

**Medicaid Transportation Management Initiative – New York City  
Funding Availability Solicitation (FAS) #1103250338**

**Responses to Written Questions**

- 1. Is the Department of Health seeking a risk-based capitated brokerage model?**

No. The Department of Health is seeking a contractor to perform only the administrative functions related to the management of nonemergency Medicaid transportation listed in the Funding Availability Solicitation. All payments to transportation providers, typically paid by brokers under a risk-based capitated model, will under this contract instead be paid by the Department of Health through its robust claims system.

- 2. Assume in a given month there are 220,000 Medicaid enrollees eligible to receive transportation. Will I be reimbursed for all 220,000 at the amount I list for Volume Level Category C, or will I be reimbursed the first 100,000 at the Volume Level Category A, the next 100,000 at the Volume Level Category B, and the remaining 20,000 at the Volume Level Category C?**

<b>Volume Level Category</b>	<b>Medicaid Enrollees Eligible to Receive Transportation</b>	<b>Per Enrollee, Per Month Cost Bid</b>
A	0 to 100,000	
B	100,001 to 200,000	
C	200,001 to 400,000	
D	400,001 to 1,000,000	
E	1,000,001 and above	

Reimbursement for the entire 220,000 enrollees will be made using only the bid amount listed for Volume Level C.

- 3. What is the timetable for adding the additional four boroughs? Will the additional four boroughs be added incrementally?**

There is no timetable. Implementation of the four remaining boroughs will be incremental, with a schedule agreed upon between the contractor and Department of Health.

- 4. What is the timeline for transitioning Medicaid Managed Care enrollees to the fee-for-service transportation management selected contractor?**

The timeline for transitioning Medicaid Managed Care enrollees to fee-for-service transportation management will be approximately four months after the last borough is implemented.

- 5. In addition to Medicaid, will the Family Health Plus (19 and 20 year olds), Managed Long Term Care, and Medicaid Advantage programs also be moved under Medicaid Fee-for-service?**

The contractor will not be responsible for any transportation of Family Health Plus enrollees (including 19 and 20 year olds), or enrollees of Managed Long Term Care or Medicaid Advantage programs.

- 6. Should bidders provide pricing for the borough of Brooklyn only (Volume Level D) or does the Department of Health wish bidders to propose a Per Member Per Month (PMPM) rate for Volume Level E which would include all boroughs?**

Bidders should provide a PMPM rate for all volume levels in the bid form.

- 7. Since Brooklyn has over 800,000 members and this will be the first borough to go live, what is the need of pricing Volume Level A, B, and C?**

During the first phase of implementation of the Borough of Brooklyn, only those Medicaid enrollees currently fee-for-service will be assumed by the transportation manager—77,835 (source: **Attachment E** of the FAS). This will require a bid for Volume Level A.

- 8. For Brooklyn, Attachment E shows 708,066 MC members + 77,835 FFS for a total of 785,901.**

**Chart 1, page 46 shows 708,066 + 108,138 fee-for-service for a total of 816,204. Since the difference is mostly FFS members with no address, how would they ever access this program and therefore should bidders truly use the lower 785,901 to determine their management cost?**

In Attachment E, Chart 5. The 77,835 FFS count is a subtotal (see column heading). The Grand Total (Column I) is listed at 108,138.

- 9. Attachment E, Chart 1 shows 2,392,246 one-way trips for Brooklyn and 5,759,642 for all boroughs while Chart 4 shows 3,321,169 one-way trips for Brooklyn and 7,031,793 for all boroughs. Can you please explain the differences in these two charts?**

The discrepancy in numbers between Attachment E Chart 1 and Chart 4 is due to the Chart 4 numbers including emergency ambulance transportation, whereas Chart 1 does not.

Emergency transportation is not the responsibility of the transportation manager. Therefore, a revised Chart 4 is below, using the nonemergency trip numbers of Chart 1:

**Chart 4**

**Number of Medicaid Trips by New York City Borough  
With Percent of Total  
Calendar Year 2009**

<b>Borough</b>	<b>One Way Trips</b>	<b>% To Total</b>
BRONX	736,414	12.54%
BROOKLYN	2,392,246	40.75%
MANHATTAN	1,145,401	19.51%
QUEENS	1,118,690	19.06%
STATEN ISLAND	366,891	6.25%
Other--Outside New York City	110,548	1.88%
Grand Total---->	5,870,190	

- 10. Please confirm that the nonemergency one way trips reflected in Chart 1 include all the nonemergency transportation trips currently performed under the managed care organization and Fee-for-service (FFS)?**

**Can you please provide a breakdown of the nonemergency one way trips reflected in Chart 1 separating the trips by fee-for-service versus each individual managed care plan?**

The last column of **Chart 1, Attachment E**, is titled “Fee-for-service Transportation: Responsibility of the Transportation Manager. Nonemergency One Way Trips Ordered by Practitioners/Facilities Located in Borough.” The reflected numbers reflect only fee-for-service transportation; the Department does not have the number of trips provided by managed care organizations.

- 11. The transportation data for nonemergency trips is for 2009. Can this same data be provided for 2010 including nonemergency one way trips ordered by practitioners/facilities by borough, by vehicle type, and unduplicated users?**

The Department of Health does not have this data available at this time.

- 12. What is the ratio of transportation requests made by medical provider, transportation provider, or member?**

The Department of Health does not have this ratio.

- 13. Please define what the bidders should use as the membership figure in proposing their rates for Brooklyn?**
- **Is it the members being transported to a destination address in Brooklyn?**
  - **Is it the entire population listed as Brooklyn, 816,204?**
  - **Is it the entire population listed as Brooklyn without the “no address members”, 785,901?**
  - **Is it a portion of any of these as these facilities are rolled in?**

Upon assuming the Borough of Brooklyn, the contractor will be responsible for the fee-for-service transportation requests made by every medical practitioner/facility within the boundary of Brooklyn. These requests may include Medicaid enrollees residing in boroughs other than Brooklyn.

- 14. On Chart 1, Attachment E, you list the number of “Enrollees Eligible for Fee for Service Transportation” at 256,668. However, New York City continues to move fee-for-service enrollees into managed care plans which include the costs of transportation. Has this number changed?**

The 256,668 number has changed. In the April 2011 managed care report found at [http://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/2011/docs/en04\\_11.pdf](http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2011/docs/en04_11.pdf) (page 8), the number of enrollees now in a Medicaid managed care plan is **2,007,054**. Therefore, the number of “Enrollees Eligible for Fee for Service Transportation” is currently 231,931.

- 15. The Medicaid Redesign Team has recommended that transportation services that are now covered by the managed care plans be removed, with transportation of Medicaid managed care plan enrollees becoming fee-for-service. Does this mean New York City Medicaid managed care enrollee transportation will become the responsibility of the transportation manager?**

Yes. The Department intends to transfer the responsibility of authorizing transportation services from managed care plans to the transportation manager after the transportation manager has successfully implemented all five boroughs of New York City.

As described in the Funding Availability Solicitation, the transportation manager will begin operation in the Borough of Brooklyn for the current cohort of fee-for-service enrollees. Based upon an agreed upon timeline with the Department of Health, the transportation manager will roll out its operations to the remaining four boroughs. At this time it is planned that soon after this implementation is completed, all managed care enrollee transportation will be shifted to the transportation manager, who will then assume responsibility for the current 2,007,054 enrollees now in a managed care plan. However, this is subject to any changes deemed necessary after consultation with the health plans and the transportation manager.

- 16. Does the Department have any statistics on the volume of transportation authorization activity for those Medicaid enrollees currently enrolled in a managed care plan?**

The Department of Health does not have data regarding the volume of transportation authorization activity from the New York City managed care plans. Analysis of data is complicated, as the rates paid to manage care plans include not only the management of enrollee transportation, but also the costs of that transportation.

Historically, the majority of managed care enrollees used public transit for travel purposes; the more disabled population remained in Medicaid fee-for-service. While other modes of transportation have always been required, only as managed care plan enrollment has increased has an increasing need for livery and ambulette transportation been authorized by managed care plans.

**17. Who will be setting the transportation provider fees?**

The New York State Department of Health will set transportation provider reimbursement fees.

