DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Rosie Kusek

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 7

2. STATE:

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01-01-00

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 431 Subpart M

7. FEDERAL BUDGET IMPACT:
a. FFY _____ $ _____
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.16 - 168 effective 1-1-00

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.16 - 168 effective 7-1-95

10. SUBJECT OF AMENDMENT:
Cooperative Agreement between the Missouri Department of Social Services, Division of Medical Services and The Missouri Department of Health, Bureau of Special Health Care Needs, Head Injury Program for Non-Emergency Medical Transportation Administration.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
James J. Lacy

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
3/30/00

16. RETURN TO:

Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/31/00

18. DATE APPROVED:
MAY 05 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-00

20. SIGNATURE OF REGIONAL OFFICIAL:
James J. Scanlon for

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Vadner
Ite
Stangler
CO

SPA Control
Date Submitted: 03/30/00
Date Received: 03/31/00

FORM HCFA-179 (07-92)

Instructions on Back

COOPERATIVE AGREEMENT BETWEEN THE MISSOURI DEPARTMENT OF SOCIAL SERVICES Division of Medical Services and the MISSOURI DEPARTMENT OF HEALTH Bureau of Special Health Care Needs Head Injury Program

NON-EMERGENCY MEDICAL TRANSPORTATION

I
STATEMENT OF PURPOSE

The Missouri Department of Social Services (DSS), Division of Medical Services (DMS) and the Department of Health, Bureau of Special Health Care Needs, Head Injury Program (DOH/BSHCN), in order to provide the most efficient and cost effective Non-Emergency Medical Transportation (NEMT) services, hereby agree to the conditions included in this cooperative agreement.

II
MUTUAL OBJECTIVES

1. To ensure transportation services to and from covered Missouri Medicaid services for head injured Medicaid eligible recipients age 21 or over, who have no other transportation resources. Transportation will be provided through the DOH/BSHCN for described individuals in the most appropriate, least costly manner.

III
RESPECTIVE RESPONSIBILITIES

DSS agrees to:

1. Reimburse DOH/BSHCN the Title XIX Federal share of actual and reasonable costs established for the administration of medically necessary non-emergency medical transportation. The rate of reimbursement for eligible costs will be 50%. Changes in Federal regulations affecting the matching percentage, and/or costs eligible for enhanced

or administrative match, which become effective subsequent to the execution of the agreement will be applied as provided in the regulations.

2. Provide DOH/BSHCN access to the information necessary to properly provide transportation administration and information regarding Medicaid eligibility.

3. Meet and consult on a regular basis, at least annually, with DOH/BSHCN on issues related to this agreement.

4. Develop and conduct periodic utilization reviews in cooperation with DOH/BSHCN to ensure payments made to DOH/BSHCN do not duplicate other Medicaid NEMT payments.

5. Refer recipients who meet the following criteria to the DMS NEMT broker: have not reached their 21 birthday; are injured before age 22; or are on the DOH waiting list for transportation by DOH, but for which DOH funds are not available. Referral for NEMT services should be to the appropriate NEMT broker depending on the county of residence.

6. Maintain the confidentiality of client records and eligibility information received from DOH and use that information only in the administration, technical assistance and coordination of activities authorized under this agreement.

DOH/BSHCN agrees to:

1. Identify Medicaid eligible head injury recipients age 21 or over who have been approved by DOH for Comprehensive Day Rehab service and determine those who do not have access to free non-emergency medical transportation for scheduled medically necessary, Medicaid covered services.

   To be eligible for Medicaid coverage of NEMT services, individuals must be eligible for Medicaid or MC+ under a federally matched eligibility category. Individuals eligible under State Only Eligibility Categories: (ME Codes 02, 08, 09, 51, 52, 57, 59 and 64), are not eligible for the Medicaid NEMT program nor QMB (ME Code 55), nor Medicaid Expansion recipients (ME Codes 71-77 and 80).

2. Arrange/Schedule the most cost-effective, non-emergency medical transportation service appropriate for the needs of the recipient.

   A. DOH Program Staff will identify those individuals who have reached their 21

birthday and are receiving transportation services through the Comprehensive Day Rehab program funded by Medicaid.

B. Notify DSM (via disk) of all recipients approved for transportation to Medicaid funded Comprehensive Day Rehab services for which DOH will certify the state share and claim services under the terms of this agreement.

C. Notify DMS of all recipients who are on a waiting list for DOH transportation, and as the waiting list is updated, the updated listing will be forwarded to the DSM NEMT coordinator in disk format.

DMS will use the waiting list to identify those individuals who are eligible to receive NEMT to Comprehensive Day Rehab services through the broker. As individuals are moved from the waiting list to the approved list (item B) DOH will assume the responsibility for transport.

D. DOH program staff will report transportation costs for Medicaid eligible recipients receiving transportation from DOH as provided under the terms of this agreement.

3. Certify to DSS the provisions of the non-federal share for transportation services via completion of DMS Certification of General Revenue for the Department of Social Services Division of Medical Services Title XIX Transportation Program form (Appendix A) and on each invoice for Medicaid Administration of Transportation (Appendix B). DOH will supply DMS with a copy of their methodology for reimbursable DOH contracted transportation vendors for whom they will submit invoices for cost of transport of Medicaid recipients.

4. Provide, as requested by the state Medicaid agency, the information necessary to request Federal funds available under the state's Medicaid match rate. Information will include at least: Recipient name; Medicaid Departmental Client Number (DCN); Date of Service; Name of Medicaid provider to whom recipient was transported; and actual cost of NEMT service and mileage.

A. Submit claims on a quarterly basis via Invoice for Medicaid Administration of Transportation form (Appendix B).

B. DOH will supply DMS with a copy of their methodology for reimbursing DOH contracted transportation vendors for whom they will submit invoices for cost of transport of Medicaid recipients.

5. Accept responsibility for disallowances and incur the penalties of same resulting from the activities associated with this agreement. Return to DSS any Federal funds which are deferred or ultimately disallowed or both arising from the administrative claims submitted by DSS on behalf of DOH/BSHCN.

6. Meet and consult on a regular basis, at least annually, with DSS on issues arising from this agreement.

7. Conduct all activities recognizing the authority of the state Medicaid agency in the administration of the Medicaid State Plan on issues, policies, rules and regulations on program matters.

8. Maintain all necessary information for a minimum of five (5) years to support the claims and provide HCFA any necessary data for auditing purposes.

9. Maintain confidentiality of client records and eligibility information received from DSS and use that information only in the administration, technical assistance and coordination of activities authorized under this agreement.

IV
TERMS OF THIS AGREEMENT

The period of this Cooperative Agreement shall be from January 1, 2000 and remain in effect until canceled by one or both parties. This agreement may be canceled at any time upon agreement by both parties or by either party after giving thirty (30) days prior notice in writing to the other party, provided, however that any financial arrangement(s) pertaining to this agreement shall remain in effect and reimbursement shall be made for the period when the contract is in full force and in effect. This agreement may be modified at any time by the written agreement of both parties.

Gary L. Stangler, Director
Department of Social Services

3/30/2000
Date

Maureen Dempsey, M.D., Director
for Department of Health

03/16/00
Date

TN# 00-07 Approval Date MAY 05 2000
Supersedes TN# 96-31 Effective Date 01/01/00