Medi-Cal Summary

Medicaid Transportation Services

I. Introduction

Title XIX of the Social Security Act and accompanying regulations require that in their state Medicaid programs, states cover medical care and services *and* fulfill administrative requirements necessary to operate the Medicaid program efficiently. Among these administrative requirements is the mandate that a State plan "specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe methods that the agency will use to meet this requirement."[1] While transportation may not always be a medical service, it ensures that individuals can get to and from needed care and thus is necessary for the effective administration of Medicaid-funded health care services. In order to claim federal matching funds, states may cover "necessary" transportation either as an administrative expense or an optional state plan item of medical assistance, or under both categories.

The mandate to assure necessary transportation stems from provisions of the Social Security Act and regulations requiring that medical assistance be 1) available in all political subdivisions of the State;[2] 2) provided with reasonable promptness to all eligible individuals;[3] 3) furnished in the same amount, duration, and scope to all individuals in a group;[4] 4) provided in a manner consistent with the best interests of the recipient;[5] 5) available to eligible recipients from qualified providers of their choice;[6] and 6) provided in accordance with methods of administration found necessary by the Secretary for proper and efficient operation of the state plan.[7] Additionally, the federal requirement is based upon recognition from past experience in Medicaid operation, that unless needy individuals can actually get to and from providers of services, the entire goal of a state Medicaid program is inhibited.[8]

How a state will meet its federal mandate to assure necessary transportation, is determined, in part, by its definition of the term "necessary." According to the Non-Emergency Transportation Technical Advisory Group[9], states consider the following components in deciding whether the transportation service is "necessary:"

> transportation to and from Medicaid-covered services;
> the least expensive form available and appropriate for the client;
> to the nearest qualified provider; and no other transportation resource is available free of charge.[10]

This fact sheet discusses the two ways in which states can cover transportation services, as an administrative expense and as an optional medical service, and the legal requirements for both. It also examines judicial enforcement of the federal mandate to ensure transportation and outlines the best state practices in ensuring Medicaid recipients transportation to and from medical providers. A state chart detailing the emergency and non-emergency transportation services California is attached.

II. Transportation as an Administrative Expense

States can provide transportation as an administrative expense or optional Medicaid service. Provision of transportation as an administrative expense offers states a great deal of flexibility, in part because the freedom of choice provision does not apply. When the State does claim transportation services as an administrative cost, proper and efficient operation of the plan does require an attempt by the State to use any available free services, as well as the least costly means.[11] States do not have to make direct payment to a provider when furnishing transportation as administrative cost, but can choose the most efficient and appropriate means of transportation for the Medicaid recipient, including the option of volunteers, gas vouchers, bus tokens, or quasi-public/private transportation companies.[12] Whatever costs are incurred are federally matched at the fifty percent administrative services rate, which is lower than the rate at which medical services are matched.[13]

III. Transportation as an Optional Medical Service

Rather than covering transportation as an administrative expense, some states provide it as an optional medical service. In order to recognized as such, transportation assistance must be furnished by a provider to whom a direct vendor payment may be made by the State.

Transportation covered as an optional medical expense is within the free choice rights of the recipient, meaning that the client can obtain services from any qualified Medicaid provider.[14] While the provision requires states to give Medicaid recipients a choice of providers, it does not require states to provide transportation to a recipient's personal choice of provider at an exceptional cost. If the number of choices to a particular type of provider is significantly limited, however, states may authorize transportation to allow a reasonable selection of appropriate providers.[15]

Because Medicaid is the payer of last resort, when transportation is provided as an optional service, states are obligated to utilize all available sources of free transportation services, such as friends and relatives, before authorizing Medicaid payment. State authorized transportation costs claimed as an optional service are matched at the state's federal medical assistance percentage.[16] These include expenses for transportation and "other travel related expenses" necessary to secure medical examinations and treatment for a recipient, such as:[17]

- cost of transportation for the recipient by ambulance, taxicab, common carrier or other means,
- cost of meals and lodging to and from medical care, and
- cost of attendant to accompany the recipient and the cost of attendant's transportation,
- meals, and lodging, and salary, if the attendant is not a family member.

Travel related expenses are intended to cover situations when needed transportation is other than routine. This includes circumstances in which the Medicaid recipient requires a particular medical service only available in another city, county or state.

