POLICY AND PROCEDURE MANUAL

SUBJECT Disclosure of Ownership	ACCOUNTABILITY NMRE, NMRE BOD, NMRE Provider Network	Effective Date: February 27, 2019	Pages: 3
REQUIRED BY	BBA Section: 42 CFR 438.610/455.100-455.106 PIHP Contract Section: Section 34 Other:	Last Review Date:	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: Provider Network Manager	Responsible Department: Provider Network	Reviewers:

Definitions

Agent: Any person who has been delegated the authority to obligate or act on behalf of the Entity.

CMHSP: Community Mental Health Services Program. For the purposes of this document, a CMHSP is one or more of the following: AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

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

Family Member(s): For this policy, family members include spouses, parents, children, or siblings.

Fiscal Agent: Contractor that processes or pays vendor claims on behalf of the Disclosing Entity.

Indirect Ownership Interest: An ownership interest in an entity that has an ownership interest in the disclosing entity or in an entity that has an indirect ownership interest in the disclosing entity.

Managing Employee: 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.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

Other Disclosing Entity: 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 Social Security 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 Social Security Act.

Ownership or Control Interest: An individual or corporation that:

a. Has an ownership interest totaling five percent (5%) or more in a disclosing entity;
b. Has an indirect ownership interest equal to five percent (5%) or more in a disclosing entity;
c. Has a combination of direct and indirect ownership interests equal to five percent (5%) of more in a disclosing entity;
d. Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) 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.

Subcontractor: An individual or entity that has a contract with the NMRE/CMHSP entity that relates directly or indirectly to the performance of the NMRE/CMHSP entity's obligations under its contract with the State.

Purpose

Federal regulations require Medicaid Providers, Fiscal Agents, and Managed Care entities to comply with all requirements to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. NMRE/CMHSP will ensure that all contracts, agreements, purchase orders, leases to obtain space, supplies, equipment, and services are also in compliance with federal and state requirements.

Policy

It is the policy of the NMRE to ensure compliance with all requirements to:

- Collect, maintain, and disclose information about individuals with ownership or control interests;
- Identify and report any additional ownership or control interests by those individuals in other entities, including family members with ownership or control interests;
- Report disclosures of all applicable criminal offenses and convictions of state and federal health care program-related crimes, and
- Ensure NMRE/CMHSP contractors have policies and processes in place to comply with these regulations.

Approval Signature

4/11/24

NMRE Chief Executive Officer

Date

SUBJECT Disclosure of Ownership	ACCOUNTABILITY NMRE, NMRE BOD, NMRE Provider Network	Effective Date: February 27, 2019	Pages: 4
REQUIRED BY	BBA Section: 42 CFR 438.610/455.100-455.106 PIHP Contract Section: Section 34 Other:	Last Review Date:	Past Review Date:
Policy: ☐ Procedure: ☒	Review Cycle: Annual Author: Provider Network Manager	Responsible Department: Provider Network	Reviewers:

Procedure

A. NMRE/CMHSP will require disclosure statements for:

1. Any Subcontractor who receives $25,000 or more per year.
2. NMRE/CMHSPs require each applicable subcontractor to identify their "managing employee(s)" in policy or procedure. NMRE/CMHSPs define their managing employees as: Chief Executive Officer (CEO/Executive Director), Chief Financial Officer, and Chief Operating Officer, where applicable.
3. All applicable Disclosing Entities.
4. NMRE/CMHSP Board Members.

B. Disclosure requirements

1. For subcontractors and disclosing entities:
   a. Name and address of any person (individual or corporation) with an ownership or control interest in the entity. The address for corporate entities must include as applicable primary business address, every business location, and PO Box address.
   b. Date of birth and full Social Security Number of each person with an ownership or control interest in the entity.
   c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the entity.
   d. The name, address, date of birth, and full Social Security number of any managing employee of the entity.
   e. The identity of any individual who has ownership or control interest in the entity or is an agent or managing employee of the entity and 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.

2. Additional entries for disclosing entities only:
   a. Other tax identification number (in the case of a corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest.

b. 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 family member, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a family member.
c. The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.

3. For entities without ownership (e.g. NMRE/CMHSP), include the following required information:
   a. Name and address of the disclosing entity. The address must include primary business address, every business location, and P.O. Box location.
   b. Other tax identification number of the disclosing entity, if applicable.
   c. The name, address, date of birth, and full Social Security number of all managing employees and Governing Board members of the disclosing entity.
   d. Disclosure of ownership or controlling interest in any other provider entity, subcontractor, or wholly owned supplier.
   e. Disclosure of criminal convictions, sanctions, exclusions, debarment and termination.