**18. Will the State approved fee schedule be made available?**

The fee schedule, as of July 1, 2011, is included below:

Category of Service	Procedure Code	General Description	Modifier	Fee
AMBULANCE	A0422	AMBULANCE (ADVANCED LIFE SUPPORT OR BASIC LIFE SUPPORT) OXYGEN AND OXYGEN SUPPLIES LIFE SUSTAINING SITUATION	-	\$0.00
AMBULANCE	A0425	GROUND MILEAGE PER STATUTE MILE	-	\$1.10
AMBULANCE	A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NONEMERGENCY TRANSPORT, LEVEL 1 (ALS 1)	-	\$186.70
AMBULANCE	A0427	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 (ALS 1 EMERGENCY)	-	\$186.70
AMBULANCE	A0428	AMBULANCE SERVICE, BASIC LIFE SUPPORT, NONEMERGENCY TRANSPORT (BLS)	-	\$139.20
AMBULANCE	A0429	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)	-	\$139.20
AMBULANCE	A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY, (FIXED WING)	-	\$2,842.29

AMBULANCE	A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY, (ROTARY WING)	-	\$513.00
AMBULANCE	A0432	PARAMEDIC INTERCEPT (P1), RURAL AREA, TRANSPORT FURNISHED BY A VOLUNTEER. AMBULANCE COMPANY WHICH IS PROHIBITED BY STATE LAW FROM BILLING THIRD PARTY PAYERS	-	\$0.00
AMBULANCE	A0433	ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)	-	\$186.70
AMBULANCE	A0434	SPECIALTY CARE TRANSPORT (SCT)	-	\$186.70
AMBULANCE	A0435	FIXED WING AIR MILEAGE, PER STATUTE MILE	-	\$8.06
AMBULANCE	A0436	ROTARY WING MILEAGE, PER STATUTE MILE	-	\$38.00
AMBULANCE	A0999	UNLISTED AMBULANCE SERVICE	-	\$0.00
AMBULETTE	A0130	NONEMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN	-	\$29.00
AMBULETTE	A0130	NONEMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN	TN	\$34.70
AMBULETTE	S0209	WHEELCHAIR VAN, MILEAGE, PER MILE	-	\$1.50
AMBULETTE	A0130	WHEELCHAIR VAN, DIALYSIS	AX	\$27.00
AMBULETTE	A0130	WHEELCHAIR VAN, DIALYSIS	SC	\$30.00
AMBULETTE	A0170	TRANSPORTATION ANCILLARY: PARKING FEES, TOLLS, OTHER	CG	\$0.00
AMBULETTE	A0130	NONEMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN	HE	\$10.10
AMBULETTE	A0130	NONEMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN	HC	\$25.00
AMBULETTE	A0130	NONEMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN	CG	\$0.00
TAXI/LIVERY/VAN	A0100	NONEMERGENCY TRANSPORTATION; TAXI	-	\$10.10
TAXI/LIVERY/VAN	A0100	NONEMERGENCY TRANSPORTATION; TAXI	TN	\$16.80
TAXI/LIVERY/VAN	A0110	NONEMERGENCY TRANSPORTATION AND BUS, INTRA OR INTER STATE CARRIER	-	\$11.50
TAXI/LIVERY/VAN	A0110	NONEMERGENCY TRANSPORTATION AND BUS, INTRA OR INTER STATE CARRIER	HE	\$15.00

TAXI/LIVERY/VAN	A0170	TRANSPORTATION ANCILLARY: PARKING FEES, TOLLS, OTHER	CG	\$0.00
TAXI/LIVERY/VAN	A0120	NONEMERGENCY TRANSPORTATION: MINI-BUS, MOUNTAIN AREA TRANSPORTS, OR OTHER TRANSPORTATION SYSTEMS	CG	\$0.00
TAXI/LIVERY/VAN	A0100	NONEMERGENCY TRANSPORTATION; TAXI	CG	\$0.00

- 19. Currently, there is no fee for stretcher van service in New York City. Portions of the state that have stretcher van fees have much higher rates for nonemergency ambulance.**

- a. How will the stretcher van fee be computed?**
- b. Will the nonemergency ambulance fee be raised as a result?**

The stretcher van fee will be negotiated between the Department of Health and the transportation providers willing to deliver necessary stretcher service. It is expected that this fee will be below that which is paid for basic life support ambulance. This will not impact the nonemergency ambulance fee.

- 20. Introduction of Stretcher Transportation. Will this service be expected to begin upon implementation of the contract or will this be a level of service that is phased in following implementation?**

Stretcher transportation will be phased-in following implementation.

- 21. Will the State designate a fee structure for the newly created stretcher van level of service or will the contractor be responsible for developing a new fee structure?**

The contractor is not responsible for development of a fee structure. This function will be handled by the Department of Health.

- 22. Will the manager be able to negotiate fees with the transportation providers?**

The manager will *not* be allowed to negotiate fees with transportation providers, except in the exceptional situation in which the current fees are not applicable to the transportation request. For example, the transportation manager may have to negotiate a fee for the transport of a child to a distant major urban medical center.

- 23. The Funding Availability Solicitation indicates that the transportation provider fees are established locally by NYC and then approved by the Department. Are there any exceptions (special rates) paid to providers that are not incorporated into this schedule? Are there any providers that are paid metered rates which incorporates wait and travel time that may differ from trip to trip?**

There are no provider-specific fees, nor are any fees established at the time of a trip using a meter.

**24. Is the method of payment for commercial air fare fee-for-service?**

Commercial air fare will not be reimbursed fee-for-service; rather, the cost will be determined at the time of reservation, and will be considered a payment to be made to the Medicaid enrollee.

Commercial air travel of a Medicaid enrollee to necessary medical care is a rare event.

**25. Can you confirm that the pricing is to be for administrative services only?**

The bidder's cost proposal should reflect the costs of managing the transportation services described through **Section D**. The transportation manager will not make any payments to transportation providers. The cost of the delivery of transportation incurred by a transportation provider or a Medicaid enrollee is not to be included in the cost proposal, as these transportation costs are reimbursed through other mechanisms described in this solicitation.

**26. Are there any limits on the number of one-way trips that eligible enrollees can take on a single date of service?**

There are no limits on the number of one-way trips a Medicaid enrollee can be authorized to take on a single date of service.

**27. Is out-of-state transportation covered?**

Out-of-state transportation for medical services is covered by the New York State Medicaid program when necessary.

**28. Will the State please provide a list of Medicaid covered services?**

Below is a comprehensive, though not exclusive, list of covered medical services to which a Medicaid enrollee can travel to:

- Inpatient and outpatient hospital services;
- Physician services;
- Medical and surgical dental services;
- Nursing facility services;
- Family planning services;
- Rural health clinic services;
- Laboratory and X-ray services;
- Nurse practitioner services;
- Federally qualified health center services;
- Midwife services;
- Free-standing clinic services;
- Intermediate care facility services for the developmentally disabled;

- Optometrist services and eyeglasses;
- Drugs;
- Physical, speech and occupational therapies;
- Prosthetic devices and orthotic appliances;
- Dental services;
- Audiology and hearing aids;
- Clinical psychologist services;
- Diagnosis, screening, preventive and rehabilitative services;
- Hospice;
- Inpatient psychiatric facility services for individuals under age 21 or over age 65.

**29. Does "subcontractor" include transportation providers?**

No. As this is not a risk-based, capitated brokerage model, a transportation provider may not be a subcontractor of the transportation manager. In fact, Department of Health regulation at 18 NYCRR Section 504.1(d)(7) states that "The Medicaid Program's enrollment of a provider, and that provider's acceptance of the conditions of Medicaid participation, is considered a binding agreement." Therefore, acceptance of the provider by the Department of Health is considered a contract and is the only agreement necessary for participation.

**30. Can we place materials and plans referenced in the solicitation response in an appendix section or as an attachment? Can the bidder include attachments in the proposal and if so are they outside of the page count limitations? For example, a Microsoft Project Work Plan?**

Yes. The bidder can include attachments or appendices to the proposal, which will not be counted toward the specified page count limitations.

**31. Can the letters of commitment from the transportation providers be included in an appendix as they will take up all the available page count for the section?**

This solicitation requires no letters of commitment from any transportation provider.

