
METHODS USED TO ASSURE TRANSPORTATION OF BENEFICIARIES TO AND FROM PROVIDERS

Transportation of beneficiaries to and from providers of services is available in two categories: ambulance and non-ambulance. Coverage of ambulance transportation is limited to the transportation of beneficiaries to their home, or to the nearest appropriate medical facility site only when the condition of the beneficiary absolutely precludes another method of transportation, or to a nonhospital drug and alcohol detoxification or rehabilitation facility from a hospital when a beneficiary presents to the hospital for inpatient drug and alcohol treatment and the hospital has determined that the required services are not medically necessary in an inpatient facility.

Please see Attachment 3.1A, page 9a and 3.1B, page 8a, for ambulance service limitations and 4.19B, page 2bbbb, for ambulance payment methodology.

- I. Qualified ambulance transportation providers must be currently licensed by the Department of Health to provide Basic Life Support (BLS) services, Advanced Life Support services (ALS) or both and must be Medicare certified.

The Commonwealth assures emergency and non-emergency ambulance transportation through the following methods:

A. Emergency BLS and ALS ambulance transportation

- When a BLS or ALS ambulance is dispatched under the Public Safety Answering Point (PSAP or 9-1-1 emergency call system), the qualified, enrolled ALS or BLS ambulance provider that transports the beneficiary will be paid in accordance with the rates on the agency's fee schedule.

B. Non-emergency BLS and ALS ambulance transportation

- Payment for non-emergency ambulance transportation services requires that services must be medically necessary. Conditions for medical necessity include:
 - a) The beneficiary is incapacitated as the result of injury or illness and transportation by van, taxicab, public transportation or private vehicle is either physically impossible or would endanger the health of the patient.
 - b) There is reason to suspect serious internal or head injury.
 - c) The beneficiary requires physical restraints.
 - d) The beneficiary requires oxygen or other life support treatment en route.
 - e) Because of the medical history of the patient and present condition, there is reason to believe that oxygen or life support treatment is required en route.
 - f) The beneficiary requires transportation from a hospital to a nonhospital drug and alcohol detoxification facility or rehabilitation facility and the hospital has determined that the required services are not medically necessary in an inpatient facility.
- If conditions are met, the ambulance provider will be paid in accordance with the rates on the agency's fee schedule.

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- ii. The commonwealth assures non-emergency non-ambulance transportation for Medical Assistance (MA) beneficiaries to and from MA providers through the Medical Assistance Transportation Program (MATP). The MATP is administered in accordance with the regulations, policies, and requirements established by the single state agency through agreements with local county governments and primary contractors (individually, the Grantee) in all counties except Philadelphia.

The state assures NEMT transportation via a state negotiated contract with a brokerage in Philadelphia County.

A. Grant agreements between the commonwealth and local entities

1. Grant agreement between the commonwealth and local county government.

- a) Local county governments are given the right of first refusal to administer the MATP in their respective counties through a grant agreement. Upon acceptance of the grant, the county government subcontracts with a qualified program administrator (either a public or private entity) based on a negotiated trip fee to deliver transportation in its designated service area.

Payment Method

The single state agency provides funding to county governments through an annual public assistance block grant. The grant is allocated through advance payments, which are 100 percent state-funded, provided quarterly and equal to 25 percent of the county government's program budget for a given fiscal year, subject to revisions as described below. The purpose of the advance payments is to ensure sufficient funding throughout the year to avoid interruptions in medical services for MA beneficiaries due to a lack of transportation.

After two quarterly advance payments, additional quarterly payments shall not be made until the county government submits eligible expenditures for review and approval. All expenditures for the year must be supported by a CMS approved quarterly cost report detailing actual eligible administrative and transportation expenses charged to the program. The single state agency reviews payments against actual expenditures and makes appropriate adjustments against subsequent payments.

The grant goes to support the cost of operations (i.e., operating a customer service center; verifying eligibility; assigning trips to lowest-cost, appropriate mode and provider of transportation; managing subcontracts including vehicle inspections and reviewing driver background checks; reviewing subcontractor invoices for the direct transportation services), to purchase transportation on behalf of MA beneficiaries, and to pay subcontracted transportation carriers.

The amount of the grant is based upon an average of the actual historical administrative and transportation expenditures over a three-year period and the county government's projected cost to provide services. The single state agency does not pay for beneficiary no-shows or "no-load" miles. Adjustments may be made to the initial projection based on policy or utilization changes that materially affect the program.

