

# Medicaid Non-emergency Transportation: Three Case Studies



*National Consortium on the Coordination  
of Human Services Transportation*

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## *About the National Consortium on the Coordination of Human Services Transportation*

The National Consortium on the Coordination of Human Services Transportation is an association of non-profit organizations representing both transit and human services. The consortium conducts research and provides educational activities related to coordinating human services and mobility services. The consortium members are:

- AARP
- American Association of State Highway and Transportation Officials
- American Public Human Services Association
- American Public Transportation Association
- American Public Works Association
- American Red Cross
- Association of Metropolitan Planning Organizations
- Children's Health Fund
- Community Transportation Association of America
- Easter Seals Project Action
- National Association of Area Agencies on Aging
- National Governors' Association
- National Conference of State Legislatures
- Taxicab, Limousine and Paratransit Association
- United Jewish Communities.

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## **Medicaid Non-emergency Transportation**

Providing non-emergency transportation for necessary medical care and services is an ongoing challenge for every state. Federal Medicaid regulations afford states broad flexibility in designing, implementing, and paying for Medicaid transportation programs. Regulatory requirements, funding options, and three case studies demonstrating the evolution of service delivery models and related issues are discussed in this paper.

Medicaid non-emergency medical transportation has become a significant source of funding for state transportation networks. Recent information indicates that state and federal funding for non-emergency medical transportation dwarf all other human services transportation expenditures. Indeed, these expenditures amount to almost 20% of the entire federal transit budget. In a very real way, choices that states make regarding provision of non-emergency medical transportation are shaping the transportation infrastructure in this country.

In the summer of 2002, the American Public Human Services Association, through National Consortium on the Coordination of Human Services Transportation, undertook a study of Medicaid financing of non-emergency transportation services for persons enrolled in the state Medicaid program. In the process of evaluating the survey results, states with innovative approaches to design and administration of non-emergency medical transportation services were noted and three of these states, Utah, Delaware, and New York, were selected for additional case study.

## **Regulatory Basis for Medicaid Non-emergency Transportation Services**

The options that have evolved for provision of non-emergency medical transportation are based on federal Medicaid regulations, which mandate that each state provide necessary transportation for recipients to and from providers, and specify the methods used in doing so (42 CFR Ch. IV § 431.53). Medicaid regulations further stipulate that states may claim federal funding for direct vendor transportation payments at the medical services rate, which varies based upon a yearly calculation (42 CFR Ch. IV § 440.170). If arrangements other than direct vendor payments are made, however, then federal funds are available as an administrative cost (i.e. 50-50 state-federal match).

## **Two Options for Funding**

States can classify non-emergency medical transportation services as either an administrative service expense or an optional medical service expense, which determines the federal reimbursement rate. Administrative expenses are reimbursed at 50%; medical services reimbursements are determined by a yearly per-capita income calculation which can fall anywhere from 50% to 83%. Overall, the federal government finances about 57% of all Medicaid costs annually.

To qualify as an optional medical service, non-emergency medical transportation services must meet certain criteria, such as recipient freedom of choice in selecting providers, open participation by all providers who meet agency requirements, and provision of the same level of service across the state and to clients with similar needs.

### **Medicaid Managed Care**

State Medicaid agencies have been transitioning from fee-for-service reimbursements to healthcare providers in favor of capitated payments to managed care organizations. Under a capitated arrangement, the managed care organization is paid a fixed monthly payment for each beneficiary enrolled in the plan. Since 1981, federal regulations have permitted states to enroll Medicaid recipients in managed care organizations on a voluntary basis<sup>1</sup>. Prior to 1997, states needed to obtain a waiver of the Medicaid “freedom of choice” requirements to mandate enrollment<sup>2</sup>. A new requirement of the managed care organization system is the need to submit encounter data, which are Medicaid managed care records that include claim elements similar to information required on fee-for-service claims. Encounter data are frequently used to assist in rate setting and program management and evaluation. States are also mandated to establish internal grievance procedures under which Medicaid enrollees, or their medical providers, may challenge a denial of coverage. Additionally, managed care organizations are required by law to monitor or resolve, typically within 30 days, any written or verbal complaint or other expression of dissatisfaction with any aspect of the managed care organization or its operations. Access to the state’s fair hearing system must also be assured.

