MEDICAL ASSISTANCE TRANSPORTATION TRAINING PROGRAM

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Training Agenda

- Introductions
- History of NEMT
- Presentation: Program Guidelines and Requirements
- Scenario Challenge
- Presentation: Budget Protocol

Learning objectives

- By the end of the training day the locals should be able to understand the mandated COMAR (10.09.19) regulations, Transmittals, Guide to Transportation, and CFR Medicaid Transportation Federal regulations (42CFR§431.53)

- By the end of the training session locals should be able to identify and locate the appropriate resources when addressing NEMT questions.

- By the end of the session the locals should be able to appropriately submit budget request.

History

BEFORE GRANT

- Recipient contacted provider directly
- MA reimbursed provider at MA rate
- Little control over service utilization
- Little control over service quality
- Little or no cost control-fraud and abuse reported

AFTER GRANT

- Recipient calls grantee
- Grantee reimburses rate
- Grantee screens for appropriateness of transport and alternative resources
- Cost control achieved through scheduled, shared ride

NEMT MISSION STATEMENT

- It is the mission of the Maryland Medicaid Program to improve the health and well-being of low-income Marylanders by assuring access to medically necessary health care services. Transportation is an essential component to assuring access to health care.

NEMT PROGRAM OUTLINE

What are *YOU* responsible for as an NEMT Representative?

- Screen recipients' requests for transportation to assure recipient eligibility and necessity of transportation.
- Arrange for and/or provide the most efficient means of transportation where no other transportation is available.
- Ensure that Medicaid-funded transportation is used in a manner consistent with the requirements of COMAR 10.09.19, Transmittals, Conditions of Award, and Transportation Guide.
- Timely submission of requested documents.

Terms and definitions

- Please become familiar with the terms and definitions of NEMT. It is imperative to clearly understand and recognize the language used in the program.
  - Please refer to listing of terms of definitions

Transportation Grant Program

- Program covers Medicaid Recipients (red/white MA card or MCO card)
- Maryland's 24 local jurisdictions (23 counties and Baltimore City) administer the transportation services
- The grantee in each jurisdiction, except Montgomery County is the Local Health Department (LHD); in Montgomery County it is the Department of Transportation.

Health Choice-MCO's

- AMERIGROUP Community Care - www.amerigroupcorp.com
- Jai Medical Systems - http://www.jaimedicalsystems.com/
- Kaiser Permanente- http://www.kp.org/medicaid/md
- Maryland Physicians Care - www.marylandphysicianscare.com/
- MedStar Family Choice - www.medstarfamilychoice.net
- Priority Partners - www.ppmco.org/
- Riverside Health of Maryland - http://www.myriversidehealth.com/
- UnitedHealthcare - www.uhccommunityplan.com

Transportation cannot be provided to:

- Family Planning Program Recipients (Purple/White Card)
- Qualified Medicare Beneficiary (Gray/White Card)
- Supplemental Low Income Medicare Beneficiary (No Card Issued)

KEY POINTS

- While the program covers all modes of transport (ambulance, wheelchair van, sedan, aircraft etc.), it is a scheduled, shared ride program for transportation during normal business hours.
- Advanced notice is required for scheduling purposes, but the regulation requires a minimum of 24 hours advanced notice.
- Certain allowances are made whenever possible e.g. oncology transports, aero medical evacuation

COMAR 10.09.19

- Screen recipients (initially and quarterly)
- Request documentation when determining eligibility.
- Refer recipients to other available resources
- Develop and expand transportation resources
- Refuse transportation services when requests are less than 24 hours

Covered services

- Recipients of NEMT must be transported to services that are covered by Medicaid. There are cases when particular services are not clear and further assistance maybe required.
- If clarification of covered services for Health Choice recipients are needed contact the Administrative Care Coordination Unit (ACCU).
- If grantees need clarification of covered services for fee-for-service recipients, contact Recipient Relations 410-767-5800.

Fundamentals of screening

- Grantees are to conduct an initial screening for all first time request and a follow-up screening at least quarterly.
- Screening can be conducted via telephone or written application
  - When using **written application** process grantees must provide a reasonable "interim" period that allows the applicant to have transportation services during this process.
- Grantees must notate any Limited English proficiency or whether recipient is able to read/write effectively.

