Draft Comments to Proposed Regulations Concerning Non-Emergency Medical Transportation

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 problems have been pervasive and ongoing and, 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 effectively denied, simply because the enrollee could not reliably get to the appointment.**

In turn, this causes "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.

The proposed DSS NEMT regulations were prepared without input from the members of our committees, despite our role, both on paper and in practice, of having oversight of the NEMT program. Prior to publication, a draft was shared only with committee co-chairs and only on the inexplicable and unwarranted condition that it not be shared with other members of the committees. Accordingly, the Department never received the substantial benefit of input from our several members who are actual users of NEMT benefits and thus intimately knowledgeable about the access problems.

Given this lack of input, it is not surprising that the regulations fail to set an adequate framework for addressing these issues and are-defective in a variety of areas. With this in mind, we attempt to address this lack of input by providing detailed comments to these proposed regulations, and urge that you make the language changes set forth below.

Before we provide our specific proposed language changes, section by section, however, we thought it might be helpful to lay out the larger problems and how they can each be addressed through more comprehensive regulations covering this service. And, while we recognize that not all of the ongoing problems can be addressed through regulations alone, more clearly spelling out the responsibilities of DSS and its transportation broker should certainly help in this regard.

II. OVERVIEW OF PROBLEMS AND NEEDED REGULATORY REVISIONS TO CORRECT THEM

Inappropriate medical decision-making by non-medical Logisticare staff

Almost every decision Logisticare makes is medical in nature, from deciding whether a person can use a cheaper form of transportation than requested or should see a closer provider than the one requested, to whether a person should not be required to share a ride with a stranger or needs a companion for a ride. 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.

Under federal law, it is permissible for DSS to contract with a utilization management company such as Logisticare to conduct these reviews. But federal law also 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. To the extent the decisions to overrule treating providers are being made by non-licensed individuals with no clinical medical background, this standard cannot be met. All of those decisions are therefore legally insufficient and challengeable under federal law.

But it is not just compliance with federal law that is at issue. If non-medical staff are making these decisions, the quality of the decision-making is likely to suffer, such that erroneous decisions which may in the long run cost much more to the state (for example, if a child decompensates because the denial of appropriate rides results in lack of access to behavioral health services and he has to be hospitalized) will occur. It is not necessarily the case that a licensed medical professional must make all of these decisions, but certainly if the intention is to overrule the recommendation of a treating provider and deny a requested service or the requested level of service, such expertise is required.

In addition, a non-licensed decision-maker should attempt to reach a treating provider for input before making any decision which involves a medical necessity determination, if no such opinions are already on record. Finally, the identity of the actual decision-maker should be provided in the notice of action in the event of a denial or termination, which also should serve the salutary purpose of more conscientious decision-making.

Failure to factor in larger costs in determining "least expensive" means of transportation

Both in practice and in the proposed regulations, the Department has taken a narrow view in deciding what is the "least expensive, medically necessary" means of transporting individuals. The proposed regulations do not recognize the greater expense that the department will likely have to incur in the event medical services are not provided when needed, solely because the member could not safely or reliably get to the medical appointment.

The overall costs to the Medicaid program of no-shows because of transportation access issues, including expensive medical conditions that develop when inadequate early intervention is not provided, should justify paying a little more for a different mode of transport. We suggest that this larger cost-benefit analysis should be a factor in the calculation when deciding whether a particular alternative means of transport really is the "least expensive." It also is appropriate for the department to recognize other resulting costs for taxpayers if health services are not readily available, even if not costs incurred under the Medicaid program; these also should be factored into the cost-effectiveness determination. We all know the consequences to society when people in need of regular mental health treatment are unable to access it.

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 a variety of excuses 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 foolish 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 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 memorializing these accepted policies is warranted, to avoid any possibility of confusion.

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. Our position is that 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. 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 that case, the recertification period should be three months or as prescribed by the treating provider, subject to revision if necessary (e.g., if complications occur).

In addition, for those with permanent physical conditions, like quadriplegia, the once per year allowance for those with a "static" condition is too frequent. The reality is that the condition is not going to change. If the department must monitor this, then it should extend the recertification to once every five years for permanent physical conditions requiring special modes of transportation.

Finally, for those with chronic mental health problems, the need for frequent recertification can and does exacerbate their symptoms. Again, 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.

No shared rides

The Department has developed an appropriate informal policy of prohibiting cab companies from requiring a member to travel with a stranger where there is a medical need for such a prohibition. However, this is often hard to access, with Logisticare call center staffers seemingly unfamiliar with any such policy, so the regulations ~~need to~~ should clearly spell out the policy. The proposed regulations inadequately memorialize this and do not 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.

Inconsistent statements about use of and compensation for private care usage

It has repeatedly been made clear to DSS and Logisticare at meetings of our committees that 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, while suggesting that the availability of such private transportation might be the basis for the broker denying 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 totally unacceptable- less than 20 cents

per mile, which is barely enough to cover the cost of gasoline. 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 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, it 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, allowing the person to maintain the benefits unreduced if a hearing is requested prior to the termination date to contest a decision by Logisticare.

The proposed regulations also fail to require inclusion of all information required by the federal regulations cited (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, not 16.

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, giving discretion to the broker to nevertheless deny services which meet these criteria, through language providing that it "***may*** reimburse," etc., is inappropriate. 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.

Failure to provide numerical requirements essential to ensuring meaningful access

Most of the access complaints 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). The proposed regulations fail to provide any standard for what it considers to be a timely ride. We remedy that in our proposed language by defining an untimely ride as one which is either 15 minutes early or 15 minutes late. We base this on what most medical providers allow as leeway before they refuse to see a patient.

Similarly, the regulations provide no specification for timely telephone answering by a live individual at the broker's call center. We remedy that deficiency as well, and also provide a standard for timely response to any request for prior authorization.

Additional DSS and broker responsibilities needing spelling out

Perhaps the largest source of complaints against Logisticare over the past few years concerns rides which come late or early-- or not all—though approved and arranged by that broker. 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, e.g., cab companies.

Historically, the fact the transportation itself is provided by subcontractors has been used as an excuse for the failure of Logisticare to ensure timely rides. But, to the extent the broker is not scheduling rides appropriately, the problem is directly caused by the broker. To the extent the problem is with the cab companies, a progressive system of enforcement would go a long way towards improving performance, e.g., if termination from all Medicaid contracting after three violations would be the ultimate result of continued poor performance, we would expect substantial improvement by the individual subcontractors. The proposed regulations are essentially silent on the imposition of any responsibility on the broker to ensure such compliance.

Similarly, 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 proposed regulations also are essentially silent on the imposition of any responsibilities on the **department** to see to it that the broker complies with the regulations or the terms of its contract with the state. This also has to be remedied. We have remedied both severe short-comings in our proposed language below.

Need for independent monitoring board

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.

III. 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 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."

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 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
(E) For recipients over 18, their medically necessary caretakers, 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:

"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

(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

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

"(j) 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.

"(k) The broker shall invite, record and report to both DSS and the Medical Transportation Review Board all complaints about NEMT received in any form.

"(l) 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)

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 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."

10/20/14