PART II

POLICIES AND PROCEDURES
For
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2022 (Subject to Change)

2022 NEMT POLICY REVISIONS RECORD

Part II Policies and Procedures Manual for Non-Emergency Medical Transportation Services.
Current Year's revisions or updates are noted on a Quarterly basis (if applicable).

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE **A**=Added **D**=Deleted **M**=Modified	CITATION (Revision required by Regulation, Legislation, etc.)
07/01/2022	Section 100.1	All Service Regions for the NEMT/Broker contract must have "shooter vans" available. Prior to this change, only the North Region required shooter vans.	A	
07/01/2022	Section 100.2	Modification of requirements for rate negotiations between public paratransit services and the Brokers for clarity.	M	
07/01/2022	Section 100.9	The term "out-of-state" has been added to this section and updates have been made for Members enrolled in a CMO to contact their CMO for out-of-state treatment and transportation.	M	
07/01/2022	Section 100.12	First sentence revised to state "no later than forty-five (45) calendar days…." Sentence previously stated "Approximately three (3) weeks"	M	
07/01/2022	Section 200.3	The term "Volunteer Driver" has been changed to "Independent Driver". Updates have been made throughout the policy manual.	M	
07/01/2022	Section 300.3	Pick-Up and Delivery requirements have been updated to focus on the time of arrival to the Medicaid member's appointment and not initial time of pick-up of A leg.	M	
07/01/2022	Section 300.4	The term "Urgent Care" has been changed to "Same Day Request" and is referenced as such throughout the manual. The definition has not changed, only renamed for clarity.	M	
07/01/2022	Section 400.3	Second paragraph. Revised statement, "DCH does not require the Project Director and scheduling staff to be located in the Central Business Office in each NEMT region.	M	
07/01/2022	Section 400.10	First sentence revised to state "Within thirty (30) calendar days…." Sentence previously stated "No more than forty-five (45)..."	M	
07/01/2022	Section 400.12	This section was added to include information regarding the required Security Plan.	A	
07/01/2022	Section 400.13	This section was added to include information regarding the Independent Service Auditor's Report.	A	
07/01/2022	Section 400.14, 400.15 and 400.16	These section numbers were changed due to new Sections 400.12 and 400.13. Section 400.14 is now "License, Permit and Certification Requirements;" Section 400.15 is now "Computer Requirements;" and Section 400.16 is now "Disclosure of Ownership and Control Statement".	M	
07/01/2022	Section 500.7	Requirement for submission of Certified Financial Audit has been changed from within six months to within three months of the DCH fiscal year end. The submission of Quarterly Unaudited Financial Reports is no longer required and has been deleted from the manual.	M	
07/01/2022	Appendix A	Last paragraph. The word "driver" has been added for clarity.	M	

PREFACE

This manual contains basic information concerning the Non-Emergency Medical Transportation (NEMT) Program and is intended for use by all participating providers and in conjunction with the Part I Policies and Procedures Manual for *Medicaid and PeachCare for Kids*. Part I of any DCH manual outlines the Statement of Participation for participating providers. Part II of any DCH manual outlines the policies and procedures specific to that program as well as the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of Part I and Part II of the manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning program policies, coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), Division of Medical Assistance (Division) policy. Manuals are updated and posted quarterly on the Gainwell Technologies (GAINWELL) web portal at www.mmis.georgia.gov and if applicable, will include any amendments when such amendments are made. These postings shall constitute formal notification to providers of any changes or amendments. The amended provisions will be effective on the date of the notice on the manual or as specified by the notice itself. All providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your interest and participation in Georgia's Medicaid/PeachCare for Kids program and the Non-Emergency Medical Transportation program. Your service is greatly appreciated.

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I. GENERAL INFORMATION

Background

The Georgia Medical Assistance Program (Medicaid) became effective in October 1967, under the provisions of Title XIX of the 1965 amendments to the Social Security Act (42 USC 1396 *et seq.).*

On July 1, 1977, the Georgia Department of Medical Assistance (DMA) was created to administer the Medicaid program (GA Laws 1977, p. 384).

On July 1, 1999, the Department of Community Health (DCH) was created to administer health care programs in Georgia, including Medicaid. DMA then became the Division of Medical Assistance within DCH (GA Laws 1999).

DCH is the single State agency charged with the responsibility of administering the Medicaid program. DCH is responsible for assuring that needy Georgians can request and receive Medicaid services through an eligibility process and that providers of these services are reimbursed. DCH administers the Medicaid program through several contracts, in addition to the direct employment of departmental staff. DCH is divided into multiple divisions and offices responsible for administering Medicaid services and other health care programs in Georgia.

In accordance with Code of Federal Regulations (CFR) (42 CFR 431.53), the Non-Emergency Medical Transportation (NEMT) program offers transportation services for eligible Medicaid members who have no other means of transportation to secure the necessary health care that they need. The Georgia Medicaid program covers transportation to and from health care services that are covered under the State's Medicaid Plan or through waivers. This is based on the recognition that unless individuals can get to and from health care services, the entire State's Medicaid program is compromised.

Prior to FY' 97, the DMA reimbursed on a fee-for-service basis for NEMT services to transport Medicaid members to receive necessary Medicaid-covered services from enrolled Medicaid providers. Members could access these services on demand through direct contact with enrolled NEMT Providers, Department of Human Services' County Departments of Family and Children Services and the County Offices of the Department of Public Health.

In FY' 97, the DMA requested proposals for the implementation of a NEMT Broker system, which divided the State into five (5) regions for NEMT services and sought a Broker contractor for each of the five (5) regions. Three (3) Brokers were eventually selected from among the offerors to provide brokered NEMT services in the five (5) regions. That program became operational on October 1, 1997. Each of the Brokers were responsible for verifying eligibility for NEMT services, as well as for scheduling transportation for members determined in need, through a network of transportation resources under agreement with the Brokers. The Brokers were paid a capitated rate for each eligible Medicaid member residing in their region(s).

NEMT Brokers are selected through a bidder's process. Awards are made on a periodic basis, to be determined by DCH.

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Definition of Service

Non-Emergency Medical Transportation services are defined as medically necessary transportation for eligible Medicaid members (and escort, if required) who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment.

Members enrolled in certain programs, including but not limited to the Mental Health, Mental Retardation and Substance Abuse (MHMRSA), Comprehensive Support Waiver (COMP) and New Options Waiver (NOW) are deemed to have other means of transportation if the program includes transportation services for the type of medical treatment being sought by the member.

Transportation may be provided to health practitioners or entities that are not participating in the Georgia Medicaid program if the services furnished to the member are covered under the Georgia Medicaid plan and therefore would be payable were the member to go to a Medicaid participating provider; and, if a member obtains the medical service from the type of provider that could be a Medicaid participating provider had the provider applied to participate.

Severability Clause

If any provision or any portion of any provision of this Manual conflicts with State law, federal law or federal regulation or is otherwise held invalid, the other provisions of this Manual and the remaining portions of said provisions shall not be affected thereby and shall continue in full force and effect.

Categories of Service Reimbursed

The NEMT program provides transportation through a Brokerage System. Five NEMT regions have been established in the state: North, Atlanta, Central, East, and Southwest. The Department has contracted with a Broker in each of the five NEMT regions to administer and provide NEMT for eligible Medicaid members. Appropriate vehicles will include minibus, wheelchair van, stretcher vans and public or Para-transit. The Brokers are reimbursed a monthly capitation rate for each eligible Medicaid member residing within the NEMT region.

General Reimbursement Principles

Prudent Buyer. The Department's goal is to make quality health care services available to all eligible members. To maximize allocated funds, the Department has employed the concept of the "Prudent Buyer." Briefly stated, if two different plans of treatment will meet the need of the member, the less expensive treatment should be employed, all other conditions being equal. The NEMT Broker should apply the same principle in providing services to Medicaid members.

