Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs

A Guidebook for State Medicaid Agencies

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Ms. Sally Richardson, Director
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Dear Ms. Richardson and Mr. Bullen:

I am pleased to forward to you **Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs: A Guidebook for State Medicaid Agencies.** This guidebook, written by the members of the Health Care Financing Administration (HCFA) and the National Association of State Medicaid Directors' (NASMD) Non-Emergency Transportation Technical Advisory Group (NET TAG), is the product of more than two years of hard work.

Millions of Americans depend on Medicaid-funded transportation to reach medical appointments. This service—of particular importance to clients needing critical services such dialysis, rehabilitation, or chemotherapy—allows them to reach doctors and hospitals and receive care. In rural areas where medical providers are often in short supply, communities are far from primary care physicians or specialists, and public transportation systems are usually nonexistent, Medicaid transportation fulfills a critical need.

This guidebook was written by state Medicaid transportation managers for Medicaid professionals. It is not designed to give a specific blueprint for the operation of NET services. Rather, its purpose is to bring to the attention of its readers a variety of issues and challenges which could be considered by NET program managers and suggestions to address these concerns. It provides specialized chapters on areas of particular importance, such as brokered transportation, operating within managed care systems, and fraud and abuse.

It has been an honor for me to serve as chair of the NET TAG. I want to thank several individuals and organizations for their assistance. Most importantly, the members of the TAG worked tirelessly to gather information and write and rewrite their respective chapters. Bruce Weydemeyer, formerly the New Mexico Medicaid director, and Mary Vollin and Joyce Jackson of HCFA's Center for Medicaid and State Operations contributed immensely to the guidebook. John Peller at APWA provided outstanding staff support to the NET TAG, and in that capacity he edited the chapters, contributed to the text of the guidebook, and organized the TAG's activities. Without these individuals, the guidebook would certainly not be the comprehensive, practical and well-written document that it has turned out to be.

And finally, I want to thank HCFA and NASMD for understanding the importance of this project and their willingness to finance it. We encourage readers of this guidebook to reconsider the role of non-emergency transportation in their states. It has become clear to all of us involved in this project that NET programs, and the health systems that serve as the context in which they operate, change rapidly and must be constantly adjusted and readjusted to deliver services as efficiently and cost-effectively as possible. It is this challenge to which Medicaid program administrators must continually adapt. I hope this unique work will serve as a valuable resource to them for years to come.

Sincerely,

Jan Larsen, Chair, Non-Emergency Transportation TAG
Director, Division of Contracts Monitoring, Mississippi Division of Medicaid

About the Authors

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1. Overview

John Peller, American Public Welfare Association

America is a nation of cars. As a society, we value the open road, the lure of speed, the captivating aura of a shiny new vehicle. Our cities, suburbs, and rural areas are designed for getting around in a car. Only in a select few areas are public transportation networks sufficiently developed that residents can live comfortably without a car.

But what about the millions of Americans who don't have a Ford, a Honda, or a Jeep? Disproportionately poor, young, and elderly, how do these individuals get around? How do they shop, or go to church, school, work, and the doctor? For these individuals, finding the transportation that so many of us take for granted can be a daily struggle.

Inability to reach health care services is of particular concern for the low-income, disabled, or elderly Americans served by the Medicaid program. The best doctors in the world are powerless to cure the sick if their patients cannot reach their services. A program designed to assure that high-quality medical services are available is meaningless if beneficiaries cannot physically reach providers. Recognizing this fact, the architects of the Medicaid program required all states to ensure that their clients have transportation to health services. Medicaid non-emergency transportation (NET) is a ride, or reimbursement for a ride, provided so that a Medicaid beneficiary with no other transportation resources can receive services from a medical provider. By definition, NET does not include transportation provided on an emergency basis, such as trips to the emergency room in life-threatening situations.

Each state operates its Medicaid transportation program differently. Depending on a number of factors, such as the rural or urban nature of a state, the availability of private resources in a community, the scope of public transportation, and the region's fiscal capacity, states have developed Medicaid NET systems that vary widely. While Pennsylvania gives subway tokens to many clients in Philadelphia, Alaska flies clients to medical appointments and has found it cost-effective to fly doctors to their patients. Other states, such as Mississippi and Vermont, have extensive networks of volunteer drivers whom the state reimburses for taking their neighbors to medical appointments. Still others have developed elaborate methods for pre-approving rides and arranging rides through organizations called brokerages.

Who relies on Medicaid transportation? The most frequent users are disabled individuals, elderly persons, children who are receiving counseling or other services on a regular basis, and individuals who travel regularly to medical appointments for services such as dialysis, mental health treatment, chemotherapy, or physical therapy for the severely disabled. All states require individuals with working cars of their own or access to a vehicle owned by a friend or family member, or with access to any other transportation resource, to use these services before turning to the Medicaid program for help. Most Medicaid agencies will reimburse clients for gas or mileage if they drive themselves.

In 1997, according to an analysis by David Raphael of the Community Transportation Association of America (CTAA), roughly $1.2 billion, or slightly less than 1% of the state and federal combined Medicaid budget, was spent on NET services.[1] An unpublished survey of 36 states by the state of Alaska estimated that they spent $777 million in fiscal year 1994. The Health Care Financing Administration (HCFA), the federal agency that administers Medicaid in partnership with the states, does not collect separate data on NET expenditures. HCFA does not collect or identify transportation as a discreet data element.

This publication represents an attempt to identify effective state practices and to raise issues that states need to resolve in providing NET services. Unlike other NET studies, *Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs* was assembled by a team of state Medicaid transportation program managers. With knowledge of the program like no one else, they have drawn on their own and their colleagues' experiences in writing this guidebook.

The project is a collaboration between HCFA's Medicaid Bureau, which helped fund the effort, and the Medicaid Management Institute, a project of the American Public Welfare Association.[2] Each author was a member of the NET Technical Advisory Group (TAG), which was convened specifically to examine NET issues. The TAG is composed of 10 state staff members (one representative from a state in each of the 10 HCFA regions) who operate or oversee transportation programs. In addition, staff from the HCFA's Center for Medicaid and State Operations (central and regional offices) were active participants. A list of members is attached (see Appendix A).

The TAG's Goals

The NET TAG was founded in 1995 in response to several factors. First, there was no forum at the time for states to discuss the challenges they faced in the NET program. State Medicaid directors saw their NET expenditures balloon and felt there was a lack of information on steps other states were taking to control costs and utilization. Furthermore, high-profile media stories alleged widespread fraud and abuse in several states, including but not limited to Arkansas, Florida, Georgia, and New Jersey. (These states have undertaken active prevention strategies that have effectively combated fraud and abuse.) These problems, and others, contributed to the perception that the program needed more attention on the state and federal levels.

Unlike most Medicaid services, NET is not inherently medical in nature. Setting transportation policy requires an intimate knowledge of such topics as taxi rates, the development of transportation networks, and methods to provide services cost-effectively.

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[1] Community Transportation Association of America, *Managing Medicaid Transportation: A Manual Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans.* Washington, D.C., December 1997.

[2] The National Association of State Medicaid Directors, an APWA affiliate, also provided financial support for this project.

Most state Medicaid directors and administrators do not have an extensive background in transportation, and must instead rely on the expertise of persons in those fields.

The NET TAG aimed to identify strategies to help states better manage the NET program by controlling expenditures, providing more efficient and effective services, and preventing and prosecuting fraud and abuse. The group's recommendations are discussed in detail in the chapters that follow. In addition, they are summarized in the "Findings" chapter. In some cases, states do not need permission from the federal government to enact changes in their programs. In others, states must obtain from HCFA a waiver of certain provisions of the Medicaid statute. Finally, changes in federal law may be required to adopt some of these recommendations.

Claiming Transportation Costs

One of the factors that states must consider when designing or reviewing their Medicaid NET programs is federal matching funds. All state Medicaid expenses are matched at varying rates by the federal government. There are two ways to claim these matching funds for transportation expenses: as an optional medical service or as an administrative service. (A state can use both claiming methods at the same time.) The two options are described in more detail below.

Regardless of whether a state claims NET costs as an optional medical service or an administrative expense, the state must determine the necessity of transportation services. Payment for services must be consistent with "efficiency, economy, and quality of care," and administrative costs must be necessary for the "proper and efficient operation" of the state plan, as described in Title XIX of the Social Security Act and the Medicaid regulations. Furthermore, regulations require that when several modes of transportation are available, states must use the least costly means that is appropriate to the medical needs of the beneficiary.

- **Optional Medical Service.** Transportation can be claimed as an optional medical service only when provided by a vendor to whom the Medicaid agency makes a direct payment. For example, when a provider bills for services and receives payment directly from the agency, transportation costs claimed as an optional service are matched at the state's federal medical assistance percentage (FMAP). Each state's FMAP is based on the amount of per capita income in each state; FMAPs ranged nationwide from 50 to 78 percent in fiscal year 1995. The rates are adjusted annually.

  As an optional service, transportation must meet the definitions outlined in the Medicaid regulations (at 42 CFR 440.170(a)) and all other requirements relating to Medicaid services. These include beneficiary freedom of choice, which permits a client to obtain services from any qualified Medicaid provider. For example, the state must contract with any willing provider who meets the agency's standards, must make available the same level of service across the state, and must provide the same level of service to all clients with similar needs. Under this option, beneficiary freedom of choice also applies to Medicaid services, including transportation, and permits clients to receive services from

any Medicaid provider of their choosing. States cannot restrict beneficiary freedom of choice without a waiver from HCFA.

- **Administrative Service.** Transportation costs claimed as an administrative expense include the use of vendors, reimbursement to the client, direct vendor payment, or other arrangements. These costs are matched at the 50 percent administrative services rate. Transportation provided in this way must meet requirements for the "proper and efficient operation" of the state plan as outlined in Section 1902 of the Social Security Act. States have a great deal more flexibility under this option to design their transportation systems. Furthermore, freedom of choice does not apply, so states may contract with a limited set of providers.

States often weigh financial considerations heavily when deciding which claiming method to use. Because the 50 percent administrative services match rate is lower in most states then the FMAP, some states choose the medical services option even though it can significantly limit their flexibility, while other states forsake the higher match rate for additional flexibility. Mississippi and Pennsylvania, for example, claim transportation as an administrative expense because of the increased flexibility and program control that comes with that option. States can receive waivers that allow them more flexibility while still receiving the higher match rate.

Strategies for Effective Program Management

Through their work on this report, TAG members have identified several effective transportation management strategies that can control or reduce costs, prevent fraud and abuse, and provide better service to clients. A similar list of strategies has also been identified by other transportation researchers, including the U.S. Department of Health and Human Services (HHS) Inspector General[3] and Jon Burkhardt, of Ecosometrics, Inc., in a 1995 study funded by HHS. Effective strategies include contracting with brokers, restricting freedom of choice of providers, and coordinating with other transportation providers. Described in more detail throughout the report, these strategies are summarized below.

- **Brokers.** A number of states contract with brokers, either in limited areas or across the entire state. Brokers usually enroll and pay providers, determine the most appropriate type of transportation service for a client, authorize services, and arrange and schedule rides. The staff are usually intimately familiar with an area's geography and transportation resources, and are able to manage provider's vehicle fleets to transport clients as efficiently as possible. In most states, brokers do not provide rides themselves, but contract out these services.

- **Restricting freedom-of-choice of providers.** Several states have improved their management of transportation by contracting only with certain providers. In most cases, states must apply for and receive a waiver of certain provisions of Section 1902 of the

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[3] HHS Office of Inspector General. "Controlling Medicaid Non-Emergency Transportation Costs." Betty Apt, Josiah Townsel, Wynethea Walker, and Jacqueline Andrews. April 1997.

Social Security Act to restrict freedom of choice of providers, but waivers can significantly reduce costs. by allowing states to competitively bid transportation services.

- **Coordination with other human service providers.** Many states have gained substantially from coordinating with other programs that provide transportation, including Area Agencies on Aging, Head Start programs, Community Action Agencies, public transportation authorities (both Americans with Disabilities Act paratransit and fixed-route), and providers of welfare-to-work transportation. Many of these programs serve the same clients. Although coordination can be challenging, some states have found that it reduces costs and provides better services to clients. Medicaid is often the largest single funder of transportation in a region, and the greater efficiencies that result from transportation coordination can have ramifications throughout a local transportation system.

Medicaid Transportation and Welfare Transportation: Toward a Coordinated System

In August 1996, President Clinton signed the landmark Personal Responsibility and Work Opportunity Reconciliation Act of 1996. For the first time, the law requires states to move almost everyone receiving cash assistance into job training or work activities. One of the many challenges states face in moving clients from welfare to work is transportation. Low-income clients entering the workforce need assistance with transportation services to provide access to child care and job training, and travel between work and home.

Many states, counties, and cities are realizing that they need to provide transportation to their clients to help them achieve self-sufficiency. As states do this, they must make use of existing transportation networks and resources. Although Medicaid cannot be expected to fund welfare-to-work transportation efforts, the transportation services established to serve Medicaid clients may also be used as part of the network of transportation providers that serve welfare clients. As states move towards implementing welfare reform transportation programs, they should consider working with Medicaid and other human service agencies to develop coordinated transportation networks. For more information, see Chapter 3, "Coordinating Medicaid Non-Emergency Transportation with Public Transportation and Other Agencies."

Conclusion

All states recognize the importance of the Medicaid transportation program. Some states have implemented legislative mandates to trim the program's growth or to provide more efficient services. These efforts should be undertaken with care, since any change in the program may affect access to medical services. Furthermore, since Medicaid is often the single largest funder of transportation services in many communities, the impact of any change on a region's often fragile and underfunded transportation network must be carefully evaluated.

This guidebook contains valuable strategies that states can use to make a variety of program changes, from containing costs to improving access to services. The final chapter recommends a number of changes that are needed to allow states greater flexibility in managing the NET program and accomplishing the program's goals.

2. Considerations in Defining the "Assurance" of "Necessary" Transportation

Patricia Darnell, Nebraska Department of Health and Human Services

Medicaid is a federal program that is designed to provide medical coverage to certain children and adults in low-income households. Persons with limited incomes frequently lack reliable transportation, which is integral to accessing medical care. Federal Medicaid regulations thus require states to assure necessary transportation to medical care. This chapter discusses the assurance requirement and the considerations a state may use in defining "necessary" transportation.

Assurance of Transportation

Federal regulations mandate that each state Medicaid agency specify in its state plan that it will "ensure necessary transportation for clients to and from providers" and "describe the methods that the agency will use to meet this requirement" (42 CFR 431.53). The Medicaid agency is further directed to offer and provide clients of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services with "necessary assistance with transportation," if requested (42 CFR 441.62).

These regulations require Medicaid administrators to recognize the importance of transportation in accessing medical care, examine the options available, and establish a plan for ensuring that transportation needs are met. In determining how it will assure transportation, a state often considers the following factors:

- the political environment within the state;
- the financial and staff resources available to the state;
- the existing transportation resources and infrastructure;
- the rural/urban components of the state;
- the ability of county and local jurisdictions to play a role in developing, coordinating, implementing, or operating aspects of the state's transportation program;
- the ability of managed care plans to adequately provide transportation;
- the capacity of the state department of transportation (DOT) or other agencies to assist in developing alternatives;
- the possible consequences of an inadequate non-emergency transportation (NET) program, including the use of higher cost modes of transportation (e.g., non-emergency ambulance); and
- the outcomes desired by the state agency.

A comprehensive NET program may assist states in achieving a variety of desirable outcomes. The health of Medicaid clients may be improved by increasing their access to medical care, especially in areas such as preventive and prenatal care. Adequate transportation can result

in fewer missed appointments, thus making physicians and other health care providers more willing to participate in the Medicaid program. By making available lower-cost NET services, more costly emergency care and transportation may be avoided.

Although states must meet the federal mandate to assure transportation, they have flexibility in establishing the methods used to do so. States use a variety and combination of methods to assure transportation, including:

- direct provision (e.g., contracting with transportation providers, use of public transportation, etc.);
- helping clients to obtain transportation services through coordination with other programs and resources; and
- providing reimbursement directly to clients.

The flexibility that states are permitted in designing their NET programs allows them to establish standards that are appropriate for local communities and individual clients. For example, in areas where transportation resources are limited, some states actively recruit providers. Other states offer mileage reimbursement when it is appropriate for a client, e.g., no transportation is available, and still others have developed comprehensive networks for coordinating transportation among human service agencies serving a common client base.

A state's options in establishing methods to assure transportation may be limited by certain requirements imposed by the way it claims transportation costs. These requirements and limitations are discussed in detail in the Chapter 1.

Defining "Necessary" Transportation

The way a state defines "necessary transportation" forms the basis for its NET program, determining both which clients may receive transportation assistance and the circumstances under which it will be provided. Limitations and restrictions established by the state must be reasonable in meeting the need of clients, appropriate for the community in which clients reside, and not so restrictive as to conflict with the state's responsibility of assurance. Variations among communities and localities will naturally require differences in this definition. For example, air or water transportation will be important in some states and irrelevant in others.

The following components are included in many states' definitions of "necessary" transportation:

- **Transportation to or from Medicaid-covered services.** States generally limit their NET coverage to transportation required to obtain Medicaid services.

  Some states limit coverage of transportation to services that the agency *actually* funds; other states allow transportation to services that *could be paid for by the agency* even when they are aware that another source will fund the service and consider it a method of "cost avoidance." Examples include services funded by Medicare, private insurance, and the Department of Veterans' Affairs. The term "Medicaid-compensable or coverable services" may be used in place of "Medicaid-covered services" to take these situations into

account. Some states place limits on the frequency of services such as physician office visits and allow transportation only for services that do not exceed those limits. Others allow transportation regardless of service limits.

A state may need to consider establishing a process to consider transportation to services not generally covered under the state plan, such as medically necessary "non-covered" services mandatory under the expanded EPSDT benefit.

In making these choices, states have found that it is important to consider whether a medical service will be covered and funded by an agency before authorizing or paying for transportation, and the extent the requirement will be monitored.

- **Use of the least expensive mode of transportation available that is appropriate for the client.** There are two components in this requirement—"least expensive available" and "appropriate for the client."