4. Time of Disclosure. Any entity must furnish a disclosure statement at any of the following times:
   a. When a provider submits a provider application (including credentialing process);
   b. Upon execution of agreement or contract;
   c. During re-credentialing or re-contracting;
   d. Within 35 days of any change in the ownership of an entity;
   e. Every three years if there is no material change.

B. Contract Language

NMRE/CMHSP requires contractors, through written agreements, to have processes for obtaining attestation of criminal convictions and full disclosure of ownership statements identified in 42 CFR Part 455 Subpart B. Contractors must also have procedures to report to NMRE/CMHSP any individuals with criminal convictions described under 1128(a) and 1128(b)(1), (2) or (3) of the Social Security Act, or individuals that have had civil monetary penalties or assessments imposed under section 1128A of the Social Security Act.

C. Monitoring

NMRE/CMHSP will conduct a search of all required databases at the time of hire or contract and monthly thereafter for as long as the individual or entity is employed or under contract. The database searches will also be performed monthly on all entities and on any individuals with ownership or control interest identified on the disclosure form. Network Providers will communicate all database search matches to NMRE/CMHSP within three business days of discovery. Network Providers shall demonstrate evidence of monthly searches and findings, upon request, and at least annually, as part of the annual performance and compliance review. NMRE/CMHSP ensures all contractors have a process for obtaining attestation of criminal convictions and full disclosures (identified in 42 CFR Part 455 Subpart B) from managing employees, Governing Board members, individuals with beneficial ownership, and individuals with an employment, consulting, or other

arrangement with the contractor or subcontractor. The NMRE will monitor for compliance no less than once every year.

D. Reporting Criminal Convictions

CMHSPs and/or Network Providers will notify NMRE within three business days when disclosures are made by subcontractors about those offenses detailed in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or that have had civil money penalties or assessments imposed under section 1128A of the Social Security Act. NMRE will notify the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Program Development, Consultation and Contracts of any applicable disclosures immediately upon notification.

E. Failure to Comply

Failure to fully complete the disclosure form as required within 35 days of request, or the submission of false or misleading information to NMRE/CMHSP or a Network Provider, will be subject to contractual sanctions up to and including immediate suspension of funding and termination of the contractual agreement.

F. CMS Direction on Collection of Disclosures

Based upon privacy and security concerns, including data breaches that include personally identifiable information (PII), a provider that is performing services on behalf of the state Medicaid plan should not be required to disclose PII to multiple entities. Additionally, to mitigate the risk that PII will be compromised in a data breach, PII should be stored in the fewest number of locations necessary to meet the requirement of the regulations.

Other Related Policies

NMRE Social Security Number Privacy
NMRE Credentialing/Recredentialing
NMRE Excluded Provider Checks

Other References

42 CFR 455.100-455.106
Medicaid Provider Enrollment Compendium (MDEC), 1.4.1.A.1.a pg. 25
Social Security Number Privacy Act, MCL 454 of 2004; Sections 1128(a) and 1128 (b) (1) (2), or (3)

ATTACHMENTS

NMRE Disclosure Blank Statement

Approval Signature

NMRE Chief Executive Officer

4/11/24

Date

Disclosure of Ownership, Controlling Interest, and Management Statement

Prepaid Inpatient Health Plans (PIHPs) must comply with federal regulations to obtain, maintain, disclose, and furnish required information about ownership and control interests, business transactions, and criminal convictions as specified in 42 CFR §455.104-106. As a PIHP, Northern Michigan Regional Entity (NMRE) is required to collect disclosure of ownership, controlling interest and management information from providers that participate in the Medicaid and/or the Children's Health Insurance Program (CHIP) managed care network pursuant to a Medicaid and/or CHIP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with an ownership or controlling interest; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of mangers and others in a position of influence or authority; and 4) criminal conviction, sanction, exclusion, debarment, or termination information for the provider, owners, and managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN), and tax identification number (TIM).

Completion and submission of this Statement is a condition of participation in the Medicaid and/or CHIP managed care network and is a contractual obligation with NMRE (PIHP) for services to members under Medicaid and CHIP benefit plans. Failure to submit the requested information may result in denial of a claim, a refusal to enter into a provider contract, or termination of existing provider contracts.

