Instructions for Mississippi Medicaid Provider Disclosure Form (Section C-2)

The Code of Federal Regulations set forth in 42 CFR § 455.100-106 requires that all providers disclose specified information regarding business ownership and control, business transactions, and criminal convictions to the Mississippi Division of Medicaid (DOM). In addition, state law provides that Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These disclosures will be used to determine the applicability of Miss. Code Ann. § 43-13-121(7).

The Provider Disclosure Form is due at any of the following times:

1) Upon submission of a provider enrollment application,
2) Upon change of required disclosing information,
3) Upon request of DOM during revalidation of enrollment, and
4) Within thirty-five (35) days after any change in ownership of provider, and/or request by Mississippi Medicaid.

General Instructions

- ✓ Please answer all questions as of the date of submission.
- ✓ Additional pages should be completed as necessary to provide accurate responses.
- ✓ Every question should be answered in an accurate manner and applicable responses provided.
- ✓ Retain a copy for your files.

Definitions

The definitions below are designed to clarify certain questions on the Provider Disclosure Form. These definitions may be found in 42 CFR § 455.101 and the Mississippi Medicaid Admin. Code (Part 200, Rule 4.1), both of which should be consulted for any amendments.

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

B. **Authorized Official** means an appointed official (for example chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide by all applicable state and federal law, regulations, policies, and requirements of the Medicaid program. **Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider and (2) the enrollment application that must be submitted as part of the periodic revalidation process.** The provider can have as many authorized officials as it wants. Each authorized official must be reported in Section B of the Mississippi Medicaid Provider Disclosure Form.

C. **Delegated Official** means an individual who is delegated by an authorized official with the authority to report changes and updates to the entity's enrollment record. A delegated official does not have the authority to sign the enrollment application or the revalidation application on behalf of the provider. A delegated official must be an individual with an "ownership or control interest," in (as that term is defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the entity. Delegated officials may not delegate their authority to any other individual. Each delegated individual must be reported in Section B of the Mississippi Medicaid Provider Disclosure Form.

D. **Director** is a member of the provider's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title (e.g. departmental director, director of operations). Moreover, where a provider has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "directors". Thus, if the provider has a governing body titled "board of trustees," as opposed to "board of directors," the individual trustees are considered "directors" for Medicaid enrollment purposes.

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

F. **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).

G. **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.

H. **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.

I. **Officer** is any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

J. **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:
    - 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);
    - Any Medicare intermediary or carrier; and
    - 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.

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

L. **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.

M. **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.

N. **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.

O. **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).

P. **Termination** means:
1) For a (i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and (ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. (ii)The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to (i) fraud; (ii) integrity; or (iii) quality.

Q. **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.

The definitions below should be used in answering questions on the Provider Disclosure Form concerning relationships to excluded, penalized, or convicted persons (Section D). These definitions may be found in 42 C.F.R. § 1001.1001, which should be consulted for any amendments.

A. **Agent** means any person who has express or implied authority to obligate or act on behalf of an entity.

B. **Immediate family member** means, a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

C. **Indirect ownership interest** includes an ownership interest through any other entities that ultimately have an ownership interest in the entity in issue. (For example, an individual has a 10 percent ownership interest in the entity at issue if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the entity in issue.)

D. **Member of household** means, with respect to a person, any individual with whom they are 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.

E. **Ownership** interest means an interest in:
(a) The capital, the stock or the profits of the entity, or
(b) Any mortgage, deed, trust or note, or other obligation secured in whole or in part by the property or assets of the entity.

Determination of Ownership or Control Percentages

Instructions for determining ownership or control percentages are reproduced here for your convenience. This information may be found in 42 CFR § 455.102, which should be consulted for any amendments.

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

B. Person with an ownership or control interest. In order 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 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Mississippi Medicaid Provider Disclosure Form

MISSISSIPPI DIVISION OF MEDICAID

This provider disclosure form is for:	
☐ Provider Application/Enrollment ☐ Change of Disclosing Information ☐ Change of Ownership (CHOW) Date of CHOW: _____	☐ Re-validation ☐ Request of Division of Medicaid

SECTION A
Disclosing Provider Information

If this form is for an individual, complete this area.

Last Name (including suffix)	First Name	MI	Title (M.D., D.O., etc)

If this application is for a group/organization/sole proprietor, complete this area.

Legal Business Name	
EIN/SSN:	NPI:

Address (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P O Box addresses.)

Address	City	State	Zip	County

If the disclosing entity is an existing MS Medicaid Provider, please enter the current Medicaid Provider number.	