- b) *Grant agreement between the commonwealth and an entity other than a local county government.*

When local county governments choose not to administer the MATP, the single state agency, may enter into a direct agreement with a qualified public or private entity (primary contractor) to provide non-emergency medical transportation for MA beneficiaries to and from providers.

Upon acceptance of the grant, the primary contractor delivers transportation in its designated service area based on a negotiated trip fee.

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Payment Method

The single state agency provides funding to primary contractors based on a negotiated trip fee. The primary contractor will submit invoices on a monthly basis. Payments are calculated by multiplying the applicable negotiated trip fee by the number of completed trips identified in the primary contractor's invoice.

The single state agency will reimburse the primary contractor on a monthly basis for co-payments paid on behalf of a MA beneficiary to access public or private transportation. This includes the cost of fares in excess of an established general fare structure, where applicable, not subsidized by other programs or funding for which a MA beneficiary may also qualify.

The negotiated trip fee supports the cost of operations (i.e., operating a customer service center; verifying eligibility; assigning trips to lowest-cost, appropriate mode and provider of transportation; managing subcontracts including vehicle inspections and reviewing driver background checks; reviewing subcontractor invoices for the direct transportation services), purchasing transportation on behalf of MA beneficiaries, and paying subcontracted transportation carriers.

The single state agency negotiates a trip fee for each contract period(s) based upon an average of the actual historical administrative and transportation expenditures over a three-year period and the primary contractor's projected cost to provide services. The single state agency will track actual expenses and may choose semi-annually to adjust the initial negotiated trip fee based on policy and utilization changes that may materially affect the program.

2. *Transportation to and from Providers of Services*

Non-emergency medical transportation includes transportation to and from a medical facility, physician's office, dentist's office, hospital, clinic, pharmacy or purveyor of medical equipment for the purpose of receiving medical treatment or medical evaluation or purchasing prescription drugs or medical equipment.

The Grantee assures that transportation is available only to get beneficiaries to and from qualified Medicaid enrolled providers of their choice who are generally available and used by other members of the community or locality in which the beneficiary is located. Exceptions may be granted upon discretion of the Grantee, with oversight from the single state agency, for good cause such as the unavailability of a general range of appropriately qualified Medicaid providers and/or a unique medical condition for a beneficiary.

3. *Authorization of Transportation Services*

Grantees operate customer service centers/lines and interact with Medicaid beneficiaries requesting transportation to a medical appointment. The single state agency provides the means for Grantees to verify Medicaid eligibility and the Grantee assures that transportation is not otherwise available and is necessary to receive a Medicaid covered service.

The need for medical transportation services is determined through an assessment of a beneficiary's mental and physical capability to use various modes of transportation available in the county and the ability of an individual to meet his/her own transportation needs, and the individual's ability to utilize transportation services funded by other State and Federal programs. The Grantee authorizes the least costly and most appropriate mode of transportation.

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The following is a general list of modes of transportation that could be considered when determining service (this is not an all-inclusive list):

- Fixed-route public transportation
- Fixed and deviated route public transportation tickets or tokens
- Beneficiary mileage reimbursement/fuel cards
- Fixed and deviated route public transportation monthly passes
- Volunteer drivers
- Paratransit services
- Mileage reimbursement (at a rate specified by the single state agency)

On a case-by-case basis, an individual beneficiary's situation is reviewed and a mode of transportation is authorized if it is the least costly and most appropriate mode of transportation. The Grantee will not authorize transportation if a beneficiary could have been transported at no cost to Medicaid or if other options other than Medicaid funded transportation are available.

4. *Recruit and Maintain Adequate Transportation Provider Networks*

Grantees must establish a sufficient network of transportation providers to deliver non-emergency medical transportation services to MA beneficiaries. Grantees must have vehicles that can accommodate persons with disabilities. Rates may be negotiated through competitive bidding or other strategies to ensure that the most appropriate and least costly transportation services are provided. Access to transportation services must be at least comparable to transportation resources available to the public. In addition, service delivery must meet the needs of beneficiaries for routine scheduled trips, non-routine scheduled trips, urgent care trips either within the home county or to and from medical services outside of the county.

5. *Maintain a Complaint and Denial Process*

Grantees are required to develop, implement, and maintain a complaint process that provides for resolution of a beneficiary's complaint and the processing of requests for agency fair hearings in instances where transportation services are being denied.