This Statement should be submitted with the initial contract and updated every three (3) years or at the renewal of the contract and at any time there is a revision to the information, change in ownership, or upon request for updated information. A statement must be provided within 35 days of a request for this information. Physician and health care professional members of a group practice that are credentialed or enrolled into the Medicaid or CHIP managed care program by NMRE (PIHP) or by a delegate of NMRE (PIHP) must submit a signed Individual Provider Statement attesting to the requirements under these regulations at the time of credentialing, enrollment, or contracting, if requested by NMRE (PIHP) or by a delegate of NMRE (PIHP). ***Any members of a group practice that have an ownership or controlling interest in that Provider as defined below or is related to another owner or person with a controlling interest in that Provider, must submit a signed Individual Provider Statement.***

*NMRE maintains policies and practices that protect the confidentiality of personal information, including social security numbers, obtained from its providers and associates in the course of its regular business functions. NMRE is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which sections those attachments refer.

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. If the form is unreadable, the form will not be processed. *These fields cannot be left blank; "NA" or "applied for" are acceptable responses.

As applicable, if Provider is a medical group or facility, attach a roster of individual providers covered under this Statement. Please include provider name, address, date of birth, and social security number.

I. Contracted Provider Information *(**all** complete this section)*

Type of Entity *(choose appropriate category)*	**Name of Person Completing the Form**
___ Individual Contracted Practitioner ___ Individual Member of a Medical Group*	
___ Partnership ___ Non-Profit	**Title**
___ Corporation ___ Government/Public Entity	**Phone Number**
___ Fiscal Agent ___ Other: _____	**Fax**
*If affiliated with a Group, do you have a Private Practice as well? ___ Yes ___ No	**Email**

Legal Name (***"Provider Entity"):***	**DBA Name** (if different from Provider Legal Name):
Complete address *(must include at least one street address; corporations must include the primary business and every business location and **PO Box address**)*: **Street** **City** **State** **Zip**	
Additional Addresses *(list **all** Practice locations and PO Box addresses – attach a separate sheet if necessary)*:	

****Federal Tax ID#/SS#:**	***Medicaid ID#:**	***National Provider ID (NPI)#:**	**CAQH#:**

****These fields cannot be left blank; "NA" non-applicable and "applied for" are acceptable responses. **Individual providers please use social security number; field cannot be left blank: "NA" non-applicable and "applied for" are acceptable responses.***

II. Provider Entity Ownership Information

Are there any individuals or organizations/corporations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? ___ Yes ___ No

If Yes, list the name, title, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Provider Entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and PO Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater (42 CFR 455.104). ***Attach additional sheets if necessary***.

Name of Owner	**Title**	**DOB** (mm/dd/yyyy)	**Complete Address** (Street/City/State/ZIP)	**SSN** (individual) and/or **TIN** (Organization) *List both as applicable*	**% Interest**

III. Ownership in Other Providers & Entities

Do any of the **Owners** (not including parties with only a control interest) *identified in **Section II*** have an Ownership or Controlling Interest in any other provider or entity that would qualify as a **disclosing** entity? ___ Yes ___ No

If Yes, list the name of the other disclosing entity in which the **Owner** identified in **Section II** also has an Ownership or Controlling Interest {42 CFR §455.104(b)(3)}. ***Attach additional sheets as necessary. See Glossary for definition.***

Name of Owner from Section II	**Name of Other Disclosing Entity**	**% Interest**

IV. Subcontractor Ownership

Does the Provider Entity have an ownership or controlling interest of 5% or more in any subcontractor? Yes No

If Yes to the previous question, does any other individual or organization also have an ownership or controlling interest in the same contractor? ___ Yes ___ No (if **Yes**, list information below; if **No** go on to **Section V**)

List the name and percent of ownership for any Subcontractor, along with the name and percent of ownership for each individual or organization (identified in Section II or otherwise), and TIN if organization, with an Ownership or Controlling Interest in that Subcontractor {42 CFR §455.104(b)(iii)}

Legal Name of Subcontractor	**Name of Owner from Section II or other Owner** (*if applicable*)	**Tax ID#** (*if Organization*)	**% Interest**

V. Familial Relationships of All Owners

Are any of the individual identified in **Sections II** or **IV** related to each other? Yes No

If Yes, list the individuals identified and the relationship to each other (e.g., spouse, domestic partner, sibling, parent, child) {42 CFR §455.104(b)(2)}