Collection Agencies. Federal law prohibits payments for Medicaid services to anyone other than a provider, except in specified circumstances. Expressly prohibited are payments to collection agencies working on a percentage or other basis unrelated to the cost of processing the billing.

Covered Services. A "Covered Service" is an item of medical or remedial care or service, including dispensation of equipment and drugs, for which reimbursement is allowed through the

Georgia Medical Assistance Program. Refer to **Appendix A Georgia Medicaid Covered and Non-Covered Services** for covered services within the NEMT Broker Program.

II. ENROLLMENT

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The Department of Community Health (DCH) utilizes a broker system to administer its NEMT program. Transportation providers interested in providing transportation services to Medicaid members must contact and arrange a service agreement with the NEMT Broker for the region(s) in which they are willing to provide transportation services.

III. GENERAL CONDITIONS OF PARTICIPATION

As general conditions of participation, NEMT Brokers must:

1. Comply with State and federal statues, policies and regulations applicable to the Medicaid program;

2. Provide services in compliance with Title VI of the Civil Rights Act of 1964, as amended. Title VI provides that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance;

3. Provide services in compliance with Section 504 of the Rehabilitation Act of 1973 and the American with Disabilities Act of 1990 (ADA). Section 504 provides that no otherwise qualified handicapped individual shall solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance;

4. Not intentionally or negligently damage or endanger the health, safety or welfare of any member;

5. Rev. 10/15 The Broker, owner, and managing employee(s) cannot appear on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List and the System for Award Management (SAM). The Broker is required to check both systems on a monthly basis and maintain documentation of results.

6. Rev. 10/15 The Broker is required to check the Social Security Administration's Death Master File (DMF) for each of its employees, transportation providers and drivers and independent drivers at the time of employment and on an annual basis thereafter.

7. Rev. 10/15 Not employ or contract with a person, provider, owner, partnership or corporation previously terminated or suspended from the Program, barred from enrollment, or on the OIG's sanction or Exclusion list and SAM. Brokers may search the DHHS-OIG and SAM websites to capture exclusion and reinstatements.

8. Notify the Department of any of the following changes immediately:

a. Change in business and/or email address, telephone and/or facsimile number;
b. Change in corporate status or nature;
c. Change in business location;
d. Change in solvency;
e. Change in corporate officers, executive employees, or corporate structure;
f. Material changes in ownership (i.e. more than 25% a month); and/or
g. Change in federal employee identification number or federal tax identification number.

9. Not engage in any illegal activities related to the furnishing of services.

10. Adhere to all the applicable policies and procedures of the Department.

IV. MEMBER ELIGIBILITY

DCH establishes eligibility criteria for Medicaid/PeachCare for Kids benefits based upon federal regulations. Eligibility criteria for major coverage groups are identified in Appendix E. The Department contracts with the Department of Human Services' Division of Family and Children Services, and the Social Security Administration to perform eligibility determinations. Individuals and families should be referred to local offices of these agencies for their eligibility determinations.

Newborn Eligibility Verification

"Newborn" as a Medicaid coverage group refers to the Medicaid coverage available to infants who are born to Medicaid eligible mothers. To provide immediate enrollment for newborns, authorized providers may obtain a temporary Medicaid identification number for a newborn infant, born to a mother eligible for Georgia Medicaid benefits.

Any physician, nurse midwife, nurse practitioner, health check provider, pharmacy, hospital, Health Department, durable medical equipment provider or birthing center enrolled as a Georgia Medicaid provider is authorized to obtain a temporary Medicaid identification number for these newborn infants. Enrolled providers can access Gainwell Technologies (GAINWELL) on-line to obtain a Medicaid identification number. The manual process of completing a Newborn Medicaid-Certification form DMA-550, remains in place for enrolled providers who are unable to execute the on-line process. See Appendix D for sample of DMA-550. Upon completion of the form providers may contact GAINWELL at 1-800-766-4456 to obtain a Medicaid identification number. To confirm issuance of the number and Medicaid eligibility, providers must mail the white copy of the form to GAINWELL, P. O. Box 105200, Tucker, Georgia 30085-5200, Fax (866)483-1045.
A child is eligible for Newborn Medicaid for up to 13 months beginning with the month of birth and continuing through the month in which the child reaches age one.

Medical Assistance Eligibility Certification

Generally, Medicaid coverage is available for the month of application for those individuals and families who meet the eligibility standards. Medicaid members covered under one of the Care

Management Organizations (CMO) will receive a card which identifies the CMO responsible for the member's care. Members not enrolled in one of the CMOs receive a MHN ID card.

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Pending Eligibility

A pending eligible individual is defined as any individual who has been admitted to a Medicaid certified facility and has made an application for Medicaid benefits. Pending Medicaid eligible individuals are eligible for NEMT services. The Broker must accept the monthly per capita rate reimbursement as payment in full, inclusive of all administrative costs, transportation costs, overhead, and profit, for all services required.

V. PROGRAM REQUIREMENTS

CHAPTER 100 - BROKER RESPONSIBILITIES

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Section 100.1 Recruiting and Negotiating with Transportation Providers

The NEMT Broker shall establish a network of independent transportation providers to deliver transportation and negotiate individual service delivery rates with each qualified transportation entity.

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The Broker shall submit to DCH copies of all executed Transportation Provider service agreements five (5) business days from date of execution, and shall include all documentation for driver qualifications along with the initial written verification that provider is not listed on the following: Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List; the System for Award Management (SAM); and the Social Security Administration's Death Master File (DMF) as referenced in Part III General Conditions of Participation of this manual. The required monthly and/or annual checks of the aforementioned shall be maintained by the Broker and made available to DCH upon request.

The NEMT Broker is responsible for identifying, recruiting, and negotiating service agreements with transportation providers for all service regions. The provider network must be sufficient (numbers and types of vehicles, drivers, and attendants) and under service agreements to meet the needs of the members in that region(s) so that the failure of any provider to perform will not impede the ability of the Broker to provide services in accordance with the requirements of the NEMT program.

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Transportation providers who have service agreements with NEMT Brokers, must be registered/licensed where required by law or appropriate authority (Georgia Department of Public Safety, County Government, etc.) to provide transportation services and/or be certified/licensed by the Georgia Department of Public Health's Division of Emergency Medical Services (EMS) in the case of emergency ambulance providers. Active valid registrations must be maintained throughout the term of the service agreement with the Broker.

The Broker is prohibited from establishing or maintaining service agreements with transportation providers who have been determined to have committed fraud of a State or federal agency or been terminated from the Medicaid program.

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The Broker must terminate a service agreement with a transportation provider when substandard performance is identified and/or when the transportation provider has failed to take satisfactory corrective action within the required timeframe. DCH reserves the right to correct failures identified by the Broker and to terminate any service agreement with a transportation provider when DCH determines it to be in the best interest of the State. The transportation provider is allowed fifteen (15) calendar days from the date of written notification of termination to request a review of the decision by the Broker or DCH or both. Failure to request a review within (15) calendar days from the date of written notification of termination waives the provider's rights.

The Broker is encouraged to utilize federally funded and public transportation whenever possible if it is cost-effective, and to negotiate service agreements with such entities when appropriate.

The Broker must submit for DCH review and approval a model service agreement that the Broker will use to obtain transportation service. This model should be reasonably representative of the actual service agreement to be used with the transportation providers.

