APPENDIX B-3

Disclosure Form for Entities

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As set forth in 42 CFR §§ 455.100-106, MassHealth providers, managed care entities (MCEs), fiscal agents, and other disclosing entities seeking to provide MassHealth services (including Accountable Care Organizations (ACOs)), must disclose information regarding business ownership and control, business transactions, and criminal convictions, including submission of all relevant tax identification numbers (TINs), (e.g., social security number (SSN) or federal employer identification number (FEIN)) in order to ensure proper administration of the MassHealth program.

As set forth in 42 CFR § 455.101, MCEs include the following (as defined in 42 CFR § 438.2).

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

The MassHealth agency may at its discretion disapprove a provider contract, and may terminate an existing contract, if the provider fails to disclose any information in accordance with the provisions of 130 CMR 450.222, 130 CMR 450.223, or 42 CFR §§ 455.100–106, 42 CFR § 455.436, 42 CFR § 1002, or as otherwise required by state or federal law (See 130 CMR 450.227).

NOTE: All sections of this form must be completed.

Unless otherwise instructed by MassHealth, all MCEs, fiscal agents, and other disclosing entities, including ACOs, must use this form when disclosing such information to MassHealth upon:

- enrollment
- re-enrollment (following disenrollment from MassHealth)
- revalidation
- a change in managing employee(s)
- a change of ownership or control interest
- at the request of MassHealth
- any subsequent change(s) to any of the information stated on this form in accordance with 130 CMR 450.223(B)

CONTACT INFORMATION FOR INDIVIDUAL COMPLETING THIS FORM

Name	
Tel.	Email

DEFINITIONS

The following definitions provided here for reference are found at 42 CFR § 1001.2, 42 CFR § 455.101 and 130 CMR 450.221.

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

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

Familial Relationship: parent, child, sibling, or spouse.

Fiscal Agent: a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of Practitioners: 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).

Immediate Family Member: a person's husband or wife; natural or adoptive parent; child or sibling; step-parent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

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 interest in the disclosing entity.

Managed Care Entity (MCE): managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs, as defined by 42 CFR §455.101.

Managing Employee: 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.

Member of Household: with respect to a person, any individual with whom he or she is sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Other Disclosing Entity (ODE): 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, 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: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with Ownership or Control Interest: 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; (f) is a partner in a disclosing entity that is organized as a partnership, or (g) owns directly or indirectly an interest of five percent or more in any real property leased to a disclosing entity for use as a nursing facility, rest home, or hospital.

An individual is deemed to own any beneficial interest owned directly or indirectly by or for his or her minor children or spouse.

Significant Business Transaction: any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent (5%) of a provider's total operating expenses.

Subcontractor: (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: 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: 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.

SECTION 1: Disclosing Entity Service Location / "Doing Business As" (SL/DBA) Name

Enter the SL/DBA name, address, and all other information requested below, applicable to this service location (SL) where services will be provided or are currently provided to MassHealth members.

Disclosing Entity SL/DBA Name		
Address (Street, Building or Suite)		
City, State & Zip Code		
NPI	PID/SL (for existing MassHealth providers)	FEIN

SECTION 2: Ownership or Control Interest in Disclosing Entity

List any individual or corporation with an ownership or control interest in the disclosing entity. Instructions for determining ownership or control percentages can be found at 42 CFR § 455.102 and 130 CMR 450.221(B). **Individuals must provide their home address. Corporations must list, as applicable, their primary business address, all business locations, corporate addresses, and P.O. Box addresses.**

Which of the Ownership or Control Interest describes you (select one): ☐ Ownership interest, ☐ Control interest, ☐ Both.

Name of Individual or Corporation	Board of directors (if individual) ☐ Yes ☐ No	Date of Birth (if individual) (MM/DD/YYYY)
Address (Home Address if Individual; Primary Business Address if Corporation)	City, State & Zip Code (9 digit)	
SSN (if individual)	FEIN (if corporation)	% of Ownership / NPI (☐ check the box if None)

For Individuals Only: If the individual listed above is related as a parent, child, sibling, or spouse to another person with an ownership or control interest in the disclosing entity, complete the following: Name of other person with ownership or control interest and relationship to the individual listed above (check one)

1. _____ ☐ parent ☐ child ☐ sibling ☐ spouse
2. _____ ☐ parent ☐ child ☐ sibling ☐ spouse
3. _____ ☐ parent ☐ child ☐ sibling ☐ spouse

For Corporations Only: Use the space below to report the address of all other business locations, corporate addresses, and P.O. box addresses.

1. _____
2. _____
3. _____

Which of the Ownership or Control Interest describes you (select one): ☐ Ownership interest, ☐ Control interest, ☐ Both.

Name of Individual or Corporation	Board of directors (if individual) ☐ Yes ☐ No	Date of Birth (if individual) (MM/DD/YYYY)
Address (Home Address if Individual; Primary Business Address if Corporation)	City, State & Zip Code (9 digit)	
SSN (if individual)	FEIN (if corporation)	% of Ownership / NPI (☐ check the box if None)

For Individuals Only: If the individual listed above is related as a parent, child, sibling, or spouse to another person with an ownership or control interest in the disclosing entity, complete the following: Name of other person with ownership or control interest and relationship to the individual listed above (check one)

1. _____ ☐ parent ☐ child ☐ sibling ☐ spouse
2. _____ ☐ parent ☐ child ☐ sibling ☐ spouse
3. _____ ☐ parent ☐ child ☐ sibling ☐ spouse

For Corporations Only: Use the space below to report the address of all other business locations, corporate addresses, and P.O. box addresses.