Type of Business – Privately Owned or Non-profit Providers only

☐ Individual/Sole Proprietorship ☐ Corporation ☐ Partnership/Limited Liability Partnership ☐ Limited Liability Company (LLC)	☐ Government Owned ☐ Non-Profit

SECTION B Ownership and Control
NOTE: ONLY REPORT ORGANIZATIONS IN THIS SECTION. INDIVIDUALS WITH OWNERSHIP/MANAGING CONTROL MUST BE REPORTED IN SECTION B-2. The disclosing entity MUST have at least ONE owner and at least one managing employee. If there is more than one business entity with ownership/control interest that should be reported, copy and complete this section for each.

SECTION B-1 Entity with Ownership Interest and/or Managing Control Identification Information				
Select one: ☐ Owner ☐ Partner ☐ Managing Control			Percentage of ownership	
Effective Date:				
Legal Business Name as Reported to the Internal Revenue Service				
Doing Business As Name (if applicable)		Tax Identification Number (required)		
Primary Business Address				
Line 1 (Street Name and Number)				
Address Line 2 (Suite, Room, etc.)				
City	State	Zip Code	County	
Mailing Address (P.O. Box)	City	State	Zip Code	County

Business Location 2			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

Business Location 3			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

Business Location 4			
Address Line 1			
Address Line 2			
City	State	Zip Code	County

SECTION B-2 Individuals with Ownership Interest and/or Agents/Managing Control			
The following individuals must be reported in Section B-2: • **All individual owners with 5% or more direct/indirect ownership** • **All officers and directors of the disclosing provider (whether for profit or non-profit)** • **All managing employees of the disclosing provider** • **All authorized and delegated officials noted in the Mississippi Medicaid Enrollment application** If there is more than one individual with ownership/control interest that should be reported, copy and complete this section for each individual.			
Last Name	First Name	MI	Suffix
Title (M.D., D.O., etc.)	Social Security Number (required)	Date of Birth (MM/DD/YYYY)	Gender (M/F)
Home Address Line 1			
Address Line 2			
City	State	Zip	County

If the above noted individual is an owner, please select one of the following options and give the effective date:	
☐ Owner ☐ Partner	Percentage of ownership
Effective Date (MM/DD/YYYY)	

Title	Effective Date (MM/DD/YYYY)
☐ Director/Officer	
☐ Contracted Managing Employee	
☐ Managing Employee (W-2)	
☐ Agent	

If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:	
☐ Authorized Official	☐ Delegated Official
Effective Date (MM/DD/YYYY)	

If the individual or legal entity (disclosed in Section B) has ownership or control interest, is an officer, agent, managing employee, director, or shareholder and is related to each other as spouse, parent, child, or sibling, please note the name and relationship:	
Name	Relationship

Section C
Criminal Convictions and Other Sanctions

Provide the requested information in this section for any person who:

(1) Has an ownership or control interest in the disclosing provider OR is an agent or managing employee of the disclosing provider

AND

(2) Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services since the inception of those programs,

OR

(3) Has been convicted of a crime referenced in Miss. Code Ann. § 43-13-121(7)(c) – (h),

(4) Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43-13-121(7)(c-h),

(5) Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,

(6) Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program,

(7) Has had his/her/its license or certification revoked, or

(8) Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program

Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation.

Name	Criminal Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal Sanction Information	Date
Agency/Court/Administrative Body	Resolution	
Name	Criminal Sanction Information	Date
Agency/Court/Administrative Body	Resolution	

SECTION D
Relationships to Excluded, Penalized, or Convicted Persons in Accordance with 42 CFR § 1002.3

Identify and provide the requested information in this section regarding any person who:

1) has been convicted of a criminal offense as described in Sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act;
2) has had civil money penalties or assessments imposed under Section 1128A of the Social Security Act; OR
3) has been excluded from participation in Medicare or any of the state health programs AND
4) also has one or more of the following relationships to the disclosing provider:
   i. has a direct or indirect ownership interest (or any combination thereof) of five percent (5%) or more in the group/organization;
   ii. is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the group/organization or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent (5%) of the total property and assets of the group/organization;
   iii. is an officer or director of the group/organization, if the group/organization is organized as a corporation;
   iv. is a partner in the group/organization, if the group/organization is organized as a partnership;
   v. is an agent of the group/organization;
   vi. is a managing employee, that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the group/organization or part thereof, or directly or indirectly conducts the day-to-day operations of the group/organization or part thereof; or
   vii. was formerly described in subparagraphs (i) through (vi), immediately above, but is no longer so described because of a transfer or ownership or control interest to an immediate family member or a member of the person's household as defined in this section, in anticipation of or following a conviction, assessment of a civil monetary penalty, or imposition of an exclusion.

NOTE: Please refer to Page 1 of the Instructions for Provider Disclosure Form for applicable definitions.

