NATIONAL HEALTH LAW PROGRAM

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FACT SHEET: MEDICAID TRANSPORTATION SERVICES

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I. INTRODUCTION

Title XIX of the Social Security Act and accompanying regulations require that in their state Medicaid programs, states cover health care services *and* fulfill administrative requirements necessary to operate the Medicaid program efficiently. Among these 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] 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.[2] In order to claim federal matching funds, states may cover "necessary" transportation either as an administrative expense, an optional service, or as both.

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[3], states consider the following components in deciding

[1] *See* 42 C.F.R. §431.53.
[2] *See* 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 This Manual, though superceded in many instances by the State Medicaid Manual, contains important statements of early agency policy.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 others have not accorded it great weight.
[3] The Non-Emergency Transportation Technical Advisory Group was a collaborative organization of ten state staff members working on Medicaid transportation issues, HCFA Center for Medicaid and State Operations staffers and

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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.[4]

This fact sheet discusses states' coverage of transportation services as an administrative expense and as an optional medical service and the provisions in the Deficit Reduction Act and accompanying regulations that enable states to establish transportation brokerages without a waiver. It also examines judicial enforcement of the federal mandate and outlines the best state practices in ensuring Medicaid recipients transportation to and from medical providers.

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 requires an attempt by the State to use any available free services, as well as the least costly means.[5] 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.[6] Whatever costs are incurred are federally matched at

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analysts from the American Public Human Services Association. This organization was convened specifically to examine non-emergency transportation issues.

[4] *See* Non-Emergency Transportation Technical Advisory Group, Designing and Operating Cost Effective Medicaid Non-Emergency Transportation Programs: A Guidebook for State Medicaid Agencies 8-10 (Aug. 1998), *available at* http://www.ntl.bts.gov/lib/12000/12200/12290/medicaid.pdf. 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.

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

[6] Non-Emergency Transportation Technical Advisory Group, *supra* note 4, at 4.

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the fifty percent administrative services rate, which is typically lower than the rate at which medical services are matched.[7]

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 be recognized as such, transportation assistance must be furnished by a provider to whom a direct vendor payment is 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.[8] 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, states may authorize transportation to allow a reasonable selection of appropriate providers.[9]

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 before authorizing Medicaid payment. State authorized transportation costs claimed as an optional service are matched at the state's federal medical assistance percentage.[10] These include expenses for transportation and "other related travel expenses" necessary to secure medical examinations and treatment for a recipient, such as:[11]

- cost of transportation for the recipient by ambulance, taxicab, common carrier or other means,

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[7] *Id*.
[8] Centers for Medicare & Medicaid Services, State Medicaid Manual §2113.
[9] *Id*.
[10] *See* Non-Emergency Transportation Technical Advisory Group, *supra* note 4, at 3. In 1995, the federal medical assistance percentage ranged nationwide from 50 to 78 percent. In 2007, the federal medical assistance percentage ranged from 50 to 75.89 percent. 70 Fed. Reg. 71,856, 71,857 (Nov. 30, 2005), *available at* http://aspe.hhs.gov/health/fmap07.htm.
[11] 42 C.F.R. §§440.170(a)(1) and (3).

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- cost of meals and lodging to and from medical care,
- cost of attendant to accompany the recipient, and
- cost of attendant's transportation, meals, lodging, and, if the attendant is not a family member, salary.

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.

III. TRANSPORTATION FOR CHILDREN THROUGH EPSDT

EPSDT, the Early and Periodic Screening, Diagnostic 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" an illness, disease or defect.[12] Among those services are preventive, rehabilitative care and treatment services recognized by the state.[13] Regulations implementing these provisions mandate coverage of transportation to and from medical care for Medicaid-enrolled children who would not otherwise be able to access these services.[14] 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.

EPSDT requires transportation to be offered "prior to each due date of a child's periodic examination."[15] Additionally, the state Medicaid agency must provide information stating that necessary transportation and scheduling assistance are available to EPSDT-eligible individuals

[12] *See* 42 U.S.C. §1396d(r)(5).
[13] *See* 42 U.S.C. §§1396d(a)(4)(B) and 1396d(r). These services include screening vision, dental and hearing services.
[14] *See* 42 C.F.R. §431.53.
[15] *See* 42 C.F.R. §441.62(a). Centers for Medicare & Medicaid Services, State Medicaid Manual §5150. *See* Salazar v. District of Columbia, 954 F.Supp. 278, 331 (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).