IV. Transportation for Children Through EPSDT

EPSDT, the Early and Periodic Screening, Diagnosis and Treatment Program designed by the federal government to provide comprehensive medical services for children receiving Medicaid, requires that services listed in 42 U.S.C. §1396d(a) be covered if needed to correct or ameliorate a problem.[18] Among those services are preventive and rehabilitative care and other medical services recognized by the state.[19] Regulations implementing these provisions mandate coverage of transportation to and from medical care for those Medicaid recipients who would not otherwise be able to access these services.[20]

EPSDT requires transportation to be offered "prior to each due date of a child's periodic examination."[21] Additionally, the state Medicaid agency must offer the family or recipient necessary assistance with scheduling appointments for services.[22] The agency must provide information stating that necessary transportation and scheduling assistance are available to EPSDT-eligible individuals upon request.[23] States participating in EPSDT can provide transportation services to EPSDT beneficiaries through Medicaid or cooperative agreements with public or volunteer organizations or with the beneficiary's friends or family members.[24]

Transportation costs covered by Medicaid include related travel expenses determined to be necessary by the state agency to secure medical examinations and treatment for a recipient.[25] The related travel expenses are covered in situations where the EPSDT recipient requires a particular medical service which is only available in another city, county or State and the distance and travel time warrants staying in that place overnight.[26] Thus, even if the state does not cover transportation as an optional service for adults, it must do so for children when it is medically necessary.

V. Judicial Enforcement of Transportation Requirements

On a number of occasions, courts have been asked to enforce federal transportation requirements. While the courts have generally held that states are mandated by federal Medicaid laws to assure necessary transportation for Medicaid recipients to and from providers of medical services, they have applied varying standards in determining what exactly is required.[27] In *Daniels v. Tennessee Department of Health and Environment*, the court found that at a minimum, states have an obligation to assure that transportation will be available for recipients to access qualified medical providers of their choice who are generally available and used by other residents in the community.[28] However, the court held that Tennessee could satisfy this requirement by establishing a network of paid volunteers.[29] Other courts have been more demanding in their interpretation of the federal requirements. In Kentucky, the court held that the state regulation limiting transportation to four visits per month was invalid.[30] In West Virginia and Texas, the federal transportation mandate was held to include reimbursement of travel costs for Medicaid beneficiaries and necessary attendants.[31]

VI. Best State Practices

To respond to pressures of rising costs and lack of efficiency, a number of states have developed new approaches for satisfying federal transportation requirements. For non-emergency transportation, these approaches include the use of transportation brokers and administrative managers, and a shift to capitated transport services.[32] Transportation brokerages are entities created to coordinate transportation services for Medicaid recipients,

including screening of recipients, determination of eligibility and arrangement and payment of actual transportation. Administrative managers are state Medicaid agency staff members who assume the position of gatekeeper in arranging or contracting out the administrative responsibilities. Capitated services involve the transfer of responsibility for transportation to the managed care provider.

Through utilization of these models, a number of states have been able to improve transportation services for their Medicaid recipients while controlling costs. Washington state has done this through use of transportation brokerages. There, the state Medicaid agency has established thirteen medical transportation service districts and contracted with a network of regional transportation brokers to cover the entire state.[33] Brokers receive an administrative fee to coordinate the program as well as reimbursement for direct costs. When a client needs a ride to a medical provider, she calls the broker, who verifies Medicaid eligibility, determines the necessity of each trip and assigns the appropriate provider.[34] Depending on the client's needs, the broker can use a variety of resources, such as volunteers, transit buses, mileage reimbursement and shared-ride taxis.[35] Providers are reimbursed for each ride based upon a pre-arranged fee.

In Idaho, a statewide administrative managed system, contracted through Integrated Transport Management (ITM), has been established. ITM handles requests for transportation through toll-free telephone lines.[36] Similar to transportation brokers, ITM employees verify eligibility, obtain authorization and refer Medicaid recipients to approved transportation providers. Unlike the brokerage system, ITM manages the program statewide and it does not reimbursement providers; reimbursement is paid directly by the state Medicaid agency.[37]

Under a capitated transportation services model, non-emergency transportation is "carved in" to Medicaid managed care contracts.[38] Here, the capitated rate includes projected transportation costs to and from medical providers and the health plan assumes responsibility for providing necessary transportation to Medicaid recipients. In Rhode Island, an innovative program has been developed with the Rhode Island Public Transit Authority (RIPTA). RIPTA, through its contracts with health plans, provides regular bus service as well as paratransit taxi or van service to Medicaid recipients.[39] Because 90% of Rhode Island's Medicaid population lives within ½ mile of an established bus route, recipients are encouraged to use free bus passes that are offered to all Medicaid clients.[40] For those who are unable to use the bus system are provided 24-hour door-to-door service through RIPTA's paratransit service.