### **1915(b) Freedom of Choice Waivers**

Under a special dispensation known as a section 1915(b) waiver<sup>3</sup>, states may implement brokered, capitated and managed care arrangements for the provision of non-emergency medical transportation services. This waiver allows states to be reimbursed for non-emergency medical transportation as a medical service expense, while avoiding the freedom of choice requirement normally mandated as part of medical service expense criteria.

### **Bus and Transit Passes**

While state Medicaid agencies may issue bus or transit passes for non-emergency medical transportation, they must first determine whether passes are a cost-effective means of providing transportation for each Medicaid-eligible individual. The cost-

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<sup>1</sup> The Omnibus Budget Reconciliation Act of 1981 (OBRA) allowed states to enroll Medicaid recipients in managed care.

<sup>2</sup> The Balanced Budget Act of 1997 allowed states to mandate managed care enrollment for certain categories of Medicaid beneficiaries.

<sup>3</sup> Such waivers allow section 1915(b) of the Social Security Act to be waived. To find out more about section 1915(b)(4) waivers, see <http://www.cms.hhs.gov/medicaid/1915b/default.asp>

effectiveness test states that the cost of a monthly pass cannot exceed the cost of individual transit trips. Although the cost of individual transit trips may not be compared to the cost of trips by other modes for this calculation, the cost of transit passes must also be determined to be less costly than other modes of travel.

Payment for transit trips may be made on a basis other than monthly. Tickets or tokens may be purchased through discount for a set number of individual trips. For example, a bus pass for ten (10) individual trips might be purchased for a discount from the cost of ten (10) individual tokens. The state might also negotiate a bulk purchase of individual tokens for a discounted amount.

The state must also determine a transit pass is appropriate to the needs and personal situation of the individual. The following points should be considered by the state in determining the cost-efficacy of transit passes appropriate to the needs of the individual: medical condition, direct route availability, distance and length of trip, scheduling of medical appointments, and availability of other resources for provision and payment of transport. In addition, cost allocation may be necessary if other funding sources are available before assuming the entire cost of the transit pass under Medicaid. Such cost allocation would not be required if other uses (including personal use) for the pass are not substantial.

Finally, if transit services are available in only selected areas of the state, the state must assure equivalent transportation by other means in other areas, or obtain a waiver of the statewide service requirement. States with distinct regional differences in availability and accessibility of transportation modes may find it effective to have separate non-emergency medical transportation systems for geographical subsections of the state (see New York below).

### **Least Expensive Most Appropriate Mode**

States have great flexibility to construct service delivery models that focus on cost-effective and efficient systems. Many states incorporate matrices of travel modes, based on availability, accessibility, and cost. Efforts to construct policies ensuring the use of the least expensive appropriate mode of travel usually include mandates to make use of free volunteer transportation whenever feasible. Policies on reimbursement of mileage vary from state to state. Some states do not reimburse a car owner for mileage for short trips, while other states rely on individual mileage reimbursement, particularly for rural areas. See Utah below for an innovative approach to mileage reimbursement.

**Case Studies: Delaware, Utah, and New York**

Following are studies of how three states designed and implemented non-emergency medical transportation to meet their state's unique client needs, in a manner appropriate to geographic and regional variations, and cognizant of the state's fiscal resources. New York and Delaware both have medical services match rates that equal the administrative match rate, i.e., 50%. Utah has a medical services match rate of 70% for fiscal year 2002. All three states have recently implemented some brokered non-emergency medical transportation arrangements, and all three have transit pass programs. All three states have a major concentration of population in urban areas, combined with sparsely populated and relatively undeveloped rural areas. The case studies demonstrate innovative ways the states have implemented non-emergency medical transportation programs which address the complexities of their state characteristics and applicable regulations.

