Northeast Michigan Community Mental Health Authority

FY 2027 Disclosure of Ownership

Controlling Interest and Management Statement

DISCLOSING ENTITY

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 managers 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 (TIN).

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 a request for updated information. A Statement must be provided within 35 days of a request for this information.

*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 section 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; 'N/A' 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*)

<table>
<tr><td rowspan="4">Type of entity (choose appropriate category):
___Sole Proprietor
___Partnership
___Non-Profit
___Corporation
___Limited Liability Corporation (LLC)
___Government/Public Entity
___Other:_____</td><td colspan="2">Name of Person Completing the Form</td></tr>
<tr><td colspan="2">Title</td></tr>
<tr><td colspan="2">Phone Number</td></tr>
<tr><td colspan="2">Email</td></tr>
<tr><td colspan="3">Legal Name (Contractor):</td><td>DBA Name (if different from Contractor Legal Name):</td></tr>
<tr><td colspan="4">Complete Address (must include at least one street address; corporations must include the primary business and every business location and P.O Box address):
STREET CITY STATE ZIP</td></tr>
<tr><td colspan="4">Additional Addresses (list all Practice locations – attach a separate sheet if necessary):</td></tr>
<tr><td>**Federal Tax ID/SSN #:</td><td>*Medicaid ID #:</td><td>*National Provider ID (NPI) #:</td><td>*CAQH #:</td></tr>
</table>

II. Provider Ownership Information (*only **disclosing entities** (and fiscal agents) complete this section*)

Are there any persons (individual or corporation) with an Ownership or Control Interest in the Disclosing Entity (or Fiscal Agent)?
Yes ____ No ____

If Yes, list any INDIVIDUAL (post name, title, date of birth, home address, social security number (SSN), and % interest in top section below) or CORPORATE ENTITY OWNER (post the name, Tax Identification Number (TIN), primary business address (and **every business location, and P.O. Box address**), and % interest in bottom section below) with an Ownership or Controlling Interest in the Disclosing Entity (or Fiscal Agent). (42 CFR §455.104) ***Attach additional sheets as necessary.***

Name of Individual Owner	Title	DOB (mm/dd/yyyy)	Complete Address (Street/City/State/Zip)	** SSN (individual)	% Interest

Corporate Entity Owner Name	Complete Address (Street/City/State/Zip)	TIN (organization)	% 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***

III. Ownership in Other Providers & Entities (*only **disclosing entities** (and fiscal agents) complete this section*)

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* **disclosing entity** (or **fiscal agent)**? **Yes ☐ No ☐ N/A ☐**

If Yes, list the name of the **other disclosing entity (**or **fiscal agent)** 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 (*only **disclosing entities** (and fiscal agents) complete this section*)

Does Disclosing Entity (or Fiscal Agent) have a Direct or Indirect Ownership Interest of 5% or more in any subcontractor? **Yes ___ No ___**

If Yes, does another person (individual or corporation) also have an Ownership or Controlling Interest in the same subcontractor?
Yes ___ No ___

If Yes, list the following information for each person (individual or corporation) with an Ownership or Controlling Interest in any Subcontractor in which the Disclosing Entity (or Fiscal Agent) also has Direct or Indirect Interest of 5% or more. (42 CFR §455.104(b)(1)(iii))

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's*** **DOB (mm/dd/yyyy)**	***Other Owner's*** **SSN (individual) or TIN (organization)**	**% Interest in Subcontractor**

V. Familial Relationships of All Owners (*only **disclosing entities** (and fiscal agents) complete this section*)

Are any of the individuals identified in **Sections II or IV** related to another person with ownership or control interest in the Disclosing Entity (or Fiscal Agent) as a spouse, parent, child, or sibling? **Yes ☐ No ☐**

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

Attach additional sheets as necessary.