**32. For the references, do you want actual letters of reference or just the names and contact information? If you want the actual references letters, can they be placed in an appendix so as not to count against the page count?**

For references, the Department of Health seeks only the name, title, postal and email address, and telephone number of the reference contact person. Letters of reference should not be submitted.

**33. Would the Department allow alternative pricing models such as an Administrative percent (off the transportation cost)?**

The Department of Health will not consider alternative pricing models to determine the fee to be paid to the contractor.

**34. Is there a page limit to the Executive Summary?**

There is no page limit to the Executive Summary.

**35. Are all members of the core management team expected to be permanently located in the NYC area?**

Members of the core management team do not have to be permanently located in the NYC area. As stated in section C.1. of the FAS, "The contractor shall identify the proposed general location of this team, and explain how this location will allow the management team access to New York City in order to fulfill the requirements of the FAS."

**36. D.4.4.4. Additional Solicited Activities (5 pages), on page 41, the items covered under this bullet generally require fairly detailed explanations, will the DOH consider increasing the page limit to 10 pages?**

The page limit for section D.4.4.4. Additional Solicited Activities will remain 5.

**37. D.4. Technical Proposal and D.4.4. Performance Criteria, both state "The technical proposal should address all of the Project Specifications"; however, not all sections in the Project Specification section are itemized in the requested response sections. Further, given the page limits, it will be difficult to fit an itemized listing of a response to each Project Specification into the technical proposal. How should this be handled by the vendors?**

Bidders are not asked to respond to Section C, **Project Specifications**. Bidders should respond to the request for information listed in Section D, **Proposal Requirements**. Further, this response should be no more than the number of allowed pages.

**38. A transportation provider cannot submit a bid. However, can a company that has ownership in a transportation provider (but is a separate company) submit a bid?**

If the bidder has ownership in a transportation company, and this transportation company delivers Medicaid transportation in NYC, this bidder's proposal will not be considered. If this transportation company delivers no Medicaid transportation in NYC, this bidder's proposal will be considered.

**39. E.3. Submission of Proposals, page 49, first paragraph in this section, please clarify if one (1) electronic copy is required or eight (8) electronic copies are required for both the technical and cost proposals.**

One electronic copy is required for both the technical and cost proposal.

**40. E.16. M/WBE Utilization Plan for Subcontracting and Purchasing, page 59. Considering the contractor will have no preference over transportation providers (and will not be paying them) and given the low level of opportunity**

**for M/WBE participation in purchasing services for this administrative contract (the highest cost factors will be employees and rent), please describe how the goal of 20% can be met.**

Bidders may consider the subcontracting of any services, including janitorial, printing, mailing, office supplies, etc., when developing their M/WBE Utilization Plans.

- 41. E.16. M/WBE Utilization Plan for Subcontracting and Purchasing, page 59. Please describe how this section will be scored.**

The M/WBE Utilization Plan will not be scored. Rather, it will be reviewed for compliance only. Non-compliance may result in disqualification of a bidder's proposal.

- 42. Is it correct that at the time the proposal is submitted, that only the M/WBE Utilization Plan form is submitted? How long after the bid is awarded are the remaining M/WBE forms submitted?**

It is correct that at the time of proposal submission only the M/WBE Utilization Plan form is to be submitted. The remaining forms will be submitted during the contract development period. A contract cannot be executed without the submission of required forms.

- 43. Since the Agency is responsible for paying the transportation providers, is it correct to assume that the M/WBE utilization plan refers to the administrative services that could be subcontracted out (such as agency fees, maintenance, office supplies, cleaning ,etc.)?**

Yes, that is correct.

- 44. Are M/WBE-certified transportation providers considered subcontractors?**

No. Unlike under at-risk brokerage models, transportation managers cannot subcontract with transportation providers.

- 45. State Consultant Services Reporting. Are the "State Consultant Services Form A" and "State Consultant Services Form B" required to be submitted with the proposal, or only submitted by the winning bidder following the actual bid award?**

These forms are only to be submitted by the winning bidder(s).

- 46. We are asked to list all of our current governmental contracts with associated contact information. This list is extensive. Can we list them in an Appendix so that listing doesn't go against our page count?**

The list of current government contracts, with the name, title, postal and email address, and telephone number of the government contact person can be placed in an appendix, and will not be charged against the page number limit.

- 47. As part of a publicly traded company we will be providing audited and unaudited financial statements for three years and a narrative crosswalk to explain to fulfill this requirement. All of this can be provided in a binder or electronically on a CD. Is it acceptable to provide this information on the “Company’s Financial Capacity and Stability” on a CD as it will fill a binder all by itself?**

Unaudited financial statements are only required when audited statements are not available. Information on the “Company’s Financial Capacity and Stability” should be submitted with the required number of copies as outlined in the FAS.

- 48. Will the successful bidder be expected to mail an introductory letter prior to transportation services beginning? If yes, will the mailing to Medicaid eligibles be sent to all Medicaid eligibles or only the current users of transportation services, and how often will these mailing be expected to occur?**

No. The contractor will not be expected to mail an “introductory letter” to Medicaid recipients, transportation providers, or medical practitioners.

However, letters of instructions and information pertinent to the efficient operation of the call center and prior authorization process may be mailed by the contractor to transportation providers or medical practitioners, as part of the contractor’s work plan, to be determined solely by the contractor. Further, ongoing mail may be required to be sent to individual Medicaid eligibles, transportation providers or medical practitioners as part of the prior authorization process. In all communications, the Department encourages maximum use of electronic mail.

- 49. Can a bid be submitted to manage one or some of the NYC boroughs?**

No. While the Department of Health has the option to award a contract to more than one bidder, bidders must submit a proposal to manage all of NYC.

- 50. Please indicate approximate date of award announcement for FAS New York State Medicaid Transportation Management Initiative – New York City.**

The date of award announcement has not been established at this time.

- 51. Can you elaborate on the process used to evaluate the proposals? Will a formal numerical-based system be used? What comparative weights will be given to the Technical Proposal and the Cost Proposal in evaluating each proposal?**

The Department of Health will evaluate the technical and cost proposals. The Department will not be disclosing any evaluation criteria at this time.

- 52. Please provide utilization data for each of the five (5) boroughs in New York City (Bronx, Brooklyn, Manhattan, Queens, Staten Island) separately or combined for the last six (6) months for the following:**

- **Average monthly call volume during normal business hours**
- **Average monthly call volume after normal business hours**

The Department of Health does not have any call volume data.

- 53. Can you provide the one-way trips in Chart 1 broken out by either Current Procedural Terminology (CPT) Code and or Levels of Service (ambulette, livery, etc.)?**

The number of one way trips by mode of transportation is given in **Chart 2, Attachment E**. Quantification of this data by CPT code is not available.

- 54. What is the percentage of livery and ambulette trips that are within the Common Medical Marketing Area (CMMA) and outside CMMA? For outside CMMA, how many are trips within city limits and outside?**

During Calendar Year 2009, the percentage of ambulette trips inside the CMMA to the trips outside the CMMA is 64% to 36%; the percentage of livery trips inside the CMMA to the trips outside the CMMA is 61% to 39%.

The Department of Health does not have data on the percentage of trips inside and outside the NYC limits.

- 55. If available, please provide current NYC Medicaid Prior Authorization call center statistics, including total incoming calls, calls answered by staff, and abandoned calls, for 2009 and 2010. If not available for a full year, please provide daily call center statistics for a recent month(s).**

The Department of Health does not have this information.

- 56. The information provided on Pages 99-102 contains enrollee data for November 2010 and trip data for CY 2009. Since these do not correlate precisely, can you also provide enrollee data for November 2009 and trip data for CY 2010?**

The enrollee information for November 2010 is the most accurate information to be used for analysis purposes; 2009 enrollee data is out-of-date and may unintentionally mislead potential bidders.

The Department does not have extensive, validated CY 2010 trip data at this time.

- 57. Please provide the total volume of regularly reoccurring trips by month by borough. What is your present trip reservation process for regularly reoccurring trips?**

The Department of Health does not have this information.

- 58. Will the State consider giving the Contractor a recurring data file of all eligible transportation providers so the Contractor can import the data into their information system?**

The Department of Health will provide a data file of all eligible transportation providers to the contractor.