## Delaware

Delaware excluded non-emergency medical transportation from the statewide-managed care program implemented in 1996. Reaping the successes of Medicaid managed care, and increasingly concerned about underutilization of non-emergency medical transportation services, Delaware began to think about a managed care model for non-emergency medical transportation. Since Delaware's medical service match rate has long stood at 50%, Medicaid officials realized they could implement a managed care brokered model without a freedom of choice waiver simply by switching the state plan designation from coverage of non-emergency medical transportation as a medical service expense to coverage as an administrative expense.

Delaware has a total population of 796,165, 18.6% of which received Medicaid at some point in the preceding fiscal year. Delaware is a small state geographically (1,954 square miles) with only three counties. About 17% of the state's population is concentrated in the three largest cities (Wilmington, Dover, and Newark). Residents in the less populated southern half of the state may have easier access to medical care in the metropolitan areas of the bordering states of Pennsylvania, Maryland, and New Jersey.

In the year preceding its implementation of a capitated, brokered non-emergency medical transportation system, Delaware spent about \$8.5 million dollars on non-emergency medical transportation, somewhere between 1-2% of the state's total Medicaid expenditures. Between 10-15% of Delaware recipients used non-emergency medical transportation services during this period of time, with 84% of the trips provided by ambulette or medical coach, 15% by paratransit van, and only .05% of these trips by taxi.

Delaware's Medicaid conversion to managed care in 1996 excluded non-emergency medical transportation, but the state's managed care successes convinced Medicaid administrative staff to take a second look at a capitated, brokered service delivery model for non-emergency medical transportation. Special focus was given to resource allocation to ensure compliance with least expensive mode requirements, as well as concentrated outreach and education to ensure clients knew of non-emergency medical transportation services available and how to access them.

Since reimbursement at the medical services expense rate was no longer relevant, Delaware modified its service delivery model via a state plan amendment in lieu of the more labor-intensive freedom-of-choice waiver. Switching the state's non-emergency medical transportation program from a medical service to an administrative service also allowed the levy of a \$1 co-payment on each one-way trip (with the exception of transit and paratransit trips).

Delaware's non-emergency medical transportation conversion to a managed care model was effective in October 2002; subsequent to the state plan amendment approval process, and an open procurement and contracting process for a statewide non-emergency medical transportation broker.

Delaware's non-emergency medical transportation contract was awarded to Logisticare, a corporate manager of non-emergency medical transportation services based in Georgia. A toll-free call center is the single point of contact for verification of eligibility, determination of the least expensive, most appropriate mode of transport, and scheduling of travel. Logisticare does not provide direct transportation services, instead subcontracting with a network of local, independent transportation providers for the direct transportation services. Logisticare is also responsible for non-emergency medical transportation provider enrollment, including verification of licensure. Under terms of the contract, Logisticare provides outreach and education for Delaware Medicaid-eligible individuals, as well as data reporting and customer satisfaction. To find out more about Logisticare, see [www.logisticare.com](http://www.logisticare.com).

Delaware's flat capitated rate for provision of non-emergency medical transportation is \$6.04 per member per month (PMPM) for each Medicaid-eligible recipient. Recipients are responsible for a \$1 co-payment per one-way trip, exclusive of bus or paratransit travel. The PMPM capitation includes travel within 50 miles of the Delaware state line that is considered to be cost-effective and medically necessary. For out-of-state trips that exceed the 50-mile limit, the contractor Logisticare makes necessary arrangements but is reimbursed separately. Such costs are billed to the state by Logisticare and passed through the company to the subcontracted provider.

### **Bus Passes**

Prior to Delaware's implementation of a brokered system in October 2002, the state had a bus pass program in place, which has been incorporated into the brokered system. Bus passes are one of the options available for determining the least expensive most appropriate mode of travel. At the outset of the brokered arrangement, the broker distributed bus passes to previous recipients. Future plans include data matches to identify Medicaid recipients who live on fixed routes and who have ongoing medical appointments with providers on fixed routes. This will assure that all individuals who are able to use this most economic mode of travel are doing so. Delaware's bus pass program meets its goal of increased access for Medicaid recipients and provides assurance of using the least-expensive appropriate mode of travel. Recipients benefit from using the bus passes for purposes other than medical travel, thus increasing their personal mobility, as well as foregoing the \$1 per trip co-payment required for other modes of travel.

