Region 10 PIHP & St. Clair County Community Mental Health

Conflict of Interest Attestation – Provider Entity

Disclosure of Ownership, Controlling Interest and Management Statement

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. PIHPs are 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 a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.15; 3) the identity of managers and others in a position of influence of authority; and 4) criminal conviction 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 (TIN).

Completion and submission of a *Disclosure Statement* is a condition of participation in the Medicaid and/or CHIP managed care network and is a contractual obligation with Region 10 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 annually prior to the contract renewal period, and at any time there is a revision to the information, change in ownership, or upon a request for updated information. A Statement must be provided within 30 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 Region 10 PIHP or by a delegate of Region 10 PIHP must submit a signed *Individual Provider Statement* attesting to the requirements under these regulations at the time of credentialing, or contracting, if requested by Region 10 PIHP or by a delegate of Region 10 PIHP. ***Any members of a group practice that have ownership or controlling interest in the Provider Entity identified below or is related to another owner of the Provider Entity, must submit a signed Individual Provider Statement.***

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 section those attachments refer.

Contracted Provider Entity Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will not be processed and will be returned for corrections/completeness. If the form is unreadable due to illegible handwriting, the form will not be processed.

As applicable, if Provider Entity 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.

Type of disclosing entity: **Please choose the appropriate category:** ☐ **Partnership** ☐ **Non-Profit** ☐ **Corporation** ☐ **Limited Liability Corporation (LLC)** ☐ **Government/Public Entity** ☐ **HCBS Provider** ☐ **Other: _____**	**Name of Person Completing the Form** **Title** **Phone Number** **Fax** **Email**
Legal Name ("Provider Entity")	**DBA Name (if different from Provider Entity Legal Name)**
Complete Address (must include at least one street address; corporations must include the primary business address *and* every business location and P.O. Box address): **STREET:** **CITY** **STATE** **ZIP**	
Additional Addresses (list all Practice locations – attach a separate sheet if necessary):	

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

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

CONFLICT OF INTEREST ATTESTATION

Section I: Provider Entity Ownership Information

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

If yes, list the name, primary address, date of birth (DOB), personal phone number, 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 P.O. 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 as necessary.]*

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

***SSN and TIN required under §455.104; see Sect 4313 of Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No. 22*

Section II: Ownership in Other Providers & Entities

Does the Provider Entity's Owner identified in **Section I** have an Ownership or Controlling Interest in any other provider or entity? ☐Yes ☐No

If yes, list the name and the SSN or TIN of the **other provider or entity** in which the Owner identified in **Section I** also has an Ownership or Controlling Interest. (42 CFR §455.104(b)(3)). *[Attach additional sheets as necessary.]*

Name of Owner from Section I	Name of Other Provider or Entity	Other Provider or Entity's SSN (individual) or TIN (entity)

Section III: Subcontractor Ownership

Does the Provider Entity have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐Yes ☐No

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? ☐Yes ☐No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity also has Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104). *[Attach additional sheets as necessary.]*

Legal Name of Subcontractor			
Name of Subcontractor's Other Owner			
Other Owner's Complete Address (Street/City/State/ZIP)			
Other Owner TIN	**Other Owner SSN**	**Other Owner DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**
Legal Name of Subcontractor			
Name of Subcontractor's Other Owner			
Other Owner's Complete Address (Street/City/State/ZIP)			
Other Owner TIN	**Other Owner SSN**	**Other Owner DOB (mm/dd/yyyy)**	**% Interest in Subcontractor**

Section IV: Familial Relationships of All Owners

Are any of the individuals identified in Section I, II, or III 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)). *[Attach additional sheets as necessary.]*

Name of Owner 1:	Name of Owner 2:	Relationship

Are any members of the group related to the listed owners or those with a controlling interest? ☐Yes ☐No

If yes, list the following information for each group provider member related to the listed owners and those with a controlling interest. *[Attach additional sheets as necessary.]*

Note: each provider member listed must submit a signed Individual Provider Statement

Name of group provider	Relationship	DOB (mm/dd/yyyy)	SSN

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment and Termination*

a) 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 every been **indicted or convicted of a crime** related to that person's involvement in any program under Medicaid, Medicare, CHIP or a Title XX program? ☐Yes ☐No

If yes, list those persons and the required information below (42 CFR §455.106).
[Attach documentation and additional sheets as necessary.]