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upon request[16] and must offer the family or recipient necessary assistance with scheduling appointments for services.[17]

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.[18] Transportation costs covered by Medicaid may also include related travel expenses determined to be necessary by the state agency to secure medical examinations and treatment services which are only available in another city, county or state.[19]

V. MEDICAID TRANSPORTATION AND THE DEFICIT REDUCTION ACT OF 2005

The Deficit Reduction Act of 2005 (DRA) addresses a wide range of issues from housing and education to Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).[20] In the Medicaid context, it creates the state option to establish a non-emergency medical transportation brokerage program to help states ensure provision of Medicaid transportation services.[21] The purpose of this program is to "more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation . . . ."[22]

Under the DRA's transportation brokerage option, transportation services may include wheelchair vans, taxis, stretcher cars, secured transportation, and/or bus passes or tickets.[23] Services can be conducted under contract with a transportation broker selected through a competitive bidding process.[24] The broker will monitor beneficiary access and complaints and

[16] *See* 42 C.F.R. §441.56(a)(2)(iv).
[17] *See* 42 C.F.R. §441.62(b).
[18] *See* Centers for Medicare & Medicaid Services, State Medicaid Manual §5340.
[19] *See* 42 C.F.R. §440.170(a)(1).
[20] *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006).
[21] *See id*. §6083 (adding 42 U.S.C. §1396(a)(70)).
[22] *See id*.
[23] *See* 42 U.S.C. §1396(a)(70)(A).
[24] *See* 42 U.S.C. §1396(a)(70)(B)(i).

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ensure that personnel providing transportation are licensed, qualified, competent and courteous.[25] Under the DRA, traditional Medicaid requirements of statewideness, comparability and freedom of choice of providers may be ignored as states set up brokerage systems.[26] This section of the statute became effective on February 8, 2006 when the DRA was enacted.

A March 31, 2006, Dear State Medicaid Director letter offers additional guidance to states on establishing brokerage systems.[27] The letter explains that prior to enactment of the DRA, states were required to obtain a § 1915(b) waiver in order to use a broker to provide non-emergency medical transportation as an optional medical service. As stated above, states may now use a brokerage system to provide transportation as medical assistance without a waiver. With the letter, the Centers for Medicare & Medicaid Services (CMS) made available a preprint for states to use when submitting a state plan amendment.[28] Additionally, CMS issued draft regulations on August 24, 2007 to formalize the guidance; the regulations affirm the statute's declaration that states can establish a transportation brokerage system without adhering to traditional Medicaid principles of comparability, freedom of choice and statewideness.[29]

A number of states had already been using non-emergency transportation brokers, as a response to the pressures of rising costs and lack of efficiency in providing transportation, and obtaining federal financial participation for the administrative expense even before the DRA was enacted. The states that had previously used 1915(b) transportation waivers to use brokerages were Arkansas, Florida, Georgia, Kentucky, New York, Oregon, and Utah.[30] Other states that

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[25] *See* 42 U.S.C. §1396(a)(70)(B)(ii).
[26] *See* Dear State Medicaid Director Letter #06-009 (Mar. 31, 2006).
[27] *See id*.
[28] *See id*.
[29] *See* 72 Fed. Reg. 48604 (August 24, 2007), *available at* http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2234P.pdf. *See also*, National Health Law Program, Medicaid Transportation Proposed Rule Comments, available at www.healthlaw.org.
[30] *See* National Consortium on the Coordination of Human Services Transportation, Medicaid Non-emergency Transportation: National Survey 2002-2003 12-13 (Dec. 2003), *available at* http://cwd.aphsa.org/publications/docs/NEMT_survey_report_Dec2003.pdf.

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utilized some type of broker system even without the waiver included Colorado, Connecticut, Delaware, Missouri, Nevada, Pennsylvania and Washington.[31]

After the DRA enactment, Alaska, Georgia, Idaho, Kentucky, Mississippi, Nevada, New Jersey, and Oklahoma have officially used the CMS preprint to amend their state plans.[32] Furthermore, other states like Iowa and New Hampshire are investigating the possible transition. Iowa has begun research to design a brokerage system for possible implementation.[33] Since many states have used brokerage systems in the past and several others have recently established such systems, it may be only a matter of time until the remaining states follow.