Although Delaware's October 2002 implementation of a brokered system is too recent for significant analysis of its success, state administration is pleased with the conversion thus far.

For more information on Delaware's non-emergency medical transportation program, contact Joyce Pinkett at (302) 255-9616, or [jpinkett@state.de.us](mailto:jpinkett@state.de.us).

## Utah

Utah uses a tiered system to provide non-emergency medical transportation. Although it recently implemented a brokered system under a freedom of choice waiver, bus passes and individual mileage reimbursement are excluded from the brokered system and claimed at the 50% administrative match rate. Utah's success is demonstrated by cost savings to the state, in addition to high customer satisfaction, which is evidenced by its low grievance rate.

Utah has an estimated total population for 2002 of 2,316,256, of which 10.8% was on Medicaid at some point in the preceding fiscal year. Utah is a large state geographically (82,144) with about 90% of the population in a four county area (Utah, Salt Lake, Davis, and Weber), spanning the metropolitan area from Provo to Ogden. The other 10% of the population is thinly spread through the remaining areas of the state, some of which are undeveloped and remote enough to be classified as "frontier" rather than "rural".

### Utah's Recently Implemented Section 1115 (Eligibility) Waiver

Beginning in February 2002, Utah obtained a federal waiver allowing the state to expand coverage to a population not otherwise covered by Medicaid, and to retool the Medicaid benefit package for certain optional Medicaid eligibility groups. Such "Section 1115" eligibility waivers allow the state to receive federal matching funds even if the coverage does not meet federal minimum standards, or extends beyond available federal options. These waivers allow states to waive certain requirements of the Social Security Act, including certain Medicaid requirements. In 2001, the federal government invited states to submit program waivers demonstrating innovative ways to expand coverage to populations otherwise ineligible for Medicaid benefits<sup>4</sup>.

The Utah plan extends free or reduced-cost, bare bones health packages to uninsured, low-income adults, while reducing the benefit package to other eligibility groups. The program's intent is to offer gap coverage to working adults until their income enables them to obtain more complete coverage, or until their employers pay a larger share of their health benefits. This waiver enables Utah to offer coverage to an additional 25,000 residents. The program imposes eligibility requirements, including being aged 19-64, being uninsured for six months, having an employer who pays for less than 50% of a healthcare benefit, and having income less than 150% of the federal poverty level. This new benefit package offers primary and preventive care including office visits, flu immunization, urgent care visits, medical equipment, oxygen, basic dental care, and prescription drugs, among others. Utah's vision for this innovative program is to equalize the distribution of available health care dollars to cover more people with some level of benefits, rather than providing very broad coverage to some and leaving others with no coverage at all.

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<sup>4</sup> This initiative is called the "Health Insurance Flexibility and Accountability" or HIFA initiative. To find out more about HIFA, see <http://www.cms.hhs.gov/hifa/>

The new coverage is financed by reductions in coverage to an estimated 17,600 Medicaid recipients, who are parents of children on Medicaid, or who are receiving both Medicaid and Temporary Assistance to Needy Families. This group of individuals will no longer be afforded Medicaid coverage for vision services, physical therapy, chiropractic services, or non-emergency transportation. Their dental and mental health services will have some new limitations. Co-payments for this group of eligibles are slightly increased, with physician co-payments increasing from \$2 to \$3, and prescription co-payments increasing from \$1 to \$2.

Benefits for children, individuals with disabilities, individuals 65 and over, pregnant women, and women with breast and cervical cancer are not subject to the reduced benefit package. No co-payments are required for non-emergency medical transportation services.

### **1915(b)(4) Freedom of Choice Waiver**

In July of 2001, Utah began to provide Medicaid non-emergency medical transportation services under a statewide capitated brokerage system. The state was granted permission to waive the freedom of provider choice requirement of the medical services match, allowing the state to use a contracted provider. The state reasoned that the benefits of conversion to a brokered system included a higher priority on medical necessity and least expensive mode determinations, and the resultant cost savings.

