affiliation.
2. Whether the affiliation still exists, and if not, how long ago the affiliation ended.
3. The degree and extent of the affiliation.
4. If applicable, the reason for the termination of the affiliation.
5. Regarding the affiliated provider's or suppliers disclosable event, all of the following:
    a. The type of disclosable event.
    b. When the disclosable event occurred or was imposed.
    c. Whether the affiliation existed when the disclosable event occurred or was imposed.
    d. If the disclosable event is an uncollected debt –
        (1) The amount of the debt;
        (2) Whether the affiliated provider or supplier is repaying the debt; and,
        (3) To whom the debt is owed.
    e. If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.
6. Any other evidence that DMAHS or MFD deems relevant to its determination.

If a particular affiliation poses an undue risk of fraud, waste, or abuse, it may result in, as applicable, the denial of the provider's initial enrollment in Medicaid/NJ FamilyCare or CHIP or the termination of the provider's enrollment in Medicaid/NJ FamilyCare or CHIP.

Detailed Instructions:

These instructions are designed to clarify certain questions on the form. Instructions are listed in question number order for easy reference. NO instructions have been given for questions considered self-explanatory. It is essential that all applicable questions be answered accurately, completely and that all information is current.

Item I - Under identifying information, specify the trade name and D/B/A of the disclosing entity

Items II and III - Self-explanatory.

Items IV through IX - See below, and the definitions above.

For Items IV through IX, "YES" is checked, list additional information requested in the Remarks section on the last page of the application. Clearly identify which item is being continued on separate pages.

Item IV - (a & b) If there has been a change in ownership or control within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is YES, list the name of the management firm and employer identification number (EIN) or other tax identification number, or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the business.

Items VI, VII, VIII, and IX - Self-explanatory.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Nature of disclosing entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Limited Liability Company (LLC) ☐ Non-Profit Organization
☐ Unincorporated Association ☐ Other (please specify)_____

I. Identifying Information:

Name of Disclosing Entity:_____

Trade Name and D/B/A:_____

Business Address (Street, City, County, State & Zip Code):

_____

_____

_____

Telephone Number:_____

Provider Number and/or NPI:_____

EIN or Other Tax ID Number:_____

II. Answer the following questions by checking "YES" or "NO". If any of the questions are answered “YES”, list names and addresses of individuals or entities, and supporting details, under Remarks on the last page. Identify each item number to be continued.

(a). Are there any individuals, entities, or affiliated providers having a direct or indirect ownership or control interest of 5 percent or more in the disclosing entity that have been charged with or convicted of a state or federal criminal offense related to the involvement of such persons or entities in any of the programs administered in whole or in part by DMAHS, or any of the programs established in New Jersey or any other State, or by the federal government, under titles XVIII, XIX, XX or XXI of the Social Security Act?
☐ YES ☐ NO

(b). Are there any directors, officers, agents, managing employees, trustees, or affiliated providers of the disclosing entity who have ever been charged with or convicted of a state or federal criminal offense related to their involvement in the programs administered in whole or in part by DMAHS, or any of the programs established in New Jersey or any other State, or by the federal government, under titles XVIII, XIX, XX or XXI of the Social Security Act?
☐ YES ☐ NO

(c). Are there any individuals or affiliated providers currently employed by the disclosing entity in a managerial, accounting, auditing, or similar capacity who were employed by the disclosing entity's Medicare fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only) ☐ YES ☐ NO

III. (a). In accordance with 42 CFR 455.104(b)(1)(i), list the name and address of any individual or entity with an ownership or control interest in the disclosing entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(b). In accordance with 42 CFR 455.104(b)(1)(ii), for each individual, list the date of birth and Social Security Number.

(c). In accordance with 42 CFR 455.104(b)(1)(iii), for corporations or other entities with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a 5 percent or more ownership or control interest, list any other tax identification number.

Name	Address	Ownership or Control %	ID Number(s)	DOB (individuals only)
			SSN or Tax ID: NPI:	
			SSN or Tax ID: NPI:	
			SSN or Tax ID: NPI:	

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(d). In accordance with 42 CFR 455.104(b)(2), list whether any individual or entity with an ownership or control interest in the disclosing entity is related to another individual with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

or whether any individual or entity with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more ownership or control interest is related to another individual with ownership or control interest in the disclosing entity as a spouse, parent, child or sibling.

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(e). In accordance with 42 CFR 455.104(b)(3), list the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(f). In accordance with 42 CFR 455.104(b)(4), list the name, address, date of birth, and Social Security Number of any managing employee or agent(s) of the disclosing entity.

Name and Title	Address	DOB	SSN

*If you need extra space please continue list under Remarks on the last page, indicating item number to be continued.