  One factor in determining the "least expensive mode of transportation" is the types of transportation available in a given area. Modes of transportation range from public transportation systems to door-to-door services. States with a wide variety of modes of transportation have more options from which to choose the least expensive mode. A state may find that in certain areas, multiple options do not exist. If lower-cost modes of transportation are not available, higher-cost options may be necessary. When determining the least expensive mode of transportation, states may choose to examine not only the direct-service cost of transportation, but also the administrative costs involved.

  Determination of the mode of transportation "appropriate for the client" is often based on two factors—the client's condition and the conditions under which transportation is required:

  - The client's physical, mental, or medical condition often dictates the appropriate mode of transportation. Some states require certification from a physician or other health care professional to document a client's need for "higher level" modes of transportation, such as a wheelchair van.

  - The conditions under which transportation is required may also affect the decision as to which mode is most appropriate for the client. For example, the need for long-distance transportation may not be accommodated by fixed-route public transportation, but may require a paid volunteer driver. When short notice for transportation cannot be avoided, a higher cost mode such as a taxi may become necessary.

- **Restriction to the nearest qualified provider.** There are several issues related to restricting transportation to the nearest qualified provider.

  The way in which a state defines a "qualified provider" will affect the impact of this requirement. Often states define qualified providers as those that are enrolled in the Medicaid program and agree to bill Medicaid for services rendered. A state may also consider providers that are not Medicaid-enrolled to be "qualified providers" if they allow transportation when the Medicaid program will not actually fund the services, such as those provided by the Department of Veterans' Affairs. States with Medicaid managed

care programs may consider the client's primary care physician as the "qualified provider," allowing transportation even though it may not be the nearest provider.

States may allow flexibility when applying the nearest provider restriction. This flexibility may be related to the outcomes desired by the agency. For example, a client's regular physician may be located across town. If there is a closer provider, the state may require that the client use the nearer provider, thus saving on transportation costs. On the other hand, the state may take the view that, although the client's established physician is farther, to require the client to change doctors may, in fact, reduce the likelihood that the client will seek medical care early or for preventive services. To avoid more costly emergency services, the state may choose to consider the established physician to be the "qualified" provider and allow transportation. This could lower the state's overall costs, although transportation costs could increase.

Concerns about freedom of choice often surface with discussion of restrictions to the nearest qualified provider. Under the Medicaid program, states are required to allow clients freedom of choice of providers unless the state is granted a waiver of this requirement. This is meant to allow clients the same opportunity to choose among available providers as the general population. (Note: The freedom-of-choice requirement does not apply to administrative expenses; therefore states which provide transportation under this method do not have to permit free choice of transportation providers.)

There are two components to the freedom-of-choice issue—choice of the actual transportation provider and choice of the medical provider to which the transportation is required.

Freedom of choice, when required, gives the client the opportunity to choose any transportation provider *within the least expensive, appropriate mode.* For example, if there are two wheelchair van services, clients may select the provider of their choice. Freedom of choice does not, however, apply to the mode of transportation. A client cannot choose a taxi for transportation services, for example, if public transit (e.g., subway, bus) would be the least expensive, appropriate transportation for the client.

Freedom of choice does *not* give clients the opportunity to obtain medical care from the provider of their choice *and have the state bear the expense of transportation to that provider.* According to the *State Medicaid Manual* (Section 2113), states are not required to provide transportation at an unusual or exceptional cost to accommodate a client's personal choice of provider—that is, states may elect to limit NET services to the nearest qualified provider.

The requirement that transportation be to the nearest qualified provider may, in practice, restrict clients' freedom to choose their medical providers. However, it does *not* conflict with the federal freedom-of-choice requirement.

- **No other transportation services available free of charge.** Since Medicaid is the payer of last resort, states generally require clients to use available free transportation before authorizing services through their NET programs. Free transportation may include that provided by friends, family members, unpaid volunteers, and nonprofit agencies.

- **Exclusions for clients receiving services that include a transportation component.** States may choose to provide transportation as a component of other Medicaid services. For example, nursing home reimbursement often includes a transportation component. Nursing home residents would then be excluded from coverage through the state NET program.

Some states also restrict coverage of NET services within geographic boundaries. For example, a state may not provide transportation coverage to clients obtaining medical care within their community or within certain geographic or mileage boundaries, unless needed medical care is not available in the area. When implementing this type of restriction, states may take the view that, within the client's community, the client should make arrangements for medical care just as he or she would for other basic needs such as shopping or participating in community events. Restrictions of this type should be applied in a reasonable manner, taking into consideration the needs and circumstances of the individual client.

Related Travel Expenses

Federal regulations allow states to pay for "other related travel expenses" determined necessary "to secure medical examinations and treatment for a client" (42 CFR 440.170). States are not *required* to cover related travel expenses, but may choose to do so.

Related travel expenses generally include meals and lodging for clients when traveling to and from and while receiving medical care, and the cost of an attendant to accompany the client, if necessary. The cost of an attendant may include transportation, meals, lodging, and, if the attendant is not a member of the client's family, salary. States are allowed to somewhat expand upon or modify the federal definition of related travel expenses to meet the needs of clients in their individual states.

Related travel expenses allow a state to assist clients when distance and travel time warrant overnight stays, and when a client's condition prohibits traveling alone. The following factors are often used to determine if related travel expenses are "necessary":

- the client's physical, mental, or medical condition;
- the type and frequency of medical care required; and
- the time required to travel to and from the health care provider.

Using the Definition of "Necessary"

Many states use their definition of "necessary" transportation as a screening tool to determine coverage for individual clients and to control for appropriate use of NET services. Prior authorization of services is the most commonly used method. States often confirm the service to which transportation is authorized by a variety of methods, such as a signature from the medical provider or direct contact with the provider office. Unusual services such as long-distance or out-of-state travel generally require greater monitoring. On a post-payment basis, some states use a comparison of transportation services with a review of claims payment history to verify that

transportation was provided to a covered service. These methods safeguard against unnecessary or inappropriate use of transportation services.

Key Points

States may use a variety of methods to assure transportation. Requirements and limitations are necessary to administer a cost-effective NET program; however, these limitations should not unreasonably restrict access to medical providers. In developing and managing NET programs, states must keep in mind the purpose of their programs and their responsibility to meet the mandate to assure transportation.

States often consider the following in their definition of "necessary" transportation:

- to and from a Medicaid-covered service;
- the least expensive mode of transportation available that is appropriate for the client;
- to the nearest qualified provider;
- no other transportation resource is available free of charge; and
- it excludes clients receiving services that include transportation.

Related travel expenses, such as payment for attendants, meals, and lodging, may be included in a state's NET program to assist clients who must travel long distances or who cannot travel alone.

3. Coordinating Medicaid Non-Emergency Transportation with Public Transportation Providers and Other Agencies and Programs

Darryl Nixon, California Department of Health Services

The ability of states to effectively coordinate their established transportation resources, both public and private, is crucial in meeting the Medicaid program's "assurance of transportation" requirement. States that effectively coordinate their transportation services will be able to control escalating Medicaid transportation costs and maximize scarce transportation resources, both fiscal and physical. Further, Medicaid can play an important role in setting the tone for coordination of other human service transportation resources. We hope that this chapter will advance new, more cooperative models of coordination that are beneficial to all parties.

Federal Assurance Requirement

When developing plans to assure transportation, states have found that access to necessary care is an important element. Despite the apparent rigidity of the transportation mandate, states have a great deal of flexibility in defining the term "necessary" as used under federal regulation (see Chapter 2). States have used this flexibility to define "necessary" broadly in terms of the population that will be served, the medical care services to which transportation will be provided, and the modes of transportation that will qualify for Medicaid payment. States' ability to develop models of coordination that maximize all modes of transportation can assist in meeting the assurance requirement.

Claiming Issues

In meeting the assurance requirement, states may claim federal financial participation (FFP) as an optional medical service, as an administrative expense, or both. The Social Security Act also requires states to administer their Medicaid plan properly and efficiently [Section 1902(a)(4)] and to provide services in a manner that is efficient, economical, and conducive to quality care [Section 1902(a)(30)].

These provisions require that Medicaid serve as the payer of last resort. The Health Care Financing Administration (HCFA) requires states to make sure clients use all available free transportation services (i.e., relatives and friends) before authorizing Medicaid expenditures when transportation is covered as an optional service. Additionally, proper and efficient administration of a Medicaid plan requires states to use the least costly mode of transportation if multiple modes of transport are available (this includes maximizing clients' use of available free resources). States can comply with these provisions, as well as with the general assurance requirement, by utilizing the established transportation infrastructure, both public and private, and by developing successful models of coordination.

Steps to Successful Coordination

Assessment of Transportation Resources. As the first step in developing a model of coordination, Medicaid agencies should assess the transportation resources available within their state or locality. In conducting this assessment, it is important for agencies to gather complete information on all the sources of transportation, both public and private, that are available to Medicaid clients. Assistance in gathering this information is available through a variety of local, state, and federal resources including the Department of Health and Human Services (HHS) and the Department of Transportation (DOT) Joint Coordinating Council on Human Services Transportation, the Federal Transit Administration, state departments of transportation, regional transit agencies, metropolitan transit agencies, state social welfare agencies, state health agencies, and nonprofit organizations. In addition, some states may have a human service transportation coordinating council that is working statewide to coordinate transportation. At minimum, state coordination efforts involve the state department of transportation and human service agencies.

Information Resources. The Community Transportation Assistance Project (CTAP) may also serve as a valuable resource in gathering the information required for assessing state transportation resources. CTAP is funded by a grant from HHS and is operated by a consortium made up of the Community Transportation Association of America, the National Easter Seals Society Project ACTION, and the Region IV Transportation Consortium, now known as the National Transportation Consortium of States.

CTAP offers a wide range of information, including databases of relevant legislation and regulations such as the Americans with Disabilities Act of 1990 (ADA); information about funding sources; publications and training packages on a number of transportation issues, including the use of volunteers in community transportation, how to make a system accessible to people with disabilities, alternative fuels, and considerations for the transport of seniors and persons with disabilities; and a growing national network of peers who offer hands-on help in many areas. For more information on CTAP, contact the project at (800) 527-8279.

Developing a Successful Model

To meet the assurance requirement, some states have found that they need to establish a formal basis for coordinating available transportation resources. Coordination, which can be conducted under a variety of models, both public and private, may include collaborating with state or local agencies, nonprofit organizations, private brokerages, or any combination thereof. Political and economic factors may influence the type of model developed. States need to be flexible when designing their transportation models, both to provide assurance of services and to ensure that the program will be viable within the state's political and economic environment.

Federal funding to help states develop coordinated systems may be available through the Federal Transit Administration (FTA). States can determine the availability of such funding when planning and developing their coordination models. Additionally, to maximize their resources, states can determine the funding for transportation that may be available through other human resource programs.

Medicaid and the ADA

The ADA has played an important part in the development of local resources that can assist states in meeting the transportation assurance requirement. The ADA required all transportation authorities to operate a transit system that provides curb-to-curb service for people with disabilities within a several-block corridor that is parallel to all regular transit routes. States must recognize, however, that the ADA was not funded by the federal government. The act's requirements have severely strained the fiscal resources of public transportation agencies due to the substantial capital investment and high operating costs of paratransit systems.

The limits placed on how much local transportation agencies can charge for their services under ADA regulations is an issue that affects access to public transportation for ADA-eligible Medicaid clients. ADA rules prohibit transit agencies from charging disabled individuals more than a set amount per trip (no more than twice the fare charged to a physically able rider). Such limits, intended to protect disabled individuals from high costs, mean that ADA-regulated fares rarely cover the cost of providing the trip. If these limits are determined to apply to trips provided to ADA-eligible Medicaid clients, transportation providers will be less likely to help Medicaid programs develop public transportation alternatives. In recognition of this fact, several regional offices of HCFA have sent letters to states informing them that Medicaid can pay transportation providers a negotiated rate based on the cost of providing the service.

Transit agencies and other members of the human service transportation community have expressed concern about "dumping" by Medicaid agencies. Allegedly, when the ADA was implemented, some Medicaid agencies initially required clients to use ADA-paratransit services instead of the Medicaid-funded wheelchair van service. The NET TAG did not investigate this practice to determine if it was or is in fact occurring. One ways states can ensure that the fiscal burden of transporting clients is not unfairly placed on ADA-paratransit services is by negotiating rates with the transit agency providing services.

The ADA allows agencies to negotiate rates for providing ADA-paratransit services to clients. In many cases, this can be a win-win situation for states and transportation providers. The Medicaid agency can negotiate a rate that is lower than the regular rate for a Medicaid wheelchair van, yet higher than the amount the ADA paratransit service would charge a regular rider. While Medicaid might not cover the full cost of providing the paratransit services, such an arrangement would lower Medicaid's costs and allow the transit agency to increase its revenue and trip volume.

Medicaid: An Alternate Source of Funding for NET Services?

Despite the significant number of grants and federal matching funds available to enhance the transportation infrastructure of states, localities, and other organizations, Medicaid is sometimes viewed as an alternate source of funding by transportation agencies. While it is important to recognize that transit agencies can help to significantly reduce Medicaid transportation costs, Medicaid agencies must actively educate transit agencies on Medicaid's role.

State Medicaid programs and local transit agencies could work together to design cost-effective coordination models that can benefit from the provision of Medicaid transportation and assist in funding transit requirements. As one example of such collaboration, HCFA recently decided to allow Medicaid programs to pay for monthly bus passes for clients when it is cost-effective to do so. It is important to note in determining cost-effective collaborations that all factors of cost need to be considered in evaluating cost-effectiveness. For example, Federal Transit Grants may be provided to nonprofit human service organizations. Such grants, while provided to a specific group, were designed to benefit the general population. Thus, such grants should not be used to offset true costs during any evaluation process for determining the cost-effectiveness of similar modes of transportation.

State Coordination Efforts

The following section provides information on how some state Medicaid agencies are working to coordinate transportation with other agencies.

California

California's Medicaid program, known as Medi-Cal, uses a variety of methods to assure transportation services for eligible clients. These methods include the provision of medical transportation as a direct benefit of the Medi-Cal program, and as an indirect benefit of other programs and resources, including public and private transportation. As a direct benefit, Medi-Cal covers NET services, subject to prior authorization, when the transportation is required for the purpose of obtaining necessary health care covered by Medi-Cal, and when a client's medical and physical condition is such that transport by ordinary means of public and private conveyance is medically contraindicated (i.e., the individual is wheelchair- or bed-bound and can travel only in specially designed vehicles).

Medi-Cal does not provide payment to individual clients or others as an administrative cost for public or private transportation to necessary health care. The Medi-Cal Program depends indirectly on California's transportation infrastructure, both public and private. Medi-Cal clients who do not qualify for medical transportation are advised of the availability of these public and private resources. This coordination of resources allows California to meet Medicaid's "assurance-of-transportation" requirement.

Florida

Florida state law requires transit services to be coordinated at the county level. Coordination is directed by the Commission for the Transportation Disadvantaged and the state uses county or regional transportation coordinators who operate as part of the state's program to provide transportation to Medicaid clients, either directly or through brokers.

Medicaid clients in Florida who need rides to necessary medical services contact the community transportation coordinator (CTC). The CTC then either provides or arranges for the trip and bills the state's fiscal agent. If transportation is not available in a particular area, the client contacts the regional Medicaid office. Eligibility for transportation is determined by the CTC or the regional Medicaid office.

Florida's Medicaid transportation program is operated as an entitlement program. The underlying philosophy of the program places an emphasis on service without regard to cost. The transportation program operates as an optional medical service, making it eligible for high federal matching rates.

Florida's program is innovative because of the coordinated approach it uses to provide NET services. Under the statewide mandate, all programs that receive or administer state funds for transportation must participate in the coordinated transportation network.

Pennsylvania

Pennsylvania operates an extremely cost-effective program known as the Medical Assistance Transportation Program (MATP). The MATP is a county-based program that uses local transportation resources and direct management at the local level. In Philadelphia, the state contracts with a broker that directs clients to the appropriate and least costly transportation mode (i.e., either fixed-route transit or paratransit provided by local subcontractors).

Counties may provide services directly, broker services through subcontracts with public or private agencies, or use a combination of methods. Funds can be used to provide transportation through a number of systems, including providing tokens or bus passes, reimbursing eligible clients for fares, coordinating volunteers, entering into contracts with integrated public transit services, providing services directly using county-owned vehicles and staff, and reimbursing clients for private vehicle expenses. The guiding principle for the MATP is the use of the most cost-efficient service available that meets the client's needs.

Oklahoma

In many rural areas, school buses are the only form of public transportation. During the summer, and between 9 a.m. and 3 p.m. during the school year, school buses often sit empty. These buses, however, represent a tremendous capital investment that some state and local agencies have considered tapping into. In addition, with the new welfare reform law that requires states to move an unprecedented number of welfare clients into job training and work activities, transportation to jobs and job training is a challenge in many areas.

The Oklahoma Medicaid agency is currently working with the state Department of Education to evaluate a recommendation proposed by a school transportation task force. The task force recommended that the state design an interagency transportation program in which human service agencies would contract with common and vocational-education districts to use school buses to transport welfare clients to education facilities and Medicaid clients to medical facilities. The proposal suggests that school buses be used to transport adults between 9:00 a.m. and 3:00 p.m. during the school year, and on a full-time basis during the summer. Oklahoma sees this proposal as creating a win-win situation for its citizens, and plans to enact a pilot program to help evaluate the proposal. Although the recommendation is still in the early stages of evaluation, it looks as though it will be a promising endeavor for Oklahoma.

Key Points

- Developing successful models of coordination can assist states in meeting the assurance-of-transportation requirement while simultaneously controlling the rising cost of NET services.

- The first step in developing a successful model is an assessment of the transportation resources available. National, state, and local agencies are available to assist in gathering information on transportation resources.

- Federal funding may be available for the development of local models of coordination. The FTA can provide more information.

States need to consider all sources of transportation in the development of successful models and keep in mind the potential impact on the entire transportation infrastructure.