Utah went through a procurement and contracting process to select and engage a single statewide non-emergency transportation broker. Four in-state, and one out-of-state entities responded to the request for proposals. The contract was awarded to PickMeUp Medical Transportation, Incorporated, a local business operating out of Orem, Utah. The PMPM fee is \$0.99.

PickMeUp Medical Transportation, Inc. provides the majority of the direct transportation services, as well as administrative services. A limited number of subcontracted local transportation companies also provide transportation services. Data submission is done quarterly via encounter data.

### **Broker Complaint and Grievance System**

Managed Care Organizations (managed care organizations) with Medicaid contracts are required to have a grievance and appeal process and tracking system. This method of documenting every expression of dissatisfaction is a highly sensitive indicator of recipient satisfaction with service delivery. In fact, approval of Utah's non-emergency medical transportation waiver program by the federal Medicaid agency was contingent upon providing transportation program complaint logs to the regional oversight office on a quarterly basis. Utah's average quarterly rate of .3% grievances per number of services rendered indicates a program with a high degree of customer satisfaction.

## **Bus Passes**

As noted above, bus passes are excluded from Utah's managed care transportation system, and thus funded at the 50% administrative match rate. The Medicaid agency, rather than the broker administers the bus passes.

Utah chose to implement the "bulk purchase" method for procurement of bus passes. The Utah automated eligibility system includes a field for bus passes and the authorized number of trips. The information is entered into the eligibility system, which then automatically issues and mails a bus pass to the eligible individual along with the Medicaid identification card. The bus passes work on a "punch card" system that prepays for a specified number of bus trips.

An average of 10,000 bus passes are issued each month, with an average of 14 rides per pass (per month). Cost to the state ranges around \$510,000- \$525,000 annually (50% of which is picked up by the federal government).

The decision process that Utah applies for determination of the most appropriate venue of transportation is as follows:

- 1) If there is a personal vehicle registered to the client or a family member living at the same address, the client is not eligible for brokered services. They may, however, be eligible for non-emergency medical transportation services via the mileage reimbursement program (see Mileage Reimbursement below).
- 2) If there is no personal vehicle as described in 1) above, the client must use the public transit bus system. NOTE: 90% of Utah Transit Authority buses are wheelchair accessible. Eligibility workers issue bus passes.
- 3) If there is no public bus system available in the area and no personal vehicle as described in 1) above, the client contacts PickMeUp for services.
- 4) If the client has a disability that prohibits use of the public transit bus system, and there is no personal vehicle available as described in 1) above, the client contacts PickMeUp for services. In order to receive PickMeUp's door-to-door service, the individual must be evaluated and denied services by the public paratransit system, if available (which provides curb to curb service).

Bus pass cost is not cost-allocated with other agencies.

## **Mileage Reimbursement**

Utah has an innovative method of issuing mileage reimbursement for individuals driving their own car or being driven by a family member or friend to a medical appointment. The recipient contacts the eligibility worker, who issues credit for the projected mileage amount through the Horizon Card system at the rate of \$.18 per mile. Horizon cards are issued to all traditional Medicaid recipients. Cash credit is also issued on the card in instances where the individual is traveling distances requiring meals or an overnight stay.

Utah Medicaid and the Utah Transit Authority are working on issuing bus passes on the Horizon card as well. UTA technological enhancements are projected to take two (2) years, but given the population density of the four-county metropolitan area served by UTA, the enhancements would certainly streamline the non-emergency medical transportation delivery system.

**Comparison-Non-emergency Transportation Costs Before and After Implementation of the Brokered System**

Utah reports that in fiscal year 2001, non-emergency transportation costs totaled \$1,787,495. In fiscal year 2002, the year the brokerage began, the costs totaled \$1,352,667, for savings of \$434,828 in the first year of implementation. The number of clients receiving non-emergency transportation declined from 2,752 to 1,855 in the same time period, with the number of rides reduced from 62,809 to 53,798. Utah officials attribute the decrease in utilization and costs to better adherence to policies specifying that paid modes will not be used if free transport is available, and that the least costly mode appropriate to the individual's situation be used.