Screening fundamentals

- Through the screening function, grantees must:
  - Check EVS before transports
  - Request Provider Certification Documents
  - Contact Physician office or check MMIS to see if service covered by Medicaid or the MCO
  - Verify the mode of transportation
  - Transportation covered by another segment of the program

COMAR 10.09.19.04 (B)

- Does recipient or family member own a vehicle
- Availability of vehicles owned by friends or relatives not in household
- Any voluntary transport services by private citizens, public or private agencies
- Availability of free transport services by other city, county or state agencies
- How recipient accesses non-medical services, such as grocery store
- Can recipient walk to medical service
- Public transportation available between home & medical service
- Is recipient mentally or physically disabled
- Is medical service required on frequent or ongoing basis (chronic illness)
- Can appointment be re-scheduled

Electronic verification system (EVS)

Must be verified for *EVERY* recipient

Recipients must receive FULL MEDICAID BENEFITS

- During screening and before transport
- EVS can be either done via online or through the telephone
- Must be documented
  - Must indicate what the EVS message states, date, time of EVS verification, and confirmation number.
  - Must be attached with recipient file

Familiarize yourself with EVS messages sheet and NEMT Exclusions and Limitations

Provider Certification

- Provider Certification forms are used to document the following:
  - A recipient being transported to a provider while bypassing a provider of the same specialty;
  - Validating the medical need for wheelchair or stretcher /ambulance transportation;
  - The need for ambulatory transportation when public transportation is available;
- Intermittent certification-needed if a recipient's condition changes that indicates the need of a different mode of transport; and
- To clarify if the service to be rendered is covered by Medicaid.

PROVIDER CERTIFICATION FORM

- Forms must be filled out in it's *ENTIRETY*
- Cert forms are required for each recipient and must be renewed annually.

Appropriateness of mode of transport

- Although Medicaid covers all modes of transport, the program will only cover the least costly mode appropriate for the transport of the recipient
- This can be determined by the use of the provider certification form.
- The provider must notate in the form which mode is appropriate for the recipient.
- If the provider attests that the recipient is not capable of riding public transportation, then the provider must indicate the medical reason in the form.
- The most expensive mode of transportation, ambulance, is covered only for recipients who require stretcher transport for the following reasons:
  - Recipient must be transported in a lying-down position;
  - Their medical condition requires the presence of at least basic life support (BLS); and
  - Upon hospital discharge, the recipient's wheelchair is not available for transport to the home or nursing facility

Necessity of transportation

An integral part of screening

Necessity of Transportation

Have you asked all the required questions to determine necessity?

- **Transportation Resources—**
  - Are there other resources available?
    - Does recipient live ¾ mile from a fixed route or para-transit?
    - Does recipient have a car?
- **Provider Resources---**
  - Is it the closest appropriate provider?
  - Is it a choice of the recipient?
  - Are there any other closer providers in-network?

Has the appointment been verified and deemed medically necessary?

Public Transportation Trip Planner

- Appropriate for Baltimore County, Baltimore City and Howard County (some parts).
  - http://mta.maryland.gov/m/trip-planner
  - http://www.mdtrip.org/

  - Appropriate for Prince George's County, Montgomery County
    - http://www.wmata.com/rider_tools/tripplanner/

Bus Passes and tokens

- At this time grantees are not required to provide funds for the use of public transportation.
- In cases where a recipient need to attend frequent trips (3 or more/week) the program may pay for the trips.
- In order for trips to be covered by the Transportation program a provider certification form will be required from the treating or referring provider to verify frequency and duration of recurrent medical appointments.

Other Resources

- Grantees must become knowledgeable of any other resources in the county.
  - Department of Aging
  - Para transit
  - Church that may provide transportation services

Appropriate provider

- An appropriate provider is defined as a provider that:
  - Participates in the Maryland Medicaid Program; or
  - Has the training and skills necessary to provide the needed care (includes but is not limited to applicable licensure and/or certification); and
  - Is willing to accept the recipient as a patient.

