

Draft Comments to Proposed Regulations Concerning Non-Emergency Medical Transportation

From the combined Coordination of Care Committee of the Behavioral Health Partnership Oversight Council and the Consumer Committee of the Medical Assistance Program Oversight Council

January 2015

I. INTRODUCTION

Our combined committees, the Coordination of Care Committee of the Behavioral Health Oversight Council and the Consumer Committee of the Medical Assistance Program Oversight Council, have had a major role in overseeing the issues with non-emergency medical transportation (NEMT) under the Medicaid program for several years.

The committee has documented problems that are pervasive and ongoing. Though DSS and Logisticare officials have appeared before our committees, the issues with this critical service continue. **The consequence is that access to essential medical services covered under the Medicaid program is often effectively unavailable, simply because the enrollee could not reliably get to the appointment.**

Inappropriately organized transportation also results in clients becoming “no shows” for providers, which causes them to waste resources and makes them less willing to see Medicaid enrollees, exacerbating what is already a significant Medicaid access problem, particularly for specialists.

This document is submitted recognizing the need of the Department to have the substantial benefit of input from ~~our several~~ committee members who are actual users of NEMT benefits and thus intimately knowledgeable about the access problems. This is particularly important as the committees have an oversight role concerning NEMT.

We have also sought, and incorporate in this document, input from others including service providers to identify the issues at another point along the procedural continuum.

Use of this broad-based input will result in the development of more effective and efficient regulations and utilization of this critical resource.

We begin with a description of the overarching problems and issues that we have identified; these will serve to inform the rationale behind the detailed regulatory suggestions. **We urge ~~that you~~ to make the language changes set forth below.** We recognize that not all of the problems can be addressed through regulations alone, and therefore we have also included suggestions that identify where considerations are procedural. In general, these should be cohesive in terms of clearly spelling out the responsibilities of DSS and where there should be contractual consideration regarding its selection of and oversight of its transportation broker.

II. OVERVIEW OF PROBLEMS

Medical decision-making by non-medical Logisticare staff

These DSS regulations are regarding “Non-emergency **medical** transportation.” Thus, this service is essentially a medical one. The definition section of the proposed regulations should be explicit about the fact that these are medical determinations. For most of these determinations, a treating provider must first justify the need for whatever the particular member is requesting. But on the broker side, it appears that it is non-medically licensed individuals who are making the decisions, including overruling the judgment of the treating licensed medical providers.

Some of the areas of **inappropriate medical decisions made by non-medical Logisticare staff** that have had a negative impact:

- **Deciding that a person should use a cheaper form of transportation** (e.g. a bus rather than a cab) has meant that the transportation “provided” is not able to be utilized. There are many reports of people expected to use a mode of transportation that is inconsistent with their medical needs. Some examples:
 - o A person with a wheelchair sent a non-accessible cab.
 - o A person has with behavioral or physical barriers that mean they are not able to utilize a bus that is within the typical mileage parameters.
- **Requirement for the client to see a closer provider than the one requested.** In cases reported this was not a matter of a different part of the state, but very minimal distances within the same city.
- **Decisions about whether a person should be required to share a ride with a stranger or needs a companion for a ride.** The problems in this area were many and are therefore detailed in a separate section, below.
- **Logisticare staff have over-ruled medical staff and staff who work with the client and understand their needs.** This should not be tolerated. Federal law is clear that the treating providers’ judgment is entitled to substantial weight and can be overridden only when there is significant medical evidence to the contrary.

In addition to having a negative impact on the client’s access to services, and the waste of resources for a provider allocating time for a patient who is unable to get there, these issues also **end up costing the state more**, rather than saving money. Some examples that have occurred:

- A child with behavioral health issues required to take multiple buses – time and stress overcoming their capacity and resulting in decompensation.
- The denial of appropriate rides resulting in being unable to access necessary behavioral health services and resulting in deterioration or even hospitalization.

The right care at the right time is the most cost-effective process and should justify paying a little more for the most appropriate mode of transport. “More expensive” can in the long run mean a comprehensive and inclusive expense that is really is the “least expensive.”

Clearly, the first priority should be to schedule transportation that is appropriate and consistent with the needs of the client, as determined by the medical professional should such a recommendation be on record. If there is any doubt, a non-licensed decision-maker should attempt to reach a treating provider for input *before* making any decision. An additional factor to be utilized should be the information about needs as provided by the client. Again, if this cannot be done, that determination should be made only after seeking the input of an appropriate professional for the situation.