4. Assessing and Meeting Medicaid Non-Emergency Transportation Needs in Rural Areas

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State Medicaid agencies face some unique challenges in meeting their obligation to assure access to necessary medical services for rural residents. As this chapter describes, solutions to the problems inherent in providing transportation in rural areas require creative thought and consideration of the impact of change on the local delivery system. Programs in rural areas are generally more expensive to administer than are programs in more urban areas.

Definition

There is no established definition of rural transportation that applies to all states. What is considered "rural" differs from state to state and is not necessarily linked to geographical factors. The following, however, can serve as a functional definition of rural for the purposes of this chapter. Rural areas may have some or all of these characteristics:

- long distances to centers of population;
- significant distance or time required to reach medical services;
- absence of the type of transportation resources generally found in more urban areas;
- economically depressed area;
- sparsely populated area; and
- no established center for specialty medical and social services within a reasonable distance.

Factors Contributing to Rural Transportation Difficulties

A number of factors make the provision of transportation in rural areas complex and difficult.

- There are fewer medical resources, particularly for specialty services.
- There is an absence or limitation of public transportation services.
- There are limited private transportation resources other than ambulances.
- Travel distances can be great and there can be extended periods of travel time with no passenger on board ("dead-heading").
- Residences are more difficult to locate.
- Weather plays a disproportionate role in service delivery.
- Trips across jurisdictional (county, state, reservation) lines may be required to access certain services.
- Attendants are necessary more often than in urban areas because of factors related to distance and time.
- It is more difficult to achieve a quick response to same-day requests for service.
- Overnight stays may be involved for both passengers and drivers.

- Clients may not have access to telephones.
- Drivers may have to wait for clients to complete medical appointments, since distances can preclude fitting in another trip.
- There may be a greater need for trips by airplane, ferry, boat, train, and commercial bus.
- Major geographical barriers such as water and mountains may exist.
- Language and cultural differences may be more predominant, requiring additional planning and expense to ensure that these differences do not create barriers to receiving services.

State Response

There will always be tension in NET programs between the limited resources available to serve the general public in rural areas and the need to assure access to medical care for Medicaid clients. To meet the assurance mandate, states may need to provide services to the Medicaid population which exceed those available to the general population.

Because circumstances differ from state to state and even among the rural areas within a state, each state must tailor its program to meet its unique needs. Solutions will vary from one state to the next and may even vary within a state.

When rural transportation resources are inadequate, states have found that they often need to develop their transportation capacities solely to transport Medicaid clients. States can develop a comprehensive transportation system for rural Medicaid clients, meet the needs of individuals who cannot find rides using available local resources, or use a combination of the two approaches.

Regardless of the approach a state chooses, it is important to engage in long-term, locally focused planning to ensure that a state does not upset the existing service-delivery system of the area, which can sometimes be delicate. For example, if a nonprofit van service depends on Medicaid payments as a key part of its operational budget and Medicaid makes transportation a service offered through managed care organizations, the nonprofit van that is critical to the area's non-Medicaid population may go out of business if the managed care organization does not use its services. Although Medicaid agencies are not obligated to ensure the survival of local businesses, states cannot ignore the fact that, as a major purchaser, Medicaid can have a disproportionate impact on the market. The interrelationships among local service providers can be disrupted if Medicaid agencies do not engage in collaborative planning efforts. Since it is more difficult to provide services in rural areas, state Medicaid agencies must ensure that they are a productive part of the interdependent local systems in which they operate.

States can be flexible in making case-by-case decisions that balance their need to run cost-effective programs with the need to maintain a certain level of infrastructure in rural areas. States have found that it is important to look at the big picture and at long-term cost-effectiveness. For example, if a private provider is put out of business in California, another may quickly appear to take its place. If a private provider is put out of business in rural Maine, no other alternative may develop. In the long term, the need to assure access and the lack of a competitive environment could drive costs up.

Factors influencing a state's approach to meeting assurance requirements in rural areas may include the following:

- the political environment within the state;
- the financial and staff resources available to the state;
- the ability of county and local jurisdictions to play a role in developing, coordinating, implementing, or operating aspects of the state's transportation program;
- the ability of managed care plans to adequately participate in transportation provision;
- the capacity of the state Department of Transportation (DOT) to assist in developing alternatives; and
- the degree of sophistication and activity of the rural councils within the state.

Potential Solutions to Rural Transportation Difficulties

To assure transportation in rural areas, states can implement any combination of options such as:

- coordinating with other health and human service agencies to share vehicles and group rides;
- developing and maintaining a network of volunteer drivers who will transport Medicaid clients at an established rate;
- developing a system to provide vouchers for gas to clients who own vehicles and are able to drive themselves, or to reimburse them at an established rate;
- working with the state DOT on the placement of vehicles purchased through government-sponsored programs, or on the development of new transit areas;
- working with county transit systems to arrange for extended route service or special routes to accommodate clients who are able to use such a service;
- working with health care providers to ensure that appointments are scheduled to coordinate the availability of transportation or to allow for the grouping of rides;
- working with county health care coalitions to explore taking services to rural areas, instead of transporting clients to medical facilities (traveling well-child vans, for example);
- developing programs of "distance medicine" that involve teleconferencing and other approaches that do not require transporting the client or the provider;
- creating coordinated systems that pool dollars and resources to consolidate demand, draw more providers to rural areas, and better use existing resources;
- including transportation costs and responsibility in the facility rate for group homes, nursing homes, and other treatment facilities;
- including transportation costs and responsibility in the managed care rates for the managed care organizations;
- seeking technical assistance from the Community Transportation Association of America or the National Rural Development Partnership in maximizing the system of community/public/private resources within the state;
- contracting with a broker to develop and arrange for the delivery of transportation services;
- entering into agreements with counties, tribes, or other local jurisdictions for the provision of transportation services to rural communities; and
- participating on rural councils at the state and local levels to look for opportunities to jointly plan, develop resources, and coordinate services.

Suggestions

Managed Care

States that have incorporated transportation into their managed care contracts have found it important to consider the following questions and issues.

- Is the contract clear as to requirements and expectations?
- Are data available to adequately develop a rate for rural areas, particularly if the population has been historically under-served?
- Does the state have effective monitoring tools available to ensure that managed care organizations (MCOs) don't restrict services to a client based on a desire to avoid transportation costs?
- Will the MCO use transportation as a competitive edge to get more enrollees and will this conflict with federal rules on marketing?
- Will the rural community be negatively impacted if MCOs are made responsible for transportation?

Administration

The costs of program administration will generally be higher in rural areas. In Washington State, for example, the administrative charges of the transportation brokers in primarily rural counties are twice that of urban counties.

States have found it important to consider the staff resources needed to:

- work collaboratively at the local level to plan, coordinate, and integrate services;
- arrange trips that involve special case planning (attendants, overnights, airplane and boat rides, crossing jurisdictional lines);
- monitor the program to ensure that transportation is assured when a local jurisdiction, broker, or MCO is responsible for providing services; and
- work with other agencies to develop additional transportation resources such as gas vouchers, extended public transportation routes, or a volunteer network.

Service Costs

- Service costs are likely to be higher because of factors related to distance and the generally limited availability of public transportation.
- It may be necessary to engage in differential rate setting in urban and rural areas in states with rates that are developed by the Medicaid agency.
- Limited competition in rural areas may drive up the costs of private transportation.

Key Points

In order to successfully operate rural Medicaid transportation programs, states have found it important to:

- become an integrated part of the local system—it is important not to try to function independently;

- be open to new ideas, approaches, and creative solutions; and

- ask for help from the state DOT and those with experience solving service-delivery problems in rural areas.

Be prepared to accept and explain the higher costs associated with service provision in rural areas.

5. Setting Medicaid Non-Emergency Transportation Rates in a Fee-for-Service Environment

Karen Peed, Minnesota Department of Human Services

Each state uses a variety of transportation strategies to ensure that clients have access to medically necessary care. The types of transportation used by each state may have significant interplay with the state's rate-setting strategy. Many factors influence state rate-setting practices for NET services. The factors that come into play depend on each state's circumstances and the particular challenges that it must overcome.

Regardless of whether a state uses a brokered system or one of the more traditional "per-ride" payment systems, and regardless of whether the program is administered at the state or county level, the state must have sufficient information about its transportation environment to effectively establish rates or evaluate any proposal. Information may be the most significant consideration in setting fee-for-service rates.

Knowledge of the transportation infrastructure at both state and local levels, and information regarding eligible populations, is critical to successfully setting rates that will ensure the availability of transportation that is needed to provide access to medical care while still meeting the federal requirements for cost-effectiveness. This chapter focuses on "common carriers"—transportation provided by bus, taxi, or train, or another service available to the general public for a fee, including (for purposes of Medicaid and other programs) services provided by nonprofit entities that provide a service to selected members of the public at cost or as a community service.

Practical Considerations

Some of the practical considerations state Medicaid agencies should keep in mind when setting their rates include:

- whether the state provides NET services under the administrative option or as an optional medical service;
- location and demographic characteristics of the state's Medicaid-eligible population (e.g., children versus elderly, institutionalized versus community-based, number of persons with disabilities);
- location of the enrolled provider base, particularly for specialty services;
- location of alternative-care delivery sites, such as school-based clinics, that may not require transportation to allow clients access;
- areas which are significantly under-served in terms of public transportation or particular types of medical care;
- the extent to which a commercially based "common carrier" infrastructure is available;
- the types or modes of transportation available (i.e., are there any wheelchair van providers in the community?);

- "usual and customary" fee structures for various types of transportation; and
- whether the state is primarily urban or rural.

Administrative Service Option

As mentioned, states may choose to operate their transportation programs under the administrative- or optional-medical-service state-plan option. One advantage of the administrative-service option is that it allows states to contract with one or more brokers for transportation services without seeking a freedom-of-choice waiver. The use of one or more transportation brokers does have a significant effect on rate-setting. Most states that use a brokered system do not set rates. A brokered system lends itself to competitive rate-setting, although this is by no means the only way to set rates in a brokered system. The process of selecting a broker is usually handled by issuing a request for proposals (RFP). Transportation brokers submit projected costs or prices as part of their proposals, so the rates are, in effect, competitively bid. The broker must justify its costs and is responsible for contracting with providers or subcontractors within the rate contracted by the state. Brokered systems are structured in a variety of ways. Some brokers bid for the cost of the ride and administration, whereas others are paid a fee for administrative services while being responsible for soliciting the best available rate.

In some cases, counties are permitted or required to issue the RFP and select the broker. The state approves the final rates, so that local rates are appropriate within the context of the state. Brokered systems are discussed in detail in Chapter 7, "Brokerage Operations for Non-Emergency Transportation."

Rural Considerations and Regional Versus Statewide Rates

States with well-developed transportation systems may provide very little common-carrier transportation. Many states, however, experience difficulty in finding transportation providers for all necessary routes or locations. This is a particular problem in rural areas. States with large rural areas may lack a significant transportation infrastructure in some or all of these areas. Such states usually rely on a variety of arrangements, including contracts with specialized transportation systems or programs affiliated with other agencies (e.g., the area Board on Aging). Many states also rely on volunteer driver programs where the driver is paid based on mileage or on mileage plus a "pickup" or "load" fee.

Each state must decide for itself whether to establish regional or statewide rates. Some states allow rate-setting at the local level, with states responsible for approval of final rates. In many states, the rate that is established depends on the level of service required and the availability of the service. To assure certain types of long-distance transportation in rural areas, or some types of common carrier transportation, states may pay a negotiated rate or make an exception to an established rate.

Reimbursement and Rate-Setting Strategies

There are many types of rate-setting methods and reimbursement strategies. These are, to some extent, interrelated. A state may opt to use one strategy or many, depending on its circumstances. Information about existing providers, their usual rates and fees, and their historical use of such services is critical to states that are developing and evaluating proposed rates.

Following is a brief list of some types of reimbursement and rate-setting strategies:

- **Per mile.** Most often used to reimburse individual clients or volunteer drivers. May provide incentives for covering rural areas, especially in situations where long distances need to be traversed.

- **Per trip.** This may be most effectively used when setting rates for established routes that are commonly covered by "fixed-route" or "circulator" type transportation providers or other types of common-carrier transportation.

- **"Load" fee plus mileage or per-trip payment.** This may most effectively be used in setting rates for established routes that are commonly covered and may allow the state some savings by having a load fee be incremental when several riders are traveling the same route. It may be an alternative for providers such as multi-passenger vans rather than such common-carrier transportation as buses or subways.

- **Legislatively mandated rates.** This strategy may allow states to limit their growth in transportation expenditures by placing a limit on rates that is not tied to cost or use. These rates, however, are subject to change depending on the makeup of the legislature and the strength of the transportation lobby. A related strategy is to tie reimbursement for individual mileage or volunteer drivers to state employee contractual arrangements for mileage.

- **Full "Usual and Customary" (U&C) rate.** This strategy assumes the availability of common-carrier providers, and assumes that a U&C rate has been established. Absent an established "U&C," it simply means that the state will pay whatever the provider bills for the service provided. It may be a useful strategy for increasing the availability of common-carrier providers in areas that are not well served, allowing the state to move to discounted or negotiated rates in the future.

- **Discount from U&C.** Again, this strategy assumes the availability of common-carrier providers, and assumes that a U&C rate has been established. Given the existence of competing providers or sufficient volume, states may be able to negotiate discounts from available providers. In areas where transportation providers are sparse, this may not be an effective strategy.

- **Cost-based rates.** Payment of a provider's reasonable cost may allow states to develop common-carrier options where they do not currently exist or where there is a lack of competition. Cost-based reimbursement does not have to be a permanent approach to payment for transportation services, but may be an effective way to develop options.

- **Rates based on historical use and cost.** This strategy is similar to that above, except that it may allow states to more accurately evaluate how to target their resources. It may also serve as an interim step away from a pure cost-based model. Including historical use in the rate-setting process may allow states to hedge against inappropriate increases in transportation use under a cost-based model.

- **Negotiated rates.** This strategy allows states to establish rates outside of the U&C fee schedule. States may be able to negotiate rate corridors that allow increased discounts based on higher volume, while limiting the risk of over-utilization. The converse is also true. States may need to negotiate a higher rate of payment for some types of infrequently used transportation services (e.g., airplanes) to meet their assurance obligations.

- **Competitive bids.** This strategy is discussed in Chapter 7, "Brokerage Operations for Non-Emergency Medical Transportation." Competitive bidding has the advantage of placing the responsibility for developing and justifying the proposed rates on the provider or broker. Submission of a low-cost proposal is advantageous. Competitive bidding might also be used as an option under a traditional fee-for-service program: by setting out a competitive bid process, a state can gain information on the rates providers are willing to accept. However, states providing transportation under the medical-service option must assure choice of provider for transportation services. A "winner takes all" model cannot be adopted in such cases. In setting rates under a competitive-bid format, it may be necessary to allow all providers to enroll who meet the state's qualifications, provided they are willing to accept the rate established under the competitive process.

Key Points

- There are a variety of options to use in setting fee-for-service rates. States can select strategies and methods based on their needs and opportunities.

- The rate structure will have a significant impact on the willingness of providers to participate in the NET program. States have found that they may need to have different rate structures in different areas.

- Information about existing providers, their usual rates and fees, and the historical utilization rates is critical to states that are developing and evaluating proposed rates.

6. Medicaid Non-Emergency Transportation Provider Qualifications and Standards

Jan Larsen, Mississippi Division of Medicaid

An integral part of the provision of NET services is the establishment of qualifications and standards for providers that transport Medicaid-eligible persons to medically necessary services. As with many aspects of the federal regulations that apply to Medicaid NET services, states enjoy considerable latitude in developing and applying NET provider qualifications and standards.

NET Provider Types

States use a variety of NET providers, which can be classified into two types: individual or volunteer providers and group providers.

Individual or volunteer providers may include:

- Medicaid clients,
- family, friends, or neighbors of the client;
- program or agency staff (such as case managers, foster parents, or social workers) involved in some capacity with the Medicaid client, and
- an individual who has no relationship with the client other than transporting him or her.

Some states qualify individuals in any of these four groups as NET providers, while other states allow only certain individuals to qualify. For example, some states will reimburse a Medicaid client to transport him or herself to medical services while other states will not.

Groups or organizations that may be qualified by various states as NET providers include:

- not-for-profit organizations such as public transit systems;
- "rider-specific" not-for-profit agencies such as services for disabled or elderly persons;
- not-for-profit organizations, such as churches, that provide transportation services in their communities as a public service;
- organizations that transport only their own clients, some of whom are Medicaid-eligible;
- for-profit transportation organizations such as taxi companies and medical-transportation-service companies; and
- for-profit or not-for-profit organizations that offer NET services for their clients although their primary purpose is to provide medical services.

As with individual NET providers, each state may use all or only some of the types of providers listed above.

The relationship of a state Medicaid agency to a NET provider depends on the model(s) employed by the state in the provision of NET services. Some states recruit and enroll NET providers directly into their Medicaid programs as they do other Medicaid providers such as

physicians and hospitals. In this case, the NET providers are paid directly by the Medicaid agency, usually on a fee-for-service basis. Other states employ a broker model for their NET services, contracting with an organization that is responsible for recruiting individual and group NET providers and paying them for their services. The broker may be paid by the state Medicaid agency in any number of ways, including fee-for-service, cost reimbursement, or on a capitated basis. Also, in states that use some form of managed care, such as health maintenance organizations, NET services may be negotiated as part of the menu of services to be offered by the managed care provider. It then becomes the responsibility of the managed care provider to work with NET providers to make transportation services available to its enrollees.

NET Provider Qualifications

States have established a variety of qualifications for NET providers. Some states adopt qualifications set by other agencies. The North Carolina Medicaid program, for example, participates in a system of transportation services that is coordinated at the county level. The drivers who participate in this system must meet qualifications established by the North Carolina Department of Transportation and the Division of Motor Vehicles. Other state Medicaid programs set their own provider qualifications, incorporating some of the requirements of other agencies such as the Public Service Commission, the State Highway Patrol, and the state Department of Transportation.

Some Medicaid agencies maintain databases on their NET providers, which usually include their data in the provider files of their Medicaid Management Information Systems (MMIS) or in specially created databases. The data is updated periodically. In some cases NET providers are responsible for providing updates on specific information such as the expiration dates of vehicle license tags, inspection stickers, and drivers' licenses.