The service agreement shall include at a minimum the following requirements in accordance with the NEMT program:

1. Payment administration;
2. Levels of transportation;
3. Companion and attendant services;
4. Telephone and vehicle communication systems;
5. Computer requirements;
6. Scheduling;
7. Pick-up and delivery standards;
8. Same Day Requests (formerly called Urgent care);
9. Driver manifest delivery;
10. Driver qualifications;
11. Driver conduct;
12. Vehicle requirements;
13. Back-up service;
14. Quality assurance;
15. Non-compliance with standards;

16. Training for drivers and attendants;

17. Confidentiality of Information;

18. Specific provision - that in the instance of default by the agreeing Broker, the agreement will pass to DCH or its agent for continued provision of transportation services. All terms, conditions and rates established by the agreement shall remain in effect until or unless renegotiated with DCH or its agent after default action or unless otherwise terminated by DCH at its sole discretion;

19. Indemnification language to protect the State and DCH;

20. Evidence of adequate Insurance for vehicles and drivers;

21. Submission of documentation as required by DCH; and

22. Appeal and dispute resolution.

The Broker may arrange for non-emergency medical transportation by:

1. Negotiating service agreements with qualified transportation providers. Any essential rural healthcare provider as defined herein; or any disproportionate share hospital as defined by DCH; or any municipally or county-owned emergency medical services department which is in a rural area shall have the opportunity to become a participating provider of NEMT services to eligible Medicaid members under a Broker service agreement if such provider meets all the following conditions:

    a. participates in the Medicare and Medicaid programs;
    b. is licensed, where required under law, and qualified to render the services required under the service agreement; and
    c. agrees to payment terms which are either the same payment terms applicable to other similar participating providers in the service agreement; or, such payment terms as may be mutually agreed upon by such provider and the Broker.

2. Entering service agreements with federally funded or public transit service, including not-for-profit agencies, transit authorities and licensed common carriers;

3. Providing tokens or passes to members, and escorts upon request, to cover the fare for federally funded, established public, or private transit service which is available when the member has the physical and mental capacity to use such service;

4. Independent Driver (formerly called Volunteer Driver); and

5. Entering service agreements with commercial taxi services to supplement its ambulatory services.

In all cases, the Broker must use the most appropriate service available, which meets the member's health needs. The Broker is encouraged to make use of public transit resources for ambulatory members.

Regardless of the method or combination of methods used to provide NEMT services, the Broker is responsible for management, supervision and monitoring of all transportation provided with funds received through the NEMT/Broker contract.

The Broker and all its subcontractors shall not itself be a provider of transportation; however, the State may require that the Broker own/operate and have available vehicles referred to as "shooter vans" in the event the scheduled transportation provider is unavailable for transport or if there are no other qualified providers available to provide the transportation. For the purposes of this program the State requires all service regions to have available shooter vans. The State acknowledges that the Broker will use shooter vans only as a back-up measure to assure that members can access medical services, and not as a standard means of transportation.

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Section 100.2 Payment Administration

From capitation payments made to the Broker by DCH, the Broker will pay transportation providers in accordance with the terms of the service agreement between the Broker and each transportation provider. Full payment of undisputed invoices for all authorized trips must be made to the transportation providers as agreed to between the parties and made a written term of the service agreement; otherwise, payment shall be made within fifteen (15) business days of the Broker's receipt of an undisputed invoice.

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The Broker shall pay no more for fixed route public transportation than the rate charged to the public, and may negotiate a rate with public paratransit service provider and pay no more than the rate charged to other State human services agencies, when applicable, for comparable services.

The Broker will:

1. validate that all transportation services paid for are properly authorized and rendered;

2. receive and transmit to DCH or its agent all applicable transactions required by HIPAA regulations in the version deemed by DCH;

3. develop safeguards against fraudulent activity by the transportation service providers and Medicaid members and fulfill DCH's reporting requirements regarding such activity;

4. in the instance it is able to offer insurance to providers, not withhold premiums from provider's payments;

5. pay the provider for the "A" leg (as defined in the Glossary) of a trip in the instance where a member fails to board the vehicle for a trip within the time frame described in Section 300.3 Pick-up and Delivery Standards. The definition for "no show" can be found in the Glossary. The Broker shall submit to the Department a report of the methodology it will use to determine a member no show. The requirements for this report can be found in Section 500.9 Member No-Show Report.

6. indemnify and defend DCH against any causes of actions or claims of payment brought by the transportation provider or Medicaid member; and

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7. negotiate with the public paratransit service providers a rate that is reasonable. The Broker shall pay no more for public paratransit services than the rate charged to other State human services agencies for comparable services when applicable.

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Section 100.3 Gatekeeping

The Broker shall oversee, orchestrate and control the arranging and coordination of non-emergency medical transportation for eligible Medicaid members residing in the awarded region (see Appendix G, NEMT Gatekeeping Policy). The Broker's gatekeeping responsibilities include but are not limited to the following:

1. verifying the member's current eligibility status for Medicaid by assessing this information via the web portal at the following address: http://www.mmis.georgia.gov or the broker may use the Medicaid Eligibility Inquiry System (MEIS);

2. assessing the member's need for NEMT services by identifying if member has other modes of transportation available or if the NEMT request is to a service that is covered by Medicaid;

3. identifying the most appropriate non-emergency mode of transportation necessary to meet the needs of the member, including any special non-emergent transport requirements for medically fragile and/or physically/mentally challenged members (See Appendix A Georgia Medicaid Covered and Non-Covered Services);

4. educating members on the use of NEMT services; and,

5. providing other gatekeeping responsibilities within program requirements and as outlined in Appendix G NEMT Gate-Keeping.

Section 100.4 Reservations and Assignments

Receive member requests for transportation and assign the trip to the most appropriate transportation provider. The Broker must assure that dispatching activities are performed, but may, at its option and under its responsibility, delegate dispatch activities to the transportation provider.

Requests for Transportation Services. At the time a request for transportation is received, a computerized member worksheet must be completed and maintained by the Broker that contains, at a minimum, the following information:

1. unique transaction identification number;

2. date and time of request;

3. name of the Medicaid member requiring transportation;

4. address of Medicaid member;

5. Medicaid identification number;

6. point of origin if different from above address;

7. point of destination;

8. type of Medicaid reimbursable service to be received;

9. date and time of medical appointment;

10. disposition of request, including type of transportation to be provided (public transportation, minibus, wheelchair van, or stretcher van);

11. scheduled date and time of pickup;

12. identification of operator who recorded the request; and

13. identification of transportation provider to which the trip was assigned.

Member Intake Worksheet. The Broker must complete a computerized member intake worksheet at the time of contact for each request made by the member. The Broker shall develop and submit to DCH, for prior written approval within sixty (60) calendar days after contract execution, a model worksheet for NEMT services that provides the following or substantially similar information:

1. Verification of or proof of eligibility:

    a. name and address;
    b. Medicaid number; and
    c. telephone number, if available.

2. Availability of suitable mode of transportation to other community locations:

    a. availability of friend and relative with vehicle; and
    b. ownership or previous transportation arrangements.

3. Necessity of Trip:

    a. point of origin and destination;
    b. reason for the trip;
    c. identification of Medicaid reimbursable service; and
    d. identify provider to be visited and a telephone number.

4. Availability of Federally Funded or Public Transportation:

a. distance from scheduled stops;
b. age and disabilities of member;
c. any physical and/or mental impairments which would preclude use of public transportation;
d. availability of funds to pay for transportation; and
e. previous use.

5. Special Needs:

a. mode of transportation needed;
b. services needed in route; and
c. need for escort or attendants.

6. Results of Interview:

a. transportation approved or denied;
b. mode of transportation if approved; and
c. date(s) of service.

Validity of Information. Except for the information contained on the Medicaid eligibility certification, the Broker shall accept the information provided verbally by the member, or person speaking on behalf of the member, as valid when determining or predetermining the need for NEMT services unless the Broker has cause to doubt the validity of information provided.

If the Broker has cause to doubt the validity of the information provided by or on behalf of the member, in accordance with approved gatekeeping protocols (see Appendix G NEMT Gate-keeping Policies), the Broker may require documentation of that information.

Section 100.5 Quality Assurance

Provide assurance that transportation providers meet health and safety standards for vehicle maintenance, operation, and inspection; driver qualifications and training; member problem/complaint resolution; and the delivery of courteous, safe, and timely transportation services.

Section 100.6 Administrative Oversight/Reporting

The Broker is responsible for the management of overall day-to-day operations necessary for the delivery of NEMT services and the maintenance of appropriate records and systems of accountability to report to DCH and respond to the terms of the NEMT program.