When is it OK to bypass the closest provider??

- Recipient or provider moves and is no longer the closest appropriate provider.
  - In turn grantees are to allow *one* trip to this provider to transfer documents to a closer provider. Additional trips may be authorized for the following:
    - Recipient undergoing a course of treatment requiring provider continuity (physical therapy, chemotherapy, surgery)
    - A pregnant recipient in the latter half of her pregnancy who has been receiving prenatal care from a certain provider will transported to the provider for the remainder of the pregnancy and a postnatal checkup.

Appointment verification

- Grantees must:
  - Perform five percent pre- and Five percent post-appointment
  - Document that it was performed
    - Doctors slip
    - Calling to verify and then documenting

*In cases where recipients have been found to misuse Medicaid transportation, grantees are to verify all trips for a period of at least three months. *

Attendant request

- All minors are required to be accompanied by a parent or guardian
- Individuals needing an attendant other than a minor must obtain a provider certification form.

Additional Passengers

- Other than the recipient receiving the Medicaid covered service and the attendant (if applicable), there are no other individuals allowed to ride unless they are receiving a Medicaid covered service.

Legally Responsible

- A legally responsible adult includes a spouse or other relative, living in the home, that is legally responsible for the recipient.

Dental transports

- Dentaquest is the dental benefit provider for MA clients as of July 1, 2009.
- MA recipients eligible for dental benefits are persons:
  - Under the age of 21
  - Pregnant women during their pregnancy
  - REM (Rare Expensive Case Management) recipients of all ages
- Some MCOs offer limited dental services to members over age 21, MA will not cover transportation for these clients.
- No time distance limitations for transportation
- Dentaquest will place the recipient to the closest provider

Dental Transports

- Subsequent visits to the same provider will require the completion of a form to ensure that transportation services are being used in accordance with program rules
- The form can be completed by the dental provider, primary care provider or other medical professional, who is knowledgeable of the beneficiary's medical condition.
- Recipients will continue to be screened to ensure that MA transportation is the provider of last resort and that the appropriate.
- Please refer to Dental service request flow chart.
- Please use Dental Medical Necessity Form.

Abortion transports

- Abortion transports are covered by Medical Assistance.

- As with any other transport, jurisdiction must obtain a provider certification form that outlines the provider to be a Medicaid Provider and the transport is medically necessary.

Distance Limitations for Transport : MCO

- MCO's are required to provide a core set of providers to recipients within a certain time and distance frame
- These providers are: primary care provider, OB/GYN Specialist, diagnostic lab, x-ray facility and pharmacy.

- Time/Distance Limits are:
  - Rural –30 minutes travel time or 30 mile radius
  - Urban– 30 minutes travel time or 10 mile radius

Transportation can be provided to the closest provider or to the provider of the recipients choice if located at a comparable distance

Distance limitations for transport: pharmacy

- COMAR 10.09.66.06 provides guidance as to the time distance limitation for the availability of pharmacy providers within a MCO network.

- Grantees shall approve all medically necessary and appropriate transportation requests to pharmacy providers as long as a closer appropriate pharmacy provider is not being bypassed.

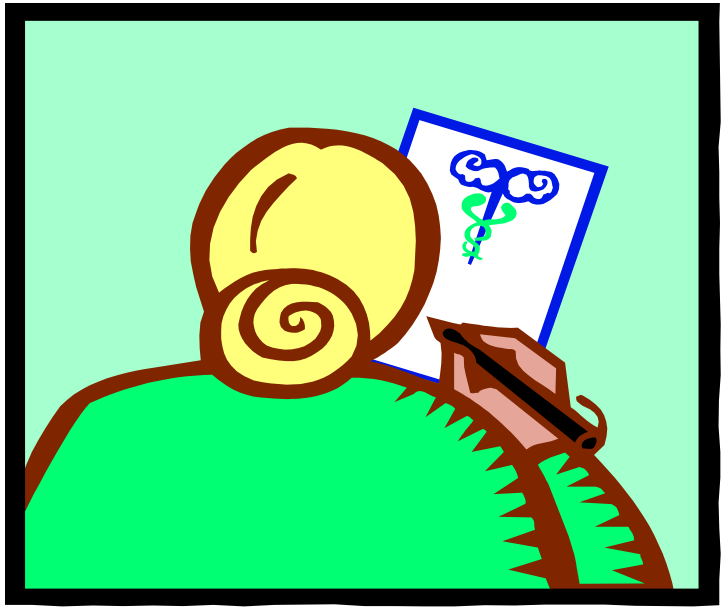
- Grantees are to record and report to the Program, via Pharmacy MCO Report, all requests for medically necessary transportation of MCO recipients to a pharmacy provider when a closer appropriate provider is beyond the time distance limitation.

