Government of the Virgin Islands of the United States

DEPARTMENT OF HUMAN SERVICES

Medicaid Division

United States Virgin Islands Department of Human Services

Provider Enrollment Manual

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1.0 Introduction

The Provider Enrollment Manual presents an overview of the minimum requirements that participating providers must meet to enroll in and be reimbursed by the U.S. Virgin Islands (VI) Medicaid Program. VI Medicaid participating providers include individual practitioners, institutional providers, and providers of medical equipment or goods and services related to the provision of health care.

2.0 Enrollment Categories

Enrollment is the process Medicaid uses to establish a provider's eligibility to participate in the Medicaid program and submit claims for Medicaid-covered services and supplies. The process includes:

1. Identifying a provider or supplier
2. Validating the provider's or supplier's eligibility to provide items or services to Medicaid members
3. Identifying and confirming the provider's or supplier's service locations and owners
4. Granting the provider or supplier Medicaid billing privileges

There are four types of enrollment processes:

- **Initial Enrollment:** when a provider has not previously been enrolled with the VI Medicaid Program.
- **Reenrollment:** when a provider has been enrolled with the VI Medicaid Program and was voluntarily disenrolled (terminated, deactivated, or otherwise removed). These providers must submit a new enrollment application.
- **Reactivation:** when a provider was enrolled and was involuntarily disenrolled by Medicaid.
- **Revalidation:** when a provider must update enrollment information. Providers must revalidate every three to five years, depending on the risk category. Providers will be notified when they are scheduled to revalidate. Failure to provide complete revalidation will result in termination of the provider's participation.

3.0 Provider Enrollment Requirements

The Affordable Care Act (ACA) and related regulations at 42 CFR 455 specify enhanced requirements for Medicaid agencies' provider enrollment and screening practices. The VI Medicaid Program and providers must comply with these federal regulations and the Centers for Medicare & Medicaid Services (CMS) Medicaid Provider Enrollment Compendium (MPEC), and any additional USVI requirements. Section 1902(a)(27) of the Social Security Act (SSA) provides general authority for the VI Medicaid Program to require provider agreements with every entity providing services under the State Plan requirements.

Providers may enroll as individual providers, corporations, limited liability corporations (LLCs), hospitals, or rendering providers. All group practices must comply with USVI law applicable to group and corporate practice. All rendering practitioners (i.e., providers who are providing services and directly bill Medicaid) and ordering, referring, and prescribing (ORP) practitioners, even if they do not bill Medicaid directly, must be enrolled as participating providers to be eligible for reimbursement of services.

The VI Medicaid Program is responsible for screening and enrolling providers into the program.

Enrolled providers, under their license and scope of practice, may be eligible to participate and receive reimbursement for services provided to Medicaid members when they:

- Have a valid signed provider enrollment application/agreement on file with the VI Medicaid Program
- Meet and remain in compliance with provider enrollment requirements
- Meet all federal requirements related to provider screening and enrollment

The required screening measures vary according to the provider's categorical risk level of "limited," "moderate," or "high" under 42 CFR 455 and 42 CFR 424.518. All screening includes mandatory disclosures related to ownership and controlling interests and information about disclosing entities, fiscal agents, or managed care entities. Screening for providers in the high-risk categories also includes site visits. The site visit requirement may be waived if Medicare has conducted a recent visit. Site visits may be conducted for low and moderate risk providers in exceptional circumstances. Screening for high risk also includes fingerprint-based background checks. All providers are screened against State and federal databases to ensure no provider is enrolled who is not deemed eligible based on federal and State criteria. A provider will not be enrolled, re-enrolled, reactivated, or revalidated until all screening activities applicable to that provider are completed.

3.1 High Categorical Risk

In accordance with 42 CFR 424.518, the following provider types who are enrolling are assigned to high categorical risk:

- Home health agencies

- DME suppliers
- Opioid treatment programs that have not been fully and continuously certified by the Substance Abuse and Mental Health Services Agency (SAMHSA) since October 23, 2018
- Skilled Nursing Facilities
- Hospice

Under 42 CFR 450(e), the Medicaid agency must adjust the categorical risk level from “limited” or “moderate” to “high” when any of the following occurs:

- The Medicaid agency imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse, the provider has an existing Medicaid overpayment, or the provider has been excluded by the Office of the Inspector General (OIG) or another State's Medicaid program within the previous 10 years.
- In the previous six months, the Medicaid agency or CMS lifted a temporary moratorium for the particular provider type, and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

Renewals of license and/or certification must be current, and providers must submit the documentation for inclusion in the provider record. A provider’s Medicaid participation may be terminated if no current license/certification is on file.