To assure that such decisions can be subject to a suitable quality assurance process, the identity of the actual decision-maker within Logisticare or any other selected vendor should be routinely recorded and available in the event of a challenge or notice of action in the event of a denial or termination.

Inclusion of necessary family members and caretakers for rides

The proposed regulations fail to recognize circumstances in which transportation of individuals other than the recipient him/herself is necessary to ensure there is access to the Medicaid-covered medical treatment, by making sure the ride takes place. They fail to recognize the ongoing need to transport young children at times, in order for an adult parent to get him/herself to health services or to accompany another minor child to and from a medical appointment needed by that child.

The Department has ~~made~~ given a variety of ~~excuses~~ reasons for being unwilling to transport young children or siblings under these circumstances, including an assertion, without legal citation, that federal law would prohibit the sibling from sharing a cab ride. It also has claimed that there may be a cost to doing this, whether or not reimbursed by the federal government. In making these arguments, the Department has lost sight of the fact that a parent who cannot afford or find a babysitter and who would otherwise have the choice of leaving a young sibling home alone (subjecting themselves to potential DCF involvement) is simply not going to do that. The result is that, in many cases, the young child needing services will not receive the needed medical treatment, when the parent cannot go because of his/her responsibility to other children. This violates the mandates of the federal Medicaid “EPSDT” requirements, which require children to receive early and periodic medical screening and treatment. It can also result in higher long-term costs, as described above.

A similar dilemma applies to health care services needed by the parent. Medicaid services for families are, by definition, provided to people who are very poor and have limited options as a result. It is counterproductive to pretend this isn’t the reality. Does anyone think a parent wants to bring her children to a gynecological appointment? It is only out of a lack of other options that this occurs.

Due to the typically long waits for medical transportation, the present system requires parents to find childcare for an unknown amount of hours (our clients have reported 6-hour round trips just to attend a 30 minute doctor’s appointment). Unless DSS is willing to provide expensive stipends for childcare during medical appointments, it is easier and more sensible to allow the parent to bring his/her children with her when s/he must go to the doctor. Otherwise, medical access is ~~an illusion~~ severely compromised for families with young children. It is a federal legal right that, in Connecticut, exists only on paper. The regulations must be revised to provide that transportation may, where necessary, include a young sibling or child.

In addition, the proposed regulations do not address the situation where a parent or guardian must go to the hospital to visit with a minor child, or where a spouse, significant other or personal care attendant must go to the hospital to receive training on caring for a recipient prior to discharge. DSS has informally recognized the need to transport individuals in these circumstances, but these policies must be clearly codified to avoid any possibility of confusion.

~~The Department has an appropriate informal policy prohibiting cab companies from requiring a member to travel with a stranger where there is a medical need for such a prohibition. However, Logisticare call center staffers are seemingly unfamiliar with this policy [this is stated under “no shared rides, below]~~

Requirement of repeated medical justifications

The proposed regulations require getting a provider’s recertification of medical need every three months, with the only exception being individuals with “static” conditions, for which the maximum allowance is one year. Recertification every three months is too frequent for many cases, especially in light of the difficulty Medicaid recipients often have in securing medical statements from their providers. This kind of requirement can be a further disincentive for providers to accept Medicaid patients. A more appropriate period would be once every six months, unless the broker *has reason to believe* that the medical condition will undergo a material change in less than that period of time, for example, a broken leg with a 6-week healing period in which case the three month period for recertification makes sense. For behavioral health treatment, it would be appropriate for the department or broker to request an estimate from the recipient’s provider of how long the recipient is likely to remain in mental health treatment, and require recertification according to that timetable.

For those with permanent physical conditions, like quadriplegia, the once per year allowance for those with a “static” condition is too frequent. Recertification once every five years for permanent physical conditions requiring special modes of transportation should be sufficient. Again, this reduces the paperwork burden on DSS, the provider, and the vendor. Every time unnecessary paperwork is eliminated, there are savings.

