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MEDICAID COVERAGE FOR URGENT CARE AND TRANSPORTATION

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You asked if the Department of Social Services (DSS) reimburses urgent care centers that treat Medicaid recipients needing urgent care, but not necessarily the level of care a hospital emergency department provides. You also want to know if DSS reimburses ambulance companies for providing trips to sites other than a hospital emergency room.

SUMMARY

DSS reimburses medical service providers for treating Medicaid fee-for-service patients in urgent care centers as long as the centers, or the treating clinician in the center, are enrolled in DSS' Connecticut Medical Assistance Program (CMAP) network. Individuals, as well as groups of providers and clinics, can be enrolled. (DSS informs us that it does not know whether these centers are reimbursed by the managed care organizations serving HUSKY A (Medicaid for children and caretaker adults) patients.)

DSS reimburses ambulance companies for providing medically necessary ambulance rides to Medicaid enrollees, whether for emergencies or non-emergencies, when these rides are the most appropriate, least expensive mode of transportation. Hence, if a Medicaid client wishes to go to an urgent care clinic that is a Medicaid provider, and his medical condition necessitates an ambulance, DSS will pay for the ride.

DSS reimburses ambulance companies about \$220 per nonemergency transport and just under \$200 for emergency rides. It also pays mileage and other add-ons, when appropriate.

In some instances, prior authorization may be required for such rides.

REIMBURSEMENT RATES FOR AMBULANCES

In general, the Medicaid program will pay for transportation services needed to enable a program recipient to receive necessary medical care. DSS reserves the right to determine the most appropriate and least expensive mode of transportation.

Specifically, DSS will pay for both emergency and non-emergency ambulance trips if:

1. a patient's condition requires, or his or her diagnosis indicates that he or she would require, medical attention during transit;
2. a patient requires hand or feet restraints;
3. the ambulance is responding to an emergency; or
4. DSS determines that no alternative, less expensive means of transportation is available (Conn. Agency Regs. § 17-134d-33, *et seq.*)

The Department of Public Health (DPH) determines which services ambulance companies can perform (emergency or nonemergency transportation). According to a DSS official, both DPH and DSS use the Healthcare Common Procedure Coding System to define those services. DPH sets the maximum rate that a company may charge for those services, but DSS sets its own reimbursement rate, which can not exceed the DPH maximum.

A typical transport involves a base rate, plus a mileage charge for out-of-town transports. Mileage is based on inter-town distances listed on the state's inter-town distance chart that the Department of Transportation maintains. The mileage is "loaded," which means that DSS pays only from the pick-up point to the drop-off point. Additionally, for emergency transports DSS pays for waiting time based on one-half hour increments after the first half-hour.

Currently, DSS pays \$196.24 as a base rate for an emergency and \$218.82 for a nonemergency, ground ambulance transport. It pays (1) \$2.88 per inter-town loaded mile and (2) \$17.44 for each half-hour of waiting time after the first half-hour. There are add-ons for things like an extra attendant, when one is medically necessary.

The emergency base rate used to be the same as the nonemergency base rate. But PA 11-6 § 125, (1) directs the DSS commissioner to reduce, by no more than 10%, the rates paid for emergency ambulance fees directly reimbursed by DSS and (2) allows the commissioner to increase the rates when he determines that there are sufficient funds and a reasonable need for the increase. The governor had proposed allowing the use of stretcher vans for non-emergency medical transportation for people who can only be transported lying down (see OLR report [2011-R-0140](#) for a summary of the proposal and background information), but the legislature adopted the ambulance rate cut instead.

PRIOR AUTHORIZATION AND PROCESSING REQUESTS FOR AMBULANCE RIDES

All transportation services require written prior authorization (PA), except emergency ambulance, nonemergency ambulance with designated medical conditions, and certain other transportation types and rides for people with certain diagnoses. An urgent care visit would not be considered an emergency, thus a ride to such would require prior authorization. Without prior authorization, DSS will not pay for the ride (Conn. Agency Regs. § 17-134d-33, *et. seq.*).

DSS contracts with an entity that acts as a broker for nonemergency medical transportation services that clients need to get to medical appointments. The broker runs a call center and a website and provides other printed material to communicate with DSS' clients and transportation providers.

The broker is also responsible for performing prior authorizations, including verifying a client's Medicaid eligibility and determining the least expensive and most appropriate transportation mode with the help of medical personnel.

It also develops and manages a network of transportation providers, helping them enroll with DSS to ensure they can receive payment for transporting clients. DSS pays the broker an administrative payment for performing these functions.

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