As a part of the federally required revalidation process, providers must verify their enrollment information and update the required disclosures at predetermined intervals. If a provider has been screened by Medicare or another State’s Medicaid or Children’s Health Insurance Program (CHIP) program within the previous three to five years, depending on risk category, information from that screening that demonstrates that federal requirements have been met, the VI Medicaid Program may accept this information. The provider will still need to upload the required documents through the provider enrollment portal.

Additional requirements may apply. Off-cycle revalidations may be carried out by the VI Medicaid Program when warranted by the situation. This could include random checks indicating health care fraud, complaints, national initiatives, etc.

The VI Medicaid Program will comply with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse actions.

4.0 Enrollment of Practice Location and Type

Facility and group providers can enroll in the VI Medicaid Program with one National Provider Identifier (NPI) or multiple NPIs for each location they want to receive payment for the services rendered at that facility. Facility and group providers with multiple locations will be enrolled under the facility billing/Pay-To provider record. All services provided will be paid to the primary facility's billing and Pay-To provider record.

Enrollment of a new or additional practice location includes a site visit when the provider falls into the high-risk category.

A separate provider enrollment form or agreement may be necessary for certain services when provided as a different provider type.

5.0 Practitioners Eligible for Enrollment

Individual licensed practitioners generally eligible for enrollment in the VI Medicaid Program to provide Medicaid-covered services within their scope of practice include, but are not limited to:

- Physicians, advanced practice registered nurses, and physician assistants
- Psychologists, social workers, counselors, and behavioral analysts
- Pharmacists
- Audiologists and speech, physical, and occupational therapists
- Opticians and optometrists
- Podiatrists
- Dental providers
- Chiropractors
- Personal care attendants

Facilities and organizations that may enroll include, but are not limited to:

- Hospitals
- Federally Qualified Health Centers (FQHCs)
- Physical and mental health clinics
- Home health agencies
- Hospice
- Independent labs and radiology
- Dialysis centers
- Ambulances and non-emergency transportation providers

There may be some restrictions related to covered services or levels of licensure/certification related to enrollment of providers in these categories. Most individual providers may enroll as billing and/or rendering providers. However, some providers, such as advanced practice registered nurses, may only be enrolled as rendering providers.

Under 42 CFR 455.410, all ordering/referring/prescribing practitioners (ORPs) (i.e., providers who may be writing prescriptions or referring members, but are not directly billing Medicaid) must be enrolled as participating providers, including those working at hospitals. Any services ordered/referred/prescribed by a practitioner not enrolled in the VI Medicaid Program will not be reimbursed.

When an ORP is eligible to enroll, providers cannot submit claims with an organizational NPI (Type 2) instead of that individual's NPI (Type 1). For example, if a hospital submits a claim with the hospital's NPI in the ordering/referring claim field and the services were ordered, referred, or prescribed by a provider type that is eligible to enroll in the VI Medicaid Program, the claim is not compliant with 42 CFR 455.440 and will be denied.

6.0 Provider Enrollment Application Process

Health care providers who are currently licensed, certified, accredited, or registered under USVI law, or under another state or territory's law where their practice is located, may apply for enrollment in the VI Medicaid Program. Submission of an enrollment application does not guarantee enrollment, and not all provider types are eligible for enrollment in the Medicaid program.

Applicants must complete all required fields, sign, and submit all applicable forms. Proof of current licensure, certification, accreditation, or registration meeting the VI Medicaid Program provider enrollment criteria must also be submitted as applicable.

By signing the enrollment form, the applicant agrees to comply with all applicable laws, regulations, and policies of the VI Medicaid Program. This includes Title XIX of the SSA, the Code of Federal Regulations (CFR), the USVI Medicaid State Plan, and all applicable territory and federal laws, standards, guidelines, and program instructions.

Provision of false information or failure to disclose required information during the application process may result in denial of participation, and the case may be referred to the appropriate legal authority.

