Sec. 17b-262-524. Provider participation

(a) To enroll in the Medical Assistance Program and receive payment from the department for the provision of goods or services to Medical Assistance Program clients, providers shall:

(1) Meet and maintain all applicable licensing, accreditation and certification requirements;

(2) meet and maintain all departmental enrollment requirements including the timely submission of a completed provider enrollment or reenrollment form and submission of all enrollment information and such affidavits as the department may require; and

(3) have a valid provider agreement on file which is signed by the provider and the department. This agreement, which shall be periodically updated, shall continue to be in effect for the duration specified in the agreement. The provider agreement specifies conditions and terms that govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Additionally, the department shall at its discretion:

(1) Require documentation or other information necessary to ensure that requirements for enrollment in a type of service and specialty have been met pursuant to all applicable statutes and regulations;

(2) require that an out-of-state or border provider submit such supplemental documentation as it requires in the event their licenses, certificates, permits or other credentials do not disclose the required information, or if the criteria for attainment of such credentials is different from similarly situated in-state providers;

(3) require submission of a schedule of charges to the general public or any other pertinent data or information necessary to facilitate review of new or existing services;

(4) approve or disapprove enrollment or reenrollment of any provider based upon the department's requirements. The department in its sole discretion shall determine whether the provider meets the requirements for enrollment;

(5) deny initial enrollment or reenrollment of any provider when such enrollment or reenrollment is determined not to be in the best interests of the Medical Assistance Program;

(6) deny enrollment or reenrollment of any provider who does not offer coverable Medical Assistance Program goods or services regardless of whether the provider meets all other enrollment requirements; and

(7) enroll out-of-state providers if they provide services to clients who are out-of-state in accordance with section 17b-262-532 of the Regulations of Connecticut State Agencies.

(c) At the discretion of the department, out-of-state providers shall be eligible for enrollment or reenrollment into the Medical Assistance Program based on documentation of current enrollment in the Medical Assistance Program in another state.

(d) Failure by the provider to submit any required documents or information for reenrollment, at such times and in such a manner as the department shall require, may result in the loss of the provider's eligibility to participate in the Medical Assistance Program.

(e) Specific enrollment requirements for provider types and specialties are set forth in the Regulations of Connecticut State Agencies dealing with the specific provider type and specialty. The department in accordance with the governing Regulations of Connecticut State Agencies shall, in its sole discretion, determine the category of provider type and

specialty into which a provider falls.

(f) For purposes of this section, the terms "institution" or "general hospital" include (1) any wholly or partially owned subsidiary of the institution or general hospital; (2) any entity that is related to the institution or general hospital, including, but not limited to, a parent company, or wholly or partially owned subsidiary of the institution or general hospital; and (3) any other entity, such as a partnership, that is established by (A) the institution or general hospital or (B) any entity related to the institution or general hospital, including a parent company and its wholly or partially owned subsidiaries.

(g) Notwithstanding any provisions of the Regulations of Connecticut State Agencies or any medical services policy, any provider who is (1) compensated directly or indirectly by an institution or general hospital or (2) located within an institution or general hospital, which includes being located in an institution or general hospital complex, campus or auxiliary or satellite location, may bill the department for services rendered to the provider's medical assistance program private practice clients who receive services at the institution or general hospital location if all of the following criteria are met:

(1) The provider maintains a practice at a location other than the location which is within the institution or general hospital complex, campus or auxiliary or satellite location;

(2) the provider is enrolled as a medical assistance program provider at the location that is separate from the institution or general hospital location and actively bills, as determined by the department, the Medical Assistance Program for services rendered at that separate location;

(3) the operations of the provider are entirely separate and independent from the institution or general hospital. The department considers the operations of a provider as entirely separate and independent if the following criteria are met:

(A) the provider does not utilize space that is directly or indirectly owned by the institution or general hospital unless the space is rented at fair market value;

(B) the provider and provider staff do not receive compensation in any form from the institution or general hospital for any reason for clinical services at the institution or general hospital;

(C) the provider and the institution or general hospital do not share administrative and support staff; and

(D) the provider and the institution or general hospital have no direct or indirect relationship relative to ownership or control;

(4) any direct and indirect costs associated with the services performed by the provider or provider staff are not included in the annual cost report of the institution or general hospital; and

(5) the provider has performed an evaluation and management service for the client at its separate location within the previous year.

(h) Notwithstanding the criteria identified in subdivision (3) of subsection (g) of this section, the provider may bill if the provider can demonstrate to the satisfaction of the department that the arrangements between the provider and the institution or general hospital do not result in duplication of payments. Evidence of lack of duplication of payments may include, but is not limited to, a copy of the provider-facility contract.

(i) Notwithstanding the requirements of subsections (g) and (h) of this section, a medical

foundation established pursuant to sections 33-182aa to 33-182ff, inclusive, of the Connecticut General Statutes may bill the department for goods or services provided to Medical Assistance Program clients only after obtaining the department's approval. In order to obtain such approval, and as requested by the department from time to time, the medical foundation shall demonstrate, to the department's satisfaction, that mechanisms are in place to ensure that there will be no duplicate billing to or payment by the department relating to the provision of such goods or services. Not later than three months after the medical foundation begins billing the department, and as requested by the department from time to time, the medical foundation shall demonstrate to the department that no such duplicate billing in fact occurs. Duplicate billing includes, but is not limited to, claims for costs associated with related party transactions among the medical foundation, the hospital and any other related party, as defined in subsection (o) of section 17b-262-531 of the Regulations of Connecticut State Agencies.

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