Name of Owner 1	Name of Owner 2	Relationship

VI. Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations*

1. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity, ever been convicted of a criminal offense described under section 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act, or had civil money penalties or assessments imposed under section 1128A of the Social Security Act since the inception of those programs? ___ Yes ___ No
If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name		
DOB	**SSN** (individual) or **TIN** (entity)	**State of Conviction**
Complete Address (Street/City/State/Zip)		
Matter of the Offense		
Date of the Conviction (mm/dd/yyyy)	**Date of Reinstatement** (mm/dd/yyyy)	

2. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **sanctioned**, **excluded**, or **debarred** from Medicaid, Medicare, CHIP, or Title XX program since the inception of those programs? ___ Yes ___ No
If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name	
DOB (mm/dd/yyyy)	**SSN** (individual) or **TIN** (entity)
Complete Address (Street/City/State/Zip)	
Reason for Termination	

Date of Termination (mm/dd/yyyy)	**State that Originated Termination**	**Date of Reinstatement** (mm/dd/yyyy)	**Terminated from Medicare?** ___ Yes ___ No

3. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program since January 1, 2011? {42 CFR §455.416(c)} ___ Yes ___ No
If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name	
DOB (mm/dd/yyyy)	**SSN** (individual) **TIN** (entity)
Complete Address (Street/City/State/Zip)	
Reason for Termination	

Date of Termination (mm/dd/yyyy)	**State that Originated Termination**	**Date of Reinstatement** (mm/dd/yyyy)	**Terminated from Medicare?** ___ Yes ___ No

At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments, and terminations (see Fed. Register, Vol. 44, No. 138).

VII. Business Transaction Information**

1. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? ____ Yes ____ No

   If Yes, list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12-month period ending on the date of this request {42 CFR §455.105(b)(1)} ***Attach additional sheets as necessary. See Glossary for definition.***

Name of Subcontractor		**Subcontractor's SSN** (individual) or **TIN** (entity)	
Subcontractor's Street Address	**City**	**State**	**Zip Code**
Name of Subcontractor's Owner		**Subcontractor's Owner's SSN** (individual) or **TIN** (entity)	
Subcontractor's Owner's Street Address	**City**	**State**	**Zip Code**

2. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or %5% of operating expenses in the past five (5) year period? ___ Yes ____ No

   If Yes, list the information for Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period {42 CFR §455.105(b)(2)} ***Attach additional sheets as necessary. See Glossary for definition***.

Name of Supplier		**Supplier's SSN** (individual) or **TIN** (entity)	
Supplier's Street Address	**City**	**State**	**Zip Code**

3. Significant Business Transactions – Subcontractors: Has the Provider Entity had any Significant Business Transactions with a Subcontractor exceeding the lesser of $25,000 or 5% of operating expenses in the past five (4) year period?

   ____ Yes ____ No

   If Yes, list the information for Subcontractors with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period {42 CFR §455.105(b)(2)} ***Attach additional sheets as necessary. See Glossary for definition.***

Name of Subcontractor		**Subcontractor's SSN** (individual) or **TIN** (entity)	
Subcontractor's Street Address	**City**	**State**	**Zip Code**
Name of Subcontractor's Owner		**Subcontractor's Owner's SSN** (individual) or **TIN** (entity)	
Subcontractor's Owner's Street Address	**City**	**State**	**Zip Code**

This information must be provided and/or updated within 35 days of a request. Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105).

VIII. Management & Control

1. **Managing Employees:** Does the Provider Entity have any Managing Employees? ____ Yes ____ No
   If Yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct The day-to-day operations of the Provider Entity (general manager, business manager, administrator, director, or other individual), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). ***Attach additional sheets as necessary.***

Name	**DOB** (mm/dd/yyyy)	**Complete Address** (Street/City/State/Zip)	**SSN**	**Title**

2. **Agents:** Does the Provider Entity have any Agents? ____ Yes ____ No
   If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of the Provider Entity, including the name, date of birth (DOB), address, and Social Security Number (SSN) (42 CFR §455.104). ***Attach additional sheets as necessary.***

Name	**DOB** (mm/dd/yyyy)	**Complete Address** (Street/City/State/Zip)	**SSN**	**Title**

3. **Board of Directors:** Does the Provider Entity have a Board of Directors? ____ Yes ____ No
   If Yes, list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR 455.104). ***Attach additional sheets as necessary.***

Name	**DOB** (mm/dd/yyyy)	**Complete Address** (Street/City/State/Zip)	**SSN**	**Title**

Approval

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Northern Michigan Regional Entity (NMRE) are screened with the applicable background check including, but not limited to, verification against the Office of the Inspector General's (OIG) List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index.asp) and the Systems for Award Management (SAM) www.sam.gov and any applicable state, federal, or other governmental exclusion or sanction databases and that the information provided herein is true, accurate, and complete. Additions or revisions to the information contained in this document and its attachments, as applicable, will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature _____ Title (indicate if authorized Agent) _____

Full Name (please print) _____ Date _____

Telephone Number _____ Fax Number _____ Email Address _____

Instructions for Disclosure of Ownership, Controlling Interest, and Management Statement

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. (For example: Section II Ownership Information, continued). Please see Glossary for definition of capitalized terms.