Provider qualifications established by the states may include the following:

- **Driver's license.** Each driver must possess a valid driver's license.
- **Inspection sticker.** Each vehicle used to transport Medicaid-eligible persons must have a valid inspection sticker or meet similar requirements for vehicle safety.
- **Liability insurance.** Each carrier is required to carry liability insurance; the type and amount of coverage varies among the states and is determined by requirements in state law and administrative policy. The Medicaid agency should be listed as a loss payee group provider. Liability insurance requirements vary between individual and group providers. In Mississippi, individual providers are required by state law to carry standard liability insurance. Florida requires a minimum liability coverage of $100,000 per person and $200,000 per incident for all providers except volunteers.
- **License tag.** Each vehicle must display a current license tag; state law determines the type of tag required.
- **Requirements of the Americans with Disabilities Act (ADA).** Group providers must comply with the ADA with regard to schedules, equipment, and other requirements. Individual or volunteer drivers who use their vehicles to transport Medicaid-eligible

persons do not have to meet the requirements of the ADA; states that choose to use such providers in their NET service programs, however, must also make arrangements with providers in the communities who are in compliance with the ADA. Reviews of NET providers for compliance with ADA requirements are conducted by different organizations from state to state. While the Medicaid agencies are primarily responsible for such reviews, some states such as Minnesota monitor ADA compliance through the state Department of Transportation.

- **Agreement or contract.** Most states require a written agreement or contract between the NET provider and the entity that engages the provider's services (that is, the state Medicaid agency if NET providers are enrolled directly, or a broker or managed care provider). In some states, NET providers sign Medicaid participation agreements. In Utah, the Medicaid agency uses the same provider agreement for NET providers as it does for all other Medicaid providers. Other states such as Mississippi have NET-provider-specific agreements or documents that outline the specific terms and conditions of the NET provider's involvement in the Medicaid program as a carrier of Medicaid-eligible persons. NET provider participation contracts and agreements are generally renewed every one to two years, though some may be ongoing in nature, automatically rolling over from year to year.

- **Types of services offered by NET providers.** Some states require that NET providers make available to the Medicaid clients whom they transport other services on an as-needed basis. These additional services might include coverage of meal and lodging costs when overnight travel is required for medical reasons, or various attendant services. These services usually require some form of prior approval or medical certification. States that require NET providers to make these additional services available reimburse providers for them separately from other services (such as transport) or include them in capitated fees paid by the Medicaid agency for NET services.

- **Driver safety records.** Some state Medicaid agencies have established requirements regarding the safety records of drivers who transport Medicaid-eligible persons. These requirements address such problems as driving-under-the-influence convictions and speeding violations. Compliance with these requirements is verified by periodic checks with the state highway safety patrol or a similar organization. Some state agencies have on-line access to drivers' records maintained by a state agency such as the department of motor vehicles or the state highway patrol.

- **Driver safety training.** Evidence of driver safety training is required of NET providers by some state Medicaid agencies. Such training may include a wide range of topics such as minor first-aid training, how to contact medical emergency personnel, and passenger-assistance training. The criteria for acceptable training vary among states. Some use the driver-safety-training requirements of the various state agencies involved in highway safety activities or the administration of public-transit funds. Other states consider programs offered by recognized organizations such as the Red Cross as acceptable driver-safety-training programs, or evaluate the programs available locally on an individual basis.

- **Required experience.** In some states, the Medicaid agency requires the NET provider to meet a related experience criterion. In these cases, the provider must be able to show that

in the past he or she has provided transportation services similar to those to be offered to Medicaid-eligible persons. For example, the Mississippi Medicaid program requires group providers to have a record of providing NET services in their states prior to becoming Medicaid NET providers. This requirement is intended to identify the NET providers who have a serious intent and real ability to provide appropriate transportation assistance to Medicaid-eligible individuals.

- **References.** Before they become NET providers, carriers in some states are required to provide references. This is true primarily of group providers, who may be asked to give the names of contact persons at organizations where they have worked.

- **Performance/surity bonds.** Some states require NET providers to carry performance bonds to ensure payment by the provider for losses to the NET program caused, for example, by fraud. The amounts of the performance bonds vary. Florida requires that, before they can be enrolled, potential NET providers must show evidence that their taxis, non-emergency vehicles, or multi-load vans are covered by a $50,000 surity bond.

- **Registration with the secretary of state.** In some states, group providers are required to register with the secretary of state. This requirement is imposed to identify providers as legitimate business organizations in the states in which they operate.

- **Applicable licensing requirements for the group provider.** Some states require that group carriers meet the requirements of various organizations such as the state health department or the public safety commission. Inquiries should be made by state Medicaid staff of appropriate agencies to identify any licensing requirements that may apply to Medicaid NET providers.

- **Vehicle requirements.** In addition to meeting the vehicle conditions required by vehicle-inspection laws and the ADA, some states, such as Washington, require that commercial vehicles used to transport Medicaid clients must be able to establish two-way contact with emergency personnel in the event that an accident occurs or a client becomes ill or injured during transport. Pagers do not meet this requirement. Car seats for children are also required when state law mandates their use. Some states also address vehicle capacity, requiring group providers to use vehicles appropriate to the "run" being made by the provider. For example, providers that are required to provide one-on-one service or service to a small group of Medicaid-eligible persons must use a vehicle that is appropriate to such transports rather than using a small bus, which costs more to operate. The Minnesota Medicaid agency does not put a limit on the seating capacity of vehicles used to transport Medicaid clients as long as the vehicle used is appropriate to the number of clients transported. New Jersey's livery program, which serves two of the state's counties, requires that providers not use vehicles that carry more than nine passengers. In the state's invalid coach program, no more than four persons may be transported at a time. The concern in New Jersey is that providers who use larger vehicles may try to transport too many clients at one time, which may reduce the quality of service. Also, in two of the state's counties, providers may not "mix" riders whose transports are funded by different contractors.

- **Age-of-vehicle limits.** Some states, such as New Jersey, put limits on the age of vehicles that may be used to transport Medicaid-eligible persons. In New Jersey's livery program, a vehicle may not be more than eight years old. Washington State has developed a comprehensive list of vehicle requirements that addresses such issues as the need for safety belts, vehicle climate control systems, and clean vehicle passenger areas.

- **Language competency.** It is important that NET providers are able communicate with the Medicaid clients they transport. NET providers should be required to communicate in the primary language of the clients whom they transport. State Medicaid staff should require language competency (in foreign languages as well as English) when the situation warrants such a requirement.

- **Cultural awareness.** In areas of states that are populated by groups whose cultures may require special NET arrangements, providers should be required to demonstrate their knowledge of these cultures and how they will accommodate any special transportation requirements that may result from them. For example, in some cultures it is not acceptable for a woman to travel alone with a male driver who is not a member of her family. It would be important to try to make a female driver available to such a client.

The qualifications that states require of NET providers vary depending on a number of factors, such as the applicable laws of these states. The qualifications listed above are offered as suggested qualifications for NET providers; each state, however, must establish qualifications that are appropriate to ensure the availability of safe and cost-effective NET services in that state.

NET Provider Performance and Quality Measurement

The NET staff of state Medicaid agencies have established various performance standards for providers that are based on the requirements and qualifications for these providers. Four of the most common indicators are client satisfaction measures, waiting-time or on-time record, accident frequency, and vehicle quality and maintenance.

Client satisfaction is most commonly determined through surveys sent to Medicaid clients who have received NET services. The surveys are distributed periodically to clients selected at random. Clients evaluate the NET assistance they received according to various criteria that address issues such as timeliness, driver courtesy, length of time the client rode in the transport vehicle, condition of the vehicle, and the ability of the driver to locate the destination. Medicaid staff use the results of these surveys to determine the quality of service provided by NET carriers and to identify where improvements are needed.

Waiting-time or on-time performance is another important quality indicator for NET providers. In its two-county livery program, the New Jersey Medicaid agency requires that Medicaid clients be picked up within 30 minutes of their scheduled pickup time. Providers are required to keep a complaint log, and Medicaid staff conduct unannounced spot checks at pickup points to monitor on-time performance. Washington requires the average pickup time to an appointment to be within 15 minutes of the scheduled pickup time, with the actual pickup time not to exceed 30 minutes. The return time for a pickup cannot exceed 30

minutes. Pennsylvania's contracted broker in Philadelphia conducts monitoring activities which include unannounced on-site reviews of NET providers' on-time performance. The broker's monitoring staff also review complaints from medical providers regarding the tardiness of Medicaid patients to their appointments to be sure that the problem does not lie with the NET providers.

Many Medicaid agencies have established procedures by which NET providers are required to report accidents that occur during the transport of Medicaid clients. The specifics of these procedures vary from state to state, but the intent is to assure that the Medicaid agency is informed when an accident occurs during a NET transport. Some state Medicaid agencies work with their local or state law enforcement agencies to locate accident information not only about NET transport organizations, but about individual drivers as well. Information regarding accident frequency and driver safety is used by Medicaid agencies to make decisions about the enrollment and disenrollment of NET providers.

The vehicles used to transport Medicaid clients are monitored by most state Medicaid agencies, either directly by their staff or indirectly by broker staff (if a broker is used) or staff of other agencies. For example, in states such as North Carolina and Mississippi, the Medicaid agency works cooperatively with staff of the state Department of Transportation or the Public Service Commission who may already be monitoring the carriers used by the Medicaid agency. North Carolina also works with local municipalities to monitor NET providers. Enrollment procedures for NET providers often require providers to list the model year and mileage for each vehicle that will be used to transport clients. Odometer readings are commonly required on billings submitted by providers for payment. Provider audits generally include a review of vehicle maintenance records. Medicaid agencies also conduct periodic and often unannounced on-site inspections of transport vehicles. In South Carolina, the Medicaid contract administrator is responsible for monitoring group providers for vehicle safety.

NET Provider Monitoring Activities

In addition to establishing and reviewing performance indicators for NET providers, Medicaid agencies conduct other monitoring activities to evaluate the performance of providers. Many of these activities are post-pay reviews that involve data manipulation and report production.

Most states have the capability to monitor their NET providers through their Medicaid Management and Administrative Review Systems and Surveillance and Utilization Review Systems reporting capabilities. These systems, which are required reporting subsystems of an agency's MMIS, provide a variety of information, largely through the production of reports, about Medicaid services, providers, and clients. Reports generated by these subsystems can be used to identify, for example, unusual increases in NET program cost and use. Some states have developed ad hoc reporting capabilities through their MMISs that allow program managers, such as NET staff, to query the Medicaid database about NET service trends, the billing behavior of specific providers, and patterns of NET service use for individual clients or groups.

Medicaid agencies use the NET data available through these various reporting systems in different ways to monitor NET providers and clients. The validity of NET claims is evaluated against medical claims in some states. In New Jersey, NET services are provided to transport an eligible Medicaid client to a medical provider to receive Medicaid-covered services. The state runs a report periodically to match NET claims against medical-service claims. If a match is not found, the NET claim is investigated. Staff also contact medical providers to verify the validity of a sample of certification forms turned in by the NET provider.

The Mississippi Division of Medicaid has recently implemented an on-line NET computer system that allows front-end monitoring of NET activities. For example, before transport is arranged, client, medical provider, and NET provider eligibility to participate in the NET program are verified. Details of each transport are stored in a database for the NET program. This database is retrieved through an ad hoc reporting system which has been being implemented to allow NET staff to query the database at will to monitor all aspects of the NET program in Mississippi. (See Chapter 9, "Strategies to Identify and Prevent Medicaid Non-Emergency Transportation Fraud and Abuse.")

Disenrolling NET Providers

As is often the case with any group of Medicaid providers, disenrolling a NET provider can be difficult. NET providers appear most often to be disenrolled due to inactivity or verified fraudulent activities. Providers may also be disenrolled if failure to meet the terms of their provider agreement or contract can be clearly documented. Suspected abuse by NET providers of NET policy loopholes or oversight are often not enough for Medicaid agencies to disenroll a provider. However, payment to providers suspected of Medicaid fraud may be suspended until a review of the provider is complete. It is important that NET staff develop clear and comprehensive NET policies that anticipate and prohibit intentional or unintentional abuse of the NET program by providers.

Key Points
- This chapter provides suggestions for qualifications for NET providers. All of the suggested qualifications may not be appropriate for each state. Medicaid staff should be mindful of their state laws; other state-specific requirements should be addressed through NET provider qualifications.
- Setting NET provider qualifications and enrolling eligible NET providers is just the beginning of a state's relationship with these providers. It is extremely important that each state develop performance indicators for NET providers and apply these performance indicators through an ongoing provider-monitoring plan that evaluates provider performance through a variety of measures such as announced and unannounced visits and client satisfaction surveys.
- It is much easier to disenroll a provider whose performance is unacceptable if the terms for disenrollment are included in and related to the provider through the provider-enrollment agreement or contract.

7. Brokerage Operations for Non-Emergency Transportation

Judith McCoy, Pennsylvania Department of Public Welfare

Several states provide Medicaid NET through brokerages, organizations with which states contract to perform administrative responsibilities related to the provision of transportation services. The administrative and management functions conducted by a brokerage are determined by its funding source, the state Medicaid agency. Specific tasks performed by the broker generally include screening clients, arranging rides, managing subcontracts for service delivery, billing for Medicaid funding, and keeping appropriate records. By using a brokerage as an intermediary, Medicaid agencies can reduce the number of transit contracts required for their transportation programs.

A brokerage consolidates management and may provide some operational services itself or contract for services with other transit providers. The transportation services a Medicaid agency wishes to obtain from a broker should be specified in contracted guidelines. A broker can potentially be used to perform all Medicaid transportation operations (i.e., registering clients and determining the level of service needed, contracting for transit operators, making trip reservations, scheduling, billing, and keeping records). Functions such as dispatching, maintenance, and insurance can also be handled by a broker, either directly or through contracts with other operators. Brokers with their own fleets of vehicles, for example, may transport some clients but contract with other providers for additional services.

A state should consider contracting with a broker when the administrative tasks required to adequately manage the state's transportation program far exceed the capacity of the state agency; if the service area is larger than that typically handled by a single transportation provider; and when there are enough operators to develop a cost-efficient, coordinated transportation system. There should also be a potentially high trip volume to justify a broker's administrative costs. Additionally, a Medicaid program may sometimes need to provide the start-up funds necessary to implement a brokerage operation.

Pennsylvania

In Philadelphia, the Pennsylvania Department of Public Welfare has used a broker to provide NET services (for recipients in both fee-for-service and managed care arrangements) since 1983. Using all modes of transportation, including transit passes, individual transit tokens, reimbursement for mileage in a car driven by the recipient, and trips provided in a wheelchair van, the broker provides over 2 million trips per year at an administrative cost of approximately $2.5 million. The broker usually costs between 15 and 17 percent of the total operation. Since the state began using brokerages, it has reduced its NET costs by one-third.

This chapter relies primarily on Philadelphia's experience, and draws on input from other states' experiences with brokers as well. Washington State, for example, uses a broker in each

of its 11 transportation districts; Florida and Louisiana also provide NET services through brokers.

Factors for Consideration

A state Medicaid program's method of claiming federal financial participation (FFP) (i.e., optional medical service or administrative support), must be considered prior to using a brokerage operation. A Medicaid program can only contract with a brokerage if it claims FFP for transportation services as an administrative cost, or, alternately, if it obtains a 1915(b) (freedom-of-choice) waiver to permit selective contracting with transportation providers.

In Philadelphia, the flexibility of the administrative support method, and the ability to reimburse clients directly for transportation costs, have contributed to the program's cost-effectiveness. The availability of an extensive public transportation system has been a factor in reducing the broker's aggregate per-trip cost.

Before embarking on a brokerage contract, states should compare the fiscal benefits of using the optional medical services and administrative support approaches.

Advantages of Brokerage Operations

Brokers can lower a state's per-trip costs by ensuring competitive bidding and by scheduling the least costly, most appropriate method of transportation for a client. A key advantage to a brokerage with no vehicles is its lack of bias and the likelihood that it will favor the least costly transit providers. With brokers who do operate their own vehicles, monitoring is important to ensure that there are no conflicts of interest due to a preference for their own fleets regardless of cost.

Through competitive bidding, a broker can establish agreements with operators of paratransit services who provide low-cost, high-quality services. Specifications for carrier contracts should include information on the scope of service required, the terms of payment for various modes of service, reporting requirements, and expectations regarding driver logs, billing schedules, and service standards. The agreement should further specify that a carrier is responsible for its drivers and the safety of its passengers. This type of contract agreement places the responsibility for the quality of carrier service on the broker (and not directly on the Medicaid program).

A broker's control of scheduling is critical to its effectiveness in finding the most cost-efficient way to provide a particular trip. It can also be a major factor in reducing fraud, since there is less opportunity for Medicaid recipients to charge ineligible trips. When scheduling is handled by a broker, carriers can be contracted on a hourly basis rather than reimbursed per trip. This practice contributes to cost reduction by stressing a shared-ride approach.

A broker could have strong ties to local medical and human service providers. These relationships link the broker to the community and can be valuable in promoting coordinated service for clients.

Disadvantages of Brokers

Since Medicaid agencies are responsible for reimbursing administrative costs for a brokerage, a high volume of trips is required to justify using a broker as the resulting administrative costs can be higher than with a non-brokered system. Any start-up costs may be extensive, due to the need to sustain administrative costs during an initial period of low trip volume. (Brokers with their own vehicles may have lower administrative costs, since they can maximize the use of their vehicles to balance the administrative costs.)

As with other types of providers, brokers require monitoring by Medicaid staff to ensure that they do not provide clients with expensive paratransit trips, for example, rather than using the less costly fixed-route system or receiving mileage reimbursement when appropriate. This lack of compliance with Medicaid's least costly and appropriate service requirement could result from a broker's attempt to increase its administrative payments by having large amounts of funding pass through its operation. The broker may also try to maintain a high level of trips for favored subcontract carriers.