- Geographic Access Standard:

  (1) Urban areas, within 10 minutes travel time or within a 5-mile radius of each enrollee's residence; and
  (2) Rural areas, within 30 minutes travel time or within 30 miles of each enrollee's residence.

Transportation request flow chart

- Medicaid vs. Managed Care organization (MCO)



Transport to MCO specialist

- Transport is provided to MCO specialists, as long as the MCO is not bypassing local specialists and sending recipients out of area for locally available specialty care.
- When an MCO doesn't have a plan specialist, but there is a specialist taking Medicaid in the area, they have two options:
  - Arrange a special contract with the non plan specialist to see the recipient; or
  - The MCO is responsible for providing transportation to their out of area specialist

Grant Manager should refer these cases to their Administrative Care Coordination Unit (ACCU)

Transportation Request for MA pending recipients

- Transmittal No. 7 discusses the process in which recipients who are residing in a nursing facility or those who need hospital discharge and are awaiting final determination (PENDING MA)

- To ensure access to medical care, grantees are encouraged to enter into an agreement with the hospital or nursing facility to ensure that the entities will pay for transportation services.

- Screening should be conducted to determine that the recipient does not have other means of transportation, closest provider etc.

Transportation between hospitals

- Transmittal No. 8 discusses circumstances when transports between hospitals are covered under NEMT.
- **Covered service**
  - Discharged from one hospital then transported to next hospital and admitted. *Example- Higher level of care is needed*

Not a Covered Service

- Recipient is not discharged from the hospital nor admitted to the second hospital as an inpatient. Example- Medical service needed at the sending hospital is not available therefore, recipient needs to be transported to another hospital.

USING YOUR ADMINISTRAIVE CARE COORDINATION UNIT (ACCU)

- For HealthChoice recipients (MCO), these individuals are only allowed to travel to providers in their network.
- If a recipient chooses to bypass the closest provider of the same service, the grantee should assist the recipient in accessing MCO-funded transportation by referring them to the county's ACCU who will in turn assist then recipient in arranging MCO-funded transportation

Transportation grant limitations

- Emergency transportation services
- Medicare ambulance services
- Transportation to or from VA Hospitals, unless it is to receive treatment for a non-military related condition
- Transportation to and from correctional institutions
- Transportation of recipients committed by the courts to mental institutions
- Transportation between a nursing facility & a hospital, for routine diagnostic tests, nursing services or physical therapy which can be performed at the nursing facility
- Transportation services from a facility for treatment when the treatment is provided by the facility in which the recipient is located
- Transportation to receive non-medical services
- Gratuities of any kind

Transportation limitations

- Transportation between an adult medical day care facility and the recipient's home
- Transportation to or from a state facility while the patient is a resident of that facility
- Transportation of non-medical assistance recipients
- Trips for purposes related to education, recreational activities or employment
- Transportation of anyone other than the recipient, except for an attendant accompanying a minor or when an attendant is medically necessary
- Wheelchair van service for ambulatory recipients
- Ambulance service for a person who doesn't need to be transported in a supine position

Transportation limitations

- Transportation between a community rehab program (CRP) and the recipient's home. CRP is now known as "psych rehab"
- Transportation between a day habilitation program and the recipient's home
- Transportation to or from services that are not medically necessary

Non-jurisdictional MA recipient requires transportation

- Verify that the transportation is appropriate through screening;
- Verify MA eligibility
- If above criteria met, you should contact the Grant Manger of the recipient's county to determine who will transport.