(g). In accordance with 42 CFR 455.105(b)(1) and (2), submit full and complete information about the following:

(1) The ownership or control of any subcontractor with whom the disclosing entity has had business transactions totaling more than $25,000 during the previous 12 months;

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(2) Any significant business transactions between the disclosing entity and any wholly owned supplier, or between the disclosing entity and any subcontractor, during the previous 5 years.

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(h). Affiliates: In accordance with 42 CFR 455.107, if you are not currently enrolled in Medicare, and you are enrolling in Medicaid/NJ FamilyCare, you have had a change in ownership, or you are revalidating your Medicaid**/**NJ FamilyCare enrollment information, please disclose any and all affiliations which you or any of your owning or managing employees or organizations has or, within the previous five (5) years, had with a currently or formerly enrolled Medicare, Medicaid or NJ FamilyCare provider or supplier that has a disclosable event. See definitions on pages 1-3.

Affiliated Provider or Supplier (Name, Address and D/B/A)	Individual/Entity from Disclosing Entity with an affiliation	Ownership or Control %	Identification Number(s) or DOB	Individual or Entity's Role in Affiliated Provider or Supplier
			SSN or Tax ID: NPI: DOB (individuals only)	
			SSN or Tax ID: NPI: DOB (individuals only)	
			SSN or Tax ID: NPI: DOB (individuals only)	
			SSN or Tax ID: NPI: DOB (individuals only)	

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(i). Do any persons with an ownership or control interest in the disclosing entity also have an ownership or control interest in a health care provider participating in a program administered in whole or in part by DMAHS? If YES, list names, addresses, provider numbers and/or NPIs of those health care providers.
☐ YES ☐ NO

Name & Address	Provider Number and/or NPI	Name and Title of person with ownership or control interest	Ownership or Control %

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

Change in Ownership or Control

Changes in ownership or control would include, but not be limited to, the following: a new officer; a change in the composition of the owning partnership even though, under applicable State law, a change in the composition of the owning partnership is not considered a change in ownership; the hiring or dismissing of any employees with 5 percent or more financial interest in the entity or parent company; or any other change of ownership.

IV. (a) Has there been a change in ownership or control within the last year? ☐ YES ☐ NO

If YES, give date and describe:_____

_____

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(b) Do you anticipate any change of ownership or control within the next year?

☐ YES ☐ NO If YES, give date and describe:_____

_____

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

(c) Has the disclosing entity filed for bankruptcy in the past seven (7) years?

☐ YES ☐ NO If YES, when? _____

(d) Is there a possibility the disclosing entity will be filing for bankruptcy within the next year?

☐ YES ☐ NO If YES, when? _____

V. Is the disclosing entity operated or fiscally managed by a management company, or leased in whole or part by another organization? ☐ YES ☐ NO If YES, provide us with the name, address, and tax ID# of the management company or other organization.

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

VI. Has there been a change in the Managing Employees, Executive Director, Director of Nursing or Medical Director within the last year? ☐ YES ☐ NO If YES, describe change(s)

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

VII. (a) Is the disclosing entity a subsidiary of a parent company? ☐ YES ☐ NO
If YES, list its name, address, and EIN or other Tax ID.

(b) If the answer to Question VII(a) is NO, was the disclosing entity ever affiliated with a parent company? ☐ YES ☐ NO
If YES, list the name, address, and EIN or other Tax ID of the chain.

VIII. Has the disclosing entity increased its bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? ☐ YES ☐ NO

If YES, give year of change _____

Current number of beds: _____

Prior number of beds: _____

IX. Has disclosing entity or its affiliated providers been involved in a disclosable event as defined on PAGE 1? ☐ YES ☐ NO

If YES, List in detail all disclosable events. Identify the disclosable event, the individual, entity or affiliate involved in the event, and whether the event has been resolved and the outcome of the event.

Date	Individual/Entity Involved	NPI	Event	Debt Owed (amount & program)	Resolution (if any)

*If you need extra space please continue list under Remarks on the last page, indicating item to be continued.

CERTIFICATION

- For the purpose of establishing or maintaining eligibility to receive direct payment for services to beneficiaries under the New Jersey Medicaid/NJ FamilyCare program and the other programs administered in whole or in part by the Division of Medical Assistance and Health services (DMAHS), I certify on behalf of the applicant that the information furnished in this disclosure statement is true, accurate and complete.

- I am aware, and by signing this disclosure statement give consent on behalf of the applicant that I represent, that DMAHS, the Medicaid Fraud Division (MFD) of the Office of the State Comptroller, and/or the Medicaid Fraud Control Unit (MFCU) of the Division of Criminal Justice may verify the accuracy of any and all information and documentation submitted in connection with this disclosure statement, including, but not limited to, conducting a civil and/or criminal investigation relating to any of the individuals or entities mentioned in this application or in any supporting documents.