Name of Owner 1	**Name of Owner 2**	**Relationship**

VI. Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations* (***all** complete this section*)

1. Has the Provider, or any person who has an Ownership or Controlling Interest in the Provider, or who is an Agent or Managing Employee of the Provider, ever been convicted of a criminal offense described under sections 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 Act? (See 42 CFR §1001.1001(a))
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)**	**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)**	

2. Has the Provider, or any person who has an Ownership or Controlling Interest in the Provider, or who is an Agent or Managing Employee of the Provider ever been **sanctioned, excluded, or debarred** from, Medicaid, Medicare, CHIP or a Title XX program since the inception of those programs? (See 42 CFR §438.610(a)(1)) **Yes ____ No ____**

If Yes, list those persons and the required information below. ***Attach additional sheets as necessary.***

Name

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

3. Has the Provider, or any person who has an Ownership or Controlling Interest in the Provider, or who is an Agent or Managing Employee of the Provider been **terminated** from participation in Medicaid, Medicare, CHIP, or a Title XX program in the last 10 years, or been terminated under title XVIII on or after January 1, 2011? (See 42 CFR §455.416(b)&(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) 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 to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (See Fed. Register, Vol. 44, No. 138)

VII. Business Transaction Information** (*Optional upon contracing; only required within 35 days notice within 35 days notice fromm the state Medicaid Agency or Secretary of the U.S. DHHS*)

1. Business Transactions - Subcontractors: Has the Provider 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 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***

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

2. Significant Business Transactions – Wholly Owned Suppliers: Has the Provider 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 any Wholly Owned Supplier with whom the Provider 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

3. Significant Business Transactions – Subcontractors: Has the Provider had any Significant Business Transactions with a Subcontractor 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 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 35 days of a request by the Secretary of Health and Human Services or the Medicaid agency. 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 (*all complete parts 1&2, **disclosing entities** (and fiscal agents) complete entire section. Must include at least one individual*)

1. Managing Employees: Does the Provider 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 (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. AT LEAST ONE PERSON MUST BE LISTED IN THIS SECTION, I.E. CEO, PRESIDENT OR SIGNER.***

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

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2. Agents: Does the Provider have any Agents? **Yes ____ No ____**

If Yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider, 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

3. Board of Directors: Does the Disclosing Entity (or Fiscal Agent) 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

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Northern Michigan Regional Entity, or one of the Community Mental Health Service Programs (CMHSPs) contracted with NMRE as comprehensive services providers, are screened with the applicable background check(s) 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) https://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 (indicate if authorized Agent)

_____ _____

Full Name (please print) Date

_____ _____ _____

Telephone FAX Email

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 definitions of capitalized terms.

Section II: Provider Ownership Information:
Please list the required information for each individual or organization that has an Ownership or 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 a group practice who have ownership or a controlling interest in Provider 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 III: Ownership in Other Providers & Entities:
Please identify any other disclosing entities (or fiscal agents) that **Owners** identified in Section II also have an Ownership or Controlling Interest in (*does not include anyone with a Controlling Interest*). This information is to identify shared and interconnected ownership and controlling interests.

Section IV: Subcontractor Ownership:
If your entity has a Direct or Indirect Ownership Interest of 5% or more in a Subcontractor, and another person (individual or corporation) also has an Ownership or Controlling Interest in the same Subcontractor, please identify the Subcontractor and provide the required information.

Section V: Familial Relationships of All Owners:
Report whether any of the persons listed in Sections II, or IV are related to another person with ownership or control interest in the Disclosing Entity (or Fiscal Agent) - identify the parties and their relationship. Provider members of a group practice who are related to the Disclosing Entity's (or Fiscal Agent'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, along with any person (individual or corporation) 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 Act. Also 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 those programs. Review all of 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 for Award Management) database https://www.sam.gov
3. State specific exclusion/sanction databases may be accessed through the State Agency's website

Section VII: Business Transaction Information:
Note: This information does not need to be provided with this Disclosure form, but must be made available within 35 days of a request by the Secretary of Health and Human Services, the State Medicaid Agency, and/or the Managed Care Organization responding to an HHS or State request.

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 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.

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.
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 Disclosing Entity (or Fiscal Agent) 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.

CHIP: The Federal insurance program for children, Child Health Insurance Program, 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 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.

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

Disclosing Entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. Examples include, but are not limited to: Hospitals, Nursing Homes, Community Mental Health Centers, Home Health Agencies, Group Homes, Clinical labs, Pharmacies, Managed care organizations, and Fiscal agents for the state.

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

***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.

***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.

***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 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: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 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*:** any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of twenty-five thousand ($25,000) and five percent (5%) of a Provider's total operating expenses.

***Subcontractor*:** (a) an individual, agency, or organization to which a Disclosing Entity (or Fiscal Agent) 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 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 or by a person, persons, or other entity with an ownership or control interest in the provider.