Medical Assistance Transportation Memorandum
MATP OPS # 02-2010-017

Date: February 1, 2010

Subject: Obligation to Screen for Medial Assistance Excluded Providers

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

From: Tyrone E. Williams, Director, MATP

Purpose:

To notify counties of their obligation to screen all employees and transportation subcontractors to determine if the Office of Inspector General (OIG) has excluded them from participation in the MA program

Background:

When the OIG excludes a provider, all Federal health care programs (Medicaid, Medicare, SCHIP) are prohibited from paying for any items or services furnished, ordered or prescribed by excluded individuals or entities until the provider has been reinstated by the OIG. The Code of Federal Regulations mandates this provision at 42 CFR Section 1001.1901.

Discussion:

Per the MATP Instructions and Requirements, **Section 7. Recruit and Maintain Adequate Transportation Network**, County MATP offices must establish a network of transportation providers to deliver medical transportation services to MA recipients. Part of that responsibility is ensuring driver clearances that include the necessary checks for any criminal history and child abuse. To comply with federal law, the Department is required to expand clearances for participation to provide services under MATP to include screening for excluded transportation carriers and staff from the MA program.

As a service reimbursed under MA, county MATP offices that enter into subcontracts with transportation carriers or hire staff to support the MATP are required to screen these providers/individuals for potential OIG exclusions. MATP support staff would include companies, drivers, dispatchers, clerks and all other employees involved in medical transportation services that MA reimburses. The OIG maintains the List of Excluded Individuals/Entities database (LEIE) that provides information about parties excluded from participation in Medicare, Medicaid and all other Federal health care programs. The LEIE Web site is located at http://oig.hhs.gov/fraud/exclusions.asp.

The on-line search engine identifies currently excluded individuals or entities. When a county identifies a match, the county can verify the accuracy of the match by using a SSN or Employer Identification number (EIN). Counties must immediately report to the Department any exclusion information discovered. **County MATP offices that secure a match from the LEIE website are prohibited from paying that excluded individual or entity for any items or services to MA recipients.**

Please be aware that civil monetary penalties may be imposed against counties who employ or enter into contracts with excluded individuals or entities to provide items or services to MA recipients.

Next Steps:

County MATP offices should begin screening their present transportation subcontractors and support staff to ensure that no excluded entities or individuals are associated with MATP operations. County MATP offices must complete these checks no later than April 5, 2010. Please forward the information to the following address using the attached form:

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. In addition, counties must begin incorporating these checks with your regular criminal history and child abuse clearances. We strongly suggest that you screen for this information at least annually.

Should you have any questions, please contact your Program Manager.

Disclosure of Exclusion (s)

Pennsylvania Department of Public Welfare

Medical Assistance Transportation Program

(As required by 42 C.F.R. §1001.1901.)

List the name of any person who:

Has been excluded in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Name	Date of Exclusion	SSN

"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: _____ (Print or Type)

Title: _____ (Print or Type)

Signature: _____

Date: _____