VI. JUDICIAL ENFORCEMENT OF TRANSPORTATION REQUIREMENTS

On a number of occasions, courts have been asked to enforce the federal transportation requirements. Two federal circuit court decisions on the enforceability of the Medicaid transportation regulations came out very differently. In *Harris v. James*, the Eleventh Circuit held that the regulations were unenforceable under §1983 because they did not define the content of any specific right conferred upon Medicaid recipients.[34] In *Boatman v. Hammonds*, the Sixth Circuit found that the regulation had the force of law and must be characterized as "law" under §1983. [35]

When courts have upheld the federal transportation mandate for Medicaid recipients to and from providers of medical services, they have applied varying standards in determining what

[31] *See id*. Note that Idaho is the only one that has been approved but has not yet established its brokerage program. Email from Jean K. Sheil, Centers for Medicare & Medicaid Services, Director of Family and Children's Health Program Group, to Kristina Devilla, National Health Law Program Clerk (July 12, 2007, 14:58 PST) (on file with author).
[32] *See* Sue Stairs, Iowa Medicaid Enterprise, Iowa Medicaid Transportation Project Overview, 2007 (*available at* http://www.iatransit.com/regulations/coordination/statewide_presentations/medicaid_transportation_project.pdf).
[33] Email from Paul Hanley, Iowa Medicaid Transportation Project Analyst, to Kristina Devilla, National Health Law Program Clerk (July 27, 2007, 11:13 PST) (on file with author).
[34] *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).
[35] *See* Boatman v. Hammons, 164 F.3d 286 (6th Cir. 1998)(holding 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).

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exactly is required.[36] 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.[37] However, the court held that Tennessee could satisfy this requirement by establishing a network of paid volunteers.[38] 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.[39] In West Virginia and Texas, the federal transportation mandate was held to include reimbursement of travel costs for Medicaid beneficiaries and necessary attendants.[40]

With the addition of the state brokerage option, the Medicaid Act, for the first time, explicitly discusses transportation services. Previously, transportation was expressly addressed only in the Medicaid regulations. This is significant because the Eleventh Circuit case *Harris v. James* held that Medicaid beneficiaries could not enforce the federal transportation regulations in a § 1983 civil rights action because the regulations alone did not create federal rights.[41] As discussed above, the regulation was considered too far removed from Congressional intent to be enforceable even if a regulation imposed obligations in order to further the broad objectives of a

[36] *See* 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).

[37] *See* Daniels v. Tennessee Department of Health and Environment, 1985 U.S. Dist. LEXIS 12145 (1985) (quoting the Medical Assistance Manual §6-20-00 at 12).

[38] *See 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.

[39] *See Fant*, 552 F. Supp. at 617-618.

[40] *See* 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).

[41] *See Harris*, 127 F.3d at 1009-10.

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statutory provision.[42] Since the passage of the DRA, determining whether regulation has the force of law is less a concern. By giving states the option of implementing a transportation brokerage program, Congress demonstrates its intent for states to ensure that Medicaid recipients have transportation to and from medical service providers. If courts previously required explicit Congressional intent and a specific federal right for enforceability, the DRA statute now satisfies these elements.

VII. BEST STATE PRACTICES

To respond to pressures of rising costs and lack of efficiency, a number of states have developed innovative approaches for satisfying federal transportation requirements. For non-emergency transportation, these approaches include the use of transportation brokers, administrative managers, and capitated transport services through managed care plans.[43] Transportation brokerages, recently authorized for state implementation without a waiver by the DRA and accompanying regulations, 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 established thirteen medical transportation service districts and contracted with a network of regional transportation brokers to cover the entire state.[44] Brokers receive an administrative fee to coordinate the program as well as reimbursement for direct costs. When a client needs a ride

[42] *See id*.
[43] *See* Community Transportation Association of America, Medical Transportation Toolkit and Best Practices, Third Edition 2005, *available at* http://www.ctaa.org/webmodules/webarticles/articlefiles/medtoolkit.pdf.
[44] *See id* at 65.

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to a medical provider, she calls the broker, who verifies Medicaid eligibility, determines the necessity of each trip and assigns the appropriate provider.[45] 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.[46] Providers are reimbursed for each ride based upon a pre-arranged fee.

In Alaska, a statewide administrative managed system, contracted through First Health Services Corp. (First Health), has been established. When a healthcare provider refers a Medicaid recipient to a doctor or specialist in another community, the provider must call First Health.[47] Like transportation brokers, First Health employees verify eligibility and will prior authorize travel. However, once a Medicaid recipient receives prior authorization, she must call a different agency, USTravel Alaska (which operates as the State Travel Office), and travel agents will arrange the appropriate travel.[48] Generally, reimbursement to providers in administrative managed systems is paid directly by the state Medicaid agency, but because the state has contracted out its administrative duties and fiscal management to First Health, First Health reimburses USTravel.[49] Unlike the brokerage system in which one broker handles all aspects of transportation coordination, the state or its contracting entity separately carries out the administrative function.