Name	Relationship	☐ Current ☐ Former
Conviction Information (Crime)		Date of Conviction
Reason for Penalty or Assessment Information		Date Imposed
Reason for Medicare Exclusion Information		Date Imposed
State Health Care Program Exclusion	State Agency and Reason	Date of Exclusion
Name	Relationship	☐ Current ☐ Former
Conviction Information (Crime)		Date of Conviction
Reason for Penalty or Assessment Information		Date Imposed
Reason for Medicare Exclusion Information		Date Imposed
State Health Care Program Exclusion	State Agency and Reason	Date of Exclusion

SECTION E Disclosure of Other Ownership and Control		
Identify individuals or legal entities as having an ownership or control interest who also have an ownership or control interest in any other disclosing group/organization.		
Name of the Individual/Legal Entity (noted in Section A or B)		
Other Legal Entity Name		
Other Legal Entity Address		
EIN of the Other:		
Are any individuals or legal entities (disclosed in Section B and/or B-2) as having an ownership or control interest, officer, agent, managing employee, director, or shareholder related to the individual/group/organization (noted in Section C) as a spouse, parent, child or sibling? ☐ Yes ☐ No		
If yes, please provide the requested information for each:		
Name	Relationship	Name of Person in B-1 and/or B-2
Name	Relationship	Name of Person in B-1 and/or B-2
Name	Relationship	Name of Person in B-1 and/or B-2

SECTION F Disclosure of Subcontractor Information			
Identify any person (individual or legal entity) with an ownership or control interest in any subcontractor in which the disclosing group/organization has a direct or indirect ownership of five percent (5%) or more.			
Name of the Individual/Legal Entity (noted in Section A or B)		Name of the Subcontractor	
Address of the Subcontractor (Individuals must provide their home address. Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box addresses.)			
Address			
City	State	Zip	County
SSN/EIN of the Subcontractor:			
Are any individuals or legal entities (disclosed in Section B-1 and/or 2) as having an ownership or control interest, officer, agent, managing employee, director or shareholder related to the subcontractor (noted in Section D) as spouse, parent, child, or sibling? ☐ Yes ☐ No			
If yes, please provide the requested information for each:			
Name	Relationship	Name of Person in B-1 and/or B-2	
Name	Relationship	Name of Person in B-1 and/or B-2	
Name	Relationship	Name of Person in B-1 and/or B-2	

SECTION G Business Transactions This section should only be completed at the direction of Division of Medicaid (DOM).	
Identify the ownership of any subcontractor with whom the provider 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 (5%) or more. If there are no such transactions to report, please respond "None".	
Name of Subcontractor	
Address	
SSN or EIN	
Name of Owner	Address
Name of Owner	Address
Name of Owner	Address
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 below. If there are no significant business transactions to report, please respond "None".	

SECTION H
Attestation and Signature of the Disclosing Provider

I certify that the information on this form, and any submitted statement(s) 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 penalty of perjury and may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

In addition, I understand that:

- In accordance with 42 CFR § 455.104(e), federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required.
- In accordance with 42 CFR § 455.106(c), DOM may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program. Further, DOM may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under 42 CFR § 455.106(a).
- In accordance with 42 CFR § 455.107 and upon request by the State Medicaid agency, a provider must disclose all affiliations that it or any of its owning or managing employees or organizations has or, within the previous 5 years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event (as defined in § 455.101).
- In accordance with Miss. Code Ann. § 43-13-121, Medicaid enrollment may be denied or revoked when providers or their agents, managing employees, or those with minimum ownership interests are convicted of certain crimes and other circumstances. These circumstances include failure to truthfully or fully disclose any and all information required on this form or making a false or misleading statement to DOM relative to the Medicaid program.
- In accordance with 42 CFR § 455.436, the State Medicaid agency and all Medicaid contractors shall do the following:
  1. Confirm the identity and determine the exclusion status of providers and contractors/subcontractors and any person with an ownership or control interest or who is an agent or managing employee of the provider or contractor/subcontractor through routine checks of federal databases; and,
  2. Consult appropriate databases to confirm identity of the above-mentioned persons and entities by searching the List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) upon enrollment, re-enrollment, revalidation, and no less frequently than monthly thereafter, to ensure that the State does not pay federal funds to excluded persons or entities.

NOTE: If the disclosing provider is <u>an individual or a sole proprietor</u>, the application must be signed by the individual provider or sole proprietor. If the disclosing provider is <u>a group/organization</u>, the signature should be that of the person legally authorized to sign on behalf of the group/organization.

Printed Last Name (including suffix)	Printed First Name	MI
Signature	Title	Date