VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Standard Operating Procedure

Title: Non-Emergency Medical Transportation (NEMT)

Issuance Date: October 25, 2023

(Must be reviewed annually)

Applicable Regulations, Guidelines, and AHS Policy:

Federal statute or rule:

- 42 CFR 440.170(a)
- 42 CFR 431.53

State Plan:

Medicaid State Plan ITEM 24: Any other medical care and any type of remedial care recognized under state law, specified by the Secretary.

Purpose:

To document the Non-Emergency Medical Transportation (NEMT) contractor(s) request and selection process in the implementation, administration and operation of the Vermont Medicaid's Non-Emergency Medical Transportation (NEMT) program.

Procedure:

Non-Emergency Medical Transportation (NEMT) is a covered service for members enrolled in Medicaid and Dr. Dynasaur programs. NEMT is a statewide service for providing transport for eligible people to and from necessary, non-emergency medical services. It is provided through a Personal Services Contract between the State of Vermont, Department of Vermont Health Access (DVHA) and the Vermont Public Transportation Association (VPTA), which is comprised of a regional network of public transit providers.

In compliance with the State's bidding process, NEMT service agreements are established with one or more companies for payment of transportation services for eligible Vermont Medicaid beneficiaries who have no other means to get to Medicaid-billable, non-emergency appointments.

The selected contractor(s) will submit claims for completed trips to DVHA through the state's fiscal agent claims adjudication system. Per the current contract, all claims will be reimbursed at zero dollars, except if the total claim exceeds $1,000. These claims

will be paid directly. For all other claims, the contractor will be reimbursed on a per member, per week basis based on a 365-day lookback period.

Requests for non-emergency transport (NEMT) more than 100 miles one way from a member's official residence requires prior approval from DVHA Member Provider Services (MPS). If the closest medical office or facility is further than 100 miles from the member's home, then DVHA's NEMT contractor may transport to the closest facility available without requiring that the member's physician fill out the referral form. Reasonable flexibility is allowed for the contractor's discretion regarding the 100-mile limit. If possible, telemedicine services should be considered. Telemedicine is a covered service under Vermont Medicaid and is reimbursable if it is clinically appropriate and within the provider's licensed scope of practice. This includes the provision of mental health and substance use disorder treatment. Vermont Medicaid has an established telemedicine Place of Service (POS) code 02 (Telehealth) for use by practitioners providing telehealth services from off site.

The member's primary care physician (PCP) or treating physician must complete a Physician Referral Form for out-of-area transports. This form must be submitted for review by MPS staff for prior approval of any exceptions to the distance limitation. Requests should be submitted to MPS at least two weeks prior to the medical appointment whenever possible. MPS staff will review the submitted information and decide whether to grant or deny the request, including any associated overnight lodging. If further information is warranted, the form will be faxed back to the referring physician's office requesting that information.

Specifically, MPS staff will be looking for:

- Closest available provider,
- Approved, current clinical prior authorization if VT Medicaid is the primary insurance,
- Ensuring requested provider is currently enrolled with VT Medicaid,
- Ensuring that the requested procedure is a service covered by VT Medicaid,
- Available transportation options in the current Medicaid household,
- Any pertinent medical information as provided by the referring physician as to mode of transport and necessary accompaniment,

If the additional information requested is not received in time to be reviewed and to make transportation logistically feasible, the request will be denied. It may be re-submitted at a later date with the additional documentation for reconsideration.

If DVHA's Medical Director has determined that not being able to keep the medical examination and/or treatment would impact the overall health of the member and it is still feasible to arrange for said transportation, the Medical Director in concert with the Transportation Unit will make additional attempts to contact the referring provider. The case may also be escalated to DVHA leadership if such would achieve resolution.

Once a decision has been made by DVHA, the front page of the form will be faxed to the contractor to initiate either setting up the least costly, most medically appropriate mode of transportation or sending out a formal denial to the member.

A member's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost to meet a member's personal choice of provider.

Revision History:

Date	Summary of Revisions
4/7/22	SOP sent to OMU
5/16/22	OMU review. Moved to ADA template.

Table 11 Revision History