- I am aware that if any of the statements made by me in this disclosure statement are false or fraudulent, or if the results of the background investigation are unsatisfactory, participation may be denied or terminated, and I and the applicant are subject to punishment, including but not limited to: criminal prosecution under applicable statutes, including N.J.S. 30:4D-17 and N.J.S. 2C:28-3; suspension, debarment or disqualification from the New Jersey Medicaid/NJ FamilyCare program and all other programs administered in whole or in part by DMAHS in accordance with N.J.A.C. 10:49-11.1(d)22; termination of any provider agreement under N.J.A.C. 10:49-3.2(f); and recovery under applicable statutes and regulations including N.J.S. 30:4D-7.h and N.J.S. 30:4D-17.

- I also understand that all of the questions in this disclosure statement must be answered, and that failure to do so may result in denial or termination of participation.

- **I agree to notify (in writing) the fiscal agent's provider enrollment unit immediately of any updates or changes to any of the information being provided in this disclosure statement and in any supporting documents.**

- I also am aware that whoever knowingly and willfully makes or causes to be made a false statement or representation in this document may be prosecuted under applicable federal or state laws.

- Finally, I am aware that knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the disclosing entity already participates, a termination of its agreement or contract with the state agency, as appropriate.

Name of Authorized Representative of Disclosing Entity (Typed or Printed)	**Title**
Signature	**Date**

Remarks: (attach extra sheets if necessary)

Federal Regulations and NJSA Code Quoted in Provider Agreement

42 CFR 455.100

§ 455.100 Purpose.

This subpart implements sections 1124, 1126, 1902(a)(38), 1903(i)(2), and 1903(n) of the Social Security Act. It sets forth State plan requirements regarding--

(a) Disclosure by providers and fiscal agents of ownership and control information; and

(b) Disclosure of information on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services program.

The subpart also specifies conditions under which the Administrator will deny Federal financial participation for services furnished by providers or fiscal agents who fail to comply with the disclosure requirements.

42 CFR 455.101

§ 455.101 Definitions.

Affiliation means, for purposes of applying § 455.107, any of the following:

(1) A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

(2) A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

(3) An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W-2 employee of the organization.

(4) An interest in which an individual is acting as an officer or director of a corporation.

(5) Any payment assignment relationship under § 447.10(g) of this chapter.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosable event means, for purposes of § 455.107, any of the following:

(1) Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of -

(i) The amount of the debt;

(ii) Whether the debt is currently being repaid (for example, as part of a repayment plan); or

(iii) Whether the debt is currently being appealed;

(2) Has been or is subject to a payment suspension under a federal health care program (as that latter term is defined in section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed;

(3) Has been or is excluded by the OIG from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed; or

(4) Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked or terminated, regardless of -

(i) The reason for the denial, revocation, or termination;

(ii) Whether the denial, revocation, or termination is currently being appealed; or

(iii) When the denial, revocation, or termination occurred or was imposed.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

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.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

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.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

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.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing 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.

Prepaid ambulatory health plan (PAHP) has the meaning specified in § 438.2.

Prepaid inpatient health plan (PIHP) has the meaning specified in § 438.2.

Primary care case manager (PCCM) has the meaning specified in § 438.2.
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.

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.

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).

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.

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.

42 CFR 455.102

§ 455.102 Determination of ownership or control percentages.

(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.

42 CFR 455.103

§ 455.103 State plan requirement.

A State plan must provide that the requirements of §§ 455.104 through 455.107 are met.

42 CFR 455.104

§ 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.

(a) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must--

(i) Keep copies of all these requests and the responses to them;

(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.

(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

42 CFR 455.105

§ 455.105 Disclosure by providers: Information related to business transactions.

(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.

(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.

(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR 455.106

§ 455.106 Disclosure by providers: Information on persons convicted of crimes.

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

42 CFR 455.107

§ 455.107 Disclosure of affiliations.

(a) *Definitions.* For purposes of this section only, the following terms apply to the definition of disclosable event in § 455.101:

(1) "Uncollected debt" only applies to the following:

(i) Medicare, Medicaid, or CHIP overpayments for which CMS or the State has sent notice of the debt to the affiliated provider or supplier.

(ii) Civil money penalties imposed under this title.

(iii) Assessments imposed under this title.

(2) "Revoked," "Revocation," "Terminated," and "Termination" include situations where the affiliated provider or supplier voluntarily terminated its Medicare, Medicaid, or CHIP enrollment to avoid a potential revocation or termination.

(b) *General.* (1)(i) *Selection of option.* A State, in consultation with CMS, must select one of the two options identified in paragraph (b)(2) of this section for requiring the disclosure of affiliation information.

(ii) *Change of selection.* A State may not change its selection under paragraph (b) of this section after it has been made.