No shared rides with strangers

The Department has an appropriate informal policy prohibiting cab companies from requiring a member to travel with a stranger where there is a medical need for such a prohibition. However, Logisticare call center staffers are seemingly unfamiliar with this policy, so the regulations ~~need to~~ should clearly spell this out. *The proposed regulations should make clear that this rule applies whenever it is medically necessary to impose such a prohibition, either for the member needing transport or for any escort.* [NOTE: italics added for emphasis]

We have heard about immuno-compromised clients being expected to share a cab with an individual who is apparently or self-disclosed as having an infectious condition.

Inconsistent statements about use of and compensation for private care usage

There are times when it will be in everyone's interest to pay private individuals- friends or family members of enrollees- to transport the enrollees to medical appointments, rather than pay a cab company. The proposed regulations do allow for this to some degree, but with inconsistent provisions.

Most problematically, they do not actually require the department/broker to provide reimbursement for private care usage. They have even suggested that the availability of such private transportation might be the basis for the broker to deny other transportation.

The regulations must make clear that any denial of requested transportation based on the availability of private transportation must be accompanied by a clear written commitment to actually reimburse friends and family for providing that service (subject to the minimums for reimbursement in the case of legally liable relatives). The proposed regulation talking about situations where the broker "may" pay for private transportation should be changed to "must."

In addition, the proposed regulations state that the compensation for private vehicle transportation is at the "rate per mile, as determined by the department." This would be acceptable if DSS was willing to pay a reasonable rate, but the current rate is unacceptable- less than 20 cents per mile, which is less than half the federal rate. The payment rate should be objective and should be pegged to the IRS rate, whatever it is at the time.

Due process notice

The proposed regulations should but do not comply with federal regulations and constitutional principles in that they fail to require the issuance of written notice, and information about appeal rights, for terminations, reductions and suspensions, as well as denials or partial denials of NEMT services.

For example, if Logisticare has authorized a certain mode of transport for an upcoming several months, but then decides during that period that a lower level of transport will be sufficient because of a perceived change, the vendor or the department must send out a written termination or reduction notice at least 10 days before ceasing to pay for the higher level of services already approved. This would allow the person to maintain the benefits ~~unreduced if~~ while the reduction is contested and a hearing can take place ~~is requested~~ prior to the termination date.

The proposed regulations also fail to require inclusion of all information required by the federal regulations (42 C.F.R. § 431.210) to be included in notices of action, including the regulatory basis for any action and the right to continued benefits pending a hearing if a notice of termination, reduction or suspension of services is timely appealed.

Age cut-off for children traveling without escort

The regulations assume that a child under 16 cannot travel without escort absent parental permission. But the age of majority is 18, so there should be parental permission on file for any transportation without escort for any member under 18.

Inappropriate flexibility to Logisticare to deny services

~~In several places, the proposed regulations talk about circumstances where rides can be provided where not otherwise authorized, such as transport to distant providers for six months only to ensure continuity of care. Although the policy is reasonable, it does give the broker the option to nevertheless deny services which meet these criteria, through language providing that it “**may** reimburse,” etc., should be changed. But discretion should be allowed for the broker to consider transportation **beyond** six months on a case by case basis, given that the existing relationship between the recipient and his or her provider may directly impact the health and well-being of the patient.~~

~~[NOTE to Sheldon: this is materially covered elsewhere in this document under denials and medically necessary arguments.]~~

Inappropriate flexibility to Logisticare to deny services

In several places, the proposed regulations talk about circumstances where rides can be provided where not otherwise authorized, such as transport to distant providers for six months only to ensure continuity of care. Although these policies may be reasonable, giving discretion to the broker to nevertheless **deny** services which meet these criteria, through language providing that it “**may** reimburse,” etc., is inappropriate. Such discretion to deny where criteria are met should not be allowed, so our language revisions remove that discretion in several places.

Timeliness to ensure meaningful access

There are many access complaints that concern arrival of the cab service too early or too late. “Too early” is a problem where the cab departs because the individual needing the ride is not ready to leave at the time the cab arrives and expects to depart. “Too late” is an issue in that the client may then miss their medical appointment, again resulting in potential adverse medical consequences to the client, and financial loss to the provider who wasted that time. The latter contributes to providers refusing to see Medicaid patients.

The proposed regulations – or required contracting language - must provide a standard for what constitutes a timely ride. We suggest defining an untimely ride as one which is ~~either more~~either more than 15 minutes early or more than 15 minutes late. We base this on what most medical providers allow as leeway before they refuse to see a patient. For rides which are not timely, or worse yet are “no show” there must be a process for appropriate sanctions of the vendor.