- 59. Will a listing be provided detailing the Medical Practitioners and Transportation Providers in Brooklyn (Kings County) so that formal notification can be sent?**

The Department of Health will provide a data file of all medical practitioners and transportation providers to the contractor.

- 60. Will the vendor receive an eligibility file that identifies Department of Social Services or HRA's Enrollees or will the Contractor be required to use ePACES?**

The Department of Health will provide a data file of all Medicaid enrollees to the contractor.

- 61. Will the Medicaid enrollees who reside in New York City that have been determined by New York State Department of Health, the Office of Persons with Developmental Disabilities, or the Office of Mental Health be included in the eligibility file given to the Contractor?**

The data file of Medicaid enrollees will include those enrollees whose eligibility is determined by the NYC Human Resources Administration, the NYS Department of Health, the NYS Office of Persons with Developmental Disabilities, or the NYS Office of Mental Health.

- 62. With what frequency will the Department of Social Services or HRA update the eligibility status of Enrollees, i.e., daily, weekly, monthly, beginning of month?**

Medicaid enrollee eligibility is updated daily.

- 63. Please explain how the Public Transportation Automated Reimbursement (PTAR) system confirms Enrollees' eligibility status.**

PTAR is an electronic system that accesses and confirms enrollee eligibility at the time the request for reimbursement is made.

- 64. How are public transportation requests made by and reimbursed to members (public transportation not through PTAR)?**

Currently, public transportation is only reimbursed via the PTAR system. Under this contract, the reimbursement of transit costs to enrollees traveling to PTAR-participating facilities will remain the same; i.e., the facility will directly reimburse the enrollee.

For reimbursement of transit costs to enrollees traveling to facilities/practitioners not participating in PTAR, the contractor will need to reimburse the enrollee directly, and seek reimbursement of this payment from HRA.

**65. Can a list of the facilities using the PTAR system be provided?**

The list of facilities participating in the PTAR system will be provided to the contractor.

**66. Will the contractor be responsible for authorizing trips for enrollees who use the PTAR system?**

The contractor will not be responsible for authorizing trips for enrollees who use the PTAR system. However, the contractor will be expected to provide guidance and education to PTAR participating facilities, and increase facility adherence to public transportation reimbursement policy. Further the contractor is expected to expand the use of PTAR among new facilities.

**67. If a medical practitioner provides reimbursement for the cost of public transportation to a Medicaid enrollee, how does the practitioner get reimbursed?**

The practitioner is reimbursed directly from the NYC Human Resources Administration, on a periodic basis determined by the practitioner, for the total amount approved for reimbursement through PTAR since the last reimbursement.

**68. What is the breakdown of Public Transportation volume?**

The Department of Health does not have this data.

**69. Will the Contractor be responsible for the distribution of Metrocard?**

The Department of Health does not anticipate that the contractor will be responsible for the distribution of any Metrocards.

**70. For public transit trips where Metrocards are currently being supplied by the medical facilities and reimbursed by HRA through PTAR, is the medical facility required to contact the contractor for authorization?**

For public transit trips where Metrocards are currently being supplied by the medical facilities and reimbursed by HRA through PTAR, the medical facility is not required to contact the contractor for authorization. The contractor's role is to expand the network of PTAR-participating facilities.

An enrollee may request transportation through the call center, and be qualified for public transit. At this point, the enrollee will be instructed how to receive reimbursement through the PTAR-participating practitioner. If the enrollee's medical practitioner is not participating in PTAR, the contractor will need to reimburse the enrollee directly, and seek reimbursement of this payment from HRA.

**71. Please define what is considered “urgent care”. Please provide utilization data for urgent care trips for all five (5) boroughs.**

Section F.21. of the Funding Availability Solicitation defines Urgent Care:

*“Urgent care means that level of care ordered and verified by the individual’s physician (online, by phone or fax) to be necessary on the day the request is made. Examples include, but are not limited to, high temperature, persistent rash, vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services. Urgent care is generally determined by the enrollee’s medical care provider, but not necessary.*

*An appointment shall be considered urgent if the medical service provider grants an appointment within forty-eight (48) hours of the enrollee’s request.*

*A hospital discharge shall be considered an Urgent Trip.”*

The Department of Health has no data on urgent care trips.

**72. Describe Department of Social Services/HRA’s present education program for Medical Facilities and Enrollees.**

The NYC Human Resources Administration provides onsite education, as well as written policy guidance.

**73. Please provide a description of the automated web based system which manages trip reservations.**

Section C.3.3.k. of the Funding Availability Solicitation (FAS) requires the contractor to “Develop and implement an automated web-based system to manage reservations, scheduling and routing of requests for nonemergency medical transportation.” The description of this system must be provided by the bidder in the response to this FAS.

**74. Must all of the Contractor’s information systems be web-based and no modules or portions of the system can be based on client-server or other technologies?**

The Department of Health seeks the use of web-based systems where such a system is feasible and informative, furthering the requirements of the Funding Availability Solicitation. Other systems that achieve these requirements can be used.

**75. Describe present system, if applicable, wherein Medical Facilities request trip reservations via a web-based system.**

Currently, medical facilities do not request trip reservations via a web-based system. Such a system will be new, to be developed and implemented by the contractor.

- 76. Creating and Maintaining a Public Website. Some of the information requested on the public website appears to be information that would not be made available to the general public, but more properly reserved for the Department to review. Can that website provide a link to a secure portal that only properly authorized individuals can access through secured login and password protection?**

The intent of the website is for public information. Any information that should be confidential shall be accessed via password-protected portal, or not included on the website.

- 77. Describe how you presently manage modal justification forms with Medical Facilities.**

Currently, mode of transportation justification forms are kept in the patient record at the medical facility; the Department does not have a repository of these forms.

- 78. Is it the responsibility of the practitioner/facility or the contractor to determine the mode of transportation?**

It is the responsibility of the practitioner/facility to describe the level of an enrollee's disability or medical need during transport, if any. It is the contractor's responsibility to seek enough information from a medical practitioner/facility in order to determine the appropriate mode of transportation.

- 79. The FAS indicates that "when the need for transport is for a mode other than public, the medical practitioner contacts a Medicaid participating transportation provider..."**

**Since often the healthcare professional requesting transportation may reach out to a transportation provider simply on availability without consideration of cost or actual mobility assistance required, would the agency want the contractor to prior authorize medical transportation requests from facilities and review for appropriateness?**

The Department does require the contractor to authorize the appropriate mode of transportation, and assign that trip to an available transportation provider.

- 80. How is the contractor expected to work with a medical facility's "electronic modal justification system" that they have in place already?**

The contractor may not be able to accommodate every facility's electronic modal justification system. However, the Department does expect the contractor to interface with those systems, where possible, to increase the efficiency of the authorization process and ultimately eliminate the use of paper and the need for data entry.

- 81. Does your current system document whether there is a documented Prior Approval form in your MMIS system prior to paying 100% of the transportation provider's trip?**

The current authorization system does not require any medical justification in the MMIS system prior to reimbursing the transportation provider's claim. The primary system requirement is that a valid prior authorization is in the system prior to the claim being paid.

**82. Will medical practitioners be charged with ensuring prior authorization of transportation services for enrollees?**

Medical practitioners will be required to request, but not ensure, authorization for livery, ambulette, and nonemergency ambulance transportation.

**83. The Funding Availability Solicitation (FAS) states, authorized staff of clinics, hospitals, nursing homes and other programs are permitted to order transportation on behalf of practitioners; however, evidence of the need for such transportation should be documented. What is considered to be evidence such that it satisfies the requirements of the FAS? Who provides the evidence?**

It is the responsibility of the practitioner/facility, or designated staff of that practitioner/facility, to describe in a manner to be determined by the contractor (in consultation with the Department of Health), the level of an enrollee's disability or medical need during transport, if any. It is the contractor's responsibility to seek enough information from a medical practitioner/facility in order to determine the appropriate mode of transportation.