- Don't just refer the caller to the Grant Manager

- Examples: Displaced recipient, visiting relatives in another county

Unruly recipients

- Grantees should follow progressive measures i.e. verbal warning, written warning etc.
- If recipient is in a mental health or drug treatment program, contact the program social worker to advise of behaviors and request assistance
- If the situation is threatening, request law enforcement (Refer to “Unruly Recipients” Handout)

No show policy

- Using ***Transmittal No. 5*** as reference, a no-show is defined as occurring when a recipient either is not at the arranged pickup point at the appointed time or refuses the ride at that time and has not canceled the trip in advance.
- Recipient has three times to no-show, after the third time the recipient must be placed on the confirmation list.
- After each offense a letter detailing the no-show and the number of time they have no-showed.
- Grant manager are not allowed to pay vendors for no-shows.

Scenario challenge

Responsibilities as a grantee

- In addition to assuring that all recipients are screened appropriately, grantees are responsible for submitting documentation when requested
- Grantees must submit documents in the required format.
- Submission must be timely.
- Screening for excluded parties
- Retention of records according to memo
- Advertising
- Send denials timely
- Budget, supplement, mod request
  - Allowable cost

Documenting

- Jurisdictions are responsible for documenting
  - Provider certification
  - Verification of appointments before and after
  - Complaints of any kind
  - MCO network issue reports
  - Quarterly expenditures
  - Denials of transportation

Timely submission

- As stated in the conditions of awards and Transportation guide the requested reports are due quarterly (October 15th, January 15th, April 15th and July 15th)

Screening for excluded parties

- As stated in General Transmittal No. 73, Maryland Medicaid is prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.
  - Grantees are to attest quarterly
  - http://exclusions.oig.hhs.gov/
  - https://sam.gov/portal/public/SAM
  - https://mmcp.dhmh.maryland.gov/SitePages/Home.aspx

Retention of records

- As stated in the memorandum, records should be retained for 6 years.

- DHMH should be able to request information and it be readily available.

Program brochure

- Each jurisdiction *must* have a brochure
- English & Spanish
- Information that should be included are:
  - Hours of operation
  - Contact information
  - What is needed to schedule a ride
  - Alternative transportation in the area
  - Explanation of program and who is covered
  - How to make a complaint

Transportation complaints

- Establish a chain of command
- Record all complaints
- Required to use the uniform complaint log created by DHMH Transportation
- Submit complaints quarterly when requested by DHMH

Denials & appeal process

- After screening is completed and it has been deemed that the recipient is not eligible for transportation, a denial letter must be sent out within ***24 hours*** after denying.
- Recipient can be denied transportation for the following reasons:
  1. Service requested not covered by Medicaid
  2. Recipient owns a vehicle
  3. Request transportation at least 24 hours*
  4. Not a Medicaid Provider
  5. Closer provider
  6. Other Transportation resources available

Appeal process

- The recipient must be notified in writing of their appeal rights with the denial letter.
- It is then that the recipient has 90 days to submit a request for a fair hearing.
- The appeal will be sent DHMH appeals unit, then the transportation unit is notified of the appeal.
- Transportation unit will contact the grant manager to supply all supporting documents pertaining to the denial.
- DHMH will review the documents submitted, contact the recipient to determine if we should proceed with the hearing.
- If the recipient wishes to continue with the appeal, a date will be set by the administrative law unit.
- Grant Managers are required to participate with hearing.

Suspicion of fraud

- There are times when a recipient indicates that they do own a vehicle, in this case if you have the vehicle information the state can search the MVA system verify that in fact the car does belong to the recipient.
- The state does not encourage conducting independent investigations on recipients, i.e. driving to the recipient homes to obtain license plate information.
- To report fraud please use the following link: http://dhmh.maryland.gov/oig/SitePages/reportfraud.aspx
- Note: Cannot search out of state tags.