Similarly, the regulations provide no specification for timely telephone answering at the broker’s call center. Again, there must be recognition that these clients are – by definition – poor. Many have limited minutes on their cell phones and an overly long wait can result in the caller giving up or running out of minutes on their phone. The standard for timely phone response to any request for prior authorization must be stipulated in regulations or contract with the vendor, with appropriate sanctions if not met.

Additional DSS and broker responsibilities:

As noted above, timeliness of rides is a pervasive issue - perhaps the largest source of complaints against Logisticare over the past few years. It is unclear in a given case if the tardiness or lack of appearance is directly attributable to the broker or to the actual transportation providers. This established a gray area that is void of accountability.

To the extent the broker is not scheduling rides appropriately, the problem is directly caused by the broker. As above, there should be appropriate sanctions for failure to meet a set standard.

To the extent the problem is with the cab companies, a progressive system of enforcement should be put in place. For example, termination from all Medicaid contracting after three violations would be expected to result in substantial improvement by the individual subcontractors.

As the department, under federal law, retains the ultimate responsibility for the provision of NEMT, whether or not it chooses to contract with one or more brokers, the regulations should clearly delineate the responsibilities of the **department** to ensure that the broker complies with the regulations or the terms of its contract with the state.

Need for independent monitoring board [SVT2]

~~Our committees have tried, we hope valiantly, to provide oversight concerning the continuing severe access problems with NEMT. But our efforts have largely been unsuccessful, despite the significant involvement on the committee of Medicaid consumers with actual experience with the shortcomings in the current system. Accordingly, we believe a separate and independent board of providers, consumers, and advocates, with non-voting participation by DSS and Logisticare officials and staff, is warranted. This Board should receive regular reports on all complaints filed with either the broker or the department concerning performance by the broker or any of its contractors. The Board should meet quarterly, and have access to all Logisticare performance data, including data on wait times and on uncompleted trips, broken down by each subcontractor. It should also have a direct reporting responsibility to the DSS commissioner. The members of this group should be selected by consumers and advocates themselves and, in the case of providers, by the providers themselves, with an orientation toward providers with direct experience dealing with the broker and the NEMT system.~~

~~[NOTE to Sheldon: As this commentary has as its basis the responsibility of the two committees involved, the recommendation for a — therefore additional and potentially redundant — oversight or monitoring board appears counter productive. I also did not hear much interest in this from the committee members. I believe this section should be deleted.]~~ [SVT3]

III. NEEDED REGULATORY REVISIONS TO CORRECT THE ISSUES AND PROBLEMS IDENTIFIED IN "II" ABOVE - SECTION BY SECTION PROPOSED LANGUAGE CHANGES AND ADDITIONAL REGULATIONS

Below are section by section proposed revisions to the proposed NEMT regulations, with limited additional explanations where appropriate. Additions are shown in **bold letters**; deletions are shown in [brackets].

Section 17b-262-1041 (Definitions):

Subsection (14): change “is confined to a wheelchair” to **“uses a wheelchair”**.

New subsection: “ ‘Medical necessity determination’ means any decision under these regulations requiring a determination of medical necessity pursuant to section 17b-259(b) of the Connecticut General Statutes, including, but not limited to, decisions about:

- 1) Who is the closest appropriate provider**
- 2) Mode of transportation which is “least costly, medically necessary”**
- 3) Prohibition of shared rides**
- 4) Non-shared rides**
- 5) Certification of need for certain type of transportation**
- 6) Recertification of need for a particular mode of transportation**
- 7) Re-certification of continued need for transportation to a particular provider**
- 8) Need for escort (other than for a minor)**
- 9) Need for attendant**
- 10) Transportation for non-recipient minors to accompany a minor recipient**
- 11) Static disability**
- 12) Permanent physical condition”**

Add to current Subsection (24):

“For recipients under 18, NEMT includes transportation for recipients and their parents, guardians, or other approved person(s) over 18 to a Medicaid covered service. Other household members under 18 will simultaneously be provided with NEMT services if the absence of transportation also provided to the minor household member would prevent the recipient from receiving the service.

For recipients over 18, NEMT includes transportation for recipients and, if medically necessary, their adult spouse, caretaker, nurse, etc.”