**84. A contractor requirement (pg.9) is outlined as, "creating and maintaining a public website for purposes of educating enrollees, etc." Will there be any requirement that this website will be available in any language other than English?**

Currently, there is no requirement that the website be available in any language other than English. However, as many Medicaid enrollees speak various languages, the contractor should be ready to expand the website to pages in other languages. This expansion will be discussed between the Department of Health and the contractor.

**85. Can a list of the most prevalent languages spoken by the Medicaid members be provided?**

At the website [http://www.baruch.cuny.edu/nycdata/chapter01\\_files/sheet011.htm](http://www.baruch.cuny.edu/nycdata/chapter01_files/sheet011.htm) Baruch College lists the known languages spoken in NYC, taken from 2000 Census data. The site indicates the most prevalent languages are English, Spanish, Russian, and Chinese.

**86. Under what circumstances can an enrollee call to arrange for his or her own transportation? If so, would the borough of origination for the request be where the enrollee lives or where her practitioner practices (assuming they are different)?**

An enrollee can call to arrange his/her own transportation. If it is for a mode other than public, the recommendation of a medical practitioner is required. At that time, if the destination facility is in a borough already implemented by the contractor, the authorization of the trip is the responsibility of the contractor. If the destination facility is in a borough not yet implemented by the contractor, the authorization of the trip is not the responsibility of the contractor. In both instances, the enrollee would be directed to contact the practitioner to express the need for transportation to the medical appointment.

- 87. Page 4 of the FAS states, “Currently in New York City, the Department relies on medical practitioners to coordinate the transportation needs of their Medicaid patients, and order trips using a paper prior authorization process established in the 1980’s.” Is there a central dispatching function within the Department that manages trip requests? If so, can you describe its structure and operations? How do you currently gain confirmation that the transportation requests have been appropriately fulfilled? Is signature collection to confirm completion of a trip currently in place under the present program? Will vendors be required to collect signatures and send to the contractor under the new program?**

The authorization of transportation is currently done under contract with the Department of Health’s Medicaid fiscal intermediary, Computer Sciences Corporation (CSC).

CSC uses two methods to receive requests: the primary avenue is scanning written requests, with low volume orders placed via a call center. The Department does not verify that a trip has been completed as part of the claims process, nor does the Department require the signature of the enrollee at the time of the trip.

The Department will not allow the contractor to require the transportation provider to secure the enrollee signature and submit that signature to the contractor.

- 88. Does an enrollee need a “primary care” practitioner to schedule all his or her trips? Or can any of the enrollee’s practitioners make trip requests on the enrollee’s behalf?**

Most enrollees do not need a primary care practitioner to schedule all his or her trips; in fact, any practitioner can request a trip, or coordinate all the enrollee’s transportation needs, regardless of destination of those trips.

Some enrollees are part of the Restricted Recipient Program, wherein a primary care practitioner (i.e., physician, clinic) has agreed to oversee all of their care. When applicable, the restricted practitioner’s Medicaid identification information must be provided on correlating prior authorizations.

- 89. If a practitioner from one borough requests a trip to a practitioner outside the enrollee’s common medical marketing area (CMMA), what responsibility does the contractor have for reviewing the request to see if the medical service might be available from another provider within the enrollee’s CMMA?**

It is the responsibility of the contractor to review requests for travel outside the CMMA for reasonableness, such as specialty care. When the request is unclear, it is the responsibility of the contractor to seek additional information from the ordering practitioner to ensure that such long distance travel is necessary.

**90. Regarding use of public transportation: Is there a transfer limit that an enrollee should be expected to make beyond which the use of a livery car would be recommended?**

There is no transfer limit. However, when the public transit routing is such that it appears unreasonable to expect the general population from using public transit, then livery transportation can be considered.

**91. Page 21 states that a public website should include “Information on utilization review of requests for transportation.” Can you elaborate on the level of detail you envision for that information?**

The Department believes this information will be very similar to that requested in the next bullet, “Information on transportation service determination criteria.” Website information should detail the criteria used to determine the appropriate mode; there is no need for “utilization review.”

**92. Can you clarify the statement “The contractor may not arbitrarily take an action on nonemergency transportation services solely because of the diagnosis, type of illness, or condition of the enrollee” on Page 27? Are you referring solely to an action taken in the complaint resolution process?**

Section C.3.5. states in part,

*“The contractor shall provide written notification to the enrollee at the time an adverse action is taken to deny or reduce a transportation service. The notice must indicate:*

- *the action taken and reasons for the action;*
- *the enrollee’s right to file a grievance and request a State Fair Hearing; and*
- *basic instructions regarding the grievance filing and State Fair Hearing request processes.*

*The contractor shall review all actions for appropriateness and provide prior verbal notification of the action in addition to written notification. The contractor may not arbitrarily take an action on nonemergency transportation services solely because of the diagnosis, type of illness, or condition of the enrollee.”*

The instruction that “The contractor may not arbitrarily take an action on nonemergency transportation services solely because of the diagnosis, type of illness, or condition of the enrollee” is to be followed with all requests, and also as a reminder when responding to a request to explain an adverse action. Essentially, the required mode of transport is determined primarily by one’s level of disability,

either permanent or temporary. A medical diagnosis usually does not dictate a particular mode of transportation must ensue.

**93. Can a transportation vendor refuse a trip it otherwise would be able to accommodate for being too long or inconvenient?**

NYS Medicaid program policy does not allow a transportation provider to refuse a trip due to its length or inconvenience. These travel situations were considered during the development of the current fee schedule.

**94. The timeframes cited on Page 29 for pick-up and drop-off seem somewhat restrictive and point to why many livery cars may be reluctant to participate in the program. Is the Department at all receptive to extending the timeframes cited in the Funding Availability Solicitation (FAS) regarding early pick-up and drop-off? Can it be done like in other counties of New York or other states with a hour or at least a half hour window between pick up time and appointment time?**

Section C.4. of the FAS lists expected pick up and drop off times. While some NYC traffic situations will lead to unavoidable delays, the Department believes these times are appropriate, and at this time will not consider changing these times.

**95. Page 28 states “For unscheduled pick up times, the transportation provider shall pick up the participant within sixty minutes of notification.”**

**Page 26 states “Approve appropriate transportation for hospital discharges (acute or psychiatric) when such requests are made by hospital clinicians (e.g. social workers, discharge planners, nurses, doctors, etc). The contractor shall contact an appropriate nonemergency medical transportation provider so that pick-up occurs within three hours of notification.”**

**Can you clarify the distinction between the two?**

The information on page 28, “...sixty minutes...” is inconsistent with the information on page 26, and is incorrect.

These two situations both reflect requests for same day transportation. Therefore, the expected pickup time for urgent care, same day transport requests is “...within three hours of notification,” as stated on page 26.

**96. Page 39 asks: “Describe your flexibility with the 72 hour threshold.” Does this imply that the Department would be receptive to a proposal of a shorter threshold, e.g.: 48 hours?**

Section D.4.4.2 of the Funding Availability Solicitation states, “Describe how you will implement the requirement that all Medicaid enrollees in need of transportation for nonemergency or non-urgent medical care, or their representatives or medical practitioners, request such services a minimum of 72 hours in advance. Describe your flexibility with the 72 hour threshold. Describe how you will allow for post-

transportation approval of transportation services, when circumstances did not allow for the 72 hour notice.”

The Department is receptive to a proposal with a shorter threshold. The request for flexibility is that, due to the volume of medical activity in NYC, there will be numerous times in which the 72 hour threshold is missed. Any effort to accommodate orderers of transportation which allows for exceptions will enhance the effectiveness and efficiency of medical care.

**97. Can you list all circumstances when an enrollee is allowed additional expenses as described on Page 27?**

Section C.3.4. of the Funding Availability Solicitation describes the need to consider special transportation requests. When travel spans an overnight, the enrollee is allowed reimbursement for the travel costs of persons needed as an attendant, lodging, food, and out of town travel expenses such as travel between a hotel and the medical site.

**98. Can you provide criteria for determining when air transportation would be indicated in place of automotive?**

Air transportation should be considered when the enrollee is unable to drive a sedan vehicle, the distance is reasonably too far for a person driving a sedan vehicle, or the cost of air travel is less than the cost of travel via a sedan vehicle.