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

b) 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 every been **sanctioned, excluded or debarred** from Medicaid, Medicare, CHIP or a Title XX program? ☐Yes ☐No

If yes, list those persons and the required information below. (42 CFR §455.436)
[Attach documentation and additional sheets as necessary.]

DOB (mm/dd/yyyy)	**SSN (individual or TIN (entity)**	
Complete Address (Street/City/State/Zip		
Reasons for Sanction, Exclusion or Debarment		
Date(s) of Sanctions, Exclusions or Debarments (mm/dd/yyyy)	**Date of Reinstatement (mm/dd/yyyy)**	**List all States where currently excluded:**

c) 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 every been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? ☐Yes ☐No

If yes, list those persons and the required information below. (42 CFR §455.416)
[Attach documentation and 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**

**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)*

Section VI: Business Transaction Information

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 any business transactions totaling more than $25,000 during the previous twelve (12) month period ending on the date of this request (42 CFR §455.105(b)(1)). *[Attach additional sheets as necessary.]*

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

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

This information must be provided and/or updated within 30 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).

Section VII: Management & Control

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 Provider Entity (e.g. general manager, business manager, administrator or director, executive officer, chief operating officer, chief financial officer, medical director, clinical program director, corporate compliance officer etc.), including the name, date of birth (DOB),home address (no P.O. Box), personal phone number, 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

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 Provider Entity, including the name, date of birth (DOB), home address (no P.O. Box), personal phone number 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

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), home address (no P.O. Box), 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

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Region 10 PIHP are screened with the applicable background check including, but not limited to, verification against the OIG's List of Excluded Individuals & Entities (https://;oig.hhs.gov/exclusions/index.asp) and the System 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 above 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 _____

Full Name [Please Print] _____ Date _____

Phone Number _____ Fax Number _____ Email Address _____

GLOSSARY

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Provider Entity an individual or entity who 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.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.

Ownership or Control Interest: an individual or corporation that –

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

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

Indirect Ownership Interest: 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 in the disclosing entity**.**

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

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. If A owns 10% of the stock in a corporation which 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 which 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) Person with an ownership or control interest. 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% 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 equates to a 4% and need not be reported.

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, SV, III, 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 XV III);
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.

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

Subcontractor: (a) an individual, agency, or organization to which a Provider 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 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., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

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

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

Managing Employee: a general manager, business manager, administrator, director or other individual who exercises operational or managerial control, or who directly or indirectly conducts the day-to-day operation of an institution. As an example, Region 10 defines its managing employees as: the CEO, COO, CIO, and CFO.

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 I Ownership Information, continued). Please see Glossary for definitions of capitalized terms.

Section I: Provider Entity Ownership Information:
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and P.O. Box address. Provider members of the group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR §455.104; please see Section 4313 of the Balanced Budget Act of 1997, 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 II: Ownership in Other Providers and 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 I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership:
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals and entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections I, II, and III 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 V: 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 related to each person's or entity's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services since the inception of these 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 https://oig.hhs.gov/exclusions/index.asp
2. Sanction information is available in the GSA's SAM (System to Award Management) database www.sam.gov
3. State specific exclusion/sanction databased may be accessed through the State Agency's website
   Michigan: https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/list-of-sanctioned-providers

Section VI: Business Transaction Information:
1. List the Ownership of any Subcontractors that you have 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 5 years.
3. List any **Significant Business Transaction** between your entity and any Subcontractor during the past 5 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 30 days of a request by the U.S. 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 VII: Management & Control:
1. List the required information for all employees that hold the 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.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. 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.