New subsection: “ ‘No shared ride’ means a medical determination that it is medically necessary for the recipient and/or his or her adult or medical companion to not have any other recipients/riders in the vehicle to and from a Medicaid covered service.

Revision to current Subsection (25):

“ ‘Notice of action’ is a document issued in accordance with 42 C.F.R. § 431.210 to a recipient when NEMT is denied, in part or in whole, or is terminated, reduced or suspended, which

details the reasons for the denial, **termination, reduction or suspension**, and the recipient's right to a hearing."

New ^[SVT4] subsections:

~~" 'Medical Transportation Review Board' means the independent entity created to oversee the provision of NEMT services to Medicaid enrollees. It shall be composed of independent providers, consumers, and advocates, with non-voting participation by staff from the department and the broker. This board shall meet quarterly, receive regular reports on all complaints filed with either the broker or the department concerning performance by the broker or any of its contractors, have access to any performance data upon request, and report directly to the DSS commissioner. Consumer and advocate members will be selected by medical transportation consumers themselves."~~

~~" 'Transportation for Parents/Guardians' means transportation services available to any parent whose child, under the age of 18, has been admitted to any hospital, including any inpatient facility, for travel to and from the hospital."~~

New subsection:

"Medical transportation oversight entity" means, collectively, the Council on Medical Assistance Program Oversight" (MAPOC) and the Behavioral Health Oversight Council (BHOC), or such committees of these councils to which they may delegate oversight of the provision of non-emergency medical transportation.

Section 17b-262-1042 (Covered Services, Non-Covered Services and Limitations):

Add, at the end of Subsection (a)(1):

"NEMT is also covered for:

- (A) Parents or guardians, or adults appointed under state law, ~~when accompanying to~~ *accompany* minors under 18 to a Medicaid covered service.
- (B) Minor siblings of a minor recipient accompanying the recipient and the recipient's parent or guardian, if the recipient would otherwise not be able to access the Medicaid covered service
- (C) Minor children of an adult recipient who would otherwise not be able to access the Medicaid covered service because of lack of child care
- (D) Parents, guardians or legally responsible adults whose recipient children are admitted to a hospital or other health care facility, for travel to and from that facility. ~~{Sheldon: on a daily basis[SVT5]2}~~
- (E) For recipients over 18, their *medically necessary caretakers to accompany the recipient*, ^[SVT6]including but not limited to spouses, caretakers, home health aides, nurses, etc.

(F) Spouses, significant others and home health providers required to be at the hospital where a recipient is an inpatient in order to receive training for ongoing care of the recipient upon discharge.”

Revise Subsection (b)(1) to read:

~~**(Sheldon — is this necessary? It seems redundant to the section above**~~ ^[SVT7]

“For someone other than the recipient, who is being transported to or from a Medicaid-covered service, including a relative of a recipient, unless [the person is acting as the recipient’s attendant or escort]:

(A) the recipient is under 18 years of age and a parent, guardian or other authorized adult is acting as an escort for the minor recipient

(B) it is medically necessary for the recipient over age 18 to have an escort, attendant, nurse, home health aide, etc. as accompaniment, and this person is acting as the recipient’s attendant or escort

(C) it is medically necessary for a minor sibling to accompany a minor recipient and the minor recipient’s parent or guardian to the appointment

(D) it is necessary for a minor children of an adult recipient to accompany the adult recipient who would otherwise not be able to access the Medicaid covered service because of lack of child care

~~**(F)**~~ **(E) the transportation is needed for the parents, guardian, etc. of a recipient who is under the age of 18 and who is inpatient in a medical facility to visit with the recipient**

~~**(G)**~~ **(F) the transportation is needed for spouses, significant others and home health providers required to be at the hospital where a recipient is an inpatient in order to receive training for ongoing care of the recipient upon discharge.”**

Subsection 17b-262-1042(c)(1)(D) and (E):

Change word “may” to “**must**” in each paragraph, so that the broker is **required** to pay for transportation to the original medical provider for an additional six months in these delineated circumstances, not just authorized to do so.

Add new subsections (F) and (G)

“(F) If the recipient in one of the situations set forth in subsections (D) and (E) above wishes to continue seeing the same provider for more than six months, the broker will consider this request on a case by case basis.