VII. Conclusion

Assurance of transportation services is a key component in accessing necessary health care for millions of Medicaid recipients. Yet, while state plans are required by federal regulations to ensure transportation assistance, they are afforded a great deal of flexibility in how they administer their programs. Through EPSDT, children are guaranteed some transportation and scheduling assistance as well as coverage of travel related costs for medical care only offered outside their city. While the courts have upheld the federal mandate, they have diluted the assurance of transportation by allowing a number of limitations on what states have to provide. Rising transportation costs have created additional pressures on states to limit transportation services. In response, some states have developed innovative strategies to increase quality and

efficiency through the use of brokers, administrative managers and capitated transportation services. States like Washington, Idaho and Rhode Island have succeeded in improving transportation services while controlling expenditures. By reviewing these models and others, advocates can determine what changes can and should be made in their own states and recommend modifications to their state Medicaid agencies.

California Implementation of Transportation Requirements

EMERGENCY TRANSPORTATION	NON-EMERGENCY TRANSPORTATION	EXPLANATION OF COVERAGE
Emergency transportation to the nearest qualified facility does not require prior authorization.	Non-emergency medical transportation is subject to prior authorization, except when provided to a patient being transferred under circumstances specified by the state. It is covered when necessary to obtain program covered services if the patient's condition precludes use of ordinary public or private conveyances.	Transportation is limited to the least expensive of the following modes that is medically appropriate and available: (a) air ambulance; (b) ambulance; (c) litter van; or (d) wheelchair van.

Endnotes

1. 42 C.F.R. §431.53. *But see* Harris v. James, 127 F.3d 993 (11th Cir. 1997)(holding that federal regulations that require state Medicaid plans to ensure necessary transportation for recipients did not define content of any specific right conferred upon Medicaid recipients by Congress and thus, the regulation was unenforceable under §1983). *Contra* Boatman v. Hammons, 164 F.3d 286 (6th Cir. 1998)(court found that the federal regulation requiring states to ensure transportation to and from medical service providers has the force of law and must be characterized as "law" under §1983).

2. 42 U.S.C. §1396a(a)(1).

3. 42 U.S.C. §1396a(a)(8).

4. 42 U.S.C. §1396a(a)(10)(B)(ii); 42 C.F.R. § 440.240(a).

5. 42 U.S.C. §1396a(a)(19).

6. 42 U.S.C. §1396a(a)(23).

7. 42 U.S.C. §1396a(a)(4)(A).

8. HEW, Medicaid Assistance Manual (MAM) §6-20-20 (1978). The Medicaid Assistance Manual is the precursor to the State Medicaid Manual. This Manual, though superceded in many instances by the State Medicaid Manual, contains important statements of early agency policy. Some courts continue to cite the Medical

Assistance Manual with favor while other courts have not accorded this document great weight.

9. The Non-Emergency Transportation Technical Advisory Group is a collaborative organization of ten state staff members working on Medicaid transportation issues, HCFA Center for Medicaid and State Operations staffers and analysts from the American Public Human Services Association. This organization was convened specifically to examine non-emergency transportation issues.

10. Non-Emergency Transportation Technical Advisory Group, *Designing and Operating Cost Effective Medicaid Non-Emergency Transportation Programs: A Guidebook for State Medicaid Agencies*, August 1998 at 8-10 (available at http://www.aphsa.org/whatsup.htm#pubs). This is also based upon the Medicaid Assistance Manual's directive that states have an obligation to assure transportation when these four conditions are met. HEW, Medicaid Assistance Manual (MAM) §6-20-00 at 12.

11. HEW, Medicaid Assistance Manual (MAM) §6-20-00 at 12.

12. Non-Emergency Transportation Technical Advisory Group, *supra* note 9, at 4.

13. *Id*.

14. HCFA, State Medicaid Manual §2113.

15. *Id*.