Review of ambulance bills

- When rendering payment for your contracted ambulance provider please be sure to obtain the following documents for each recipient:
  1. CMS 1500
  2. Patient Care Report
  3. If applicable, Medicare denial document
  4. Written denial of any third party insurance
  5. Certification of need of stretcher transport

Program budgets

- Submission of original budgets must be submitted by specified due date given by our general accounting unit.
- Those who are requesting additional funds must wait until after the beginning of the fiscal year to submit a supplement.
- When submitting original budgets, modifications, supplements or reductions; justification must be provided and then approved by Transportation staff at DHMH.

Submission of original budget

- For budgets to be approved, jurisdictions must have the following:
  1. Program Narrative
  2. Transportation data worksheet
  3. Original budget with allotment provided by the Department or MAT unit
  4. Any justifications and clarifications asked by DHMH.

Program Narrative

(Sample Narrative)

Fiscal Year: 2013

_____County Transportation Program Grantee
Medicaid Transportation Grants Program

Project Code: F738N

Goal: To ensure that Medical Assistance recipients are able to get to medically necessary Medical Assistance covered services, and arrange or provide transportation to such services when no other resources exist.

Objectives: The funds awarded to _____ County are to be used for "safety net" funding of transportation to recipients who have no other available source of transportation. Since Medicaid is the payer of last resort, all other sources of transportation must be accessed prior to the expenditure of the grant funds for transportation services.

This "safety net" funding of transportation should:

1. Continue recipient access to medical care;
2. Assure services to meet the non-emergency transportation needs of Medical Assistance recipients who have no other means of transportation to and from medically necessary covered services;
3. Encourage new transportation resources in areas where they are limited;
4. Assure the appropriate provision of transportation service by screening recipients for other transportation resources and for disabilities which impair recipients' ability to use public transportation or walk; and

Transportation data worksheet

Services Provided	Yes	No	Current Rate	Date Last Adjusted	# Recipients Using Service*		Number of Trips**		Mileage	
					FY11	FY12	FY11	FY12	FY11	FY12
Ambulance-BLS										
Ambulance-ALS										
Ambulance - Specialty Care										
Ambulance - Neonatal Transport										
Air Ambulance			$1,500 + $20.00/air mile							
Total Ambulance							0	0	0	0
Wheelchair Van										
Ambulatory Van Service										
Taxicab/Sedan										
Bus Passes										
Gasoline Vouchers										
Other Ambulatory										
Total Ambulatory							0	0	0	0
TOTAL FOR COUNTY					0	0	0	0	0	0
Number of Denials										
No-Shows***										
Additional Comments:										

*Count each recipient using transportation in one mode of transportation category only. For recipients using more than one mode of transportation, include recipient in the category that represents the most frequent usage.

**A trip is considered one-way. Example: 1 trip = a ride to the Dr's. office + 1 trip = a ride home from the Dr's. office, totaling 2 trips.

