Medical Assistance Transportation Memorandum
MATP OPS # 02-2010-019

Date: February 1, 2010

Subject: Obligation of Providers and Fiscal agents to Disclose Information on Ownership and Control

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

From: Tyrone E. Williams, Director, MATP

Purpose:

To notify counties to of their obligation to collect information on ownership and control

Background:

The regulation at 42 C.F.R. §455.104 require providers and fiscal agents to furnish to the State the following information:

(1) The name and address of each person with an ownership or controlling interest in any provider, subcontractor and/or supplier, in which it has direct or indirect ownership of 5 percent or more;

(2) Disclose whether any of the persons named is related to another as spouse, parent, child, or sibling.

(3) Disclose the name of any other provider or subcontractor in which a person with an ownership or controlling interest also has an ownership or control interest.

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 regulatory 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 ownership and control which meet 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 an 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 Ownership and Control**). 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 Ownership and Control

Pennsylvania Department of Public Welfare

Medical Assistance Transportation Program

(As required by 42 C.F.R. §455.104: Disclosure by providers and fiscal agents: Information on ownership and control)

1. List the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more:

Name	Address	Percentage Ownership or Control Interest

2. Indicate whether any of the persons identified in number one above are related to another as a spouse, parent, child or sibling:

Name	Name	Relationship

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Medical Assistance Transportation Program

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3. List the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest:

   (Note: This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must keep copies of all these requests and responses to them, make them available to the Secretary or the Medicaid agency upon request and advise the Medicaid agency when there is no response to the request)

Name of Person	**Name of Other Disclosing Entity**

"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: _____