For more information on Utah's non-emergency medical transportation program, contact Don Hawley at (801) 538-6483, or [Dhawley@Utah.gov](mailto:Dhawley@Utah.gov).

## New York Case Study

New York's non-emergency medical transportation system is complex. The system is administered through a variety of service delivery models by fifty-eight (58) separate and unique administrative districts. While the diverse service delivery models address subsections of a state with stunning regional diversity in transportation infrastructure, culture, geography, and demographics, state Medicaid administration has obvious and inherent challenges in monitoring the overall program.

New York has a population of 18,976,457, of which 15.9% received Medicaid at some point in the preceding fiscal year. New York is a large state (49,576 square miles) and is home to the most populous city in the United States (New York City has a population of 8,008,278 according to the 2000 census) as well as sparsely populated rural areas near the Canadian border. Geographic and cultural diversity added to a complex administrative organization requires program design with enough flexibility to meet the needs of its resident Medicaid clients.

In New York State, non-emergency medical transportation services use both the medical services, and the administrative service Federal match rate at 50%. The services are administered by local departments of social services and two state agencies: the Offices of Mental Health and Mental Retardation & Developmental Disabilities. The state Medicaid agency (the Department of Health) provides oversight of all activities. Each local department of social services pays 25% of the cost of services, and the state provides the other 25% needed for the 50% match. Additionally, New York pays the costs of non-emergency medical transportation in some facility and program rates.

Each New York County is a local department of social services, except for the five counties encompassed by the City of New York, which are grouped as one local department of social services. Administration is handled differently in each local department of social services. Most of the non-emergency medical transportation claims are handled and tracked by the Medicaid Management Information System (MMIS). However, some transportation claims are paid locally (primarily recipient expenditures for public transit or for personal vehicle use). These locally paid expenditures are tracked by the Medicaid agency on electronic financial forms.

In New York state, Medicaid managed care plans within the five boroughs of New York City have non-emergency medical transportation **included** in the managed care capitation rate. Most other managed care plans in New York State have non-emergency transportation **excluded** from the capitation rate.

To find out more about New York's Medicaid Managed Care Program, see:  
<http://www.health.state.ny.us/nysdoh/mancare/mcmain.htm>

A small number of local departments of social services with managed care non-emergency medical transportation excluded have separate approved freedom of choice transportation waivers, with a transportation broker or provider who coordinates services. The transportation broker may provide direct transportation, scheduling, and

payment to providers.

Local departments of social services with transportation brokers have found the benefits of this service delivery model to include:

- high level of expertise in scheduling and/or delivery of non-emergency medical transportation services;
- cost savings due to focus on determinations of the least expensive appropriate mode of travel;
- flexibility in deployment of transportation staff to other critical areas.

The total combined state and federal fee-for-service expenditures for non-emergency medical transportation in New York during calendar year 2001 was \$258,689,663. This figure does not include the cost of the capitated transportation services.

### **New York Non-emergency Transportation Program Waiver**

New York State was granted a renewal of its non-emergency medical transportation waiver, known as the New York Non-emergency Transportation Program, for the purpose of assisting local departments of social services in decreasing Medicaid expenditures and allowing alternative methods of arranging for transportation of recipients for necessary medical care. The state health department administers the New York Medicaid program and delegates responsibility for medical transportation to each of the 58 local departments of social services. Those responsibilities include ensuring availability of all transportation modes, including arrangements with providers, as well as authorization of payment for individual transport as the local departments of social services deems appropriate and necessary. The local departments of social services are knowledgeable of the transportation needs of the recipients and the transportation networks available to meet them.

Each local departments of social services waiver submits detailed information outlining:

- How the district will assure necessary transportation for all clients;
- The pre-authorization process;
- The complaint procedure for recipients; and
- Cost savings.