Grantees receive and respond to all complaints regarding the delivery of medical transportation services. Grantees must have a complaint process in place which includes:

- Documentation of the complaint in writing
- A first level review of the circumstances surrounding the complaint by someone other than those involved in the action, which is the subject of the complaint
- The timeframe by which a beneficiary will receive a written response to the first level review and how the response will be documented
- Identifying a second level reviewer or reviewers
- The timeframe by which a beneficiary will receive a written response to the second level review

Grantees must forward complaints to the single state agency in situations where the complainant is dissatisfied with the Grantee's response to the complaint at a second level review.

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B. Grant agreement between the Commonwealth and transportation brokers in the Commonwealth

For county governments that decline to administer the program, the single state agency may elect to directly contract with a transportation broker to assure transportation to and from Medicaid providers. The Transportation Broker Template is located in section 3.1A and 3.1B of the State Plan.

The State assures transportation services under contract through a transportation broker whom:

- is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, qualifications, and costs;
- operates a customer service center to provide a gatekeeper function and pre authorize trips;
- develop a network of providers and pay the providers;
- complies with such requirements related to prohibitions on referral and conflict of interest, as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

1. Payment Method

The single state agency pays the broker a risk based per-member-per month capitated fee to support the cost of operations (i.e., operating a customer service center; verifying eligibility; assigning trips to lowest-cost, appropriate mode and provider of transportation; managing subcontracts including vehicle inspections and reviewing driver background checks; reviewing subcontractor invoices for the direct transportation services) and for the broker to pay their subcontracted transportation providers.

2. Transportation to and from Providers of Services

Non-emergency medical transportation service includes transportation to and from a medical facility, physician's office, dentist's office, hospital, clinic, pharmacy or purveyor of medical equipment for the purpose of receiving medical treatment or medical evaluation or purchasing prescription drugs or medical equipment.

The broker must assure that transportation is available only to get beneficiaries to and from qualified Medicaid enrolled providers of their choice who are generally available and used by other members of the community or locality in which the beneficiary is located. Exceptions may be granted upon discretion of the Grantee, with oversight from the single state agency, for good cause such as the unavailability of a general range of appropriate Medicaid enrolled medical providers within the access standards and/or a beneficiary's unique medical condition.

3. Authorization of Transportation Services

The broker operates a customer service center and interacts with Medicaid beneficiaries requesting transportation access to a medical appointment. The single state agency provides the means for the broker to verify Medicaid eligibility and the broker assures that transportation is not otherwise available and is necessary to receive a Medicaid covered service.

The need for medical transportation services is determined through an assessment of a beneficiary's mental and physical capability to use various modes of transportation available in the county, the individual's ability to meet his or her own transportation needs, and the individual's ability to utilize transportation services funded by other State and Federal programs. The broker authorizes the use of escorts when medically necessary.

METHODS USED TO ASSURE TRANSPORTATION OF BENEFICIARIES TO AND FROM PROVIDERS

The following is a general list of modes of transportation that could be considered when determining service (this is not an all-inclusive list):

- Fixed-route public transportation
- Fixed and deviated route public transportation tickets or tokens
- Beneficiary mileage reimbursement/fuel cards
- Fixed and deviated route public transportation monthly passes
- Volunteer drivers
- Paratransit services
- Mileage reimbursement (at a rate specified by the single state agency)

On a case-by-case basis, an individual beneficiary's situation is reviewed and only authorized if it is the least costly and most appropriate mode of transportation. The broker will not authorize transportation, if the beneficiary could have been transported at no cost to Medicaid or if other options other than Medicaid funded transportation is available.

4. Recruit and Maintain Adequate Transportation Provider Networks

The broker must establish a sufficient network of transportation providers to deliver medical transportation services to MA beneficiaries. They ensure that their network has vehicles that can accommodate persons with disabilities. They may negotiate rates through competitive bidding or utilize other strategies to ensure that the most appropriate and least costly transportation services are provided. The broker shall ensure access to transportation services is at least comparable to transportation resources available to the public, and shall ensure provision of service delivery to meet the needs of beneficiaries for routine scheduled trips, non-routine scheduled trips, urgent care trips and bariatric trips either within the home county or to and from medical services outside of the county. The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity which it has a prohibited financial arrangement.

5. Maintain a Complaint and Denial Process

The broker shall develop, implement, and maintain a complaint process that provides for settlement of a beneficiary's complaint and the processing of requests for fair hearings.