Administration and Delivery of Service: The activities required for the administration and delivery of transportation include:

1. negotiating, signing and executing service agreements with qualified transportation providers;

2. scheduling and dispatching the most appropriate trip which meets the need of the

member; and

3. monitoring quality of service delivery and reimbursing transportation providers.

Section 100.7 Trend Analysis

The Broker is required to develop a methodology to gather and maintain information for, and examine and respond to, changes in member populations and member needs to insure adequate numbers and types of vehicles are available as demand dictates.

Section 100.8 Modes of Transportation

The Broker shall determine the most appropriate mode of transportation based on information provided by the member or their representative. NEMT provides the following modes of transportation:

1. **Minibus**: A multiple passenger van. Commercial taxi service may be considered a component of this mode of transportation service. The vehicle standards specified in Section 300.6 Vehicle Requirements, shall not apply to commercial taxi;

2. **Wheelchair Van**: A van equipped with lifts and locking devices to safely secure a wheelchair while the van is in motion;

3. **Stretcher (non-emergency) Van**: An enclosed vehicle that accommodates a litter and is equipped with locking devices to secure the litter during transit. Stretcher service is required for members, which are non-ambulatory and need the assistance of at least two (2) persons to be transported to and from the vehicle and the healthcare provider in a reclining position. No flashing lights, sirens, or emergency equipment is required;

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4. **Public and/or Paratransit Transportation**: Brokers are encouraged to use federally funded and public/paratransit transportation whenever possible if it is cost-effective to do so (see Section 100.2);

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5. **Transportation Network Companies (TCN)**: Refer to Section 200.3b of this manual for more details.

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6. **Other forms of passenger Vehicles (i.e. Sedans):** An enclosed vehicle having two or four doors and seats four or more persons with at least two full-width seats.

When determining the most appropriate mode of transportation for a member, the Broker must consider the member's current level of mobility and functional independence. Modes other than public transportation must be used when the member:

1. can travel independently; but, due to a permanent or temporary debilitating physical or mental condition, cannot use the mass transit system;

2. is unable to be accommodated by the public Para Transit System;

3. is traveling to and from a location which is inaccessible by mass transit (accessibility is not within 1/2 mile of scheduled stop); and,

4. is medically fragile and requires the assistance of an escort (see Appendix A Georgia Medicaid Covered and Non-Covered Services).

Section 100.9 Geographic Considerations

The transportation Broker for each region is responsible for the provision of transportation services for all eligible Medicaid members to or from a stated point of origin and to or from a specific Medicaid reimbursable service at the request of the member or person acting on behalf of the member. A chart listing the five (5) NEMT geographic regions by county is provided in Appendix C NEMT Regions & Counties Served.

1. Transportation shall be supplied without the collection of any co-payment.

2. The Broker may opt to expand the mileage limits for transportation without a healthcare provider's referral per region however, at a minimum transportation shall be provided for Medicaid members within the following general geographic access standards for health care services:

    a. 30 miles Urban;
    b. 50 miles Rural;
    c. 15 miles Adult Day Health Care Urban and 30 miles Rural; and
    d. 15 miles Pharmacies Urban and 30 miles Rural.

3. Transportation outside the general geographic access standard for health care services is to be provided only when sufficient medical resources are not available in the member's service area and a physician statement has been received attesting to medical necessity (see Appendix Q NEMT Physician's Medical Necessity Certification), or when a healthcare provider has referred the member to medically necessary health care services outside of the geographic access standard.

4. The Broker is not responsible for arranging Medicaid NEMT services for Medicaid members who reside outside the service region for which the Broker provides service. The Broker will refer eligible members to the Broker covering the member's county of residence. The Broker will arrange travel into and out of other service regions when the Medicaid member being transported is a resident of the Broker's service region.

5. Members enrolled in managed care health plans are obligated to use providers participating in the managed care health plan. Travel for such managed care plan enrollees shall be considered the same as travel based on a healthcare provider's referral.

6. The Broker is responsible for out-of-state NEMT services to and from healthcare providers of no more than fifty (50) miles beyond the state of Georgia boundaries. There are limited, specific exceptions to the fifty mile limit for certain regions such as non-Georgia hospitals in bordering states participating in Georgia Medicaid. Medicaid Members who require non-emergency medical transportation out-of-state and over the fifty (50) mile border limit, shall be referred to the DCH Exceptional Transportation

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Services program coordinated and arranged by the Department of Human Services' Division of Family and Children Services (DFCS), which has partnered with DCH to handle such requests and arrange such out-of-state transportation only when medically necessary and prior approved. Members enrolled in a CMO must contact their CMO for treatment and transportation out-of-state beyond fifty (50) miles of the state of Georgia boundaries (see Section 200.2 Exceptional Transportation Services). CMO Members are not eligible for transportation through the Exceptional Transportation Services Program.

Section 100.10 Reimbursement

The Broker shall be reimbursed monthly a capitated rate per member, per month for each Medicaid member eligible for NEMT services in the awarded region. The Broker must accept the monthly per capita rate reimbursement as payment in full, inclusive of all administrative costs, transportation costs, overhead, and profit, for all services required under the NEMT program.

Section 100.11 Implementation Work Plan and Project Schedule

The Broker must prepare and maintain an implementation work plan that includes all the activities required to begin operations successfully. The work plan must be sufficiently detailed to enable DCH to be satisfied that the work is to be performed in a logical sequence, in a timely manner, and with an efficient use of resources.

Each activity listed in the work plan (Gant Chart) must include a description of the task, a scheduled start date and a scheduled completion date. The types of activities required to be included in the work plan include but are not limited to the following:

1. acquisition of office space, furniture, and telecommunications and computer equipment;
2. hiring and training of central office, in Georgia, service staff and drivers;
3. recruitment of transportation providers;
4. completion of all transportation service agreements;
5. verification that transportation provider’s vehicles meet NEMT standards;
6. verification that drivers meet NEMT standards;
7. operational readiness testing of daily operational requirements to ensure all components are functioning adequately;
8. staff training plan and installation calendar for the trip scheduling and reservations systems;
9. member education; and

10. Development of required deliverables, including reports, operational procedures manual, encounter data submission procedures, Quality Assurance Plan, and Business Continuity and Disaster Recovery Plan.

The Broker must submit for DCH approval a final work plan (Gant chart) within seven (7) business days of contract execution.

Section 100.12 Operational Readiness Testing

Each of the successful Brokers must pass an operational readiness-testing program (see Appendix H Implementation Checklist) no later than forty-five (45) calendar days prior to the Go-Live date or such other date approved by DCH. Representatives from DCH will go to each Broker's facility to determine if all systems are operational and ready for full-time service. During this test, the Broker will ensure that:

1. telephone systems are fully operational;
2. computer system is fully operational;
3. staffing requirements are compliant; and
4. all deliverables required are available for review and approval prior to "Go Live."

The Broker will be required to demonstrate readiness of the following systems and processes:

1. a Georgia-established central office operation (this includes telephone and computer systems interaction);
2. member application process;
3. scheduling and carrier trip notification procedures;
4. after-hours coverage arrangements;
5. gate-keeping protocols;
6. denial process;
7. quality assurance;
8. member complaint and appeal process;
9. model service agreements;
10. vehicle inspection report forms;
11. encounter data submission procedure;
12. reporting procedures; and

13. any other items or functions as deemed necessary by DCH

The Brokers will have an opportunity to make corrections prior to "Go Live" and will be required, upon request by DCH, to submit proof to DCH that corrections were made. The Brokers will not be allowed to begin service until the operational readiness testing is complete and the Broker is fully ready to provide service. If Broker is not ready at "Go Live" as determined by DCH, Broker will pay any additional cost DCH may incur if DCH must use services other than those of the successful Broker to continue to supply transportation services in the region. Payment will also be withheld until the Broker passes the operational readiness tests. Once operational readiness testing has been completed and approved by DCH, the Broker will be allowed to begin taking reservations approximately one (1) week before transportation services are to begin.

