Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

Non-Emergency Medical Transportation Services

ORDER

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Delaware Title XIX Medicaid State Plan regarding Non-Emergency Medical Transportation Services. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the June 2010 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by June 30, 2010 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend the Title XIX Medicaid State Plan to implement the provisions of Section 6083 of the Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) regarding Non-Emergency Medical Transportation Services.

Statutory Authority

- Deficit Reduction Action (DRA) of 2005, Public Law 109-171, enacted on February 8, 2006
- 42 CFR §431.53, Assurance of transportation
- 42 CFR §440.170(a), Any other medical care or remedial care recognized under State law and specified by the Secretary (Transportation)
- 42 CFR §447.205, Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates

Background

Section 6083 of the DRA amends section 1902(a) of the Social Security Act by adding a new section 1902(a)(70) that provides States the authority to establish, under the State plan, a non-emergency medical transportation (NEMT) brokerage program.

Medicaid programs are federally required in their Title XIX Medicaid state plans to ensure necessary transportation to and from providers. Federal regulations, at both §§431.53 and 440.170(a), permit this coverage in either of two ways, at the state's discretion: 42 CFR §431.53 permits coverage as an administrative expense; 42 CFR §440.170 permits transportation coverage as a medical expense under its State Medicaid plan. Besides the differences in federal financial participation (FFP) for this service for some states (the medical expense is federally reimbursed higher), the most significant difference in these two alternatives is the amount of service coordination and management that is permitted by 42 CFR §431.53.

Prior to enactment of the DRA, when a State elected to provide transportation as medical assistance under its State plan, the State needed to receive a waiver under 1915(b) of the Act in order to institute a NEMT brokerage program.

The law has changed. States are no longer required to obtain a section 1915(b) waiver in order to provide NEMT as an optional medical service through a contracted broker. Under section 1902(a)(70), a State may now use a NEMT brokerage program when providing transportation as medical assistance under the State plan.

Summary of Proposal

The Delaware Medical Assistance Program (DMAP) has a non-emergency medical transportation brokerage program in place as an "administrative service". This amendment establishes DMAP's non-emergency medical transportation brokerage program in the State's Title XIX state plan pursuant to Section 6083 of the Deficit Reduction Act of 2005. This approach will allow for coverage of non-emergency medical transportation through a contracted broker as a medical service comparable to other medical services DMAP covers such as physician and hospital care.

The proposed amendment simultaneously repeals State plan language relating to transportation cost-sharing for Medicaid recipients. There will be no client co-payment requirement for non-emergency medical transportation services.

An approved state plan amendment will allow DMAP to continue to utilize a transportation broker for meeting the non-emergency transportation needs of Medicaid recipients.

The provisions of this amendment are effective July 1, 2010 and subject to approval by the Centers for Medicare and Medicaid Services (CMS).

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE

The State Council for Persons with Disabilities (SCPD) offered the following observation and endorsement summarized below. The Division of Medicaid and Medical Assistance (DMMA) considered the comment and responds as follows.

As background, DMMA adopted a transportation broker system in 2002 utilizing LogistiCare. It replaces a fee for service transportation system. This general model will continue under the new regulation. However, states have an option to fund transportation broker systems either as an "administrative expense" or a "medical expense". DMMA is proposing to change transportation from an "administrative expense" to a "medical expense" with two (2) positive results: 1) elimination of the beneficiary co-pay; and 2) State qualification for a higher federal reimbursement rate. SCPD endorses the proposed regulation since it will eliminate beneficiary co-pays and increase the federal reimbursement rate.

Agency Response: DMMA thanks the SCPD for their endorsement.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the June 2010 Register of Regulations should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend Delaware's Title XIX Medicaid State Plan regarding Non-Emergency Medical Transportation Services is adopted and shall be final effective August 10, 2010.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #10-35a
REVISIONS:

Revision:CMS ATTACHMENT 3.1-A
OMB No. Page 9a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory **DELAWARE**

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

a 1. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service).

☐ No limitations
☒ With limitations

Non-emergency medical transportation is provided statewide through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4) and all other requirements relating to Medicaid services.

a 2. Brokered Transportation

☒ Provided under section 1902(a)(70)

The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

(1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

☐ (1) statewideness (indicate areas of State that are covered)

☐ (10)(B) comparability (indicate participating beneficiary groups)

☐ (23) freedom of choice (indicate mandatory population groups)

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(2) Transportation services will include:

☒ wheelchair van
☒ taxi
☒ stretcher car
☒ bus passes
☒ tickets
☒ secured transportation
☐ such other transportation as the Secretary determines appropriate (please describe)

(3) The State assures that transportation services will be provided under contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transport personnel are licensed, qualified, competent, and courteous;

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services;

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);

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(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

- ☒ Low-income families with children (section 1931)
- ☒ Poverty-level related pregnant women
- ☒ Poverty-level infants
- ☒ Poverty-level children 1 through 5
- ☒ Poverty-level children 6 - 19
- ☒ Qualified pregnant women AFDC-related
- ☒ Qualified children AFDC-related
- ☒ IV-E Federal foster care and adoption assistance children
- ☒ TMA recipients (due to employment)
- ☒ TMA recipients (due to child support)
- ☒ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

- ☒ Optional poverty-level-related pregnant women
- ☒ Optional poverty-level-related infants
- ☒ Optional targeted low-income children
- ☒ Non IV-E individuals under 21 who are in foster care and who are under Sate adoption assistance agreements
- ☐ Individuals under 21 who are in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☐ Individuals receiving COBRA continuation benefits
- ☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard

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☒ Individuals receiving home and community based waiver services who would only be eligible under State plan if in a medical institution
☒ Individuals terminally ill if in a medical institution and will receive hospice care
☐ Individuals aged or disabled with income not above 100% FPL
☐ Individuals receiving only an optional State supplement in a 209(b) State
☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
☒ Individuals working disabled who buy into Medicaid under TWWIIA Basic Coverage Group
☐ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids)

(6) The State will pay the contracted broker by the following method:

☒ (i) risk capitation
☐ (ii) non-risk capitation
☐ (iii) other (e.g., brokerage fee and direct payment to providers)

Effective Date:

DELAWARE will implement this State plan amendment on **July 1, 2010**.

DMMA FINAL ORDER REGULATION #10-35b
REVISIONS:

STATE PLAN UNDER TITLE XIX UNDER THE SOCIAL SECURITY ACT ESTABLISHMENT AND MAINTENANCE OF STATE AND FEDERAL STANDARDS
STATE OF DELAWARE
ATTACHMENT 3.1-D
METHODS OF PROVIDING TRANSPORTATION

Transportation is ~~covered as administrative service through a broker system~~ provided statewide through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act, 42 CFR 440.170(a)(4) and all other requirements relating to Medicaid services.

DMMA FINAL ORDER REGULATION #10-35c
REVISIONS:

ATTACHMENT 4.18-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905 (a) (1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determination
	Deductible	Coinsurance	Co-payment	
~~1.Non-Emergency Medical Transportation~~	~~-0-~~	~~-0-~~	~~$1.00 per one-way trip~~	~~1. This co-payment is effective October 1, 2002 and is based on the ranges specified in 42 CFR §§44754 and 447.55.~~
~~2.~~ Pharmacy	-0-	-0-	X	~~2.~~ This co-payment is effective January 10, 2005 and is based upon the cost of the drug as follows: Medicaid Payment for the Drug — Co-payment $10.00 or less — $ .50 $10.01 to $25.00 — $1.00 $25.01 to $50.00 — $2.00 $50.01 or more — $3.00

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B. The method used to collect cost sharing charges for categorically needy individuals:

X Providers are responsible for collecting the cost sharing charges from individuals

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

~~Non-Emergency Transportation (NET) Co-payment~~

~~Non-Emergency Transportation (NET) is provided as an administrative activity under the State Plan. The State's position is that as an administrative activity, NET co-payment requirements are not subject to 42 CFR 447.53(b), exclusions from cost sharing.~~

~~The Transportation Broker or Transportation Provider will, based on information available to them, make a determination of the client's ability to pay the co-payment. Non-payment of this standard cost-sharing amount may result in denial of the service at the Transportation Broker's or Transportation Provider's discretion. Providers may voluntarily provide transportation to client who cannot pay the co-payment amount, however the State will not reimburse the Transportation Broker or the Transportation Provider any co-payment amounts for which the client is or would have been liable. Further, the Transportation Broker or Transportation Provider have complete discretion as to whether they will pursue any unpaid co-payment amounts from clients who were provided non-emergency transportation but failed to reimburse the Transportation Provider the required co-payment fee at the time of the service. The State will not pursue unpaid co-payment amounts from clients.~~

Pharmacy Services Co-payment

The Pharmacy (Pharmacist) Provider will be advised via the Point-of-Sale System regarding the client's liability for the drug co-payment and the amount of the co-payment. When a client advises a pharmacy of an inability to pay the applicable co-payment amount at the time the prescription is filled, the pharmacy cannot refuse to fill the prescription and must dispense the drug as prescribed.

The client will remain liable for reimbursement of the co-payment amount and will be responsible for paying the pharmacy when financially able. Medicaid will not pay the co-payment amount to the pharmacy where a client declares an inability to pay. Provider payment will continue to be that sum which is the Medicaid fee minus the applicable client co-payment amount.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b) are described below:

Exclusions from cost sharing requirements are programmed into the Medicaid Management Information System and the Point-of-Sale (POS) System.

Providers are informed about applicable service and amount; and, the prohibition of service denial if client is unable to meet the co-pay amount by the following methods: (1) provider manuals, which are distributed to all providers; (2) DMAP website; and (3) provider newsletters.

Co-payment requirements are set forth in provider manuals, which are distributed, to all providers. The billing instructions are updated and transmitted to providers via the Provider Newsletter. These instructions are incorporated in the billing instruction section of the provider manuals, which are given to all providers.

E. Cumulative maximums on charges: See descriptions below:

~~X For Non-Emergency Transportation (NET) Co-payment, the State policy does not provide maximums.~~

X For Pharmacy Services Co-payment, cumulative maximums have been established as described below:

$15.00 cumulative monthly maximum co-payment amount aggregated for pharmacy services. Once a client has met the individual monthly maximum co-payment for his or her prescriptions, the Point of Sale (POS) System will NOT indicate a co-payment is due. Medicaid will keep track of the cumulative number of prescriptions for a client with co-payments. Any prescriptions dispensed after the cumulative maximum monthly co-payment amount is met are not subject to a co-payment. Reversal of a previously filled prescription with a co-payment will require a refund of the co-payment to the individual, and will cause the next prescription filled for that client to be adjudicated with a co-payment.