The Health Department retains the sole authority for approval of the reimbursement amounts established by the local departments of social services.

The intent of the waiver is to offer five methods of arranging transportation, including:

**1) Coordinated Transportation**

Under this option, the local departments of social services would solicit a transportation coordinator who would either directly deliver, or subcontract with other transportation providers to deliver, all necessary non-emergency medical transportation

for that district at the flat monthly reimbursement amount. The district will pay the coordinator the monthly contracted amount, regardless of the actual number of transports delivered.

District staff refers recipients in need of transport to the coordinator, who then achieves efficiencies by establishing fixed routes and grouping transports to medical appointments. The coordinator also uses public transport more effectively. The coordinator, when feasible or necessary, will subcontract with another provider to deliver the non-emergency medical transportation services, but is not required to subcontract with every provider who wishes to be a subcontractor.

The coordinator is the only participating provider in the district. Recipients who require non-emergency medical transportation to access medical care and service must use the coordinator for their transportation needs.

Finally, payments to a coordinator are made as a Medicaid service expenditure, and are eligible for reimbursement at the medical services rate.

**2) Regional or District- wide Rate Setting**

Under this option, a district or a group of contiguous districts will establish a reimbursement amount for a particular mode of transportation in the region encompassed by those districts, or, for a district-wide rate setting, a single rate will be established throughout the district. The new amount will be less than the highest blended amount previously reimbursed, but at a level that would attract enough provider participation to assure that mode of transportation for necessary medical services is available to recipients.

Provider freedom of choice is still available to that district's recipients, but is limited to those providers who have agreed to the new reimbursement amount. Providers who choose not to accept the new reimbursement amount will no longer be participating in Medicaid transportation in those districts.

**3) Competitive Bid Procurement**

Under this option, a district or group of districts will solicit bids for the transportation for a group of recipients who are transported on a daily or other regular basis to necessary medical care or services. The transportation provider who submits the most qualified and cost-efficient bid is selected to transport the group of recipients. The reimbursement amount may be either a lump sum monthly amount or a per-person per-day amount during the life of the contract.

Under this option, the recipients are not allowed to choose another transportation provider, even if the other provider is willing to transport at the same reimbursement rate paid to the selected bidder. This limitation prevents other transportation providers from delivering the shortest, most efficient transports while leaving the most costly transports to the subcontractor who was awarded the contract.

**4) Cost-effective/Directed Transportation**

Under this option, the district directs recipients to the least expensive provider available at the time the service is needed. The district will not use other providers who are reimbursed at a higher rate while the least expensive provider has available capacity for transporting recipients.

The district may designate different providers on different transports, based on provider availability, type of transportation needed, and rate of reimbursement.

**5) Select Arrangement for Transportation Efficiencies**

The district enters into an arrangement with a provider or a select group of providers to meet the transportation needs of recipients traveling to medical facilities. For example, a district may choose a taxi provider to provide all non-emergency ambulatory transportation to a regional medical center. Due to the volume and routing of trips, the provider is able to deliver this transport at an amount lower than could be purchased through multiple providers. The provider may also make arrangements with a public transportation operator using existing public transit to complement capacity for transport to a given destination.

Under this option, a recipient will not have freedom to choose another transportation provider if the recipient requires transport to that particular medical center.

**Waivers in New York**

The thirteen local departments of social services with waivers are: Albany, Schenectady, Rensselaer, Chautauqua, Chenango, Greene, Herkimer, Ontario, Orange (for dialysis, ambulette and taxi, and Westchester Medical Center), Steuben, Cortland, Chemung, and Oswego.

**Fee-for-service**

Local departments of social services without non-emergency medical transportation waivers pre-approve all non-emergency transportation services. Individuals receiving non-emergency medical transportation services as fee-for-service may use any Medicaid-enrolled provider for the appropriate and approved mode of transport.

Provider enrollment policies are implemented by the Health Department's Bureau of Provider Enrollment. Transportation vendors must meet certain criteria (licensing and local departments of social services support) to enroll and obtain payment through the Medicaid fiscal agent.