CHAPTER 200 - PROGRAM POLICIES AND PROCEDURES

This section describes the criteria to be used in determining whether NEMT services are necessary and appropriate. Federal requirements mandate that Medicaid funds be expended only for the purchase of services for Medicaid members. Medicaid state and federal matching funds cannot be used to provide services to individuals who are not Medicaid members on the date(s) of service.

Section 200.1 General Requirements

Rev. 4/16

NEMT services are defined as medically necessary transportation for any eligible Medicaid member and companion, if required, who have no other means of transportation available to any Medicaid-reimbursable service for the purposes of receiving treatment, medical evaluation, obtaining prescription drugs or medical equipment. Medicaid reimbursable services are described in Appendix A Georgia Medicaid Covered and Non-Covered Services. For clarification purposes, NEMT shall be provided to healthcare practitioners or entities that are not participating in the Georgia Medicaid program under the following three (3) conditions:

1) the services provided to members are Medicaid reimbursable services under the Georgia Medicaid plan;

2) transportation services are provided not more than 50 miles beyond the State of Georgia border line; and

3) the type of provider performing the medical service could be a Medicaid participating provider had the provider applied to participate.

Rev. 10/17

NEMT vehicles and drivers, including stretcher van providers/drivers, are not equipped to supply, maintain, and/or administer oxygen to or care for a member who is ventilator-dependent or who requires other life-sustaining medical equipment while being transported. Members utilizing NEMT services must have battery-operated ventilator and/or medical equipment that is portable and fully charged and travel with an individual or escort who has been trained to provide care needed for the member if applicable and to manage required medical equipment. (Please see Appendix A Georgia Medicaid Covered and Non-Covered Services).

Section 200.2 Exceptional Transportation Services (ETS)

Exceptional Transportation Services (ETS) is defined as non-emergency transportation that is necessary under extraordinary medical circumstances that requires traveling out-of-state for health care treatment not normally provided through in-state healthcare providers. This transportation, including commercial air and ground travel, is limited to out-of-state travel. ETS services are arranged through the Department of Human Services' (DHS) Division of Family and Children Services (DFCS) and is outside the scope of the NEMT Broker's responsibility. Members enrolled in a Care Management Organization (CMO) must contact their CMO for these types of services. Medicaid members requiring transportation to and from medical appointments within the state of Georgia and no more than 50 miles beyond Georgia's borders must contact the NEMT broker assigned to the county in which he/she resides, provided they are eligible to receive NEMT services.

Rev. 4/20

Requests for ETS must be referred to DHS (State) DFCS at 404-657-7543. More information can be found in DCH's Policies and Procedures Manual for Exceptional Transportation Services.

Rev. 07/22

Section 200.3a Independent Driver (formerly called Volunteer Driver) Transportation

Independent Driver transportation is supplied to individuals or agencies that receive no compensation or payment other than expenses for the provision of this transportation. Independent Driver travel is not considered to be Exceptional travel as this type of travel can be provided in state or out-of-state. Non-profit agencies, such as senior citizen centers or community action agencies ordinarily provide this service. The county DFCS offices may also offer some Independent Driver transportation through networks they have developed. If use of Independent Driver transportation is contemplated, the Broker must arrange transportation with the Independent Driver organization directly, including scheduling appointments and notifying members of arrangements. Additionally, the Broker shall be responsible for payment of the expenses of the Independent Driver transportation. The Broker may develop Independent Driver services as part of the responsibility to provide NEMT services. Use of Independent Driver transportation does not alleviate the Broker's responsibility to assure the safety, comfort and appropriate mode of transportation to meet the member's health care status. The Broker must ensure that all Independent Drivers and vehicles used to provide Independent Driver transportation are properly licensed, insured and inspected.

The Broker shall have written oversight procedures for ensuring that Independent Drivers are legally licensed by the State of Georgia or other valid state issued driver's license, completed driver training and Broker's orientation programs and maintain required insurance coverage. In addition, the Broker must develop and implement at a minimum an annual vehicle inspection process to verify that all vehicles meet the requirements of Section 300.6 Vehicle Requirements.

Independent Driver transportation requirements include:

1. The Broker must have procedures in place to verify and document that vehicles used in Independent Driver transportation are adequate to meet the safety and comfort needs of the member, including, but not limited to:

    a. appropriate State operating requirements and registration;
    b. child safety seats when appropriate; and
    c. passed vehicle inspection.

2. The Broker must have procedures in place to verify and document that drivers used in Independent Driver transportation meet the following requirements:

    a. have a valid Georgia driver's license or other valid state issued driver's license;

    b. maintain certification for first aid training, passenger assistance orientation program and a safety and sensitivity program to ensure a safe operating environment; and

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    c. all drivers and attendants must have no prior convictions for a sexual crime or crime of violence.

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    d. the transportation provider shall not utilize drivers who have been convicted of driving under the influence of alcohol, narcotics or drugs/medications within five years prior to date of employment. If the transportation provider suspects a driver to be driving under the influence of alcohol, narcotics or drugs/medications that would endanger the safety of members, the transportation provider shall immediately remove the driver from providing service to Medicaid members. Any person who has been convicted of a felony during the last five (5) years will drive and/or attend passengers only after satisfactory review by the Broker and DCH or its agent.

3. Reimbursement for Independent Driver transportation is limited to payment of expenses. The Broker must obtain DCH approval for the basis and method for which reimbursement to Independent Drivers will be made.

Rev 07/19

Section 200.3b - Transportation Network Companies -(TNC) (formerly referenced as Ride Share Companies)

The use of TNCs may be a viable and cost-effective option, in addition to the more traditional forms of non-emergency medical transportation currently utilized by the Broker.

For purposes of the NEMT program, a TNC is defined as an entity with no direct contractual relationship with DCH that is primarily engaged in the business of using electronic software applications and algorithms to provide its customers with transportation service through the owner or operator of a privately-owned vehicle and, as applicable, is licensed in Georgia as a TNC. Prior to utilizing TNCs, the Broker shall establish that the TNC adheres to all applicable Georgia laws governing their services.

The use of TNCs **does not** alleviate the Broker's responsibility to provide safe, comfortable, and courteous transportation to Medicaid members.

The Broker shall only use TNCs under the following circumstances:

1. as back-up in cases of "provider no-shows," where the scheduled or assigned transportation provider does not show up to transport member;

2. only for ambulatory members who require no physical assistance;

3. when no transportation provider is available to transport member to or from their scheduled appointments; and,

4. if requested by the member or member's representative and approved by the Broker in accordance to the guidelines stated herein.

The Broker shall only utilize a TNC with the prior knowledge or consent of the member or the member's representative and shall maintain a record of that consent (via recording, electronically, hard copy, etc.). The Broker shall consider any special needs that the member may have and must determine if transport via a TNC is appropriate and meets the needs of the member along with the requirements as stated herein.

The Broker shall **not** utilize TNCs for the following:

1. transportation of Medicaid members to and from nursing home facilities;
2. transportation of Medicaid members to and from adult day health facilities;

When the Broker has determined that use of a TNC is appropriate to provide NEMT services, the Broker shall:

1. arrange transportation directly with that TNC, including scheduling appointments and notifying members of the arrangements;

2. determine the appropriateness of this type of transport for the Medicaid member;

3. follow up with any TNC with which it contracts to address complaints, accidents, and incidents involving Medicaid members and any TNC drivers;

4. reimburse the TNC when utilizing its services. Reimbursement shall be negotiated between the TNC and the Broker;

5. have procedures in place to verify with the TNC that drivers meet the following requirements:

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   a. have a valid Georgia driver's license or other valid state issued driver's license;
   b. have no prior convictions for a sexual crime or crime of violence; and,
   c. have not been convicted of driving under the influence of alcohol, narcotics or drugs/medications within five years prior to date of employment with TNC.
   If a driver is suspected of driving while under the influence of alcohol, narcotics or drugs/medications that would endanger the safety of members, the Broker shall immediately notify the TNC and immediately discontinue or remove that driver from transporting Medicaid members.