The broker receives and responds to all complaints regarding the delivery of medical transportation services. The complaint process includes:

- Documentation of the complaint in writing
- A first level review of the circumstances surrounding the complaint by someone other than those involved in the action, which is the subject of the complaint
- The timeframe by which a beneficiary will receive a written response to the first level review and how the response will be documented
- Identifying a second level reviewer or reviewers
- The timeframe by which a beneficiary will receive a written response to the second level review

The broker shall forward the complaint to the single state agency if the complainant is still dissatisfied after at least two levels of broker-level review.

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6. Monitoring of NEMT program:

The State uses a variety of methods to monitor the broker. The State has established monthly, quarterly, semi-annual, and annual requirements, primarily in the area of required reporting, to ensure contract compliance and to measure cost effectiveness. The reports correlate with performance standards which have potential liquidation damages associated with them. Additional methods used to monitor the broker are onsite visits, teleconferences, and community meetings. The frequency of monitoring includes the following:

Monthly:

Review of Monthly Trip Summary Report – This report summarizes the number of requested and completed trips, provider or recipient no-shows, canceled, late, and urgent trips. In addition, the report includes completed trips by mode (Paratransit, Public Transportation, mileage reimbursement) and by medical reason.

Monthly Call Center Report – This report lists call center performance in the following areas: total number of incoming calls, number of answered calls, average speed of answer, blocked call rate, rate of call abandonment, percentage of calls answered in under two minutes, average talk time, number of calls placed on hold and length of time on hold, number of abandoned calls, number of outbound calls, and number of available operators by time.

Financial Expenditure Reports - These reports include the Balance Sheet, Income Statement, and Statement of Cash Flow.

Monthly Customer Satisfaction Report – Each month, the broker is required to conduct telephonic surveys with MA recipients to assess their satisfaction with timeliness, driver safety and service, as well as, cleanliness and maintenance of vehicles.

Encounter Data File - This file provides detailed information on all completed trips including the recipient's MA ID number, date of trip, mode, address of pick-up, and address of drop-off. This file assists us in determining and evaluating utilization of transportation services.

Incident Report – This report outlines significant incidents that include but are not limited to assaults, injury/accident, and abuse on paratransit vehicles.

Quarterly:

On-site Monitoring (on a quarterly basis at a minimum) – The State also performs on-site monitoring on an "as-needed" basis and at least on a quarterly basis to discuss operational and MA recipient issues.

Regularly Scheduled Teleconference Phone Calls - These meetings focus on improving quality service delivery outcomes.

Philadelphia Advisory Committee Meetings -These meetings allow the broker and the State to update MA recipients and medical providers on the status of the program. These meetings also provide the opportunity to receive feedback on program operations.

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Semi-Annually:

Data Validation Reviews - the State performs trip validation and verifications of trip utilization data to determine that monthly data file elements are accurate and complete and that reported trips have the necessary supporting documentation indicating eligibility and completion within the allowable pick-up time.

Upon validation of data elements, the State generates a statistically valid random sample of completed trips that includes a recipient's MA ID number, date of trip, mode, address of pick-up, and address of drop-off. The State will request from the broker their source documentation to support that a completed trip took place (regardless of mode) and review source documentation and determine the number of errors. The review for errors will encompass the following areas: eligibility of the individual, eligibility of the medical service, adequacy of documentation that the trip was performed, and timeliness of the trip.

Annually:

Submission of an Independent Certified Public Accountant's Financial Audit - This audit is performed to obtain the broker's current financial status.

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D. Special Transportation Services provided by School-Based Service Providers (42 CFR 440.170(a))

The Special Transportation Services for School-Based Services is located in Attachment 3.1A of the State Plan.

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C. Non-contractual.

In those counties in which the Commonwealth does not contract for non-ambulance transportation as described in A above, the cost of recipients' transportation to covered medical services is paid by the County Assistance Office located in the county in which the recipient resides. The County Assistance Office evaluates the need for recipients' transportation as follows:

1. Medical services requested are covered by the Medical Assistance Program.
2. There are definite appointments and arrangements made for the provision of care.
3. All other resources are explored, i.e., family, friends, County Court, Veterans Administration facilities.
4. Use of nearest Medical Assistance resource unless specialized service necessitates additional travel.

Payment is made for public transportation in accordance with the rates as established for the general public. For recurring transportation needs, categorically needy recipients may receive either a County Assistance Office disbursement or have an allowance for public transportation included in their regular grant. Medically needy recipients may receive County Assistance Office disbursement not to exceed the actual cost for a three month period.

If public transportation is not available, payment for private vehicles is at the rate of \$.12/mile. If the total transportation cost is more than \$50.00 per month for a recipient, it must be approved by the Executive Director of the County Assistance Office or his/her delegate.