Provider Enrollment Operations can be contacted as follows:

USVIProviderEnrollment@gainwelltechnologies.com

5328 Yacht Haven Grande, Unit 21
St. Thomas, USVI 00802-5008

833-579-9299 (toll free)

6.1 Health Care Provider Numbers

A health care provider must have an NPI to enroll and bill for services to Medicaid members. If the provider is not eligible for an NPI under National Provider and Plan Enumeration System (NPPES) rules, the VI Medicaid Program may assign an atypical provider identifier (API). In addition, the enrollment process may require additional identification numbers, such as, but not limited to, Social Security Number, Federal Employer Identification Number (FEIN), Medicare Identification Number, Drug Enforcement Administration (DEA) number, and Clinical Laboratory Improvement Amendments (CLIA) number.

6.1.1 National Provider Identifier

All eligible providers **must** obtain an NPI based on the NPPES criteria. Providers can apply for an NPI online at the NPPES website at https://nppes.cms.hhs.gov. Individual providers will get a single NPI (Type 1) and an organization will be assigned an organizational NPI (Type 2). Type 2 NPIs are assigned to organizations that render health care services, are

group practices, or furnish health care supplies to patients. Individual NPIs may be associated with more than one organizational NPI and must be associated with all organizations for whom they provide services.

Entities with subparts must have an NPI for each subpart as defined by NPPES. It may be necessary for providers with multiple service locations to obtain additional NPI numbers for each location providing differing services. Sole proprietors must have only one NPI regardless of the number of locations.

The NPI of the provider who ordered or referred items and/or services must be present on all claims.

6.1.2 Atypical Provider Identifier (API)

An Atypical Provider Identifier (API) will be assigned by the VI Medicaid Program to providers that do not meet NPPES criteria to obtain an NPI number. An atypical provider is an individual or organization that provides non-traditional services that are indirectly healthcare related. An example of a provider that should be assigned an API is lodging. If an NPI is available, the provider is required to obtain one.

6.1.3 Medicare Identification Number and Enrollment

Medicare enrollment is a prerequisite for USVI Medicaid enrollment if a provider renders Medicare covered services for members enrolled in Medicare. A Medicare provider must have their Medicare identification number(s) on file with the VI Medicaid Program. This will help expedite prompt and accurate payment for services rendered to Medicaid members who are also eligible for Medicare benefits. For these “dual eligible” members, Medicare is the primary payer, and Medicaid is the secondary payer, as explained in the General Information Chapter, Section 8.

Additionally, to ensure accurate claims processing, providers must notify the USVI Medicaid Program through the provider portal of any change to their Medicare identification number or any Medicare identification number received after Medicaid enrollment. Erroneous or missing Medicare numbers may result in denials and inaccurate or delayed Medicaid payments.

7.0 Disclosures

Federal regulations require all Medicaid providers to disclose complete information regarding individuals or entities that own, control, represent, or manage them. This requirement applies to all provider types that are either enrolling or revalidating as a Medicaid provider – regardless of business structure (e.g., large corporation, partnership, non-profit).

Disclosures are due:

- Upon provider application
- Upon executing the provider enrollment agreement
- Within 35 days of being requested by the Medicaid agency
- During the revalidation enrollment process
- Within 35 days after any change in ownership of the disclosing entity

When disclosures are required, the enrollment application must capture both direct and indirect owners.

8.0 Information on Ownership and Control

Under 42 CFR 455.104, providers must submit the following information:

- The name and address of each person (individual or corporation) with an ownership or control interest in the disclosing entity or in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more. The percentage of ownership interest will be based on the federal regulation at 42 CFR 455.102. The address for corporate entities must include, as applicable, the primary business address, every business location, and P.O. Box addresses, if any.
- Date of birth and Social Security Number of all individuals subject to disclosure.
- Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.
- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
- The name, address, date of birth, and Social Security Number of any managing employee or member of the Board of Directors of the disclosing entity.

Medicaid reports any ownership discrepancies noted between the provider application and the information on file in the CMS Provider Enrollment, Chain, and Ownership System (PECOS) to CMS. An email is sent to CMS that includes specific provider demographic information and the ownership information reported to the VI Medicaid Program.