6. provide Medicaid member with the name of the TNC driver, and the make and model of vehicle driven.

All NEMT policy requirements of the broker may not apply when using TNCs. Examples include but are not limited to: signage on exterior of vehicle; number of vehicle inspections, training requirements; and, procedures for processing complaints.

Section 200.4 Public Transportation

In some areas of Georgia, public transportation may be a viable and cost-effective alternative to more traditional and expensive forms of non-emergency medical transportation available to the Broker. Public transportation is transportation available through the payment of a rider fee to the general public.

Transit companies, county or city governments or federally funded transportation authorities may provide public transportation. This type of transportation may be used to provide a full trip or portion of a trip to or from a health care service. This includes Para transit.

The Intermodal Surface Transportation Efficiency Act (ISTEA) provides funding for different types of transportation systems designed to meet public rider demand. Large urban transportation systems, such as Metropolitan Atlanta Rapid Transit Authority (MARTA), receive funding through Section 9 of this Act. Section 5311 provides funding for rural public transportation. In 2005 there were ninety (90) systems statewide receiving Section 5311 funding. Section 5310 funding is available for entities providing transportation to the physically fragile (including the elderly). The Department of Human Services currently offers Section 5310 transportation on a statewide basis.

Brokers are encouraged to use federally funded and public transportation whenever possible if it is cost-effective. The criteria included in **Section 100.4 Reservations and Trip Assignments** may be used to determine appropriateness. The Broker must send tokens or passes to members and escorts, if applicable, for use in traveling to or from scheduled health care appointments by public transportation in cases where the member or companion cannot afford to purchase them.

The Broker must have procedures in place to determine whether public transportation is accessible to and appropriate for the member requesting service. The Broker must have procedures for timely distribution of the tokens/passes to the member or escort to ensure receipt prior to the scheduled transportation. In case of the use of Para transit services the Broker must comply as earlier described.

Section 200.5 Non-Covered Transportation

NEMT services do not include emergency ambulance transportation or transportation to any service not reimbursable or covered through the Georgia Medicaid program. The use of Medicaid-funded transportation for any purpose other than as stated in NEMT policy, or in violation of any State, federal law or regulation is fraudulent activity subject to criminal prosecution and civil and administrative sanctions. Members should call 9-1-1 in the case of an emergency.

Section 200.6 Residence in NEMT Service Region

Brokers are responsible for assuring that NEMT services are provided to Medicaid members and pending Medicaid eligibility members in a Medicaid certified facility, residing within the

Broker's region who require medically necessary services and who have no other means of accessing said services. The Broker is not responsible for arranging Medicaid NEMT services for Medicaid members who reside outside their service region. The Broker will arrange travel into and out of other regions when the Medicaid member transported resides within the Broker's region. The Broker may enter into service agreements with Brokers or individual transportation providers in other regions to provide return trips in cases where a member must travel outside the region of residence in order to obtain appropriate health care services.

The Broker is not responsible for providing transportation when the healthcare provider is located outside the geographic access standards (Section 100.9 Geographic Consideration) for health care services in the member's area if other similar and appropriate healthcare providers of type who offer same or similar services appropriate for the member's needs and who will accept the member as a patient are located closer to the member's residence. However, members enrolled in managed care health plans such as CMO, are obligated to use providers participating in the managed care health plan. Travel for such managed care plan enrollees shall be considered the same as travel based on a healthcare provider's referral. Travel based on a health- care provider's referral must be provided regardless of the distance within the State.

The Broker may request a written referral signed by the referring provider and attesting to the need for travel outside the member's region of residence. Members who are denied NEMT services must be given a written notice of the reason for denial and right to an appeal within three (3) business days of receipt of the denial notice.

Section 200.7 Transportation Associated with Minors

Visitation of Hospitalized Minor(s). A parent, foster parent or guardian is eligible to be transported to visit his or her Medicaid member minor children (under age of 18) who are an inpatient of a hospital, whether or not the parent is Medicaid eligible themselves. These trips are limited to the period of the minor child's hospitalization and the availability of transportation resources on the part of the assigned NEMT Broker. Transportation of individuals (parent, foster parent or guardian) who are not Medicaid members should be reported under the minor child's Medicaid eligibility number. Transportation to visit an inpatient adult Medicaid member is not covered.

Rev. 4/17

Minor(s) Traveling Alone. Children under the age of eighteen (18) years shall be escorted to medically necessary appointments. The child's parent, foster parent, caretaker, legal guardian or the Department of Human Services' Division of Family and Children Services (DFCS), where appropriate, shall be responsible for providing the escort.

Rev. 1/17

For those members enrolled in Georgia Families 360˚ an escort is required for ages 18 and under (see **APPENDIX O Georgia Families 360˚**).

Minor(s) Traveling with Adult Member or Adult Escort. There may be times when an adult may request a minor(s) to accompany him/her to their appointment, not as an escort, but because of one of the following:

1. the adult is a Medicaid member who has the appointment and requests that his/her child travels with them because there is no one available to stay with the child; or

2. the adult serves as the escort to the child (minor) requiring treatment/services and is requesting for an additional child to travel with them because there is no one available to stay with that additional child.

The Broker may use its discretion to allow the additional child to travel in the above circumstances if there is room or an available seat that is not being occupied by another member requiring treatment/services.

Section 200.8a Member Education

DCH will provide member notification regarding NEMT service availability and advance scheduling prior to the Broker assuming responsibility for the provision of transportation services.

Separate from **Member Rights** and **Member Responsibilities** outlined in Sections 200.8b and 200.8c, the Broker is responsible for developing an educational plan for members that includes each member's rights and responsibilities while utilizing NEMT services. All information materials used or developed by the Broker that is intended for a member or a healthcare provider shall be reviewed and approved by DCH in writing prior to mailing or otherwise disseminating. All educational materials must be available in alternative formats as required by special needs of members, such as those with visual impairments.

Initial Member Notice. The initial notice to be disseminated by DCH shall inform members within the respective regions of the availability of NEMT services, including the Broker's name, address, telephone numbers, and hours of operation, as well as a brief description of how to utilize the Broker to arrange for NEMT services. The initial notice shall be mailed to the members prior to the start of services.

Monthly Notices. A written notice shall be provided through DCH to all newly eligible members at the time of eligibility certification.

Other Notices. Any other mutually agreed upon notices shall be mailed at a date and time agreed to by DCH and the Broker.

Section 200.8b Member Rights

Members have rights regarding participation in the NEMT Program. They include but are not limited to:

1. You have the right of access to accurate and easy-to-understand information;

2. You have the right to be treated with respect and to maintain one's dignity and individuality;

3. You have the right to file complaints or incidents regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal;

4. You have the right to confidential treatment of all information in the member's record or file;

5. You have the right to receive care and services without discrimination;

6. You have the right to receive at least two (2) warning letters from the Broker regarding inappropriate behavior/cancellations at pick-up/no-shows before adverse action can be taken against you;

7. You have the right to an appeal for termination of services by NEMT Broker. Member must request appeal to DCH within 30 calendar days from the date of the termination letter. Failure to request appeal within 30 calendar days waives the member's right to further appeals **(see Section 300.16 Member Appeals);**

8. You have the right to report matters involving Medicaid fraud and program abuse. If you do not want to identify yourself, you may remain anonymous. You may notify us by:

   e-mail: oiganonymous@dch.ga.gov or pianonymous@dch.ga.gov; on-line: visit our website at http://dch.georgia.gov/report-fraud; and or telephone - 1-800-533-0686; and,

9. You have the right to receive transportation services in accordance with NEMT policies and procedures if you are eligible.