“(G) The determination of the closest appropriate medical provider is a medical necessity determination”

Subsection 17b-262-1042(c)(2)(A): change the age of “16” to the age “18” in two places

Subsection 17b-262-1042(c)(2)(B): change the age range of “12 to 15” to the age range “12 to 17” in subsection (i) and change the age of “16” to the age “18” in two places in subsection (ii)

Section 17b-262-1043 (Prior Authorization Requirements)

Revise Subsection (a) as follows: Insert the words “,conservator or authorized representative” after “family member”

Revise subdivisions within Subsection (c) as follows:

- (1) **“the recipient’s [and provider’s] proximity to mass transit, whether the recipient has any mental or physical medical conditions that would impede the ability to use public transportation, and the proximity of the public transit to the medical provider, including but not limited to consideration of existence of traffic lights, sidewalks, safe road visibility, etc.”**
- (2) **“the recipient’s access to a safely functioning vehicle”**
- (4) **add at the end of this subdivision: “, including any overall increase in Medicaid expenditures for other health services or other costs to state taxpayers that are likely to result due to lack of access to a more expensive mode of transportation that has been requested”**

Revise subsection (d) as follows:

“Whenever practicable, the broker shall utilize shared rides for recipients, unless [it is medically necessary] the need for a no shared ride order is established based on the medical necessity [to] of transporting a recipient or his or her parent, guardian or other escort alone.”

Revise subdivisions of Subsection (e) as follows:

- (6) **“Whether a friend or family member is available and capable of transporting the recipient with a safely functioning vehicle and with compensation as is authorized under these regulations”**
- (7) **“Proximity of the recipient and the provider to public transportation, the type of transportation that ~~the requester believes is~~ is medically necessary and medical information concerning the recipient’s ability to use public transportation, and”**

Revise Subsection (g): In second sentence, revise to read: “Where medical need is shown, multiple trips may be authorized for periods up to [three] **six** months.”

Revise subdivision (h) as follows:

“For certain modes of transportation, the recipient must submit medical documentation detailing the need for the type of transportation **and the period for which that level of transportation will be needed.** Except as provided by subdivisions (1) and (2) of this subsection, re-certifications of the continued need must be submitted to the broker at least every **[three] six** months based on medical necessity, **except that if the medical documentation does not demonstrate that the medical condition requiring the particular mode of transportation is expected to last for six months, the authorization will be limited to three months or such shorter time period as is prescribed by the treating provider.**

“(1) If the broker determines that a recipient has a static disability and has no other means of transportation, the timeframe for such re-certification [may] **shall** be extended to once per year, **except that in the event of a permanent physical condition constituting a static disability, the timeframe shall be extended to once every five years.**”

Create new Subsections Section 17b-262-1043(i) and (j) reading:

“(i) Any request for prior authorization involving a medical necessity determination must be decided in accordance with the recommendation(s) of a treating provider, unless a licensed medical professional (MD, DO, LPR, RN, APRN, Psychiatrist, Psychologist, LCSW), with expertise in the area involved, disagrees with the treating provider’s recommendation based on medical evidence in the recipient’s file.

“(j) The medical necessity determination made by the broker and the name and title of the individual making the determination shall be documented in the recipient’s NEMT file and stated in the notice of action if the recipient is denied a prior authorization request.”

Section 17b-262-1044 (Broker responsibilities).

Revise Subsection (c):

Revise subdivision (1) to read: “The call center shall operate seven days a week and at hours approved by the department, **and shall have an average wait to speak to a broker staff person of 5 minutes or less.**”

Revise subdivision (3):

“Both call centers shall provide language assistance and utilize scripts approved by the department **and ~~by the~~ by the medical transportation oversight entity ~~the~~**

~~independent Medical Transportation Review Board established under these regulations.”~~

Revised Subsection (f):

Revise subdivision (f)(3) to read as follows:

“determine whether an attendant **or escort (parent, guardian, spouse, significant other, home health care provider, etc.)** is medically necessary based on the recommendation of a Medicaid provider;”

Add a new subdivision (f)(6) reading:

“Act on any request for prior authorization within one hour of the time of request.”