**99. How will contracts and agreements that currently exist between transportation providers and health care facilities be handled?**

Contracts and agreements that currently exist between transportation providers and health care facilities are not binding on the authorization and assignment of trips. Existing contracts and agreements will be reviewed by the Department to determine their appropriateness under this FAS.

**100. How will trips be distributed among transportation providers?**

Ordering practitioners/facilities will be asked what transportation providers are generally used in that neighborhood. When there is no preferred transportation provider, the contractor shall consider the grouping of rides and the assignment of rides on a rotational basis among all participating providers in that neighborhood.

**101. What are the average distances of trips by livery and ambulette for both within the CMMA and outside of the CMMA?**

The Department does not have this information.

**102. The Funding Availability Solicitation (pg.8) states that the transportation manager will manage, “the appropriate level of transportation based on patient need.” It also states on pg 25 (Section C.3.3.6. f.) that, “Once the completed form is received by the contractor’s staff, the information on the form shall be expeditiously reviewed and the request for prior authorization**

**for nonemergency transportation will be approved or denied based upon the NYS Medicaid program criteria.” Section C.3.5 further outlines how the contractor will have to approve or deny transportation requests based on information gathered from all sources and also establish a quality review system.**

- a. Will there be clinical expertise readily available in the management company to assess the appropriate level of transportation based on medical need?**
- b. In addition, in cases of claim denials, will there be clinical expertise available within the management company available to resolve the difference without resorting to a State Fair Hearing?**

The Department does not believe that clinical (medical) expertise will be needed in this authorization process. The need for a certain mode should be clearly indicated, using terms such as wheelchair user, stretcher transport with no medical car required, ambulatory. There is no need to synthesize a medical diagnosis in order to determine the mode of transport. If clinical expertise is required, the ordering practitioner can supply this expertise and make a sensible request during the authorization process.

A request for a Fair Hearing will not be honored in cases of a claim denial. A Fair Hearing is an enrollee right, and is used when the enrollee believes that their request for transportation is not being honored. There will be no need for clinical expertise during the hearing; the contractor should resort to the documentation used in reaching the decision on the transportation request.

- 103. There are many references throughout the Funding Availability Solicitation where the contractor is asked to document the work they have done that is similar in “size and scope” to what will be required in NYC. How will the contractor demonstrate their experience/ability to deal with the diverse cultural and language differences that will occur with Medicaid enrollees, medical providers and transportation vendors? Clearly, Brooklyn isn’t Kansas yet the State isn’t requiring that the call center be located in NYC or even New York State.**

In Section A, **Introduction**, the FAS states, “The statute requires that the transportation manager or managers selected by the Commissioner must have **“proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York State”** within which the contractor would manage such services.”

The Department is aware that this procurement seeks a transportation manager of a very large and unique urban setting, encompassing a significant number of covered lives whose size is not comparable to other procurements.

The Department seeks a contractor which has experience managing a large, diverse urban city with different languages spoken. This FAS asks bidders to

demonstrate that past transportation management experience does qualify the bidder to manage NYC.

**104. If the State decides to select more than one contractor, how will they decide how the boroughs or specific responsibilities will be divided?**

At this time, the Department is considering only one contractor. At this time, the Department has not determined how the boroughs will be split or specific responsibilities will be divided, if a second contractor is selected that will split NYC.

**105. Why has the Department of Health decided to not hold a bidders conference?**

A bidders' conference is not required by the FAS process. Due to the Department's desire to contract with a transportation manager as quickly as possible, the Department chose not to hold a bidders' conference.

**106. The Hudson Valley FAS indicated county participation was voluntary; do boroughs have the same right to opt out if desired?**

No. The Human Resources Administration is the agency responsible for administering the Medicaid transportation program in New York City. No borough makes the decision to opt into this initiative and therefore, will not have the option to opt out.

**107. What are the current strengths of the transportation system in NYC?**

New York City is home to a robust public transit system not available elsewhere in New York State. Additionally, there are generally multiple providers available to perform neighborhood-based trips.

**108. What are the current weaknesses of the NYC Medicaid transportation system not specifically mentioned in the Funding Availability Solicitation?**

The challenges pertinent to the Medicaid transportation program in NYC are listed in the FAS; at this time, there are no other pertinent challenges of which the Department is aware.

**109. If the revised PA option is used to fix a problem with the initial request, does the initial request still count as an error?**

Section C.12. of the FAS lists several prior authorization performance standard penalties:

- The wrong transportation procedure code was assigned;
- The wrong dollar amount for the applicable procedure code was assigned;
- The wrong number of procedure code units was assigned for the transport;
- The calculation of miles assigned for a trip was wrong, as determined by a generally accepted standard of mileage determination, as agreed upon by the Department and the contractor;

- More than one prior authorization containing the same information is requested;
- A prior authorization for the same transport was requested for at least two different transportation providers; and,
- The submission for a prior authorization was made over thirty days from the date of service.

If any of these errors in prior authorization activity occur, they will count as an error, even when the error is subsequently fixed with a revised prior authorization.

**110. Page 54 – Prior Authorization Activity Penalty – Why are prior authorization requests made over 30 days from the date of service considered improper?**

**“The submission for a prior authorization was made over thirty days from the date of service.” This is listed as an error, but at times there are external factor that delay the PA process, such as ‘restricted clients’. In these cases are they still counted as an error?**

As designed, the contractor should have knowledge of the trip prior to the trip occurring, unless the trip is an urgent situation which occurs on an evening or weekend or a holiday. We expect the contractor to be able to reasonably complete the authorization process, by submitting a request for the authorization to eMedNY, within 30 days of the date of service.

The Department will not count as an error submissions over 30 days from the date of service when the authorization submission is not possible due to technical eMedNY system restraints.

**111. C.12. Assessment of Financial Penalty Regarding Contractor Performance of Call Center and Prior Approval Requirements, on page 31, in relation to the penalties assessed for the call center standards that are listed, is a monthly average going to be utilized?**

The Department will have an actual count of the authorization errors for those authorizations submitted on any day during the month under review, and will compare this number to the total submissions. The Department will not use a monthly average. The contractor will be given a copy of this report, prior to the assessment of any penalty.

**112. Do rejected PA requests count as errors when re-submitted?**

Rejected prior authorization submissions will count towards the penalty, if any of the performance standards listed in Section C.12. have been violated.

**113. If a PA was requested with incorrect information and then Cancelled, does this still count as an error?**

Every submitted prior authorization shall meet the expected performance standards, even those authorization submissions which are subsequently cancelled.

**114. For transportation providers that may experience trouble with ePACES, are there any other approved 3<sup>rd</sup> party methods for billing?**

Yes, there are other approved methods of billing for transportation services. ePACES is one of several avenues transportation providers can use when submitting a claim for service to eMedNY.

**115. What have been the most common types of fraud uncovered in the NYC Nonemergency Transportation system?**

Two common types of fraud are submission of a transportation claim when the trip did not occur, or the level of transportation service authorized was not actually rendered.

**116. Is Nonemergency Medicaid Transportation in NYC coordinated with any other social services transportation program?**

No. Nonemergency Medicaid transportation in NYC is a stand-alone social service transportation program.

**117. Based solely on the “Introduction” & “Background” information provided; it does not appear that there is an entity providing same “or” similar services currently for this population. Is there currently an entity providing same “or” similar services?**

We believe this Funding Availability Solicitation seeks a manager who will strategically intervene in underdeveloped areas. This is obviously very different from typical requests for proposals, wherein a State seeks a nonemergency transportation broker. However, some of the aspects of this FAS are similar to what would be sought under a brokerage (i.e., generating prior authorization).

**118. Section A, Introduction, Page 3; paragraph 4 states: “Access to health care for Medicaid enrollees requires both ensuring access to an appropriate number of and types of medical practitioners, and the necessary mode of transportation to the services the practitioners provide.” Would the contractor be required to recruit medical practitioners?**

No, the contractor is not required to recruit medical practitioners to participate in the Medicaid program. However, if the contractor finds there is a need for a particular medical service in a particular area, that information should be submitted to the Department for consideration.