Section 200.8c Member Responsibilities

Non-emergency medical transportation services are provided for eligible Medicaid members who have no other way to get to their medical appointments. NEMT only provides transportation to members to receive Medicaid **covered** services. When participating in the NEMT program, members have certain responsibilities.

1. It is your responsibility to provide the Broker with correct information so that they can verify your eligibility and schedule transportation. Information required to request a trip:

   a. your name, address, phone number and Medicaid ID number;
   b. date and time of appointment and time appointment will be completed;
   c. physician/facility name, address and phone number
   d. type of Medicaid reimbursable service being received (to verify if service is covered by Medicaid);
   e. type of transportation needed;
   f. any special needs (such as type of wheelchair, walker, oxygen, escort, car seat, service animal, etc.);

2. It is your responsibility to schedule transportation at least three (3) business days prior to a non-urgent scheduled appointment. Do not count the day of the appointment. Same Day Requests (formerly urgent Care) may require verification from your doctor that you must be seen that day (See Section 300.4 Same Day Request (Urgent Care)).

3. It is your responsibility to be at pick-up location for your ride. The provider will wait 10 minutes from scheduled pick-up time. If the provider arrives early for your scheduled pickup, the 10-minute wait time begins at your scheduled pickup time.

Rev. 4/19

4. It is your responsibility to notify the Broker of any cancellations to your scheduled appointment no later than one (1) hour before your pickup time if possible. Two (2) or more no-shows/cancellations may result in suspension or termination from the NEMT program (see Appendix L Member Abuse of Program). You must notify the Broker of any changes (other than cancellations) to your scheduled transportation prior to your pickup. The Broker shall determine if your change request can be met or if you have to reschedule your transportation.

5. It is your responsibility to act appropriately and responsibly. Actions of misconduct, including violent or disruptive behavior may result in suspension or termination from NEMT program (see Appendix L Member Abuse of Program);

6. It is your responsibility to supply or administer your oxygen (if needed) during transport. NEMT vehicles/drivers are not equipped to supply/administer oxygen.

7. It is your responsibility, if ventilator dependent, to notify Broker that you will have a trained escort and that your ventilator is battery operated. NEMT vehicles are not equipped to maintain ventilators and the drivers cannot care for members who are ventilator dependent.

Section 200.9 Application for Services

The member must contact the Broker to request NEMT services at least three (3) business days prior to a non-urgent, scheduled appointment. The three (3) day advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be mandatory for all NEMT services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling.
The Broker shall be responsible to provide same-day transportation services when the member has no other available means of transportation and requests services for urgent care. Valid requests for urgent care transport shall be honored within three (3) hours of the time the request is made. Same Day Requests or urgent care is defined as an unscheduled episodic situation, in which there is no immediate threat to life or limb, but the member must be seen on the day of the request and treatment cannot be delayed until the next day. A hospital discharge shall be considered a Same Day Request. The Broker may verify with the direct provider of service that the need for the Same Day Request exists.

Pending eligibility of individuals must be verified by the Medicaid certified facility. Any individual who has been admitted to a Medicaid certified facility and has made an application for Medicaid benefits shall be determined to be "pending Medicaid eligible."

Medicaid members must have a valid Medicaid card or other tangible proof of eligibility (see **Appendix E Member Coverage Group and Certification Documents**) for acceptable proof of eligibility for the date of service to receive transportation services. If the card has been lost, stolen or cannot be displayed by the member, the Broker must verify eligibility.

Individuals eligible as *Qualified Medicare Beneficiaries* (QMBs) only are not eligible for NEMT services. If the member is QMB and is enrolled in a full-coverage Medicaid group (dual eligible) the member may be eligible for NEMT services.

Individuals enrolled under the *PeachCare for Kids*® program are not eligible for NEMT services.

The Broker must obtain from the member, or an individual or agency acting on behalf of the member, sufficient information to allow a decision regarding the member's need for NEMT services. This determination must take into consideration the member's ability to provide for his or her transportation outside of the NEMT program, pursuant to the NEMT gate-keeping policy established by DCH (see Appendix G Gate-Keeping Policies) as well as the member's needed level of transportation.

Section 200.10 Member NEMT Application Process

The Broker shall structure the determination of need for service process to meet the following basic requirements:

1. Transportation services may not be provided until:

    a. the member's eligibility has been established or person is a nursing home resident and has applied for Medicaid;
    b. the member has declared that he or she is a current resident of the Broker's region;
    c. the member's Medicaid identification number and address have been recorded for reporting purposes;
    d. the member has declared that he or she needs NEMT;
    e. the member has been determined to have a valid service need; and
    f. the computerized member worksheet for services has been completed.

2. The Broker shall advise the member that:

    a. the member, under penalty of law, shall provide accurate and complete information to determine need for NEMT services;
    b. the member must provide documentation of Medicaid eligibility;
    c. when requested, the member must provide, as a condition for receiving service and being determined eligible for the service, information related to the need for services; and
    d. only transportation to or from a health care service provider for Medicaid covered services is allowable.

Section 200.11 Denial of Service

The Broker may deny a trip or immediately discontinue a trip for any member who:

1. refuses to cooperate in determining status of Medicaid eligibility;

2. refuses to provide the documentation requested to determine need for NEMT services;

3. is found to be ineligible for NEMT services on the basis of the documented information that cannot be otherwise confirmed;

4. exhibits uncooperative behavior or misuses/abuses NEMT services **(see Appendix L**

Member Abuse of Program/Warning Letters);

5. is not ready to board NEMT transport ten (10) minutes after the scheduled pick up time;

6. fails to request a reservation three (3) business days in advance of appointment without good cause. For purposes of this section, "good cause" is created by factors such as, but not limited to, any of the following:

    a. urgent care;
    b. post-surgical and/or medical follow-up care specified by a healthcare provider to occur in fewer than three days;
    c. imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more; or
    d. the result of administrative or technical delay caused by the Broker and requiring that an appointment be rescheduled.

The Broker must provide in writing a letter to members or their legal representatives who have been suspended, denied or terminated from NEMT services. The letter must: 1) include the specific reason for the suspension, denial or termination; and, 2) advise the members of their right to an appeal. If the denial is given as a result of the transportation request being made to a service that is not covered by Georgia Medicaid, then no member appeal is warranted **(**see Section 300.16 Member Appeal for notice requirements and Appendix F Member Appeal Notices). A copy of that letter must also be provided to DCH.

Neither Brokers nor providers will discriminate against members based upon political affiliation, religion, race, color, gender, physical handicap, age, or national origin.

Section 200.12 Criteria for Wheelchair or Stretcher Services

Services other than minibus or public transportation may be required when one of the following conditions is present.

1. The member requires a wheelchair and is unable to use public transportation.

2. The member has a disabling physical condition which requires the use of a walker, cane, crutches or brace and is unable to use a minibus, commercial taxi or public transportation.
3. An ambulatory member requiring radiation therapy, chemotherapy or dialysis treatment, which results in a disabling physical condition after treatment, causing the member to be unable to access transportation without physical assistance.

4. The member is unable to ambulate without personal assistance of the driver in entering or exiting the member's residence and medical facility; or the member has a severe, debilitating weakness or is mentally disoriented as a result of illness or health care treatment and requires personal assistance.

Brokers are not precluded from using more intensive modes of transportation if the Broker determines the use to be appropriate. One of the above limiting conditions may exist before other than minibus or public transportation is considered; however, the existence of a limiting condition does not necessarily mean that a more intensive mode of transportation is required. While the

above conditions may demonstrate the possible need for wheelchair or stretcher services, the functional ability and independence of the Medicaid member should also be considered in determining the mode of transportation required. The key to the use of more intensive modes of NEMT services is that such services be adequate to meet the health needs of the individual.

Rev. 4/16

For clarification purposes, stretcher transportation providers are not allowed to use their stretchers for purposes of having members treated on them by the treating provider or facility.

Section 200.13 Escort and Attendant Services

An **escort** is defined as an individual whose presence is required to assist a member during transport and while at the place of treatment. The escort leaves the vehicle at its destination and remains with the member. An escort must be of an age of legal majority recognized under Georgia law.

