Federally Required Disclosures

Federal law requires fiscal agents, managed care entities (MCEs), and other MassHealth providers, including applicants and certain bidders seeking to provide MassHealth services, to disclose some or all of the following: business ownership and control, business transactions, and criminal convictions. See 42 CFR §§ 455.100–106. MassHealth requires the submission of tax identification numbers (TINs), for example, social security number (SSN), or employer identification number (EIN) for purposes necessary to properly administer MassHealth (See 42 U.S.C. § 1320a-3 and 42 U.S.C. § 405(o)(1)).

Fiscal agents, MCEs, and other providers must use this form to disclose this information to MassHealth, unless otherwise instructed by MassHealth.

The following terms are defined in 42 CFR § 438.2.

- Health Insuring Organization (HIO)
- Prepaid Ambulatory Health Plan (PAHP)
- Managed Care Organization (MCO)
- Prepaid Inpatient Health Plan (PIHP)
- Primary Care Case Manager (PCCM)

Providers, other disclosing entities, and PCCMs must provide these disclosures:

(a) upon submission of a provider application; (b) upon execution of the provider agreement; (c) upon MassHealth's request during revalidation of enrollment; and (d) within 35 days after any change in ownership of the entity required to disclose.

Fiscal agents and most MCEs (MCOs, PIHPs, PAHPs, and HIOs except PCCMs) must provide these disclosures:

(a) upon submission of a proposal in accordance with the state procurement process; (b) upon renewal or extension of the contract; and (c) within 35 days after any change in ownership.

Attach a separate sheet if additional space is needed.

Definitions

The following definitions for terms that are used in this form are provided for your convenience. The source of these definitions is 42 CFR § 455.101.

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

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

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

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

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

**Other disclosing entity** means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes (a) any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII); (b) any Medicare intermediary or carrier; and (c) any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

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

**Person with an ownership or control interest** means a person or corporation that: (a) has an ownership interest totaling five percent or more in a disclosing entity; (b) has an indirect ownership interest equal to five percent or more in a disclosing entity; (c) has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity; (d) owns an interest of five percent 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 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.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five percent of a provider's total operating expenses.

**Subcontractor** means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

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

**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.
A. Identification Information

All applicants, bidders, fiscal agents, MCEs, other providers, and other disclosing entities must complete this section.

Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and post office box addresses. Attach a separate sheet if additional space is needed.

Name: 

Address: 

Provider ID/Service Location (PID/SL) for existing MassHealth providers: 

PID/SL and/or prior provider number for former MassHealth providers: 

Contact Person: 

Title: 

Phone No.: 

B. Ownership and Control

All applicants, bidders, fiscal agents, MCEs, other providers, and other disclosing entities, except individual practitioners and groups of individual practitioners, must complete this section, unless otherwise directed by MassHealth.

1. List the name and address of any individual or legal entity with an ownership or control interest in the entity providing these disclosures, and the name and address of any subcontractor in which said entity has a direct or indirect ownership of five percent or more. Attach a separate sheet if additional space is needed.

   (a) Name: 
       Address: 
       
       TIN: 
       Date of Birth (if an individual): 
       Subcontractor? □ Yes □ No

   (b) Name: 
       Address: 
       
       TIN: 
       Date of Birth (if an individual): 
       Subcontractor? □ Yes □ No

2. Identify any individuals or legal entities named in Item 1 who are related to each other as spouse, parent, child, or sibling, and identify the relationship.


3. Identify any individuals or legal entities listed in response to Item 1 who have an ownership or control interest in another disclosing entity, fiscal agent, or MCE, and provide the name of each such entity. If there are no individuals or legal entities with such interest, please respond “None.” Attach a separate sheet if additional space is needed.

   (a) Name: 
       Other Entity Name: 
       Other Entity Address: 

   (b) Name: 
       Other Entity Name: 
       Other Entity Address: 


4. Identify each managing employee. If there are no managing employees, please respond “None.” Attach a separate sheet if additional space is needed.
   (a) Managing Employee: ____________________________
       Address: ______________________________________
       SSN: ___________________________________________________________________
       Date of Birth: ____________________________
   (b) Managing Employee: ____________________________
       Address: ______________________________________
       SSN: ___________________________________________________________________
       Date of Birth: ____________________________
   (c) Managing Employee: ____________________________
       Address: ______________________________________
       SSN: ___________________________________________________________________
       Date of Birth: ____________________________

C. Business Transactions
All providers, including MCOs, must complete this section, unless otherwise directed by MassHealth. (Applicants and fiscal agents do not need to complete this section.)

1. Identify the ownership of any subcontractor with whom the provider, including an MCO, has had business transactions totaling more than $25,000 during the 12-month period before the date of this request. If there are multiple owners or shareholders, list only those with direct or indirect ownership of five percent or more. If there are no such business transactions to report, please respond “None.” Attach a separate sheet if additional space is needed.
   (a) Subcontractor: ____________________________
       Address: ______________________________________
       TIN: ___________________________________________________________________
       (i) Name of Owner: ____________________________
           Address: ______________________________________
       (ii) Name of Owner: ____________________________
           Address: ______________________________________
   (a) Subcontractor: ____________________________
       Address: ______________________________________
       TIN: ___________________________________________________________________
       (i) Name of Owner: ____________________________
           Address: ______________________________________
       (ii) Name of Owner: ____________________________
           Address: ______________________________________

2. Identify any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the five-year period before the date of this request. If there are no significant business transactions to report, please respond “None.” Attach a separate sheet if additional space is needed.
D. Persons Convicted of a Crime

Applicants, bidders, and providers must complete this section, unless otherwise directed by MassHealth.

Provide the requested information in this section for any person who has ownership or control interest in the applicant or provider, or is an agent or managing employee of the applicant or provider and who has also been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs. If there are no persons with such interest, please respond “None.” Attach a separate sheet if more space is needed.

1. Name: ____________________________
   Address: ____________________________
   Relationship: □ person with an ownership or control interest  □ agent  □ managing employee
   Crime(s): ____________________________________________
   Date of Conviction: ____________________________

2. Name: ____________________________
   Address: ____________________________
   Relationship: □ person with an ownership or control interest  □ agent  □ managing employee
   Crime(s): ____________________________________________
   Date of Conviction: ____________________________

E. Provider/Fiscal Agent/MCE/Applicant, Bidder Attestation, Signature, and Date

All providers, fiscal agents, MCEs, and applicants must complete this section.

I certify that the information on this form, and any attached statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I sign under the pains and penalties of perjury, and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's/fiscal agent's/MCE's/applicant's/bidder's signature (Signature and date stamps, or the signature of anyone other than the provider/fiscal agent, or in the case of a legal entity, person legally authorized to sign on behalf of the entity are not acceptable.):

Signature: ____________________________________________ Date: ____________________________

Printed Name: ________________________________________

Title: _______________________________________________