**119. Section B.1, Current New York City Medicaid Transportation system, Page 12, first paragraph states: “Reimbursement is also not available for use of a personal vehicle.” Is the ownership of a personal vehicle or living within a**

**residence that has access to a personal vehicle reason for not authorizing a transport?**

Typically, most residents of New York City do not own a personal vehicle, making this issue moot. However, if a person does own a vehicle, the contractor is required to assess the most medically appropriate cost efficient mode of transportation to the necessary medical service. Therefore, having access to a personal vehicle in New York City is not a reason for denying Medicaid transportation, but this will have to be considered on a case-by-case basis should the contractor uncover such a circumstance.

**120. Is there a mileage reimbursement policy?**

New York City enrollees using a personal vehicle for travel to medical care outside New York City shall be reimbursed at the Internal Revenue Service amount of \$.51 per mile. Enrollees will not be reimbursed for personal vehicle use for medical travel within NYC; rather, these enrollees should use mass transit.

At this time, no Medicaid enrollee is being reimbursed for the use of a personal vehicle.

**121. Section B.3.2., Facility/Provider Contracts with Transportation Providers, Page 14: Is there ever a case where the facility is financially responsible for the transport of Medicaid enrollees?**

When a Medicaid enrollee is in a hospital as an inpatient, and the enrollee must travel to another facility for treatment and then returned to the hospital, the hospital is responsible for the costs of that transport between the hospital and the medical facility.

**122. Section B.3.2., Facility/Provider Contracts with Transportation Providers, Page 15, first full paragraph on the page: What “control” challenges have been realized by managed care with this arrangement?**

We cannot speak to challenges realized by managed care organizations.

**123. Section A, Introduction, on page 3, paragraph 5, it states that expenditures for transportation services in New York City are projected to be \$275 million. Is this inclusive of both nonemergency and emergency transportation?**

**If yes, to the above question, what is the projected nonemergency expenditures for State Fiscal Year 2010-2011?**

The cited expenditure projection includes emergency ambulance transportation, approximately \$13 million. The projected expenditures for fee-for-service nonemergency transportation are \$262 million.

**124. B.2.2. Guidelines for Ordering Ambulette Transportation, on page 12, second paragraph, please provide more detail on what is expected from the contractors in regards to the sentence that the contractor is to “develop”**

**stretcher transportation as a mode of transport and as a requirement of this solicitation.**

Currently, when a Medicaid enrollee must be transported in a recumbent position to necessary medical care, ambulance transportation is used. However, many of these enrollees require no medical care enroute; their only need is to be lying down.

In some areas of upstate New York, non-ambulance vans are configured to transport an enrollee on a stretcher. When used, these vans successfully deliver the enrollee to the medical site, at a more efficient cost to the Medicaid program.

The contractor will be expected to find non-ambulance transportation providers willing to configure a van to stretcher-carrying capability, in order to meet this need for recumbent transports.

**125. B.2. Transportation Ordering Guidelines, on page 12, second bullet, which takes priority, the least costly mode of transport or the client choice of provider?**

First, the appropriate mode of transport is determined. Second, enrollee choice of provider within that mode of transport must be honored. Third, cost of transport can be considered.

**126. C.4. Transportation Provider Quality Standards, on page 28, second to last bullet on the page, would DOH consider expanding this standard to an hour before scheduled appointment time, given the urban nature and traffic congestion of the New York City area?**

Section C.4. states, "There shall be no more than a thirty minute gap between drop off time and the enrollee's scheduled medical appointment time." The Department does expect that in some situations, such as rush hour or a snow storm, this 30 minute time may not be met. However, in many areas of NYC, this 30 minute time is reasonable. The Department will not change this standard to 60 minutes.

**127. C.4. Transportation Provider Quality Standards, on page 28, third bullet on the page, is this an accurate statement that the contractor is required to report this information on the Grievance Report, even if the enrollee doesn't file a complaint? Possibly this report should be re-named so it doesn't imply a Complaint or Grievance was filed?**

Section C.4. states, "In the event the delay renders the participant late for the participant's appointment or causes the participant to miss the appointment, details of the occurrence and resolution must be documented and provided to the Department in the *Enrollee Grievance Report* on a weekly basis." It is expected that this information will only be available to the contractor via a complaint from an enrollee, his/her representative, of a medical practitioner. In the absence of a complaint, the contractor will have no knowledge of this situation.

- 128. D.4.4. Performance Criteria (see page limits as indicated below), on page 38, regarding the Resource Development Activities. Given that the contractor is not negotiating rates with the providers and they will be paid directly by the state, enhancing and developing additional transportation options will be difficult, as there is little incentive for the provider. Will the DOH consider removing this section?**

The Department believes there may be other components of enhancing and developing additional transportation options, other than increasing the fees reimbursed to transportation providers. It is possible that a bidder may have unique and creative ideas, based upon past success managing a similar transportation system.

The Department will not remove this section.

- 129. D.4.4. Performance Criteria (see page limits as indicated below), on page 38, regarding the Coordination Activities, with whom is this section referring to? All practitioners, or only specialty services listed in the other two bullets?**

The "Coordination Activity" component of Section D.4.4.1 relates directly to Section C.2.3. of the FAS. This section refers to specialty hospitals, dialysis treatment centers, adult day health care programs, and mental health providers.

- 130. D.4.4.2. Processing Requests for Transportation (18 pages), on page 38, there are a lot of items covered under this heading, will the DOH consider expanding the page limit to 25 pages?**

The page limit will remain 18 pages.

- 131. F.9 Medical Escort, on page 63, if an unpaid escort is not available, who is responsible for obtaining and paying a paid escort?**

When a paid escort is required, the need for and choice of a paid escort will be determined by a medical practitioner. The payment of the paid escort will be made by the transportation manager; the transportation manager will be reimbursed by NYC Human Resources Administration.

- 132. The Funding Availability Solicitation indicates that the Contractor will not be responsible for arranging the transport for enrollees who reside in Brooklyn but travel without being referred by a Brooklyn-based practitioner.**

**Please confirm that if a member resides in Brooklyn and is seeking a primary care physician and calls the reservation line for a trip to Queens that this should be denied.**

Any trip scheduled by a Brooklyn-based practitioner, irrespective of the enrollee's address or destination, is the responsibility of the contractor.

- 133. The Medicaid Transportation Prior Approval Form does not contain any unique number that can be stored in an MMIS system. How does the**

**Department currently know whether any trips that were paid contained a Prior Approval Form?**

The Transportation Prior Approval Form is used to generate a prior authorization number. The Form is scanned by the Department's fiscal agent, with the scanned form automatically resulting in a prior authorization. All nonemergency transportation claims *require* identification of the prior authorization or the claim will deny.

- 134. The Funding Availability Solicitation indicates that some Medicaid enrollees whose eligibility has been determined by the Human Resources Administration reside outside the five boroughs of NYC. For example, it is typical for many neighboring county nursing homes to have such enrollee residents. The contractor will be responsible for the transportation needs of these enrollees as well.**

**Questions: 1) Can the agency explain why the shift in approach when it comes to this population versus all others? 2) It appears that all other transportation will be managed based on the medical provider geographical area. Why would this population not be managed by which ever transportation manager is handling those counties outside the five boroughs?**

The Department wants to ensure that the most accurate payment is made to each transportation manager. Due to current restraints in determining the actual location of one's residence, in order to properly allocate per member reimbursement to the actual transportation manager responsible for the enrollee, we will require medical practitioners treating NYC enrollees residing outside NYC to contact the NYC transportation manager.

- 135. Neighborhood-Based Transportation System. Is the Department open to the contractor recommending and/or creating over time a unique and specific reimbursement rate per transportation vendor (cost per mile) based on the distance that the providers are transporting in order to encourage longer trips? For example, miles 0-5 could be reimbursed at \$1.65, miles 6-10 at \$1.73; miles 11-15 at \$1.82 and so on.**

The Department is open to any concept that would help increase an enrollee's access to the medically appropriate mode of transportation. All concepts submitted to the Department by the contractor will be thoroughly reviewed and evaluated as necessary.

- 136. Livery Transportation. As a private contractor we have previously used a credit card to obtain livery services from transportation providers that only accept cash and are not willing to wait for reimbursement from the State. Would the State be open to allowing the contractor to purchase livery trips in this manner and then submit a voucher for reimbursement from the State?**

No, at this time the contractor is not permitted to make payment to any provider for services rendered.