9.0 Information on Persons Convicted of Crimes

Under 42 CFR 455.106, providers must disclose the identity of any person who:

- Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
- Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XXI services program since the inception of those programs.

This information must be disclosed before any enrollment activity or at any time upon the Medicaid program's written request. These disclosures and any related provider enrollment action(s) will be provided to the OIG.

10.0 Licensure

A health care provider must maintain a valid license/certification number in the state(s) and territories where they practice. In addition, the health care provider might have to satisfy other credentialing requirements. **It is the responsibility of the provider to ensure that licensing or certification information is kept current.**

A provider's participation in the VI Medicaid Program may be suspended or terminated if the current status of the provider's credentials cannot be verified.

10.1 Provider-Specific Requirements

Application requirements may vary by provider type. While the items described above are generally common to all provider types, there might be additional specific requirements. For example, non-emergency transportation providers must show liability insurance other than malpractice, vehicle registration, drivers' licenses, etc.

A separate provider enrollment form or agreement may be necessary for certain services when they are provided under a different provider type

11.0 Denial of Enrollment

Under 42 CFR 455.416 the VI Medicaid Program **must** deny or terminate a provider's enrollment if any of the following conditions exist:

- Any person with a 5% or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.
- Any person with a 5% or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or Title XXI program in the last 10 years, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and the Medicaid agency documents that determination in writing.
- Any provider that is terminated on or after January 1, 2011, under Title XVIII of the Act or under the Medicaid program or CHIP of any other State.
- If the provider or a person with an ownership or controlling interest, or who is an agent or managing employee of the provider, fails to submit timely or accurate information, unless the Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the Medicaid agency documents that determination in writing.
- If the provider, or any person with a 5% or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Medicaid agency within 30 days of a CMS or a Medicaid agency request, unless the Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the Medicaid agency documents that determination in writing.
- If the provider fails to permit access to provider locations for any site visits under § 455.432, unless the Medicaid agency determines that termination or denial of enrollment is not in the best interests of the Medicaid program and the Medicaid agency documents that determination in writing.

In accordance with 42 CFR 455.416, the VI Medicaid Program may deny or terminate a provider's enrollment in the program:

- If it is determined that the provider has falsified any information on the application; or
- The identity of any provider applicant cannot be verified.

A provider may also be denied enrollment when:

- The applicant previously failed to correct deficiencies in the operation of a business or enterprise after receiving written notice of the deficiencies from a state or federal

licensing or auditing agency. For example, failure to correct a deficiency in a State-licensed facility that would pose a threat of harm to its patients;

- One or more factors exist that directly impair the applicant's ability to render quality health care to Medicaid members, including actions by persons employed by or affiliated with the provider; or
- The applicant's Medicaid participation was suspended in another state.

A provider may reapply for participation at any time after the cause of the denial is remedied. Additionally, a provider may appeal the denial of enrollment as described in Section 14: Appeals.

12.0 Mandatory Exclusions

All providers are screened against State and federal databases to assure no provider is enrolled who meets federal or state criteria for exclusion. Section 1128(a) of the SSA and 42 U.S.C. 1320a–7 mandates the following individuals and entities **must** be excluded from participation in federal health care programs:

1. Conviction of program-related crimes: Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII of this chapter or under any State health care program.
2. Conviction relating to patient abuse: Any individual or entity that has been convicted, under federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
3. Felony conviction relating to health care fraud: Any individual or entity that has been convicted for an offense that occurred after August 21, 1996, under federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
4. Felony conviction relating to controlled substance: Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

13.0 Permissive Exclusions

Section 1128(a) of the SSA and 42 U.S.C. § 1320a–7 allows the following individuals and entities to be excluded from participation in federal health care programs. The VI Medicaid Program excludes individuals meeting these criteria, except in special circumstances verified with appropriate documentation.

1. Conviction relating to fraud. Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under federal or State law—

    (A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

        (i) in connection with the delivery of a health care item or service, or

        (ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

    (B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any federal, State, or local government agency.

2. Conviction relating to obstruction of an investigation or audit. Any individual or entity that has been convicted, under federal or State law, in connection with the interference with or obstruction of any investigation or audit related to—

    (i) any offense described in paragraph (1) or in subsection (a);

    (ii) the use of funds received, directly or indirectly, from any federal health care program (as defined in section 1128B(f)).