Section II: Provider Entity Ownership Information
Please list the required information for each individual or organization that has an Ownership or Controlling Interest of 5% or more in your entity. If the Owner is a Corporation, the primary business address may be listed as well as every business location and PO Box address. Provider members of a group practice who have ownership or controlling interest in the Provider Entity must submit a separate Statement.

Providing the Social Security Number (SSN) and Tax Identification Number (TIN) (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1977, amended Section 1124, and the Federal Register Vol. 76, No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section III: Ownership in Other Providers & Entities
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section II that has an **Ownership** (*does not include anyone with a Controlling Interest*) in your entity. This information is to identify shared and interconnect ownership and controlling interest.

Section IV: Subcontractor Ownership
If your entity has an Ownership or Control Interest in 5% or more in a Subcontractor, please identify the Subcontractor and provide the required information, as well as any other individuals or entities who also have an Ownership or Control Interest of 5% or more in that same Subcontractor.

Section V: Familial Relationships of All Owners
Report whether any of the persons listed in Sections II, III, and IV are related to each other and identify the parties and their relationship. For a definition of "domestic partner," refer to your state's laws. Provider members of a group practice who are related to the Provider Entity's owners or those with a controlling interest must submit a separate Statement.

Section VI: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations

List your own criminal convictions, exclusions, sanctions, debarments, ***and*** terminations, and for any person who has an ownership or controlling interest or is an agent or managing employee of your entity. List all offenses as described under sections 1128(a), and 1128(b)(1), (2), or (3) of the Social Security Act, and any civil money penalties or assessments imposed under section 1128A of the Social Security Act since the inception of those programs. Review all the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at http://oig.hhs.gov/exclusions/indes.asp
2. Sanction information is available in the GSA's System for Award Management (SAM) database at www.sam.gov.
3. State specific exclusion/sanctions databases may be accessed through the State Agency's website.

Section VII: Business Transaction Information

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transaction*** between your entity and any Wholly Owned Supplier during the past five years.
3. List any ***Significant Business Transaction*** between your entity and any Subcontractor during the past five years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year. This information must be available within thirty-five (35) days of a request by the US Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

Section VIII: Management & Control

1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.List the required information for all individuals on the governing board or Board of Directors if your entity is organized as a corporation. The Centers for Medicare and Medicaid (CMS) requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

Glossary

Agent: Any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: Child Health Insurance Program, the federal insurance program for children. In Michigan, this is known as MIChild.

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% of the stock in a corporation that owns 80% of the stock of the disclosing entity, "A's" interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if "B" owns 80% of the stock of a corporation that owns 5% of the stock of the disclosing entity, "B's" interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

b) To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the for an individual with an ownership or control interest, 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% of a note secured by 60% of the provider's assets, "A's" interest in the provider's assets equates to 6% and must be reported. Conversely, if "B" owns 40% of a note secured by 10% of the provider's assets, "B's" interest in the provider's assets equated to 4% and need not be reported.

Direct Ownership Interest: The possession of equity in the capital, the stock, or the profits of the disclosing entity.

Managing Employee: A general manager, business manager, administrator, director, or the 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.

Other Entity: 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, XX, of the Social Security 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.

Ownership or Control Interest: Any individual or corporation that –

a) Has an ownership interest totaling five percent (5%) or more in a disclosing entity

b) Has an indirect ownership interest equal to five percent (5%) or more in a disclosing entity;

c) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in a disclosing entity;

d) Owns and interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) 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.

Provider Entity: An individual or entity that operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

Significant Business Transaction: Any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand dollars ($25,000) or five percent (5%) of a Provider Entity's total operating expenses.

Subcontractor: An individual, agency, or organization –

a) to which a Provider Entity had contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b) with which a fiscal agent entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

Wholly Owned Supplier: A Supplier that has its total ownership interest held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.