Revise Subsection (g) related to the duty to provide notices of action as follows:

-Insert the phrase “, **terminates, reduces or suspends**” after the word “denies”

-Insert the phrase “**termination, reduction or suspension**” after the word “denial”

-Add a new subdivision (3) stating “**citation to the regulatory authority for the denial, termination, reduction or suspension**” and

- Add a new subdivision (4) stating “**information about the ability to maintain services uninterrupted if a hearing is requested before the date of the intended termination, reduction or suspension of services.**”

Add new subsections reading:

(i) The broker’s process for approving requests for transportation must include prompts, approved by the medical transportation oversight entity, for its reviewers to ask appropriate questions designed to assure that the client’s needs are identified and addressed before the transportation service is booked, and for the issuance of information about consumers’ rights and responsibilities at the time transportation services are first requested[SVT8].

“(j) The broker shall ensure that the transportation provider provides rides in a timely manner, within a range of 15 minutes before or after the scheduled ride.

~~“(k) The broker will provide a car seat to the recipient if the medical provider has documented that without a car seat the recipient would not obtain medically necessary care. [Sheldon: this is not consistent with other forms of transportation wherein the parent or guardian is expected to provide the seat. Otherwise they would have to go through a whole process determining the age, weight etc of any small child/baby that would be in the van/car, including an accompanying child or baby,~~

~~shifting the responsibility from the parent to the service provider. Requiring this could make them refuse small children/babies needing to go with the parent~~^{[SVT9].}

“(l) The broker shall invite, record and report to both DSS and ~~the Medical Transportation Review~~ the medical transportation oversight entity all complaints about NEMT received in any ~~form~~^{[SVT10].}

“(m) The broker shall ensure compliance by all transportation providers with the requirements in Section 17b-262-1045 and with any contractual obligations, including the imposition of progressive sanctions for repeated non-compliance after notice and the opportunity to correct.”

Section 17b-262-1045 (Transportation Providers’ Requirements and Responsibilities)

Revise subsection (e) to read: “The department [may] **must** reimburse an individual who provides private transportation to a recipient to and from a Medicaid-covered service at a rate per mile [as determined by the department] **equal to the Internal Revenue Service mileage rate.**”

Section 17b-262-1047 (Department Responsibilities)

And this language at the end of subsection (a)(3): “...and with these ~~regulations~~^{[SVT11].}”

Add these new subsections:

“(8) Be responsible for ensuring compliance by the broker and its transportation contractors with all requirements set forth in these regulations and the transportation providers’ contracts, including but not limited to timely broker telephone response and timely provision of transportation services, the requirement that only licensed professionals may overrule a treating provider’s judgments regarding any medical necessity determinations, due process notice requirements, and appropriate decision-making based on individualized assessments of medical need.

“(9) Implement a system of progressive sanctions in the event the broker persists in non-compliance with any of these regulations, after appropriate notice and the opportunity to correct.

“(10) Invite, collect, analyze and regularly report to the medical transportation oversight entity ~~Medical Transportation Review Board~~ all complaints received by the department or its broker in any form and provide to the Board information about all corrective action being taken in response to any such complaints.

——“(11) Conduct surveys of NEMT users at least once every year to ascertain if users are identifying any access issues.”

~~— (12) Include performance measures and progressive sanctions in the contacts with the broker & to assure that services are provided consistent with these regulations.~~

~~- (13) Pay transportation providers rates sufficient to ensure that services are provided as needed consistent with these regulations. [Sheldon: I heard from a livery provider that they were expected to drive from Danbury to Kent (a good 45 minute drive), get the client, take them to a medical appointment in Danbury, wait for the client because there was no way to tell how long the visit would be, then drive the client back to Kent. Fee to livery: \$25. That did not begin to cover the staff time, gas etc. for that ride. That provider declined to again contract with Logisticare.]~~

[Sheldon: Not sure where this should go, but add:

~~— The process of determining the most appropriate ride should include prompts to assure that the client's needs are identified and articulated before the ride is booked,~~

~~— Clients should receive information at the inception of NEMT that defines their rights and responsibilities [SVT12].]~~

- ~~— (12) Include performance measures and progressive sanctions in the contacts with the broker & to assure that services are provided consistent with these regulations.~~
- ~~— (13) Pay transportation providers rates sufficient to ensure that services are provided as needed consistent with these regulations. [Sheldon: I heard from a livery provider that they were expected to drive from Danbury to Kent (a good 45 minute drive), get the client, take them to a medical appointment in Danbury, wait for the client because there was no way to tell how long the visit would be, then drive the client back to Kent. Fee to livery: \$25. That did not begin to cover the staff time, gas etc. for that ride. That provider declined to again contract with Logisticare.]~~

10/20/14

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