3. Misdemeanor conviction relating to controlled substance. Any individual or entity that has been convicted, under federal or State law, of a criminal offense consisting of a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

4. License revocation or suspension. Any individual or entity—

    (A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license or the right to apply for or renew such a license, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional performance, or financial integrity.

5. Exclusion or suspension under federal or state health care program. Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under—

   (A) any federal program, including programs of the Department of Defense or the Department of Veterans Affairs, involving the provision of health care, or

   (B) a State health care program, for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.

6. Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services. Any individual or entity that the Secretary determines—

   (A) has submitted or caused to be submitted bills or requests for payment (where such bills or requests are based on charges or cost) under Title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's usual charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

   (B) has furnished or caused to be furnished items or services to patients (whether or not eligible for benefits under Title XVIII or under a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

   (C) is—

      (i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under Title XIX, or

      (ii) an entity furnishing services under a waiver approved under section 1915(b)(1), and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under Title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

   (D) is an entity providing items and services as an eligible organization under a risk–sharing contract under section 1876 and has failed substantially to provide

medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk–sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

7. Fraud, kickbacks, and other prohibited activities. Any individual or entity that the Secretary determines has committed an act which is described in section 1128A, 1128B, or 1129.

8. Entities controlled by a sanctioned individual. Any entity with respect to which the Secretary determines that a person—

   (A)

   (i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity,

   (ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity; or

   (iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—is a person—

   (B)

   (i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

   (ii) against whom a civil monetary penalty has been assessed under section 1128A or 1129; or

   (iii) who has been excluded from participation under a program under Title XVIII or under a State health care program.

9. Failure to disclose required information. Any entity that did not fully and accurately make any disclosure required by section 1124, section 1124A, or section 1126.

10. Failure to supply requested information on subcontractors and suppliers. Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary or by the State agency administering or supervising the administration of a State health care program—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five–year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

11. Failure to supply payment information. Any individual or entity furnishing, ordering, referring for furnishing, or certifying the need for items or services for which payment may be made under Title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

12. Failure to grant immediate access. Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

    (A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

    (B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

    (C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

    (D) To a State Medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

13. Failure to take corrective action. Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

Default on health education loan or scholarship obligations. Any individual whom the Secretary determines is in default on repayments of scholarship obligations or loans in connection with health professions education made or secured, in whole or in part, by the Secretary and with respect to whom the Secretary has taken all reasonable steps available to the Secretary to secure repayment of such obligations or loans, except that (A) the Secretary shall not exclude pursuant to this paragraph a physician who is the sole community physician or sole source of essential specialized services in a community if a State requests that the physician not be

excluded, and (B) the Secretary shall take into account, in determining whether to exclude any other physician pursuant to this paragraph, access of members to physician services for which payment may be made under Title XVIII or XIX.

14. Individuals Controlling a Sanctioned Entity.

    (A) Any individual—

    a. who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

    b. who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

    (B) For purposes of subparagraph (A), the term “sanctioned entity” means an entity—

    a. that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

    b. that has been excluded from participation under a program under Title XVIII or under a State health care program.

15. Making false statements or misrepresentations of material facts. Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of Title XVIII, prescription drug plan sponsors under part D of Title XVIII, Medicaid managed care organizations under Title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.

14.0 Appeals

Providers who are denied participation or have their participation with the VI Medicaid Program terminated have appeal rights. Requests for reconsideration of provider enrollment denials may be submitted to Provider Enrollment Operations. Additional information about the appeal process is described in the VI Medicaid Program Provider Manual, General Information Chapter, Section 5.7.4.

When the VI Medicaid Program terminates a provider based on another state's termination, the appeal of the termination will only address whether the provider was in fact terminated by the initiating program, not the reasons for the original decision.

For the purpose of determining if a provider has been terminated by another state or Medicare, the provider is only considered terminated when they have:

- Exhausted appeal rights, or
- The timeline for appeal has expired.

Pending final determination of termination status, providers may be suspended and prohibited from billing. Licensing agencies determine whether a provider may continue to provide services.

15.0 Moratoria

Under federal regulations, CMS and Medicaid agencies may impose moratoria on the enrollment of specific provider types. Access to care must be considered prior to imposing a Medicaid moratorium. For Medicaid agency-imposed moratoria, CMS will be notified of the details in writing.