Implementing a Brokerage with a Waiver

Under Section 1915(b) of the Social Security Act, the Health Care Financing Administration (HCFA) is permitted to grant waivers of several provisions of the law. States have used these waivers to change many aspects of their Medicaid programs, including implementing managed care programs. At this time, three states (Kentucky, New York, and Oregon) have received waivers from HCFA that relate exclusively to transportation and allow states to operate brokered programs. In general, these waivers have allowed states to restrict freedom of choice of providers, selectively contract with certain providers, and operate their programs differently in different areas of the state.

In all cases, the waivers have allowed states to continue to operate their transportation program as an optional medical service. In two cases, states have also received federal funds at the higher match rate that comes with operating NET as an optional medical service.

The following is a summary of each state's waiver and its status.

Kentucky

Kentucky waived statewideness and freedom of choice but never actually implemented the waiver. The state recently submitted to HCFA a modification of the waiver which described their new program. The program, Empower Kentucky Transportation Delivery Process, will operate statewide by the end of 1998. One agency, the Transportation Cabinet, will oversee transportation for all state programs, and will contract with companies for all state transportation programs. The state will issue a request for proposals for one provider in each area, who will operate as a broker to deliver all transportation services. The contract will be competitively bid. The state projects a 20 percent savings in transportation expenditures, for a $4.4 million savings over the two-year life of the waiver. Services will be capitated; the provider will receive a fixed per-member, per-month fee.

New York

New York received HCFA's approval to operate a transportation waiver in 1995. HCFA permitted the state to selectively contract with providers. The waiver permits each county to select one of the following methods of operating its NET program.

- Contract with a broker to arrange all rides. The broker can provide all transportation services directly or subcontract with other providers.
- Regional or district-wide rate setting. The county can set rates that are lower than the ones in place at the time the waiver was granted. The state would contract only with providers that accept that rate for transportation.
- Competitive bid for frequent riders. A county can issue a request for proposals to transport riders who travel on a regularly scheduled basis.
- Cost-effective/directed transportation. The county directs the recipient to use the least costly provider in the appropriate mode of transportation. Other providers will be used only if the least expensive provider does not have the capacity to accommodate the rider.
- Select arrangements for certain facilities. Counties can select a vendor or group of vendors to provide all trips from within the service area to a certain facility, such as a regional medical center or specialty clinic.

The total savings of the waiver varies depending on the number of counties that choose each option. The projected savings range from 6 percent to 21 percent of current costs.

Oregon

Oregon's waiver allows Tri-Met, the Portland transit authority, to operate as a broker for services in the Portland area. The Oregon waiver, which has been operating since September 1994, is the only waiver that has been evaluated to date. Tri-Met screens clients to determine the transportation mode for which a client is eligible, ensures that the client is eligible for services, and arranges rides using the appropriate mode of transportation. Tri-Met also contracts with transportation providers. The Oregon Medical Assistance Program works closely with Tri-Met to ensure that clients receive the best possible service.

An evaluation by the Oregon Department of Transportation concluded that the brokerage is an "unqualified success." The evaluators cited the following benefits.

- The brokerage has saved taxpayers money by providing more rides at a lower cost.
- Service delivery has become more consistent.
- The delivery of services to Medicaid clients and the general public has improved because more vehicles are accessible to disabled individuals, vehicles meet higher quality standards, and drivers are better trained.

During the initial waiver period (1994–1996), the waiver demonstrated cost-effectiveness. The cost per ride, projected to be $8.46 without the waiver, fell to $6.31 per ride. With the waiver, more clients were served at a lower cost. Savings were accomplished primarily by ensuring that clients used a lower mode of transportation. While taxi rides decreased, the number of clients using bus passes increased substantially. The waiver was renewed by HCFA

in 1996. During the renewal period (1997–1998), the brokerage program is expected to save $1.17 million.

Contracting with a Brokerage

Whether or not the state uses a waiver to implement a brokered system, sound planning should be undertaken prior to establishing a brokerage contract. States may wish to consider the following suggestions.

- Determine the service demand for the area to be brokered.
- Assess the number of carriers in the service area to assure cost efficiencies through coordination.
- Decide if the broker should only bid on administrative costs or if service costs should also be included.
- Identify the expected outcome in terms of services and costs. Specify, for example, that service must be provided in accordance with program regulations and requirements, and that approved carrier vehicle specifications must be met.
- Ensure that adequate support is available to provide for a broker's start-up costs, if necessary.
- Visit brokers in other states whose programs are similar in size and cost to the one under consideration.
- Establish a reasonable time frame to allow for a redirection of the program should problems occur.

A state's contract with a broker is the agreement through which transportation is provided and funded. Given its importance, the bid document for acquiring a broker is a vital aspect of the contracting process. An effective bid document may include the following.

- A specific format for responses and identification of the entities that are permitted to bid. Bidders can be required to demonstrate experience brokering (for example, 500,000 trips per year in an urban setting).
- A description of anticipated service volume, approved modes of transportation, and expected quality of service.
- Indication of a specified service period. A beginning service period of one year is recommended with one or two one-year options for renewal. Once a broker has demonstrated its competency, there can be subsequent multi-year contracts that offer the opportunity for carrier stability and lower trip costs.
- Assurance that the broker will conduct competitive bidding for carriers.
- The state Medicaid program could consider requiring review and approval rights concerning the subcontracted carriers used by the brokerage.
- Requirement of adequate records and documentation of services provided (the submission of monthly invoices and quarterly service reports has proven worthwhile).
- Specification of the payment and billing process. The payment method can be structured to provide the broker and its subcontracted carriers with the opportunity to benefit from discounts for the prompt payment of a high volume of services.

- Identification of the level of indemnification required by the broker and its subcontractors (to help keep legal action at the local level).
- Establishment of a complaint and grievance procedure for service recipients by the broker.
- Requirement of an outside audit of the contractor's finances.
- Inclusion of a specified time period as a convenience clause for termination.
- Inclusion of the right to monitor all aspects of the broker's operations, as well as those of subcontracted carriers.

Contract Management

Effective management, oversight, and monitoring of a Medicaid agency's contract with a broker will play a significant role in the success of the brokerage. The contract specifies scope, requirements, and expectations; management by a state Medicaid program is integral to assuring effective implementation. All aspects of the contract must be subject to oversight and monitoring.

- States have found it important for state Medicaid agency staff to participate in audit-related meetings with their brokers' auditors to present concerns and provide structure to the audit.
- Billing and service reports should be carefully reviewed and analyzed for trends. Periodic meetings should be held with the broker to review reports, discuss trends, and ensure contract compliance.
- State Medicaid staff should participate in the broker's meetings with medical and transportation providers where service-related issues are discussed.
- During the contract period, there should be consideration give to thorough monitoring of the broker's operations. This includes ensuring that it is carrying out its responsibilities to determine eligibility for various modes of service, scheduling, and transportation operations as well as quality-assurance procedures.

Ongoing communication is essential for a successful brokerage relationship. State Medicaid agencies must continually stress the goal of cost-efficient service and emphasize the broker's contractual requirements.

Key Points

- By using a brokerage as an intermediary, the state Medicaid agency can reduce the number of transportation contracts that the agency needs to manage.
- A brokerage can be used if the state Medicaid agency claims FFP as an administrative cost or obtains a freedom-of-choice waiver.
- Brokers can reduce costs through competitive bidding of carriers, methods of scheduling, and other efficiencies.

The use of brokers with linkages to the human service community can promote coordinated client services.

8. Medicaid Non-Emergency Transportation Under Managed Care Systems

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During the past several years, state Medicaid agencies have increasingly turned to managed care programs to improve access to health care, contain rising health care costs, and improve quality of service. States have used a variety of approaches to provide NET in a managed care environment. NET services, essential to ensuring access to medically necessary services, are considered integral to the success of managed care programs.

Prior to the enactment of the Balanced Budget Act of 1997, states were required to seek federal approval before developing managed care programs. Medicaid agencies could apply for two types of waivers: 1915(b) waivers, which allowed states to enroll clients in managed care plans; and 1115 waivers, which allowed states to engage in demonstrations of new ways of financing and delivering health care.

While the Section 1115 research and demonstration waiver process is unchanged, the Balanced Budget Act dramatically changed states' ability to operate managed care programs without waivers. States can now implement a number of different types of managed care programs. These options include: partial programs, where only certain services, populations, or regions of a state are included; full programs, for all of a state's services; voluntary and mandatory programs; and capitated, partially capitated, and noncapitated models.[4]

Note that some states have applied for 1915(b)(4) waivers for transportation programs. These "selective contracting waivers" allow states to contract with a limited number of providers. As of October 1997, it appears that states will still have to apply for these waivers to implement selective contracting for transportation.

Despite the growing move toward managed care across the nation, most states have been hesitant to include NET services in their managed care programs. This is partly due to concerns that there are built-in incentives for managed care organizations (MCOs) to withhold NET services as a way to reduce costs. In addition, these states maintain, MCOs often have no experience in providing NET services. Some states, however, are aware that there can be benefits, such as lower program costs, in placing Medicaid NET under MCO management. For this reason, some states such as Arizona and New Mexico have included all transportation requirements in their capitated managed care contracts. The MCOs, in turn, have contracted NET to transportation management companies.

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[4] Although often considered synonymous, *managed care* is different from *capitation.* Managed care usually refers to some entity such as a managed care organization (often a health maintenance organization or primary care case management [PCCM] system) that manages enrollees' health care needs. Capitation generally refers to a prospective payment on a per-member, per-month basis, regardless of the actual services delivered. Capitation creates an incentive to better manage care, but may also create financial incentives to not perform services.

This chapter details some of the issues that state Medicaid agencies have found it important to consider in deciding whether to use a managed care program to provide NET services to clients. Readers are recommended to consult other sections of this guidebook, including Chapter 9, "Collecting and Analyzing Data to Operate a Cost-Effective Non-Emergency Transportation Program."

NET Managed Care Program Options for States

There are at least four options available to states when deciding how their NET programs will fit into managed care systems.

- **NET services as a "pass through."** Some states have chosen to include NET under managed care as a "pass through" on a non-risk basis to MCOs. States may or may not transfer the responsibility for arranging NET management to health plans, but they reimburse the plans on a fee-for-service basis for NET costs. The MCO does not incur a financial risk for NET under this model.

- **Fully capitated transportation.** States can opt to make MCOs fully responsible for NET services. The historical cost of transportation is included in the actuarial analysis of their per member per month costs. The MCO may contract with transportation vendors on a capitated or a fee for service basis. The rate will vary depending on the population served by the MCO. An organization serving a large number of disabled people, for example, may need to spend more on NET than an MCO serving a more mixed population.

- **NET "carve outs."** States refer to services excluded from their managed care capitated plans as "carve outs." Because many managed care programs are just beginning, the question of which services to include in the managed care program may be decided by issues of priority, timing, caution, and consistency; or a state may simply feel that any additional benefits are outweighed by reasons not to include a particular service. As with other carved-out services, states can decide whether to include NET services in their managed care plans.

States that carve out NET services have found monitoring to be very important. MCOs that are not responsible for the service may differ in their approaches, and the resulting costs may vary as well.

- **Other options.** A state may include NET under managed care on a partial basis (e.g., for a specific population or within a certain region). A state may even make participation in the program voluntary. By mixing populations, regions, and services, a state has an almost endless number of options available.

Regardless of the options chosen, states have found that they must carefully analyze all data before and after program implementation to determine if an MCO is providing the expected level of service. Client satisfaction surveys after the program has been implemented provide another way to track the program's success.

Considerations in Including NET Under Managed Care Programs

- **NET-specific managed care programs.** States may have more options for cost-effective programs if they operate their NET programs under waivers which can allow them to better manage transportation systems and provide more cost-effective and higher-quality services. Under a waiver program, a state may be able to control fraud or abuse and may increase coordination with other resources.

- **The MCO responsibility for all aspects of delivering care.** States may believe that the MCO responsible for managing the enrollees' health care should also be responsible for arranging for enrollees' NET needs. If the state's intent in contracting Medicaid delivery of services is to delegate management of health care and responsibility for health outcomes to the private sector, then control of transportation is part of this strategy. State officials may also feel that the manager of their health care program should be the one to handle related NET issues such as "no shows."

As with stand-alone waiver programs, states may choose to include NET in their managed care programs to provide more cost-effective, high-quality service. States may also use an MCO's provider network to ensure that NET is as close as possible to a client's home (to avoid transporting the enrollee greater distances).

- **Cost savings may be minimal at first with potential for greater saving.** States that believe they already operate cost-effective programs may choose not to include NET services in their managed care plans, feeling that there are no additional savings to be gained. Under some full-service plans, initial savings to states for service inclusion may be slight (e.g., 2 to 5 percent). States may feel that they can achieve similar transportation savings without including NET services in their managed care programs. As managed care programs are implemented in more areas and cover more populations, health care costs and use are likely to decrease as appropriate care is rendered and unnecessary services are eliminated. Similarly, a state's NET costs may decrease with the advent of managed care regardless of whether an MCO is responsible for providing this service.

- **Focus on medical care, not ancillary services.** Some states without extensive experience operating managed care programs have chosen to exclude non-medical services from their initial program implementation. MCOs may also prefer not to deal with some of the issues surrounding NET services, such as missed appointments or fraud and abuse.

- **Desire to maintain or create coordinated systems.** Medicaid agencies that effectively coordinate their NET services with other state agencies (e.g., departments of transportation, mental health services, child and family agencies, or agencies focused on older Americans) may not wish to place NET under another system. The new system could destroy a successful component of agency coordination, such as a cost-effective regional approach. Conversely, a state may see opportunities for public, private, or nonprofit partnerships not currently available.

- **Maintaining existing transportation systems.** In urban areas there are often many NET options (e.g., buses, taxis) and multiple providers. In rural areas, where there are frequently fewer options, an important interdependence may exist between NET services

for the Medicaid population and other state agencies' populations. If a managed care system is instituted using market forces such as competitive bids, the interdependence that has characterized a state's operations may be interrupted. If providers go out of business, for example, the state's infrastructure and services to other state agency clients could be adversely effected. In such circumstances, sensitivity to these relationships and interagency communication are important to avoid disruptions.

- **Change can exacerbate existing problems.** States that have had problems managing their NET programs in the past (e.g., problems with fraud and abuse or rapidly escalating costs) may choose not to place NET under managed care if they feel that the change could increase their existing problems. States may also have concerns about the potentially low client use of NET services under managed care due to MCOs' confusion, inexperience, or potential mismanagement of services. Data collection and analysis can evaluate a plan's performance and reveal problems.

States may wish to consider the following questions as they design managed care programs:

- Is the contract clear as to requirements and expectations?
- Is data available to adequately develop a rate for rural areas, particularly if the population has been historically undeserved?
- Does the state have effective monitoring tools available to ensure that its plan does not arbitrarily restrict services in order to avoid NET costs?
- Will a plan use NET as a competitive edge to increase its enrollment?
- Will rural communities be negatively impacted if MCOs are made responsible for NET?

Implementation Strategies

There are many factors to consider in implementing managed care NET programs, some of which are outlined below. It should be noted that obtaining predictable results and program control requires reliable pre- and post-implementation analysis. Quality data collection and analysis will help to measure the impact of managed care programs.

- **NET eligibility screens.** States can use NET eligibility screens (e.g., continuing the use of personal vehicles unless there is a significant change in circumstances, or making sure that a client uses fixed-route transit where available and appropriate) to help them determine if a client needs NET services. Screens are usually carried over to the managed care contracts to meet required programmatic assurances.

  If a state appropriately screens recipients for the necessity and use of NET services both before and after managed care implementation, the number of clients using services may remain constant but could also increase as more people receive better care from their primary care physician. On the other hand, the number of trips may decrease as unnecessary trips are eliminated. The cost per trip may also decrease as competitive bids or other cost savings measures are employed. These and other components of a state's NET system should be carefully monitored for trends.

- **Marketing of NET services by MCOs.** NET may not be a service for which MCOs currently contract. An MCO's management of services may, therefore, be inconsistent with a state's intentions. MCOs may go beyond seeing NET as a tool to increase access to primary care providers, for example, and may even initially advertise that they offer NET services to gain a competitive advantage in client enrollment. The MCOs may incorrectly connote membership in a managed care plan with entitlement to receiving a ride or, conversely, see NET as a place to trim costs (and deny needed rides). A clearly worded contract is essential to express the state's intentions.

- **Duplication of services.** With multiple MCOs competing for clients' enrollment, services can easily be duplicated. For example, competing MCOs may be reluctant to contract with the same provider for NET services, limiting potential cost reduction. Or, although riders who are going to the same destination (e.g., a dialysis center) could ride together, MCOs might discourage ride sharing to prevent enrollees from receiving information about other MCOs. Duplication may also be allowed to continue because of difficulties regarding cost sharing among MCOs.

- **Definition of medical necessity.** States may also face a conflict between an MCO's definition of medical necessity and a state's requirement for the assurance of NET and their and definition of what is necessary NET service. Using Medicaid's broad definition of medical necessity (which includes preventive services) may be one way to provide consistency with the requirement for NET assurance.

- **Auto-assignment to providers.** Many MCOs try to allow clients to use their pre-enrollment providers whenever possible. Some enrollees are therefore likely to have existing providers within MCO networks. In a mandatory managed care program, the remaining clients, who do not have or who refuse to choose an MCO or provider, may be "auto assigned." In such cases, states have found it important to assign clients to the nearest available provider to minimize NET costs.

Additional implementation guidelines should follow general managed care implementation plans. Plans can require the release of MCO data, require complaint and grievance processes, maintain state agency client fair-hearing rights, and insist on quality assurance programs. States can also require a performance bond by an MCO to safeguard their managed care programs, including NET. States wishing to implement managed care programs for NET services are advised to study the results of programs in other states to learn from their experiences.

For a cautious approach, states can make a gradual transition to managed care, treating NET as a non-risk pass-through. This allows an MCO to develop a knowledge of its clientele before taking on the financial responsibility for a new service such as NET.

Rate-Setting Issues

Among other requirements that must be met to obtain managed care waivers, states must calculate projected costs both with and without a waiver. A managed care program is expected to be at least cost-neutral. Service costs may decrease while administrative costs increase during the initial years of a waiver-run program.