16. Non-Emergency Transportation Technical Advisory Group, *supra* note 9, at 3. In 1995, the federal medical assistance percentage ranged nationwide from 50 to 78 percent.

17. 42 C.F.R. §§440.170(a)(1) and (3).

18. 42 U.S.C. §1396d(r)(5).

19. 42 U.S.C. §§1396d(a)(4)(B) and 1396d(r). These services include screening vision, dental and hearing services.

20. 42 C.F.R. §431.53.

21. 42 C.F.R. §441.62(a). HCFA, State Medicaid Manual §5150. *See Salazar v. District of Columbia*, 938 F.Supp. 926, 963 (D.D.C. 1996), *remedial order*, No. CA-93-452(GK), *reprinted in* Medicare & Medicaid Guide (CCH) ¶45,075 (D.D.C. Jan. 17, 1997).

22. 42 C.F.R. §441.62(b).

23. 42 C.F.R. §441.56(a)(2)(iv).

24. HCFA, State Medicaid Manual §5340.

25. 42 C.F.R. §440.170(a)(1).

26. HCFA, State Medicaid Manual §5340.

27. Smith v. Vowell, 379 F. Supp. 139, 150-152 (W.D.Tex. 1974), *aff'd* 504 F.2d 759 (5th Cir. 1974) (providing only emergency transportation did not comply with federal requirements to assure the availability of transportation to necessary medical care); Bingham v. Obledo, 195 Cal. Rptr. 142 (1983) (state plan which limited transportation to beneficiaries who were too severely disabled to ride in automobiles or buses violated federal regulations); Fant v. Stumbo, 552 F. Supp. 617 (W.D. Ky. 1982) (state limitation of transportation reimbursement to four trips per month was invalid, arbitrary limits that would deny necessary care to some

recipients); Daniels v. Tennessee Department of Health and Environment, 1985 U.S. Dist. LEXIS 12145 (1985)(determining that Tennessee's Medicaid program met the federal requirement for assuring Medicaid patients transportation by forming a network of paid volunteer groups that provided transportation); Morgan v. Cohen, 665 F. Supp. 1164 (E.D. Pa. 1987) (enjoining state transportation plan); Wolford by Mackey v. Lewis, 860 F. Supp. 1123 (S.D.W.Va. 1994) (Medicaid-eligible residents of residential board and care and personal care homes entitled to Medicaid-covered transportation to health care providers). *But see* Harris v. James, 127 F.3d 993 (11th Cir. 1997)(denying Medicaid recipients a federal right to transportation on the basis that the regulation did not define the content of any specific right conferred on recipients). *Contra* Boatman v. Hammons, 164 F.3d 286 (6th Cir. 1998)(court held that because federal regulations have the force of law, Medicaid recipients were entitled to written notice of denials of transportation assistance and adequate information about transportation services and eligibility requirements for receiving those services).

28. 1985 U.S. Dist. LEXIS 12145 (1985) (quoting the Medical Assistance Manual §6-20-00 at 12).

29. *Id*. The Court made it clear that an obligation to assure transportation exists only where it is not otherwise available. The Court interpreted this to mean that transportation assistance to a Medicaid recipient can be denied when a recipient or a member of her household owns or has access to a serviceable motor vehicle or she has been utilizing bus service or transportation provided by friends or relatives.

30. *Fant*, 552 F. Supp. at 617-618.

31. Stump v. Miller, No. 2:91-0166(S.D.W.Va., Dec. 29, 1991) (agreed order)(reimbursement provided to clients for travel costs at the rate for state employees). Frew v. Gilbert, No. 3:93CV65 (E.D.Tex., May 11, 2000)(settlement)(reimbursement of meals is furnished when children must travel for services)(Cl.Rev. No. 50,456).

32. Community Transportation Association of America, *Managing Medicaid Transportation: A Manual for Examining Innovative Service Delivery Models Under State Medicaid Managed Care Plans*. Washington, D.C., December 1997 (available at http://www.ctaa.org/pubs/medicaid/home.shtml).

33. *Id*. at Best Practices section, pg. 2.

34. *Id*.

35. *Id*.

36. *Id*. at Best Practices section, pg. 7.

37. *Id*.

38. *Id*. at Best Practices section, pg. 8.

39. *Id*. at Best Practices section, pg. 9.

40. *Id*.