1. _____
2. _____
3. _____

If additional space is needed, make a copy of this page and attach it to the signed form. **NUMBER** _____ **OF** _____

All entries must be submitted using this form. Please refer to all attached pages when completing and signing this form.

SECTION 3: Ownership in Other Disclosing Entities (ODE)

Complete if any individual or corporation identified in Section 2 has an ownership or control interest in other disclosing entities.

☐ NONE (if NONE continue to Section 4)

Name (from Section 2)	Title	ODE Name
ODE Address	City, State, & Zip Code (9 digit)	
Name (from Section 2)	Title	ODE Name
ODE Address	City, State, & Zip Code (9 digit)	

SECTION 4: Ownership in Subcontractors

List any individual or corporation with an ownership or control interest in any subcontractor in which the disclosing entity has an ownership or control interest. If none, check 'None' below.

☐ NONE (if NONE continue to Section 5)

Name of individual or corporation	TIN of individual or corporation (TIN)
Owner's Address	City, State, & Zip Code (9 digit)
Subcontractor Name	Subcontractor Tax Identification Number (TIN)
Subcontractor Primary/Home Address	City, State, & Zip Code (9 digit)
Name of individual or corporation	TIN of individual or corporation (TIN)
Owner's Address	City, State, & Zip Code (9 digit)
Subcontractor Name	Subcontractor Tax Identification Number (TIN)
Subcontractor Primary/Home Address	City, State, & Zip Code (9 digit)

SECTION 5: Familial Relationship in Subcontractors

Complete if anyone identified in Section 2 is related to a person identified in Section 4 as a parent, child, sibling, or spouse. If none, check 'None' below.

☐ NONE (if NONE continue to Section 6)

Name of individual with ownership or control interest identified in Section 2
Name of individual with ownership or control interest identified in Section 4 and familial relationship to individual identified in Section 2
Name of individual with ownership or control interest identified in Section 2
Name of individual with ownership or control interest identified in Section 4 and familial relationship to individual identified in Section 2

If additional space is needed, make a copy of this page and attach it to the signed form. **NUMBER** _____ **OF** _____

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SECTION 6: Agents and Managing Employees

Completion of all fields is required by 42 CFR § 455.104. Make copies if additional space is needed. All entries must be submitted using this form.

☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)
☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)
☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)
☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)
☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)
☐ Agent ☐ Managing employee ☐ Both	
Name	Title
Home Address	City, State, & Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)

If additional space is needed, make a copy of this page and attach it to the signed form. **NUMBER _____ OF _____**

All entries must be submitted using this form. Please refer to all attached pages when completing and signing this form.

SECTION 7: Disclosures of Criminal Convictions and Relationships to Excluded Individuals and Entities

For additional information, see 42 CFR §§ 455.106 and 455.436, 42 CFR §§ 1001.1001 and 1002.3, and 130 CMR 450.212.

Respond to the following questions on behalf of:

1. the disclosing entity
2. all individuals and corporations identified in Sections 2 and 6 of this form
3. any person who formerly held an ownership or control interest in the entity but no longer holds an ownership or control interest because of a transfer of the interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, imposition of a civil money penalty or assessment under Section 1128A of the Social Security Act, or imposition of an exclusion.

NOTE: All questions must be answered. If "yes" is answered to any of the questions in Section 7 below, a detailed explanation is required in Section 8 of this form, including the name Social Security Number (SSN)/Tax Identification Number (TIN) and address of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?
☐ Yes ☐ No

2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?
☐ Yes ☐ No

3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?
☐ Yes ☐ No

4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
☐ Yes ☐ No

5. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 4, above?
☐ Yes ☐ No

NOTE: All questions must be answered. If "Yes" is answered to any of the questions in Section 7 above, a detailed explanation is required in Section 8 of this form, including the name Social Security Number/Tax Identification Number (SSN/TIN) and address of the individual/entity; nature, date, and forum of the action; and any case or record number.

SECTION 8: Additional Explanation

If "Yes" is answered to any of the questions in Section 7, a detailed explanation is required below, including the name, Social Security Number/Tax Identification Number (SSN/TIN) and address of the individual/ entity, nature, date, and forum of the action, and any case or record number.

Attach additional pages if necessary.

If additional space is needed, make a copy of this page and attach it to the signed form. **NUMBER _____ OF _____**

All entries must be submitted using this form. Please refer to all attached pages when completing and signing this form.

SECTION 9: Attestation, Signature, and Date

All disclosing entities 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.

I agree to abide by all applicable federal and state laws and regulations, as well as the rules and regulations of particular to the type of program covered by this enrollment application.

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the disclosing entity or person legally authorized to sign on behalf of the entity are not acceptable.

In accordance with 130 CMR 450.223(B), I agree to notify the MassHealth agency in writing within 14 days of any change to any of the information submitted upon enrollment.

In accordance with 42 CFR § 455.105, I agree to disclose full and complete information regarding the following business transactions within 35 days following a request of the MassHealth agency or the Secretary of Health and Human Services:

1. Information about the ownership of any subcontractor with whom the provider, MCE, or disclosing entity has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
2. Any significant business transactions between the provider and any wholly owned supplier or between the provider and any subcontractor during the 5-year period ending on the date of the request.

Signature: .....

Printed Name _____

Title _____

Date (MM/DD/YYYY) _____

Return your completed form to providersupport@mahealth.net or mail to the following:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
PO Box 121205
Boston, MA 02112-1205

If you have questions about or need assistance with the completion of this form, please email the MassHealth Customer Service Center at providersupport@mahealth.net or call (800) 841-2900.

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