Managed care systems may employ a Request For Proposal (RFP) process to contract with providers. If they opt to do so, the contract and the RFP become the basis for resolving all disputed issues. The contract should set out clear responsibilities for all parties, including who is to handle NET services. Issues such as the definition of "medical necessity" can have an impact on all services, including NET.

States using stand-alone waivers to customize their programs will use their own financial data for comparative purposes. States placing whole packages of services under managed care can access various outside professional consultants to arrive at actuarially reliable projections based on the state's data and comparative data from other states.

States now have several options for paying for Medicaid NET costs. These include setting a fee or rate per trip or per mile, basing reimbursement on the cost of providing services, or establishing expected outcomes and reimbursing based on performance. Unlike the complicated risk-based formula some managed care plans use to motivate primary care providers to better control specialty and outside facility costs, initial NET service capitation rates can be calculated simply by using existing state agency cost data. An MCO may pay for NET services on a fee-for-service basis or opt to pass on the risk to the transportation industry through its own capitated system. As with all capitation systems, accurate collection of "encounter data" (i.e., actual data on service usage) should be employed for future capitation rate setting.

In taking on NET services, MCOs must realize that each state differs in how it determines what is necessary to meet the required programmatic assurance of NET. A state may rely on county or local volunteer programs for NET services, for example, and these costs may not show up in the data supplied by the state. Once an MCO takes over NET, however, volunteers may feel that they should no longer be responsible for transporting clients. There is potential risk for states if their programs and data are not carefully managed—if there are unnecessary costs, the MCO, and not the state, could reap the profits. For its part, the transportation industry is concerned that a capitation payment model may not accurately reflect either the actual or the historical cost of providing these services. States should consider consulting with industry representatives when developing a rate-setting methodology to ensure acceptance of the new systems by NET providers.

Conclusion

Although managed care stand-alone waivers can allow states ample opportunity to better manage their NET programs, it is anticipated that states will tend to develop major programs that encompass a substantial number of their Medicaid services, including transportation. For a state to institute such a major managed care initiative is a significant decision and a step away from an environment of regulation to an alternative environment of private management and competition. This privatization of services will establish new direct managers for each state's program. If NET is included under a state's managed care plan, the new manager will play a significant role in determining and providing appropriate services. A state agency's obligation to assure necessary NET services does not change as a result of

implementing a managed care delivery system, regardless of whether NET is included in that system.

The results of placing NET services under managed care may vary from state to state and depend on a number of factors, including: the organization of a state's existing NET program, the intent of the state agency in placing NET services under managed care, the viewpoint and practices of the new manager (the MCO), and the monitoring and oversight of the program after the responsibility is transferred to the MCO. The long-term results and effects of managed care programs, including NET services, are not known. By careful analysis, however, states can anticipate much of the impact of changing to a managed care system. At best, by using this information, states can plan for successful implementation. Similarly, ongoing analysis and management by the state agency are necessary to ensure a program's continuing success.

Key Points

- There are a number of options from which states may choose in shaping their NET managed care programs.

- Stand-alone NET waivers as well as full multi-service waiver-run programs can help states to better manage their NET programs.

- Implications for coordinated systems or effects on other populations, particularly in rural areas, should be a major concern for states making decisions to include NET services in their managed care programs.

- Data analysis and planning are essential in measuring any change in existing NET systems.

- As each state is different, so too are the issues each state must consider as it makes its decision on whether to include NET in a managed care program. A decision to include NET may be right for one state but not for another.

9. Using Data Collection and Analysis to Operate a Cost-Effective Non-Emergency Transportation Program

Debra Johnson, Oklahoma Health Care Authority

NET services provide a vital link in the overall health care delivery system for Medicaid clients. While the federal government requires each state to outline in its state plan how it will ensure that Medicaid clients receive transportation to medical providers, the federal government does not require states to collect or report detailed NET program data. HCFA, however, does require states to report their NET expenditures on either the HCFA 2082 form or the Medicaid Statistical Information System (MSIS). Data must be reported in accordance with the program method that states use to operate their NET programs (i.e., as an administrative function or as a medical service). The HCFA requirements only address the reporting of expenditures, and do not touch on the number of trips taken or clients served.

As states are obligated to purchase the most cost-effective services possible, the NET TAG wanted to provide guidance on data collection and analysis activities that would help states evaluate the cost-effectiveness of their programs. For the purposes of this chapter, a NET program will be considered "cost-effective" when: (1) states receive the maximum benefit from their selected program design, and (2) clients travel to medically necessary services at the lowest possible cost.

This chapter focuses on the TAG's findings on data collection and analysis methods that will help states to operate more cost-effective NET programs. It is hoped that the information provided in this chapter will aid states in their efforts to develop NET programs and evaluate their cost-effectiveness.

Data Collection

As outlined below, there are a number of data elements that states may want to collect for analysis. For many states, it may not be practical to collect this information through the state's claims processing systems, the Medicaid Management Information System (MMIS). Several states have therefore developed stand-alone systems.

Client-Based Data

When collecting data for program analysis, NET program managers should keep the desired outcome in mind: collecting pertinent and relevant data is the key to a building a functional database that can aid in decision-making. A functional NET program database includes information on the clients served. The following are some relevant data fields for tracking client-based information.

- Client's Medicaid identification number
- Name (optional)
- Age

- Sex
- Date of birth
- Race, tribe, or national origin
- Street address or PO Box
- City
- County
- State region
- Reservation (if applicable)
- Eligibility category
- Required mode of transportation (e.g., self-drive, wheelchair, or car)
- Tickets or passes issued
- Meal or lodging expenses
- Claim billed amount
- Claim paid amount
- Type and location of appointment (i.e., office visit or dialysis)
- Number of miles per trip
- Number of trips

Provider-Based Data (Brokers, Integrated Transportation Managers, Managed Care Organizations)

In recent years, states have tended to use brokers and other transportation managers to administer NET program services. Some states have required that managed care organizations (MCOs) provide transportation to Medicaid clients. In such cases, states may not be the source or the keeper of the information required for NET program analysis. States may therefore wish to require transportation providers to maintain functional databases, collecting pertinent data for use by agency NET managers. States may want, for example, to require outside transportation providers to collect and report the following information.

- Prior-authorized trips
- Post-authorized trips
- Reason for trip (reason code)
- Americans with Disabilities Act paratransit qualifier
- Number of trips per client
- Shared ride vs. individual passenger
- Number of trips by miles and mode
- Cost of trip per client
- Cost of trip by miles and mode
- Number of tickets or passes issued to each client

- Primary care physician (if not enrolled in fully capitated program)
- Expenditures for related services (e.g., meals, lodging)
- Administrative costs
- Destination

Collecting pertinent data is a vital first step in providing decision-makers with the information necessary to establish, evaluate, revise, or enhance programs. The following is needed by program managers to conduct program analyses and evaluate programs' cost-effectiveness:

- Number of clients served under administrative program option;
- Number of clients served under medical service program option;
- Program dollars spent under administrative option;
- Program dollars spent under medical service option;
- Transportation costs via outside providers;
- Total NET program costs;
- Number and cost of transit passes purchased; and
- Aggregate and average information on:
  1) trips by client, miles, and mode;
  2) trips by city or zip code, county, and region;
  3) costs of trips by client, miles, and mode;
  4) costs of trips by city, county, and region;
  5) meal and lodging expense;
  6) prior- and post-authorization;
  7) tickets or passes issued;
  8) tickets or passes used;
  9) gas vouchers issued; and
  10) number of miles or trips per gas voucher.

The above list includes most of the data elements needed to establish a functional database for a variety of NET program options, but does not include all possibilities. States may want to include additional data fields to accommodate their specific program designs. Further, the data fields listed above are suggestions, not requirements, for data collection.

Using Data to Design a Cost-Effective Program

In the analysis process, collected data is reviewed and interpreted to provide information to decision-makers. NET program managers need adequate and accurate information about client population, provider resources, and state transportation infrastructure to design cost-effective programs.

NET program design consists of the provider groups chosen to transport Medicaid clients and the administration thereof. There are at least two factors related to program design that determine whether the program will be cost-effectiveness: choice of provider types which will be used, and the method of program administration.

The following section offers suggestions on data collection, as well as on the analysis process, that states may find useful in evaluating their program's cost-effectiveness.

Choosing Provider Types to Design a Cost-Effective Program

First, it is important to assure that clients use the appropriate mode of transportation. States can choose from a number of categories of providers (for-profit and not-for-profit) to transport Medicaid clients:

- **Volunteers.** Usually, volunteers are individuals (e.g., family, friends, or neighbors) who provide transportation in a privately owned vehicle. Reimbursement is generally based on an established per-mile rate. Volunteers can also include program or agency staff workers, as well as Medicaid clients themselves.
- **Public or common carrier transportation.** Buses, trains, paratransit, and commercial airlines would all be included in this category.
- **Fleet providers.** This includes taxi, livery, or van service, among others for example.

To design a cost-effective program, states must decide whether to use one or more of these modes of transportation. To determine which provider types to use, states must gather data and assess their transportation resources statewide. State and local transportation departments can provide this information. County human service and health departments are an excellent source of information on volunteers and local nonprofit transportation providers.

The availability of transportation providers will differ depending on the geographical area of the state in which a program operates. Rural areas are likely to have a larger pool of volunteer providers, for example, but may have little public transportation available. In such cases, states are severely restricted by provider availability.

In areas where there are many provider types available, states should develop a provider mix where services can be rendered at the lowest cost level. An appropriate use of provider types is key to ensuring cost-effectiveness in this situation. Transporting a client to a medical facility by bus would cost less, for example, than transporting him or her by taxi. The issues of provider type selection are often more complex in actuality than in this example, yet states should use the same analysis process when designing their programs. States must also consider their clients' specific needs when selecting the providers to transport them. Depending on the availability of transportation providers, states may want to invest their resources in developing provider networks and coordinating transportation with other agencies. For more information, see Chapter 3, "Coordinating Medicaid Non-Emergency Transportation with Public Transportation Providers and Other Agencies and Programs".

Program Administration

States must also decide how to handle the administration of their NET programs. In many states, Medicaid or human service agency staff perform the entire array of administrative functions. However, other cost-saving options are available to states, such as contracting with brokerages or using managed care organizations to operate transportation programs.

A brokerage is an organization that is contracted as a service delivery intermediary. Some brokerages only have administrative responsibilities while others may perform total services, either by owning their own fleets or by contracting with other providers. Brokers can register clients, make trip reservations, schedule rides, determine the level of transportation service needed, and contract with providers. States can specify the scope of duties to be performed in their contracts with brokers. From an administrative standpoint, using brokerages to perform various functions can save money for states.

States with fully capitated Medicaid programs may use MCOs to provide NET services as well as medical services. Like brokerages, MCOs can often perform a program's administrative functions, often at lower cost than the state. States may also find that it is an advantage to have their transportation services arranged and managed by the same entity that provides medical services. While some states can benefit from having MCOs manage all transportation services, however, others may find it beneficial to limit the extent to which MCOs handle transportation. Aspects states may wish to consider are discussed in more detail in Chapter 8, "Medicaid Non-Emergency Transportation under Managed Care Systems."

Administrative Option vs. Medical Service Option

Under Title XIX of the Social Security Act, states have two federal reimbursement options: administrative service and medical service. For more information, see Chapter 1, Overview, "Claiming Transportation Costs." Administrative services, which can include transportation, are reimbursed by the federal government at a 50 percent rate. Medical services, which can also include transportation, are reimbursed at the state's federal medical assistance percentage, F-MAP for services rendered under the medical assistance option differs from state to state but is often much higher.

In designing an NET program, some states have found it cost-effective to provide services under both the administrative and medical service option. States should conduct a comprehensive analysis of their provider resources and select a provider mix that will result in an overall program savings. This can only be achieved through effective data collection and analysis activities. States should collect data on services rendered under each reimbursement model separately to allow NET managers to objectively analyze and evaluate their programs between and within program designs. Such an approach will also allow them to determine the reimbursement option that will lead to the greatest overall savings.

In some cases however, depending on factors such as provider availability, geographic location, and program administration costs, it may be more cost-effective to use a NET program design in which services rendered qualify as administrative expenses. After

adequately analyzing these factors, states may find that their overall program cost is lower under the administrative services option.

Achieving Cost-Effectiveness by Reducing Per-Trip Costs

Upon selection of the most efficient and cost-effective provider design, the issue still to be addressed is the actual per-trip cost of providing NET services. Cost-effectiveness in this area is achieved when the per-trip reimbursement paid to NET provider groups is at the lowest possible level necessary to ensure the continued availability of the provider group. If a state's program design uses volunteers to transport Medicaid clients within a geographical area, for example, then reimbursement should be set at a level that ensures the continued availability of volunteer providers. States will need to determine cost-effective per-trip reimbursement methodologies for each provider type within their program designs.

States can take the following actions to establish cost-effective reimbursement: (1) conduct market analyses of each provider type; (2) consult industry standard rates (useful for public transportation modes and volunteer providers); and (3) use the competitive bid process (useful with brokerages, MCOs, and other providers when there are numerous potential suppliers).

Other Data Collection Tools: Customer Surveys

Information collected from customer satisfaction surveys can be invaluable to decision-makers. Surveys in the aggregate or on a sample basis can be handled by states, local offices, or brokers. Customer satisfaction surveys can assist program managers in determining if programs are meeting the needs of clients. Surveys can be designed to provide information that is useful to determine the overall efficiency and accessibility of transportation services. The following data elements can be collected from clients via customer satisfaction surveys.

- Accessibility
- Appropriateness of transportation mode
- Efficiency and quality of customer service of a prior-authorization system
- Sensitivity to needs of disabled and elderly persons
- Overall satisfaction
- Cultural sensitivity of transportation providers
- On-time performance
- Dependability of transportation providers
- Suggestions for improving the transportation systems
- Vehicle ownership

Impact of Managed Care on NET Data Collection

As more states move toward managed care, the importance of data analysis in this area of service delivery will increase. States need to ensure that MCOs are providing transportation

options that ensure their clients' access to services. Health plans also need information in planning future treatment sites and staffing patterns.

When implementing managed care systems, states have found that it is important to include data collection in the early stages of planning. States that do so can take into account the time needed to build functioning data systems, and include such data requirements in their contracts with the organization that will provide transportation. States beginning managed care programs often experience a lag in receiving data. MCOs are often not ready to submit data until several months after the program begins operation, or later.

Managed care entities enjoy more flexibility in providing services than governmental agencies and have a vested interest in their programs' cost-efficiency. MCOs are likely to use less costly methods of providing transportation, such as bus tokens. In some instances, MCOs may determine that providing in-home care is more cost-efficient than paying for transportation. MCOs also control appointment scheduling and may elect to coordinate the scheduling of clients' appointments to help more efficiently control transportation costs. It is important for programs to collect data on all types of transportation, and capture alternative arrangements in the data collection process.

The accessibility of medical services is directly affected by the availability of transportation. States have found that it is important to closely monitor the availability of transportation and the level of client satisfaction to ensure that medically necessary services are being provided in the manner prescribed by their contracts with MCOs. Transportation patterns can also be used to plan future health care delivery system designs. For more information on managed care, see Chapter 8, "Medicaid Non-Emergency Transportation Under Managed Care Systems."

Key Points

- NET program managers must have reliable information to operate their programs effectively. It is very difficult to effectively evaluate programs without reliable data.
- Data collection and analysis can be costly, but the expense could be justified by potential savings.
- Improving collection and analysis of NET data is an important step towards operating a cost-effective program.
- Most MMIS systems are not designed to produce the information that NET managers need to properly analyze their programs. Independent data systems are often required to develop this capability.
- NET providers may initially differ greatly in their ability to submit reliable data. A large amount of technical assistance may be needed.

10. Strategies to Identify and Prevent Non-Emergency Transportation Fraud and Abuse

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NET plays an important role in assuring client access to medical care. Unfortunately, this transportation has recently come under greater scrutiny because it has been subject to documented fraud and abuse activity in some states. While the percentage of total program expenditures resulting from fraud and abuse has been open to debate, there can be no doubt that fraud is a significant issue in this service area. Fraud and abuse activity diverts dollars from other legitimate uses, wastes taxpayer dollars, and causes the legitimacy of transportation services to be called into question.

The purpose of this chapter is to provide information to state Medicaid agencies about NET fraud and abuse. The NET TAG has attempted to identify potential problem areas and best practices, and, where practical, propose national solutions. Identified in this chapter are types of fraud and abuse activities, factors that contribute to abuse in transportation programs, ways to detect fraud and abuse once it has occurred, and steps to prevent it. The chapter is intended to provide states with useful strategies for dealing with an aspect of NET services that, if not confronted, could overshadow their critical and vital nature.

Types of Fraud and Abuse

Transportation fraud and abuse activities are categorized as either provider fraud or client fraud, although the two often occur concurrently. The NET TAG has attempted to catalogue, in the lists that follow, the types of fraud and abuse activities that states have encountered. Of course, the list grows as states uncover new schemes.

Provider Fraud and Abuse
- Submitting "thin-air" claims, including billing for services not rendered or billing for multiple family members when only one member is actually transported.
- Billing groups at single rates.
- Double billing for the same service by one or more providers.
- Inflating mileage.
- Billing round-trip for one-way service.
- Misrepresenting client need for service or level of service, including inappropriate use of higher-level ambulance services.
- Billing Medicaid for transportation to a non-Medicaid-covered service.
- Inappropriate underutilization in a capitated environment.
- Providing a type of service or level of quality below what is purchased (e.g., transporting clients in unapproved vehicles that do not meet safety or other standards; arriving late for

appointments; or failing to provide the required level of client service, hire personnel with appropriate credentials, or show up for a scheduled ride).

- Kickbacks to referring providers.
- Kickbacks to clients.
- Falsifying records to document billings.
- Falsifying the cost of providing the trip when reimbursement is cost-based.
- Unbundling services that are part of another reimbursed service, such as billing for transportation to a service when transportation is included in the service rates (e.g., nursing homes).
- Charging Medicaid more than other clients.
- Balance billing the client.
- Inappropriate administrative charges (for example, charges that are inflated or not properly allocated among cost centers).
- Fraudulent interaction with agency staff.
- Bidding fraud, including collusion or price fixing.