- 137. Medical Site Activity. “It is anticipated that this activity will be progressively implemented, beginning with seven practitioners followed with activity among the next seven practitioner cohort.” Although there are 816,204 enrollees in Brooklyn, how many enrollees would the contractor pay for if this implementation is by facility groups?**

The contractor is not paying any transportation provider for services rendered. The contractor will receive payment from the Department of Health on a per member per month basis based initially upon the number of fee-for-service enrollees residing in Brooklyn.

- 138. We understand that the contractor will be processing a payment file that is transmitted to the Department of Health and the Department of Health reimburses the transportation providers. Will the contractor be responsible for reporting trips denials to the providers that are not forwarded for payment to the Department of Health?**

If a trip is denied by the contractor because, for example, the service to which transportation is requested is not a Medicaid-covered service, then no denial information needs to be sent to the transportation provider.

- 139. How will discrepancies between the prior authorization data submitted by the contractor and the claims data submitted by the transportation providers be reconciled?**

The Office of the Medicaid Inspector General audits claims submitted by Medicaid providers. Additionally, the claim submitted by the transportation provider must match the information submitted by contractor in the prior authorization process. If the two do not match, the claim is denied.

- 140. Transportation Provider Quality Standards. For a transportation provider to be considered on-time for a pick-up must the pick-up be on or before the scheduled time or can it be a window of up to 15 minutes before and/or 15 after the scheduled pick-up time?**

It is Department policy that on-time pick-up should include the 15 minutes before and the 15 minutes after the scheduled pick-up time, notwithstanding some extraordinary travel situation.

- 141. Medical Escort. Is the contractor responsible for paying an escort that accompanies an enrollee?**

No, the contractor is not responsible for making any such payments.

- 142. Are enrollees entitled to have extra passengers accompany them on trips and if so, how many? If allowed, then who is responsible for paying the transportation cost for the extra passenger(s)?**

Medicaid enrollees are allowed to have others travel with them, in the same manner as the general public. The Department does not have a limit on the number of additional travelers.

When mass transit is used, the Department will cover the costs of one medical escort, as defined in Section F.9. For other modes of transport, there is no additional payment made to the transportation provider for the travel costs of a medical escort or other passengers.

**143. No-Show. Are transportation providers paid for trips when the enrollee is a no-show?**

No. Per Title 18 NYCRR §505.10(e)(5), "Payment to vendors will made only where an [enrollee] is actually being transported in the vehicle."

**144. Is the prior authorization number for a round-trip reservation or single-leg trip?**

It depends upon the trip request. Some trips, such as hospital discharges, are one-way trips while other trips, such as to a trip to a dentist appointment, are typically round trips. However, the procedure codes used by the Medicaid program are based upon a single unit. Therefore, a round trip equals two units.

**145. Is it the responsibility of the contractor or eMedNY to calculate mileage? Are mileage calculations based upon shortest distance or fastest route or honor system?**

The contractor shall be responsible to calculate appropriate mileage based upon some discernable standard. Mileage calculations are based upon shortest, most direct, suggested route.

**146. What is the pertinent data that the contractor must submit to eMedNY?**

The contractor must submit, in a format to be discussed with Department systems staff, the enrollee's Medicaid identification number (CIN), ordering and transportation provider identification numbers, procedure code/s with applicable modifier when required, unit/s, effective and expiration dates, and a per-unit dollar amount.

**147. Does the file that the contractor submits to eMedNY include the prior authorization number, payment amount, and key trip data including mileage?**

The file does not include the prior authorization number as this is a number automatically generated by eMedNY upon processing of this file. Critical file data is included in the answer to number 146, above.

**148. What is the present timeliness requirement for post-transportation approval requests?**

For NYC authorization requests, the current timeliness requirement for post-transportation approval requests is 30 days.

- 149. The FAS requires that the contractor establish a fair and equitable system of assignment of trips to transportation providers. The State also expects the contractor to increase the quality of services. Will the contractor be allowed to assign more trips to providers that provide the best service?**

In consultation and agreement with the Department, the contractor will be allowed to assign more trips to providers that provide the best service, when the enrollee has no choice of provider.

- 150. What is the expected process for handling of those individuals whose Medicaid eligibility is pending? Are these members eligible for transportation during their pending status?**

When an individual has applied for Medicaid, and determination of eligibility is pending action, the individual is not eligible for transportation.

If the person is eventually made eligible, and the retroactive period of eligibility covers time when transportation was rendered to a medical site, the contractor can issue an authorization for those trips to the enrolled transportation provider, when the mode of travel was appropriate.

- 151. The Contractor is expected to create safe options for the conveyance of users of electric scooters via ambulette vehicles. A number of electric scooter manufacturers have acknowledged that electric scooters were not designed to be transported in a vehicle while the rider is on the scooter. Would the department consider a restriction on electric scooters, such as a requirement that the enrollee sit in a standard wheelchair during transport?**

If the contractor had established that the transport of a person sitting in a scooter is unsafe, the Department will accept the recommended restriction of the contractor.

- 152. If the contractor determines that an enrollee can utilize a lower level of service (LOS) than the LOS requested by a practitioner, does the contractor have the authority to change the LOS to the appropriate level?**

The medical practitioner should not be recommending a mode of transport to the contractor; rather, the practitioner should describe the level of enrollee disability to such a degree that the contractor can make a reasonable decision on the appropriate mode of transportation. It is the contractor's authority and responsibility to determine the appropriate mode of transportation.

- 153. In the current program, in cases where a medical necessity form cannot be obtained prior to transportation due to same day or urgent trip requests or when the medical practitioner has not completed the form in a timely manner, are these reservations paid retroactively? Does the State anticipate a change in the program?**

In the situation of a same day/urgent care transport request, the contractor should not expect a medical necessity form. Rather, the practitioner can convey enough information by telephone in order for the appropriate mode of transport to be authorized. The Department does not anticipate a change in the program at this time.

Further, it is possible that the enrollee in question already has used Medicaid transportation, and supporting documentation is on file with the contractor. This documentation can be used as evidence of transport mode need.

**154. If a transportation provider in good faith provides transportation for a health care institution for a patient that was initially reported to have either Medicare or some other commercial insurance, and then upon bill submission it is discovered that the patient has primary Medicaid, how can the provider submit a bill? Will the bill be denied?**

Medicaid is the payor of last resort; there will never be a situation in which Medicaid is the primary payor, followed by another insurance carrier.

All third party insurers, including Medicare, only cover ambulance service. For all other modes of nonemergency transport (ambulette and livery), this situation will never arise.

- If the ambulance service is emergency, the ambulance service will submit a claim directly to eMedNY, with no required involvement of the contractor.
- In a nonemergency ambulance situation involving Medicare, the ambulance service does not need to seek Medicaid authorization from the contractor; rather the ambulance service will bill Medicare, which then submits the adjudicated claim directly to eMedNY (Medicaid).
- In a nonemergency ambulance situation involving another insurance carrier other than Medicare, the ambulance provider should seek prior authorization from the contractor prior to the trip.

In summary, no ambulance or other nonemergency transport will be provided in “good faith,” requiring the contractor to consider authorizing the trip after the date of service due to other third party insurance involvement.

**155. How can a transportation provider apply to be considered for a seat on the Medicaid Transportation Advisory Council?**

The contractor will not be a member of the council.

As stated in the FAS on page 6, the Transportation Advisory Council will be comprised of providers of medical services and medical transportation, New York City officials, professional associations, and/or any other representatives chosen by the Department to discuss issues related to the management of Medicaid transportation services. The members will be chosen at a future date through a process separate from this procurement.

Any interested party can submit their interest via email to [MedTrans@health.state.ny.us](mailto:MedTrans@health.state.ny.us).

- 156. As noted in the Prior Authorization Guidelines Manual, please provide a copy of the List of Enrolled Medicaid Transportation Providers for NYC by service type and borough.**

**Can the State provide a listing of air ambulance companies that are currently enrolled in the Medicaid program?**

Attached is the listing (NYC *Enrolled Transportation Providers May 24 2011*) of Medicaid transportation providers operating in NYC.

The Department is currently compiling a list of air ambulance companies willing to accept the Department fee; this list will be provided to the contractor.