(2)

(i) *First option.* In a State that has selected the option in this paragraph (b)(2)(i), a provider that is not enrolled in Medicare but is initially enrolling in Medicaid or CHIP (or is revalidating its Medicaid or CHIP enrollment information) must disclose any and all

affiliations that it or any of its owning or managing employees or organizations (consistent with the terms "person with an ownership or control interest" and "managing employee" as defined in § 455.101) has or, within the previous 5 years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event (as defined in § 455.101).

(ii) *Second option.* In a State that has selected the option in this paragraph (b)(2)(ii), and upon request by the State, a provider that is not enrolled in Medicare but is initially enrolling in Medicaid or CHIP (or is revalidating its Medicaid or CHIP enrollment information) must disclose any and all affiliations that it or any of its owning or managing employees or organizations (consistent with the terms "person with an ownership or control interest" and "managing employee" as defined in § 455.101) has or, within the previous 5 years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event (as defined in § 455.101). The State will request such disclosures when it, in consultation with CMS, has determined that the initially enrolling or revalidating provider may have at least one such affiliation.

(c) *Information.* The initially enrolling or revalidating provider must disclose the following information about each affiliation:

(1) General identifying information about the affiliated provider or supplier, which includes the following:

(i) Legal name as reported to the Internal Revenue Service or the Social Security Administration (if the affiliated provider or supplier is an individual).

(ii) "Doing business as" name (if applicable).

(iii) Tax identification number.

(iv) National Provider Identifier (NPI).

(2) Reason for disclosing the affiliated provider or supplier.

(3) Specific data regarding the affiliation relationship, including the following:

(i) Length of the relationship.

(ii) Type of relationship.

(iii) Degree of affiliation.

(4) If the affiliation has ended, the reason for the termination.

(d) *Mechanism.* The information described in paragraphs (b) and (c) of this section must be furnished to the State in a manner prescribed by the State in consultation with the Secretary.

(e) *Denial or termination.* The failure of the provider to fully and completely report the information required in this section when the provider knew or should reasonably have known of this information may result in, as applicable, the denial of the provider's initial enrollment application or the termination of the provider's enrollment in Medicaid or CHIP.

(f) *Undue risk.* Upon receipt of the information described in paragraphs (b) and (c) of this section, the State, in consultation with CMS, determines whether any of the disclosed

affiliations poses an undue risk of fraud, waste, or abuse by considering the following factors:

(1) The duration of the affiliation.

(2) Whether the affiliation still exists and, if not, how long ago the affiliation ended.

(3) The degree and extent of the affiliation.

(4) If applicable, the reason for the termination of the affiliation.

(5) Regarding the affiliated provider's or supplier's disclosable event under paragraph (b) of this section, all of the following:

(i) The type of disclosable event.

(ii) When the disclosable event occurred or was imposed.

(iii) Whether the affiliation existed when the disclosable event occurred or was imposed.

(iv) If the disclosable event is an uncollected debt -

(A) The amount of the debt;

(B) Whether the affiliated provider or supplier is repaying the debt; and

(C) To whom the debt is owed.

(v) If a denial, revocation, termination, exclusion, or payment suspension is involved, the reason for the disclosable event.

(6) Any other evidence that the State, in consultation with CMS, deems relevant to its determination.

(g) *Determination of undue risk.* A determination by the State, in consultation with CMS, that a particular affiliation poses an undue risk of fraud, waste, or abuse will result in, as applicable, the denial of the provider's initial enrollment in Medicaid or CHIP or the termination of the provider's enrollment in Medicaid or CHIP.

(h) *Undisclosed affiliations.* The State, in consultation with CMS, may apply paragraph (g) of this section to situations where a reportable affiliation (as described in paragraphs (b) and (c) of this section) poses an undue risk of fraud, waste, or abuse, but the provider has not yet disclosed or is not required at that time to disclose the affiliation to the State.

N.J. Stat. § 30:4D-6.c.

c. Payments for the foregoing services, goods and supplies furnished pursuant to this act shall be made to the extent authorized by this act, the rules and regulations promulgated pursuant thereto and, where applicable, subject to the agreement of insurance provided for under this act. Said payments shall constitute payment in full to the provider on behalf of the recipient. Every provider making a claim for payment pursuant to this act shall certify in writing on the claim submitted that no additional amount will be charged to the recipient, his family, his representative or others on his behalf for the services, goods and supplies furnished pursuant to this act.

No provider whose claim for payment pursuant to this act has been denied because the services, goods or supplies were determined to be medically unnecessary shall seek reimbursement from the recipient, his family, his representative or others on his behalf for such services, goods and supplies provided pursuant to this act; provided, however, a provider may seek reimbursement from a recipient for services, goods or supplies not authorized by this act, if the recipient elected to receive the services, goods or supplies with the knowledge that they were not authorized.