Client Fraud and Abuse:

- Inappropriate use of services, including knowingly requesting transportation for an individual or other family members to a non-medical destination, including associated action to avoid detection
- Identification card-loaning to non-Medicaid eligibles.
- Use of bus pass by unauthorized third party.
- Falsifying claim for replacement of lost bus pass.
- Other fraud and abuse associated with bus passes as a negotiable instrument (i.e., fraud and abuse similar to that experienced in the Food Stamp Program).
- Unreported receipt of transportation assistance (e.g., bus passes) from more than one program.
- Falsifying documents to attain eligibility or to justify the need for transportation.
- Failure to report discontinuation of treatment following blanket authorization.
- Receiving kickbacks.
- Misrepresenting a client's access to or ability to use other means of transportation.
- Misrepresenting a medical condition to justify the need for transportation.
- "No shows" and excessive cancellations.
- Late for pick-ups.

Contributing Factors

To deal with the issue of fraud and abuse in transportation, it is necessary to examine those aspects of the service that may contribute to the existence of fraud and abuse. Some of the

factors apply to various Medicaid services, while others are specific to NET. While many of these factors have positive attributes, such as competition and freedom of choice, they may also have unintended adverse consequences.

Provider Issues

- **Lack of professional licensing on the part of providers or drivers.** Many of the individuals involved in transportation are not subject to the same licensing requirements as workers in other service disciplines. While certainly not true of all transportation providers, some less scrupulous providers lack a sense of professionalism and are in the business only to make a quick profit.

- **Solicitation.** While solicitation plays an outreach function and contributes to freedom of choice, marketing abuses as a means to "drum up business" may result in ongoing abuse of the system.

- **Competition.** Competition can result in lower costs and improved quality. It can also encourage unscrupulous transportation providers to "cross the line" to make up for lost profits. In defining a medical service, states define the criteria that a provider must meet to participate in the program. Once defined, however, any provider that meets the standards must be allowed to participate under the medical services option. This may result in an oversupply of providers, who turn to fraudulent activities to generate payments, and an inability to limit the number of providers of a medical service.

- **Frequent change in ownership.** Related to the issues of licensing and the number of providers is the fact that many new providers become Medicaid providers following the purchase of existing entities.

- **Setting up multiple provider numbers (related parties).** Further difficulties can ensue when a party has ownership interests in multiple entities. Even when ownership interest is fully reported, it requires cross-checking among multiple providers.

- **Incentive payments for drivers.** How a provider reimburses drivers may contribute to fraud. If a driver is paid on a per-ride basis instead of receiving a set salary, there is an incentive for the driver to generate as many rides as possible.

Client Issues

- **Freedom of choice.** Freedom of choice of providers is required for medical services and ensures clients access to a wide variety of providers. On the other hand, freedom-of-choice provisions make it more difficult to manage the transportation system. Freedom of choice does not apply to the mode of transportation, nor does it apply to the administrative services model.

- **Few payment sources for transportation for low-income individuals.** Clients in need of non-medical transportation may have few places to turn for assistance. This may contribute to client fraud, and may make clients susceptible to collaborating with fraudulent providers. It may even result in client advocates and other social service agencies encouraging questionable transportation-related activities to ensure that their clients have access to vital services that are not medical in nature.

- **Inability to deny services for known abuses.** Currently, states have limited ability to deny services, even for clients who have repeatedly failed to follow program requirements. This includes activities such as "no shows" for appointments and failure to preschedule non-emergency trips. "No shows" are very problematic since the provider expends resources in anticipation of providing the service.

Agency and Program Related Issues

- **Priority given to transportation, relative to other services, by Medicaid agencies.** While the assurance of necessary transportation is federally mandated to ensure clients access to services, NET service does not fit the definition of a traditional medical service that falls within the expertise of most Medicaid agency staff.

- **Priority given to fraud and abuse, relative to other functions, by Medicaid agencies.** Undoubtedly, the deterrence, detection, and prosecution of fraud and abuse are core functions of all state Medicaid agencies. The reality, however, is that these are among a number of competing demands in the rapid evolution of the health care environment. In addition, as quickly as Medicaid agencies identify and react to specific types of activities, unscrupulous providers develop new schemes to defraud the program.

- **Electronic billing and the elimination of submission of attachments.** As in other areas of health care, Medicaid programs are attempting to increase the efficiency of their claims processing through the use of electronic billing. Electronic billing, however, makes it more difficult to require claims attachments that can be used to verify the validity of the service provided. Moreover, it allows unscrupulous providers to submit large numbers of questionable claims in a short period of time.

- **Administrative cost of prior authorization in comparison to cost of individual service.** One method of controlling the questionable use of NET services is that of prior authorization. In this area, however, the administrative cost of authorizing a single service may exceed the cost of the ride itself. This must be balanced against the potential for increased costs across the service if an authorization process is not used.

- **Rate structure and other aspects of program design.** This factor includes a number of considerations. For example, including transportation in the cost of a medical service may encourage certain reactions, such as padding cost reports or unbundling services. Failure to pay for certain components, such as "no-shows," may encourage providers to engage in abusive billing in order to recoup these costs.

- **Failure to recognize that managed care is not a panacea for fraud and abuse.** Managed care has the potential to reduce some fraud and abuse through improved service coordination. It will not, however, eliminate the problem in its entirety. States must be prepared to assist managed care providers in identifying fraud and abuse. In addition, states must carefully monitor managed care providers to ensure that new types of fraud (for example, intentional withholding of services) are not occurring.

Detection Methods

There are a number of methods that states are using to detect NET fraud and abuse. Listed below are examples of the types of methods employed. The attached chart also attempts to demonstrate the relationship between detection methods and types of fraud, as well as between detection methods and preventive efforts.

Provider Monitoring

- **Vehicle approval.** As part of the provider approval process, this method ensures that all vehicles meet program standards.

- **Driver abstract reviews.** Reviewing driving records helps to assure that quality services are provided and that the safety of clients is protected. In some states, reviews are conducted routinely for all drivers. In others, reviews are done by sampling or on an as needed basis.

- **Verification of mileage.** Staff check to make sure that mileage on the odometer matches driver logs or actual distance between pick-up and drop-off points.

- **Explanation of Benefits statements.** The medical Explanation of Benefits statements can be tailored to show a client when he or she used transportation services. This allows the client to spot fraudulent billing.

- **Client satisfaction surveys.** A targeted satisfaction survey addresses quality issues and helps to identify potential fraudulent billing.

Client Monitoring

- **Targeted home visits to clients.** A program of targeted home visits to clients may assist in confirming dates of service, while allowing staff to directly observe an individual's ability to use other means of transportation.

Provider and Client Monitoring

- **Unannounced field visits and spot checks of service and vehicles.** Although they are labor-intensive, "on-the-street" reviews provide a firsthand look at the physical needs of the clients served, the condition of the vehicles used, and the quality of the services provided.

- **Pre- and post-payment claim review.** Reviewing and verifying claims is an effective way to detect fraudulent billing. Although labor-intensive, targeted pre-payment monitoring is more effective at protecting the program than post-payment review and recovery activities.

- **Verification of medical services.** Ensuring that clients actually received medical services, through "trip sheets," direct contact, or other means (e.g., calling a medical provider's office to confirm an appointment as part of the authorization process or doing random follow-ups to confirm visits), can help to prevent NET fraud and abuse.

- **Record review.** This includes reviewing all supporting documentation for a trip and verifying the accuracy of records with sources such as the treating physician.

- **Criminal investigation.** This could include undercover activities.

- **Surveillance and utilization review (SUR).** SURs can be an effective way to identify both fraudulent providers and beneficiaries. It should be noted that the date-of-service basis of SURs may result in a significant time lag in identifying problem providers.

- **Special ad hoc reports (matching transportation and medical claims).** While not foolproof (for example, a medical service may not be billed to Medicaid), at least one state has found this to be useful tool in identifying potential situations where the state was billed for transport to somewhere other than a legitimate medical service.

- **Fraud and abuse hotlines.** Well-advertised fraud and abuse hotlines may be used by clients, providers, and the general public.

- **State-by-state comparison of utilization rates.** While no two states share all the same characteristics or service definitions, comparing information concerning expenditure and utilization rates among states for like services can be useful. Of course, higher utilization rates may be a sign of diligent outreach and appropriate access.

Prevention Efforts

Of course, most states would prefer to prevent NET fraud and abuse before it occurs. Some successful strategies to do this include:

Provider-Focused

- Provider training.

- Strengthening provider eligibility standards.

- Pre-enrollment testing of providers. Developing a provider test as part of the enrollment process and requiring a minimum score ensures that providers have at least a rudimentary understanding of program requirements before services are provided and billed.

- Better coordination with the Medicaid Fraud Unit and other law enforcement agencies.

- Rapid suspension of abusing providers.

- Widespread publication of program sanctions as means of deterrence.

Client-Focused

- Client education on rights and responsibilities. While all clients should be informed of their rights and responsibilities under the Medicaid program, specific sessions should be considered on how to access transportation, the appropriate use of NET services, the penalties for misusing the transportation system, and how to report suspected fraud and abuse.

- Lock-in of clients to a single provider.

- Use of client sanctions. For example, clients found to abuse the system with repeated "no shows" could be required to make a confirming telephone call on the day of the ride or have their request canceled.

Provider- and Client-Focused

- Pre-authorization of services. Prior authorization, while labor-intensive, is an effective means of utilization management. This can be coupled with a review of service requests by medical staff. As indicated above, there is a potential issue in evaluating the cost-effectiveness of this approach. In addition, caution must be exercised in designing a system to ensure accurate validation and timely response.

Key Points

- Transportation is a vital service that must be protected.
- States must remain vigilant concerning the potential for fraud and abuse related to transportation services.
- The types of fraud and abuse are varied and ever-changing.
- There are certain aspects of the service that make it an easier target for fraud and abuse.
- States must take steps to ensure early detection of fraud and abuse in the transportation program.
- Most importantly, states must take steps to prevent fraud and abuse from occurring.

DETECTION EFFORTS	spot checks	vehicle aproval	driver abstracts	claim review	mileage verification	trip verification	record review	undercover	SURs reviews	Ad-hoc reports	EOBs	Recipient surveys	Press reports	F&A Hotlines	Compare UR rates
TYPES OF FRAUD															
Provider Fraud															
Thin air claims				X		X	X	X	X	X	X	X		X	X
Groups billed as singles	X			X			X	X	X	X	X	X			
Double billings				X		X	X	X	X	X	X	X		X	
Inflating mileage				X	X	X	X	X	X	X	X	X		X	
Billing round trip for one-way				X		X	X	X	X	X	X	X		X	
Misrepresenting need	X						X	X	X			X	X	X	X
Non-medical destination	X					X	X	X				X	X	X	
Poor quality service	X	X	X					X				X	X	X	
Kickbacks to providers								X						X	
Kickbacks to recipients								X				X		X	
Falsifying records		X	X			X	X	X						X	
Falsifying cost reports							X	X	X					X	
Unbundling services				X		X	X	X	X	X		X		X	
Charging more than other payers							X						X	X	
Balance Billing							X	X		X		X		X	
Misconduct by agency staff				X		X	X	X	X	X	X	X		X	X
Underutilization	X			X			X	X	X	X		X	X	X	X
Recipient Fraud															
Inappropriate use	X			X		X			X	X			X	X	X
Card loaning				X		X			X	X				X	X
Falsifying eligibility									X			X		X	
Receipt of kickbacks												X		X	
Misrepresenting access								X						X	
Misrepresenting need	X					X							X	X	
No shows						X								X	
Late for pick-ups						X								X	
PREVENTION EFFORTS															
Recipient Education				X			X		X	X	X	X	X	X	X
Provider Training		X	X	X	X	X	X		X				X	X	
Provider Standards	X	X	X	X			X		X			X			
Prior Authorization	X			X	X	X									
Verify High Utilizers	X			X	X	X			X	X	X				
Lock-in Recipients				X		X								X	
Recipient Sanctions				X		X	X		X	X					X
Change to Admin System						X						X		X	X
Other Design Changes		X		X		X	X	X	X	X	X	X	X	X	X
Use of Contracting Waivers		X	X							X		X			X
Use of Brokerage System		X	X							X		X			X
Capitated Payments			X												X
Law Enforcement Coordination	X			X	X	X	X	X	X	X			X	X	
Rapid Suspension	X		X	X	X	X	X	X	X	X	X		X	X	
Partnership with Social Services						X						X			
Recognize Potential Problems	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HCFA as Information Conduit	X			X					X	X			X		X
F&A Coordinating Council				X					X				X	X	
Model Edits and Screens	X			X	X										

11. Coordination of Non-Emergency Transportation for Native Americans

Rudy Schenk, Utah Department of Health

Coordinating NET services for Native Americans[5] can be challenging for many state Medicaid agencies. Most Native American reservations are frequently located in rural areas, transportation services are necessary to ensure access to medical care. In many cases, coordinated NET services are literally a matter of life or death. (See also Chapter 4, "Assessing and Meeting Non-Emergency Needs in Rural Areas.")

Many Native Americans living on reservations rely on NET services provided by Medicaid agencies to receive renal dialysis, pregnancy-related services, children's special services, and other care. Without Medicaid transportation, many Native Americans might not receive needed medical services. Based on this knowledge, states have worked hard over the past several years to provide effective NET services to Native Americans.

Building trust and positive relationships with service providers and Native American tribes is germane to the successful coordination of NET services for Native Americans. Since each tribe has unique needs and policies, states should handle issues on a case-by-case, government-to-government basis. This chapter focuses on some of the problems that have been identified in coordinating NET services for Native Americans, and some of the approaches that states have used to successfully deal with these issues.

Challenges

States have identified the following issues and challenges in designing and implementing their programs:

- **Access.** Access to medical services can be difficult given that reservations are often located in rural areas. (Native Alaskan clients frequently have access problems that require the use of air-transportation services to allow them to reach providers.)

- **Distance.** Available medical services are frequently more than 100 miles from reservations, requiring clients to travel long distances and in some cases even cross state lines to access services. These long distances and the scarcity of recipients reduces the potential for competition and increase the likelihood for fraudulent billing of miles or single-passenger trips. have the potential to lead to fraudulent billing of miles because providers may take circuitous routes to pad the miles being billed.

- **Communications.** Communicating with clients to arrange for transportation is difficult because many clients do not have telephones or other means by which they can be reached.

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[5] For purposes of this discussion, the term "Native Americans" refers to American Indians and Alaska Natives.

- **Language.**
- **Sovereignty.**
  providers who enter reservations to provide services. Tribes may not be willing to work
  with outside brokers, which may require states to work directly with tribes in a

  analysis of this aspect of NET programs.)

Sovereignty Issues

does not exist with other populations: the sovereign nation status of many tribes. Not all
Native Americans are members of tribes that have sovereign nation status. To build effective

working knowledge of the federal and state laws and policies that set the parameters for the
relationship between the tribes and the state Medicaid agency.

sovereign nations. This means that some tribes are considered nations in their own right. As a
sovereign nation, a tribe has its own governmental structure and jurisdiction over almost all

relationship with the state and federal governments when determining how, when, and to
what extent federal- and state-sponsored services are provided on tribal lands. The issue is
's right to dual citizenship, that is, as a tribal member,

Each tribe is a separate government. Therefore, it is incumbent on state to develop
relationships and work with each tribe independently. Although it may be difficult to

reached.

Issues

Medicaid agencies may need to address the following issues:

1. Decision-Makers

develop solutions, and make decisions?

From the tribe s perspective, a relationship between the state governor and the leadership of
the tribe is often the appropriate government-to-government interface. It is imperative,

state to a course of action. If this is not the case, the tribe could believe that the state is not
respecting its sovereignty. An open discussion could resolve this issue. Who in the Medicaid

the official designee of the top decision-makers?

From the Medicaid agency's perspective, it can be extremely difficult to identify the appropriate person to work with within the tribe. It may not be clear from the tribal government structure who is responsible for transportation issues. Is it the tribal council, the Indian Health Service (IHS), the health director, or the manager of the human services program within the tribe, or some other entity? Again, identifying the right person early can avert problems. It may be useful for the state to enlist the help of others in identifying the appropriate contact person for this effort. If the state has a Native American commission or other official relationships with respected Indian country leaders, they can be turned to for advice.

The importance of accurately identifying who needs to be at the table cannot be overemphasized.

2. Cultural Competency

There are definite cultural differences which the state must accommodate when working with tribes. The Medicaid staff involved should be familiar with these cultural differences and apply the knowledge in two ways: 1) in working with tribes in a government-to-government mode; and 2) in planning and delivering transportation services.

- What are the expectations, the realities, and the impact on relationships of issues such as punctuality, decision-making processes, authority, the role of spirituality, time, follow-through, trust, and respect?

- What are the cultural issues that affect service delivery? For example, some Native American clients are acutely uncomfortable sharing a ride with a non-Native American, or a member of another tribe, and might elect not to make the trip rather than to do so.

3. Entering Tribal Lands

Some tribes are reluctant to allow non-tribal transportation providers to enter tribal lands. If this is the case, negotiations are in order. Potential outcomes include the following.

- Acknowledgment by all concerned that the tribe controls the conditions under which any vehicle operates on tribal land, including jurisdiction over traffic law enforcement and accident investigation. Such an agreement may result in acceptance of other vehicles.

- Shared responsibility for trips. The tribe can transport the client to the reservation border, for example, where another vehicle can pick the client up to complete the trip.

- Hiring tribal members to drive company vehicles.

4. Service Delivery

Many tribes want complete or greater control over the actual delivery of services.

- Screening to determine if the client is eligible for the trip.

- Contracting to provide transportation to tribal members for medical services on the reservation.

- Contracting to provide transportation to all medical appointments for tribal members.

- Subcontracting to provide either of the above.

- Serving as a transportation broker.

5. Other Issues

The responsibility of IHS to provide transportation for tribal members traveling to IHS hospital raises the issue of federal treaty obligations for Native American health care. The state of Arizona has a long-standing dispute with IHS over responsibility for providing transportation to IHS hospitals. The issue pits the federal obligation for Indian health care against the Native American's rights as a citizen of the state. The issue is currently being litigated.

