Medical Assistance Transportation Memorandum
MATP OPS # 02-2010-016

Date: February 1, 2010

Subject: Obligation to furnish upon request the information related to business transactions totaling more than $25,000.

To: All Statewide County Medical Assistance Transportation Program (MATP) Offices

From: Tyrone E. Williams, Director, MATP

Purpose:

To notify counties of their obligation to collect information related to business transactions totaling more than $25,000

Background:

The regulation at 42 C.F.R. § 455.105 (b) (2) requires that upon request providers furnish to the State certain business transactions with wholly owned suppliers or any subcontractors. Specifically, they must furnish full and complete information about:

(1) The ownership of any subcontractor with whom the provider 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

As a service reimbursed under the Medical Assistance (MA) program, agencies, organizations, and/or transit authorities that administer MATP, as well as the Department, must meet federal requirements to ensure appropriate funding for the program. Since we make direct payments to the counties; and we do not enroll transportation carriers or other providers who participate in MATP into MA, they do not sign a provider agreement. The agreement stipulates compliance with several federal provisions that require they furnish certain types of information to the Department. In addition, we also did not explicitly make it a condition of participation under the MATP Instructions and requirements. To ensure federal compliance, we must begin collecting this information.

Discussion:

Because we do not specifically enroll MATP providers who participate with MATP into MA and as the entity (counties), that administers the program on our behalf, **county MATP offices are required to collect from MATP providers (Transportation carriers, suppliers and subcontractors) disclosures of significant business transactions, per the provisions outlined above.** In addition, completion and submission of this information should be a condition of participation in the MATP and a condition of approval or renewal of a provider agreement between the provider and the county program.

Definitions

We have provided the following definitions to help you identify who should provide the attached information:

Disclosing entity: A provider that provides services under the medical assistance program or fiscal agent

Provider: a named person or entity that furnishes, or arranges for furnishing non-emergency medical transportation for which it claims payment under the MA program.

Subcontractor: an individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of furnishing non-emergency medical transportation. Or an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services under the MA program.

Supplier: an individual, agency, or organization from which a provider purchases goods and services used in carrying its responsibilities under the MA program.

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entities with an ownership or control interest in a provider.

Ownership: an individual, agency, or organization that either a direct or indirect ownership interest totally 5 percent or more in a provider or subcontractor under the MA program.

Next Steps:

County MATP offices should arrange to collect the above information from any MATP participating provider (transportation carriers, subcontractors, or suppliers) using the attached form (**Disclosure of Significant Business Transactions**). The responsible MATP agency must certify to the accuracy of the information whether they list anyone or not. We strongly recommend that you survey for this information at least annually to ensure compliance.

Complete and submit these disclosures no later than April 5, 2010 and forward the information to the following address:

DPW/OMAP/MATP
DGS Annex Complex
PO Box 2675
Harrisburg, PA 17105
Fax (717) 705-8112

For audit purposes, please ensure that a copy of your completed forms is included as part of your MATP files. Should you have any questions, please contact your Program Manager.

Disclosure of Significant Business Transactions

Pennsylvania Department of Public Welfare

Medical Assistance Transportation Program

(As required by 42 C.F.R. §455.105: Disclosure by providers: Information related to business transactions)

Request Date: _____

Within 35 days of the request date, submit full and complete information concerning the following:

1. The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of this request:

Owner Name	Subcontractor	Percentage Ownership

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 this request:

Parties Involved in Transaction	Description of Transaction	Date of Transaction

Disclosure of Significant Business Transactions

Pennsylvania Department of Public Welfare

Medical Assistance Transportation Program

(As required by 42 C.F.R. §455.105: Disclosure by providers: Information related to business transactions)

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Department of Public Welfare if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name: _____ Title: _____

(Print or Type) (Print or Type)

Signature: _____ Date: _____