16.0 Maintenance of Provider Information

The information that a provider submits at enrollment may change as time passes. Participating providers must notify the VI Medicaid Program immediately of changes. Changes can be submitted through the provider portal. These changes include, but are not limited to:

- Provider name
- Provider pay-to, physical, and mailing address
- Change in banking information (electronic fund transfer (EFT))
- Provider office telephone number
- Provider legal status or practice name
- License or certification status
- Medicare provider identification number
- Practice ownership, including mergers, acquisitions, or consolidations
- Tax identification number
- Addition or termination of a location
- Closing a practice due to retirement, bankruptcy, or other reason
- Addition or loss of a practitioner
- Email address
- Any criminal conviction
- Other pertinent information

Failure to notify the VI Medicaid Program may result in denied or delayed Medicaid payments, as well as lost or delayed correspondence or other communication.

17.0 Change of Ownership

In accordance with 42 CFR 489.18, the VI Medicaid Program defines a change in ownership as follows:

- **Partnership:** In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law.
- **Unincorporated Sole Proprietorship:** Transfer of title and property to another party.
- **Corporation:** The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. **Note**: Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a change of ownership.
- **Leasing:** The lease of all or part of a provider facility constitutes a change of ownership of the leased portion.

A change in ownership automatically cancels the selling provider's enrollment in the VI Medicaid Program. The new provider must enroll in the VI Medicaid Program to participate. In addition, the prior owner must reenroll if they start a new practice independently or form a group.

New disclosures are required within 35 days of a change of ownership.

If the VI Medicaid Program learns via any means of an unreported change of ownership, it will immediately request a new enrollment application. If the new owner fails to submit a new enrollment application within the latter of the change of ownership or 30 days after the request, the VI Medicaid Program will stop payments to the provider. Payments may be resumed upon receipt of the completed enrollment application.

18.0 Voluntary and Involuntary Disenrollment

A provider's participation in the VI Medicaid Program may be discontinued voluntarily or involuntarily.

18.1 Voluntary Disenrollment

Providers may voluntarily disenroll by mailing a signed letter on the provider's letterhead to the VI Medicaid Program Provider Enrollment Unit. A provider must give at least 30 days' notice before terminating their participation. In all cases, the letter of disenrollment must include the provider's NPI/API and specify a termination date. The letter must have the provider's original signature.

In the case of an emergency that renders the provider unable to continue as a Medicaid provider, the VI Medicaid Program must be notified as soon as possible. The notice should include a brief explanation of the reason for disenrollment and must be signed by the provider or the provider's legal representative.

18.2 Involuntary Disenrollment/Termination

The VI Medicaid Program may terminate a provider's enrollment for one or more of the following reasons, including but not limited to:

- Breach of the provider agreement;
- Demonstrated inability to perform under the terms of the provider agreement;
- Failure to comply with applicable territory and federal laws;
- Loss of license or certification;
- Failure to comply with the VI Medicaid Program's regulations and policies;
- Involuntary termination of participation in Medicare, another State Medicaid, or CHIP program; or
- Medicaid inactivity for three consecutive years.

The VI Medicaid Program conducts ongoing screening against federal and State databases to help ensure continuing compliance with federal and State criteria for exclusion.

19.0 Retroactive Enrollment

In the case of retroactive enrollment for FQHCs, the retroactive FQHC enrollment will be effective on the date of the FQHC's Health Resources and Services Administration (HRSA) or CMS approval, not before.

Retroactive enrollment for all other providers is subject to review and approval by the Medicaid program under 42 CFR §431.108. The provider must supply all information requested by the Medicaid program, including all reasons justifying the request for retroactive enrollment, as well as proof of any required licensure or certification for the period. A request for retroactive enrollment is subject to the Medicaid program's review and discretion and is not a guarantee of claim payment or prior authorization. The Medicaid program may grant retroactive enrollment back to the Medicare certification date but will not grant a retroactive enrollment date that is more than three hundred and sixty-five (365) days prior to the date of the provider's application submission.

Revision History

The revision history identifies the document version number, date, changes made to the document, and a brief description of revisions applied.

Table 1: Version History

Document Version #	Date	Revisions Applied
1.0	February 2026	Initial Publication