Problems with Providers

In recent years, an increase in the number of private companies that provide NET services has led indirectly to an unnecessary use of transportation services in many areas. This has been a particular problem in some rural areas where Native Americans live. Private companies have seized the opportunity to transport Medicaid clients long distances because these long-haul trips, often with multiple riders, are very profitable. This trend, however, has led to increased, sometimes vicious, competition among companies as well as rising costs to state Medicaid programs (because of the increased amount of unnecessary use).

Some of the problems related to this intense competition are illustrated in the following examples.

- **"Upping the ante."** Competition between providers became so intense in Utah that a company started to offer perks, such as lunches, to clients who would ride with its drivers. Clients would then ask other companies what perks they would provide should they choose to change providers. This practice made it very difficult for staff to coordinate services.

- **Hiring competitors' drivers.** Clients frequently don't know the name of the company they are riding with—they choose a service provider because they know and like the driver. One company hired drivers from a competing company to attract clients. There is nothing illegal about this practice, but it can be confusing to clients and the staff who are trying to coordinate services.

- **Threatening clients.** While not a common occurrence, clients in the past have been threatened by providers for switching to a new company. Clients have then changed back due to fear of reprisal. If this situation occurs, it should be dealt with through whatever means possible, including contacting local authorities for help in alleviating the problem.

Solutions to Transportation Problems

Assuring access to NET services is required by Medicaid regulations. As described above, there are a number of potential barriers to services that can complicate the assurance and coordination of NET services for Native Americans. The following section outlines what

some states are doing to address these issues and ensure the availability of transportation services for Native Americans.

- Some states are contracting with an outside private entity, such as a broker, to coordinate all their transportation services. Native American clients receive the same

    the appointment is confirmed prior to the provision of transportation).

- **Contracting with tribes.** Several states contract directly with tribes to provide

    the state Medicaid agency directly. Services are coordinated by IHS staff or local caseworkers. (It should be noted, however, that a potential problem with this option is

    allowing them a free choice of any available provider).

- **Arrangements by caseworkers.** Local caseworkers are responsible for arranging and

    transportation services in a similar fashion.

- **Volunteers.** Several states use volunteers to provide transportation and reimburse them

- **Including transportation in managed care contracts.**
    to negotiate transportation arrangements with tribes, and gives tribes the opportunity to enter into business arrangements with the MCOs.

- **Coordination.** Some states coordinate NET services through their Medicaid agencies, allowing clients to choose from all available service providers. The service may or may not require prior authorization. Frequently, agency staff make arrangements for transportation. However, for clients (such as dialysis patients) who have to go to a facility for repetitive treatment, transportation providers make regular scheduled pickups. These pickups usually have been preapproved and arranged by agency staff.

In addition, unnecessary use has been dealt with in other ways, such as changing reimbursement methodology and enhancing competition. For example, Utah changed its reimbursement methodology to reflect the fact that multiple clients were being transported. The cost of driving a van does not generally change regardless of whether one, two, or more clients are being transported. Utah therefore changed its reimbursement schedule to reflect multiple riders, with a decreasing amount per mile based on the number of riders. This encourages providers to coordinate transportation because they will be paid more per mile when they transport two or more clients at a time. This approach may not work in all situations and states should closely monitor use.

Utah also helped a rural hospital to become enrolled as a transportation provider. This served several purposes. First, it enhanced competition in the area, making it possible for the Medicaid agency to make changes without risking a loss of access should other providers threaten to pull out of the area. (Even if other providers did pull out, clients would still have access to transportation through the rural hospital.) Second, providing NET services gave the rural hospital a new source of revenue.

Key Points

States should ensure that Native Americans receive the medical services they need. This is especially important for Native American clients who have chronic illnesses (e.g., end-stage renal disease, diabetes). Because of the remote locations of many reservations, as well as other factors, coordinating transportation can be difficult.

Nonetheless, many states have been successful in using various methods to ensure that Native American clients receive needed medical services. There is no one effective method that will assure access to needed services. The approaches mentioned above will work for some states, but may not work for others. Each state must decide what type of program will best meet the needs of its Native American population. Coordination, however, is the operative word. Coordinating programs and establishing lines of communication with local agencies, IHS, tribes, and providers will pave the way to assuring that the needs of Native American clients are met, and that abuse and inappropriate use of services are not taking place.

- When working with Native Americans, states have found it beneficial to develop and maintain a government-to-government relationship with tribes.

-
  leadership.

- States have also found it important to maintain respect for and accommodate to the greatest extent possible Native Americans cultural beliefs and practices.

- Developing tribal transportation systems and options presents similar problems to those experienced in other rural areas. These challenges, however, are compounded by

12. Findings

During their two years of work, technical advisory group (TAG) members have had the opportunity to talk with a number of NET program experts. From these conversations, the group is offering the following findings and recommendations.

Recommendations for States

- **Focus on least-cost services.** States believe that ensuring that clients use the least-costly appropriate mode of transportation, and taking every step possible to ensure that services are as cost-effective as possible, is the most efficient way to operate their NET programs.

- **Improve data collection and management.** Many states do not now have sophisticated transportation data collection instruments and systems, particularly if transportation is operated as an administrative service. As chapter 9, "Using Data Collection and Analysis to Operate a Cost-Effective NET Program" indicates, access to accurate and comprehensive NET data is critical to operating a cost-effective NET program. Several states, including Mississippi, have put significant resources into developing data collection systems; many systems are available in the public domain or through a common fiscal agent. Furthermore, as states modify or procure new Medicaid Management Information Systems (MMIS), they have found that adding an element that provides NET data analysis capabilities is cost-effective and sometimes easier than building a stand-alone transportation database.

- **Establish and implement a hierarchy of transportation modes.** States have found that one of the most important cost-control mechanisms is to effectively screen clients. An ambulatory client should not ride in a wheelchair van; a client with a car should not take a taxi. A hierarchy of transportation modes, which requires a client to use free travel first (in a personal vehicle or with a friend or family member), to receive reimbursement if needed for driving a personal vehicle second, to take public transportation third, etc., has been found by states to be cost-effective. It is essential to develop a screening system and method to enforce the use of the lowest mode possible.

- **Investigate the use of brokers.** As discussed throughout this guidebook, brokers have proven themselves to be efficient managers of transportation programs. Although their administrative costs can be high compared to a non-brokered system, it may make sense for states to have transportation professionals operate their NET programs instead of social workers or case managers in a local office. Brokers can help manage program costs, ensure that a client uses the appropriate mode of travel, and group rides to maximize vehicle capacity, among other functions.

- **Contract with nonprofit providers who receive federal grants.** States should be aware that many nonprofit transportation providers receive operating and capital grants from federal and state governments. These programs include Sections 5310 and 5311 (formerly known as Sections 16 and 18) grants. States contracting with these providers, if they pay the same rates as for-profit providers, pay higher rates than may be necessary.

- **Implement prior-authorization systems.**
  authorization of rides can be cost-effective. Prior-authorized systems must be carefully designed to make access to needed medical services as simple as possible. A poorly

  hurdles for medical and transportation providers, clients, and caseworkers. Although the somewhat high administrative costs associated with prior-authorization systems will make 's per-trip costs seem high, the systems have been shown to control the

- **Coordinate, coordinate, coordinate.**
  transportation agencies and other human service providers increases the efficiency of the transportation system, helps to control costs, and can provide better service to Medicaid

  community, state, health care, and transportation industries and the state Medicaid agency to develop coordinated networks of transportation. See Chapter 3 Coordinating Medicaid NET with Public Transportation Providers and Other Agencies and Programs.

- **Consider the impact of any Medicaid changes on the regional transportation**
  Medicaid NET programs do not operate in a vacuum. Transportation providers are dependent on Medicaid NET funds. Reducing transportation rates can have a

  same time, generous rates and policies may have created an oversupply of providers, which leads to other problems. Most state Medicaid agencies do not consider themselves

  focusing on getting clients to doctors. However, states should consider that Medicaid NET dollars may be a major source of funds for the human service transportation services

- **Consider providing transportation under the administrative service option.**
  mentioned throughout the guidebook, states have the ability to operate NET programs as an administrative service or optional medical service. Although states generally receive a ' flexibility to run

  make sense to operate their NET programs as an administrative service because this program option can allow much greater flexibility.

- **Monitor NET providers closely.** States have found that some NET providers commit fraud and abuse. NET providers can be particularly egregious. In some cases, as soon as a provider has been forced out of one state, he or she will move to a neighboring state and enroll there as a NET provider. Agencies have found that strict provider licensing requirements, among other activities, can deter fraudulent providers. In particular, states have found that making sure providers have operated in the state for a certain period of time can keep troublesome providers at bay. (See Chapter 6, "Medicaid Non-Emergency Transportation Provider Qualifications and Standards," and Chapter 10, "Strategies to Identify and Prevent Non-Emergency Transportation Fraud and Abuse," for more information.)

- **Managed care.** States are beginning to hand over responsibility for providing transportation to managed care companies. While some states believe that it makes sense for the organization responsible for medical care to also be in charge of transporting the person, others have decided to keep their NET programs in the fee-for-service environment. As managed care organizations gain experience with providing care to the Medicaid population, they will also gain experience with providing transportation. States have found that managed care companies must be closely monitored to ensure that they are providing transportation to everyone who needs the service, particularly if transportation is capitated.

For the Federal Government (Regulatory and Legislative)

The Health Care Financing Administration (HCFA) should continue to permit state flexibility in the operation of the NET program. HCFA has permitted states to operate their NET programs with a great deal of flexibility in the past. This flexibility has permitted states to operate transportation programs that meet local needs and priorities. HCFA should continue to allow states flexibility in the future.

Administrative or Regulatory Change Needed

- **HCFA should serve as conduit of information for states.** States should be aware of potential problem areas as soon as possible. The "SURs Alerts" developed by the users group and the communication by the Georgia Medicaid program are good examples of this strategy in action. HCFA can and should play a role in ensuring that this occurs, and has in fact taken a number of steps in the past year to establish itself in this role. In particular, HCFA should disseminate its policy decisions and letters widely to make sure that all regional offices and states are aware of new policies or policy clarifications.

- Currently, states have a minimal ability to provide even limited program sanctions against clients who abuse the Medicaid transportation program. States

  transportation providers and non-abusing clients by being permitted to impose reasonable and narrowly tailored sanctions against clients who repeatedly miss rides or abuse the

  with states to implement policies in this area.

- **Role of potential Medicaid fraud-and-abuse coordinating council.** The increased

  in health care becomes a more sophisticated criminal enterprise, there will be a growing need for coordinated approaches to combat its spread. This strategy will involve both 's role in information sharing and better coordination with law enforcement.

- **Development of model edits and computer screening programs.** This is another area in which HCFA could play a critical coordinating role. Currently, work is being done for the Medicare program to develop ways to detect potential fraud based on technology used by the financial industry. States may not have the resources to individually fund such research-and-development activities, nor is it cost-effective to do so. Admittedly, each

state's program and MMIS are different. However, development of model edits that could be adopted or tailored on a state-by-state basis would be helpful in providing a national framework.

- **Continue to provide a network to share successful NET practices.** TAG members feel HCFA must continue to provide technical assistance and information on Medicaid NET services, even after the NET TAG finishes its work. Networking could take the form of a transportation workgroup, a regular conference on Medicaid transportation, or a series of national conference calls on various transportation issues.

Legislative Change Needed

- **Broader authority to contract without a waiver.** Allow states flexibility to selectively contract for transportation services without applying for a waiver. This change should apply to all Medicaid services, including transportation. This would allow states to contract with specific providers, at competitively bid rates, while still receiving the medical services match rate. (Note that this change was not included in the 1997 Balanced Budget Act.)

-
  HCFA recently revised policy enhancing the states'
  accordance with Section 1902(a)(4) of the Social Security Act, states may now purchase bus passes if they can document the cost-effectiveness of the bus pass purchase. However,

  Circular A-87. The circular mandates that states allocate costs among all agencies providing services to the client, if he or she will use the pass to access those services. For

  mental health and substance program, and the job training program, as well as Medicaid, if the client were receiving services from those agencies. Personal use of the pass (to go to

  TAG would prefer that states not be required to allocate costs, but be allowed instead to opt to do so. Transportation is a critical element of states efforts to move welfare clients into work. The cost-allocation requirements will complicate efforts to use Medicaid bus

- **Allow states to receive Federal Medical Assistance Percentage (FMAP) for all**
  State flexibility to operate a cost-effective NET program is limited by the choices that states are forced to make between operating transportation as

  the medical services match rate (the FMAP) while operating the program with the flexibility of the administrative service option.

Appendix A. Contact Information

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Appendix B. Bibliography and Resources for Non-Emergency Transportation

Recent Publications

Community Transportation Association of America. *Managing Medicaid Transportation: A Manual Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans.* Washington, D.C., December 1997.

"How Will People Get to the Doctor?" *Community Transportation* 15, No. 5 (July 1997).

Betty Apt, Josiah Townsel, Winnie Walker, and Jackie Andrews. "Controlling Medicaid Non-Emergency Transportation Costs." HHS Office of Inspector General .Working Draft, April 1997.

Elisabeth Hays and Jon Burkhardt. *Innovative State Medicaid Transportation Programs.* Ecosometrics, Inc. March 15, 1995. Prepared for the Joint HHS/Department of Transportation Coordinating Council on Human Services Transportation.

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Appendix C. Legislation, Regulations, and HCFA Policy Letters on Medicaid Non-Emergency Transportation Services

In the past, there has been no widely available repository of federal legislation, regulations, and HCFA policy letters on NET services. The NET TAG members have collected as much of this information as they could find, and are presenting it in this appendix.

1.   Section 1902(a)(4)(A) of the Social Security Act. Language allowing states to operate NET programs as administration services. Section 1902 (a)(30)(A), Requirement that services must be available statewide.

2.   Federal Medicaid Regulations, 42 CFR Chapter IV, Section 431.53. Assurance of Transportation. Federal Medicaid Regulations, 42 CFR Chapter IV, Section 440.170. Any other medical care or care recognized under state law and specified by the secretary.

3.   State Medicaid Manual, Section 2113. Transportation to providers of services.

4.   March 7, 1991, HCFA "Dear State Medicaid Director" letter on transportation policy. Claiming costs as an administrative service versus optional Medical expense.

5.   Undated HCFA memorandum on ADA dumping prohibition and Medicaid payment rules.

6.   February 16, 1994, HCFA "Dear State Medicaid Director" letter on Medicaid NET and school-based health services.

7.   January 3, 1995, memorandum from director, Medicaid Bureau, to associate regional administrator, HCFA Region IV, on the need for a transportation waiver.

8.   April 24, 1995, HCFA letter prohibiting billing Medicaid clients for missed appointments.

9.   November 7, 1995, HCFA memorandum on interpretation of the term "necessary."

10. Undated explanation written by HCFA staff on optional medical expense versus administrative expense.

11. March 18, 1996, HCFA memorandum on coverage of transportation to a provider that is not enrolled in the Medicaid program.

12. March 21, 1996, letter responding to inquiries from Wisconsin on reducing transportation expenditures. Note that the letter highlights a HCFA policy allowing states to lock recipients into providers to control recipient abuses.

13. October 3, 1996, letter on Medicaid NET services and ADA paratransit services.

14. November 26, 1996, HCFA letter commenting on Florida's draft "no-show" policy.

15. December 26, 1996, HCFA "Dear State Medicaid Director" letter on use of bus passes for Medicaid NET services.

16. May 15, 1997, HCFA memorandum on provision of transportation to Native Americans in Arizona.

1. Section 1902(a)(4)(A) of the Social Security Act

The following provisions allow states to operate NET Program as administrative services; and require services to be made available statewide.

State Plans for Medical Assistance

"Section 1902 (a) A state plan for medical assistance must [. . .]

> "(4) provide (a) such methods of administration[. . .]as are found by the Secretary to be necessary for the proper and efficient operation of the plan;[. . .]"

"(30) (A) Provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan [. . .] as may be necessary to safeguard against unnecessary utilization of such care, and services and to assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area[.]"

2. Federal Medicaid Regulations, 42 CFR Chapter IV, Section 431.53. Assurance of Transportation

Sec. 431.53 Assurance of Transportation

"A state plan must -

"(a) specify that the Medicaid agency will ensure necessary transportation for recipients to an from providers; and

"(b) describe the methods that the agency will use to meet this requirement."

Sec. 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

"(a) *Transportation* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipients.

"(2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation, under sec. 431.53 of the subchapter, FFP is available as an administrative cost.

"(3) travel expense include-

"(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

"(ii) The cost of meal and lodging en route to an from medical care, and while receiving medical care; and

"(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and if the attendant is not a member of the recipients' family, salary."

3. State Medicaid Manual, Section 2113

State Medicaid Manual, State Organization and General Administration, Sec. 2113.

"2113. TRANSPORTATION TO PROVIDERS OF SERVICES.

"Federal regulation at 42 CRR 431.53 requires State s to assure necessary transportation to recipient to and from providers. A description of the method of assurance to be used must be included in the State's title XIX State plan. Transportation must be covered under the State's administrative requirements, or as an optional State plan item of medical assistance, or may be included under both categories.

"If it is apparent to you that the number of choices of any particular type of provider is significantly limited, you may authorize transportation to allow a reasonable selection of appropriate providers. For example, if there is only one dentist in a community and he is unable to meet the dental care needs of the recipients in that area with out working overtime or requiring delayed services, you may authorize transportation to services not otherwise available to alleviate the situation. Freedom of choice does not require to you provide transportation at unusual or exceptional cost to meet a recipient's personal choice of provider.

"Since the free choice provision applies only to providers of medical services, transportation services for which you claim reimbursement as an administrative expense are not subject to the freedom of choice provision. For such transportation, you may designate allowable modes of transportation, or arrange for transportation on a pre-paid or contract basis with transit companies. Transportation for which you claim reimbursement as a medical expense (e.g., ambulance service) must be considered within the free choice rights of the recipients. You may enter into contractual arrangements for "medical transportation" and inform recipients of the availability of this service. Also you may establish allowable payments for private "medical transportation" and not to exceed the costs which would have been incurred under the contract, for comparable services. However, you must not limit "medical transportation" to its contractual arrangements."