Under a managed care model, non-emergency transportation is "carved in" to Medicaid managed care contracts.[50] Medicaid can make payment as a flat fee or based on a capitated rate.[51] Under a flat fee, Medicaid pays a monthly lump sum amount for the provision of transportation. However, under a capitated rate, Medicaid pays managed care organizations a

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[45] *See id.*
[46] STATE OF ALASKA, DEPT. OF HEALTH & SOCIAL SERVICES, DIVISION OF HEALTH CARE SERVICES, ALASKA MEDICAID RECIPIENT SERVICES 11 (Apr. 2006), *available at* http://health.hss.state.ak.us/dhcs/PDF/MedicaidRecipientHandbook1.pdf.
[47] *Id*. at 12
[48] Email from Sunny Israelson, Alaska State Travel Manager, to Kristina Devilla, Summer Law Clerk, National Health Law Program (June 15, 2007) (on file with author).
[49] Community Transportation Association of America, *supra* note 43, at 169.
[50] *See id*. (showing that Rhode Island Medicaid moved from a capitated rate to a flat monthly payment in July 1999).
[51] *See id*.

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"per member per month" amount. Depending on the state, one capitated rate may be used to cover all basic medical expenses that includes transportation or a separate subrate can be used for transportation alone.[52] The rate includes projected transportation costs to and from medical providers.[53] In any case, the health plans assume responsibility for providing necessary transportation to Medicaid recipients.

In Rhode Island, an innovative program was developed with the Rhode Island Public Transit Authority (RIPTA). Previously, RIPTA contracted with Rhode Island's Medicaid health plans to provide regular bus service as well as paratransit taxi or van service to Medicaid recipients.[54] This was first done on a capitated transportation rate and later converted to a flat fee.[55] However, RIPTA now contracts directly with the Rhode Island Department of Human Services who reimburses RIPTA $44 for each monthly pass.[56] For those who are unable to use the bus system, 24-hour door-to-door service is supplied through RIPTA's paratransit service, RIde.[57] In addition, RIte Care, Rhode Island's Medicaid program for families and children, covers any of its members who is unable to access transportation services through RIPTA.[58] Funded by a transportation-inclusive monthly capitated rate, each RIte Care managed care health plan is in charge of arranging any other medically necessary transportation.[59] Other states that use a managed care model include Arizona, Arkansas, Connecticut, Georgia, Indiana, Kentucky,

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[52] *See id*.
[53] *See id*.
[54] *See id*.
[55] Bruce Landis, *RIPTA Stands to Lose Revenue Under Proposed RIte Care Cuts*, THE PROVIDENCE JOURNAL, March 3, 2006, *available at* http://www.ritecare.ri.gov/documents/press/Projo_3-3-06.pdf.
[56] RIPTA: Americans with Disabilities Act Transit Program, http://www.ripta.com/content256.html (last visited July 31, 2007).
[57] Telephone interview with Neighborhood Health Plan Member Services, Neighborhood Health Plan of Rhode Island (July 26, 2007). *See also* UNITEDHEALTHCARE, 2006-2009 RITE CARE MEMBER HANDBOOK 22 (2006) (stating RIte Care health plan transportation policy). *See also* NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND, PROVIDERS MANUAL 36 (Apr. 2005). *See also* BLUE CROSS BLUE SHIELD OF RHODE ISLAND, PARTICIPATING PROVIDER ADMINISTRATIVE MANUAL 152 (Dec. 2006)
[58] *See* CENTER FOR CHILD AND FAMILY HEALTH, RHODE ISLAND DEPARTMENT OF HUMAN SERVICES, RITE CARE/RITE SHARE ANNUAL REPORT 20 (Nov. 2006)(showing aggregate monthly capitation payment as well as separate RIPTA payment). *See also* Rhode Island Department of Human Services, Schedule of In-Plan Benefits, http://www.dhs.state.ri.us/dhs/heacre/provsvcs/manuals/inplnben.htm (last visited July 31, 2007)(listing benefits included in the capitated rate paid to RIte Care health plans).
[59] Community Transportation Association of America, *supra* note 43, at 168.

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Michigan, New Mexico, New York and Oklahoma.[60]

VII. CONCLUSION

Medicaid transportation services are a key component in accessing necessary health care for millions of Medicaid beneficiaries. States must assure provision of transportation services to and from medical provider for adults and children. Additionally, through EPSDT, children are guaranteed 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 given states a great deal of flexibility in what transportation services they provide. The Deficit Reduction Act of 2005 and its accompanying draft regulations recently have allowed states to meet their obligations by establishing transportation brokerage systems. The DRA authorization along with state strategies to increase quality and efficiency through innocative means have results in greater use of brokers, administrative managers and managed care models. States like Washington, Alaska 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.

[60] National Consortium on the Coordination of Human Services Transportation, Medicaid Non-emergency Transportation: National Survey 2002-2003 12-13 (Dec. 2003), *available at* http://cwd.aphsa.org/publications/docs/NEMT_survey_report_Dec2003.pdf.