On the Medicaid fee-for-service side, any licensed company can become a fee-for-service Medicaid provider. A variety of agencies have the responsibility for licensing non-emergency transportation providers, including the state Department of Motor Vehicles (licensing and registrations), the state Department of Transportation, which authorizes ambulette service authority and sets the standards for such authorization), the New York City Taxi and Limousine Commission (which licenses taxis and ambulances operating in New York City), and other municipal entities for licensure of local taxi services.

### **Transit passes**

In New York City, and several of the other local departments of social services, the managed care programs have non-emergency medical transportation services included in managed care. Thus, the managed care organization is responsible for credentialing, contracting, and reimbursement of transportation providers. In addition, the managed care organization provides the point of contact for Medicaid beneficiaries needing non-emergency medical transportation services, verifies Medicaid eligibility, determines the appropriate mode of transportation, and arranges the transport. The managed care organizations issue transit passes when cost effective and appropriate in these local departments of social services.

The New York City administrative district is planning several innovations to streamline the transit pass program for Medicaid recipients. The first is a new on-line feature to allow city hospitals and clinics to verify a patient's Medicaid eligibility, to issue transit passes for their round-trip travel to the treatment, and to bill Medicaid on-line for reimbursement of the pass. Introduction of this new system capability, called "Public Transportation Reimbursement System", is planned for April of 2003.

New York City is looking at implementation of a similar on-line system for issuance of monthly transit passes for Medicaid recipients receiving treatment in Methadone Maintenance Treatment facilities.

In local departments of social services outside New York City, most of the managed care programs exclude non-emergency medical transportation services, and in some of them, provision of non-emergency transportation is under separate non-emergency medical transportation waiver, the "New York Non-emergency Transportation Program Waiver". In these districts, the local departments of social services or coordinator issues transit passes. In districts without managed care non-emergency medical transportation carve-ins or the Waiver, the local departments of social services administer the transit pass program.

### **Tracking and Reporting**

Tracking and monitoring non-emergency medical transportation expenditures remains a challenge for the state of New York, given the complexity and fragmentation of service delivery and claims reimbursements. The Medicaid administration anticipates a

new non-emergency medical transportation reporting system for tracking all non-emergency medical transportation expenditures will be implemented in May 2003.

For more information on New York's non-emergency medical transportation program, contact John Hardwick at (518) 473-1171, or [JLH12@health.state.ny.us](mailto:JLH12@health.state.ny.us), or Timothy Perry-Coon at (518) 474-9219, or [TJP03@health.state.ny.us](mailto:TJP03@health.state.ny.us).

## Conclusion

State Medicaid programs have seen a massive transition from fee-for-service to managed care delivery models for medical services. The transition of non-emergency medical transportation services to managed care and brokered models is not parallel to the transition of medical services. As demonstrated by the three case studies in Delaware, Utah, and New York, transition of non-emergency medical transportation programs from fee-for-service to managed care and brokered models are transpiring at a different and more varied pace. The mix, diversity and transition of non-emergency medical transportation service delivery models is responsive to a state's transportation infrastructure, demographics, culture, and economy, as well funding issues within both the non-emergency medical transportation program and the larger Medicaid program. While states have broad leeway to construct or restructure programs within federal funding and administration parameters, the issues associated with non-emergency medical transportation program transition require thoughtful planning and coordination. Factors that states find pivotal in evaluating and designing or redesigning non-emergency medical transportation programs include:

- Tradeoff of federal funding differences between coverage as a administrative or medical service;
- Consideration of resources necessary for waiver request and administration process;
- Possible use of varied service delivery models to suit geographic or administrative subdivisions of the state with differing transportation infrastructure, cultures, and needs;
- Trade-offs in use of varied service delivery models for geographic or administrative subdivisions of the state with complexity in administration and monitoring of non-emergency medical transportation services;
- State history and experience with medical service managed care models;
- Perceptions of misuse of transportation services;
- State experience with non-emergency medical transportation growth; and
- Resources available to run a program that represents a small portion of a state's Medicaid expenditures.