Program budget

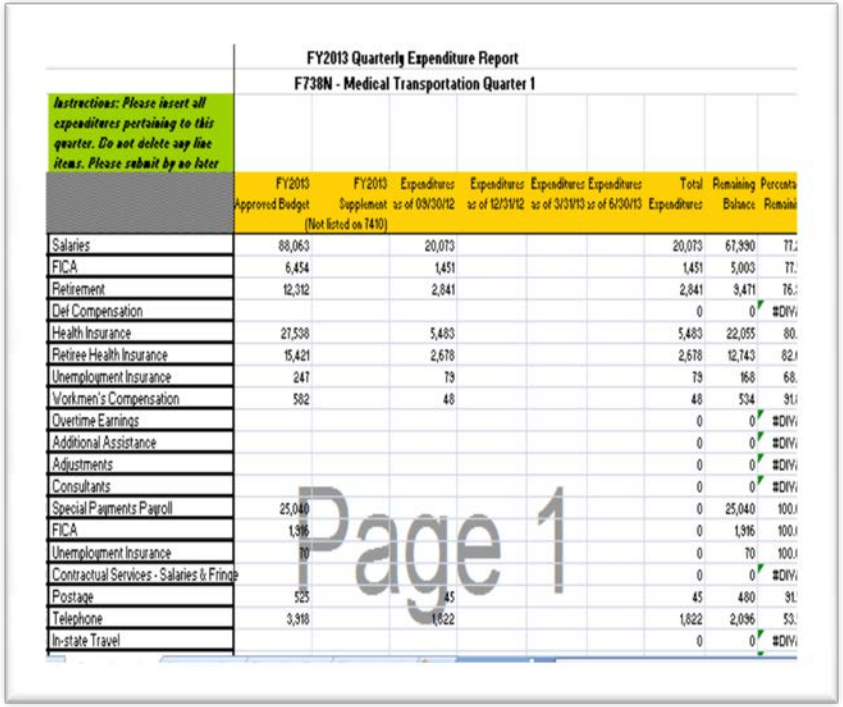
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	LINE ITEM NO.	LINE ITEM DESCRIPTION	DHMH FUNDING REQUEST	OTHER DIRECT FUNDING			TOTAL PROGRAM BUDGET (COL 3 + COL 6 + COL 11)	DHMH BUDGET MOD., SUPP or REDUCTION CHANGES (+ OR -)
				LOCAL FUNDING	ALL OTHER FUNDING	TOTAL OTHER FUNDING (COL 4 + COL 5)		
1	0111	Salaries				0	0	
2	0121	FICA				0	0	
3	0131	Retirement				0	0	
4	0139	Def Compensation				0	0	
5	0141	Health Insurance				0	0	
6	0142	Retiree Health Insurance				0	0	
7	0161	Unemployment Insurance				0	0	
8	0162	Workmen's Compensation				0	0	
9	0171	Overtime Earnings				0	0	
10	0181	Additional Assistance				0	0	
11	0182	Adjustments				0	0	
12	0201	Consultants				0	0	
13	0280	Special Payments Payroll				0	0	
14	0291	FICA				0	0	
15	0292	Unemployment Insurance				0	0	
16	0299	Contractual Services - Salaries & Fringe				0	0	

Budget justification

LINE ITEM	CHANGE	TYPE OF FUNDING	JUSTIFICATION FOR CHANGE
0111	0		
0121	0		
0131	0		
0139	0		
0141	0		
0142	0		
0161	0		
0162	0		
0171	0		
0181	0		
0182	0		
0201	0		
0280	0		
0291	0		
0292	0		
0299	0		
0301	0		
0305	0		
0405	0		
0409	0		
0415	0		
0420	0		
0604	0		

Quarterly Expenditure Report

- Must be submitted with the other required documents (Quarterly on the 15th)
- All expenditures for that quarter must be reported.
- Each report must contain previous quarters expenditures (cumulative)
- Only use the expenditure report that was created by DHMH
- DHMH will review report against the original approved budget.
- Grant Manager will receive a QERO, which is a Quarterly Expenditure Report Observation.



FY2013 Quarterly Expenditure Report

F738N - Medical Transportation Quarter 1

Instructions: Please insert all expenditures pertaining to this quarter. Do not delete any line items. Please submit by no later

	FY2013 Approved Budget	FY2013 Supplement (Not listed on 7410)	Expenditures as of 09/30/12	Expenditures as of 12/31/12	Expenditures as of 3/31/13	Expenditures as of 6/30/13	Total Expenditures	Remaining Balance	Percenta Remaini
Salaries	88,063		20,073				20,073	67,990	77.
FICA	6,454		1,451				1,451	5,003	77.
Retirement	12,312		2,841				2,841	9,471	76.
Def Compensation							0	0	#DIV/
Health Insurance	27,538		5,483				5,483	22,055	80.
Retiree Health Insurance	15,421		2,678				2,678	12,743	82.
Unemployment Insurance	247		79				79	168	68.
Workmen's Compensation	582		48				48	534	91.
Overtime Earnings							0	0	#DIV/
Additional Assistance							0	0	#DIV/
Adjustments							0	0	#DIV/
Consultants							0	0	#DIV/
Special Payments Payroll	25,040						0	25,040	100.
FICA	1,916						0	1,916	100.
Unemployment Insurance	70						0	70	100.
Contractual Services - Salaries & Fringe							0	0	#DIV/
Postage	525		45				45	480	91.
Telephone	3,918		1822				1,822	2,096	53.
In-state Travel							0	0	#DIV/

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Question & comment segment