An **attendant** is a staff person of the Broker or provider who is supplied by and trained by the Broker at the Broker's expense. The Broker must arrange with the transportation provider for the provision of one (1) attendant during transport when, in the judgment of the Broker, in consideration of all known factors or as required by the licensed healthcare provider, it is necessary to have an adult helper on a trip to assure the safety of all passengers. The attendant remains with the vehicle after the member has left the vehicle at its destination.

Rev. 4/15

The Broker must allow, without charge to the escort or member, one (1) escort to accompany a member or group of members who are residents of a nursing home, blind, deaf, mentally challenged, under 18 years of age, or as otherwise determined by DCH staff, when members are transported to receive Medicaid covered services. The Broker is not responsible for arranging for or compensating an escort for services rendered except, upon request, for the cost of public transportation.

Section 200.14 Reporting Suspected Fraud & Abuse

Fraud: Knowing and willful deception or misrepresentation, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Abuse: A manner of operation that results in excessive or unreasonable costs to the Department's Medical programs.

The Department of Community Health's Office of Inspector General investigates possible Medicaid/PeachCare for Kids fraud and abuse cases. The Program Integrity (PI) Section is responsible for appropriate follow-up on all information regarding fraudulent or abusive provider and/or member activities.

The investigation of provider activities includes, but is not limited to, billing for services not rendered by the provider, up coding, and illegal use of the provider number. The investigation of member activities include but are not limited to, illegal use of Medicaid/PeachCare ID cards and disclosure of resources. The primary responsibility of PI is to develop cases for referrals\to the State Healthcare Fraud Unit or the appropriate district attorney for prosecution. NEMT Brokers, Medicaid members, providers or other individuals who have information regarding possible fraud and abuse should contact DCH Office of Inspector General (Fraud and Abuse) at:

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Department of Community Health
Office of Inspector General
2 Peachtree Street, NW 5th Floor
Atlanta, GA 30303
404-463-7590 • 800-533-0686
E-mail: oiganonymous@dch.ga.gov (Anonymous)
Submit online at https://dch.georgia.gov/send-reports-fraud-abuse
(Not Anonymous)

CHAPTER 300 – OPERATIONAL REQUIREMENTS

Section 300.1 Hours of Operation

The Broker shall establish a duly licensed non-residential business office that is located within the service region and is open to conduct the general administration functions of the business between the hours of 8:00 a.m. and 5:00 p.m., Eastern Time, Monday through Friday. All documentation must reflect the address of this location. If a Broker is awarded both regions, one (1) central business office may be established for both regions.
The Broker shall provide scheduling services with sufficient capacity Monday through Friday, 7:00 A.M. to 6:00 P.M., Eastern Time. Time of the actual transport is predicated on the need of the member. Scheduling and business functions may be closed for New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day.

The Broker must have a telecommunications system and appropriate personnel available to allow for "paging" after-hours, including nights, weekends and stated holidays. The Broker will be responsible for arranging transportation services for non-routine appointments, and for replacing disabled or otherwise unavailable vehicles after hours.

Section 300.2 Telephone System and Scheduling Requirements

The Broker must provide Medicaid members or persons or agents acting on behalf of the member, with full, easy and long-distance toll free access to schedule trips. Access to the hearing and speech impaired may be satisfied by the use of the Georgia Relay Center **(see Appendix J Georgia Relay Center**). All calls to inquire of or schedule services by the Broker must be answered within ten (10) seconds. On hold timeframe will not exceed an average of sixty (60) seconds. The telephone system must have an automatic reporting system that records and reports the following:

1. number of calls received;
2. number of calls answered;
3. number of calls placed on hold;
4. average hold time for calls placed on hold;

5. number of abandoned calls;

6. average calls handled per hour/agent;

7. average occupancy percentage;

8. abandoned calls as a percent of total calls received;

9. average speed of answer;

10. average talk time; and

11. number of telephone operators by time of day/day of week.

The Broker shall develop performance standards and monitor telephone line performance by recording calls and employing other monitoring activities. Personnel assigned to the service telephone lines shall maintain a courteous and professional demeanor in all dealings with the public. These personnel must identify the Broker and themselves by name upon answering.

The Broker shall be responsible for obtaining periodic busy signal studies as requested by DCH. Action to correct high busy signal conditions to DCH's satisfaction will be the responsibility of the Broker.

The Broker must have multilingual capabilities to address the communication/language needs in the region. If the Broker is selected to be a Broker by this procurement process, a demonstration of the Broker's telecommunications system may be required before negotiations of the NEMT/Broker contract are complete.

Section 300.3 Pick-up and Delivery Standards

The Broker must assure that transportation services are provided which comply with the following minimum service delivery requirements and which shall be delineated in all transportation service agreements.

1. Arrival on time for scheduled pick-up shall be a standard practice. Arrival before the scheduled pick-up time is permitted; however, a member shall not be required to board the vehicle before the scheduled pick-up time. The Carrier is not required to wait more than ten (10) minutes after the scheduled pick up time.

REV. 07/22

2. Ensure that Medicaid members are transported to and from medical appointments on time. Medicaid members are to be advised of their pick-up time for transportation to appointments when the transportation request is made. For the return pick-up from an appointment, the vehicle shall arrive at the drop-off location within one (1) hour from time of notification.

3. In multiple-load situations, ensure that no Medicaid member is forced to remain in the vehicle more than forty-five (45) minutes longer than the average travel time for direct transport from point of pick-up to destination.

4. Drivers shall deliver members to their destinations on time for their scheduled appointments.

5. Late arrival will be reported to the dispatcher/transportation provider for the purposes of notifying the direct Medicaid service provider of the late arrival.

6. Trips will be monitored to ensure members are delivered to their homes in a timely manner from appointments.

7. If a delay occurs while picking up scheduled riders, the dispatcher/provider must contact proposed riders at their pickup points to inform them of the delay in arrival of vehicle and related schedule. The transportation provider must advise scheduled riders of alternate pick up arrangements when appropriate **(see Section 300.10 Back-up Services)**.

Rev. 07/22

Section 300.4 Same Day Request (Urgent Care)

The Broker shall arrange transportation services for Medicaid members when a *Same Day Request* is made and the member has no other means of transportation. For purposes of the NEMT program, a *Same Day Request*, formerly known as an urgent care request, is a type of transportation that is defined as an unscheduled episodic situation, in which there is no immediate threat to life or limb, but the member must be seen on the day the request is made and treatment cannot be delayed until the next day. The Broker may verify with the member's healthcare provider rendering service that the need does exist prior to scheduling the *Same Day Request* for transportation. Valid *Same Day Requests* shall be honored within three (3) hours of the time the request is made. The three-day notice to schedule transportation does not apply in this situation.

The requirements of this subsection shall also apply to appointments established by medical care providers allowing insufficient time for routine three (3) day scheduling.

Requests for transportation resulting from hospital discharges shall also be considered *Same Day Requests* in that the Broker has three (3) hours from the time of notification to pick the member up. The three-day notice to schedule transportation does not apply in this situation.

Section 300.5 Driver Conduct

The Broker must assure that drivers and attendants adhere to the following required standards that shall be delineated in all transportation service agreements.

1. No driver or attendant shall use or be under the influence of alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time.

2. No driver shall touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt, or as necessary to render first aid or assistance for which the driver has been trained.

Rev. 07/19

3. All drivers and attendants must wear or have visible, easily readable official company I.D.

4. At no time shall drivers or attendants smoke, eat or consume any beverage while in the vehicle or while involved in member assistance entering or exiting the vehicle or while in the presence of any member.

5. Drivers shall not engage in any behavior practices that will subject the State or the Broker to charges against protected groups.

6. Drivers and attendants must not wear any type of headphones at any time while on duty.

Rev. 10/18

7. Drivers shall not write, send, or read text based communication while operating motor vehicle in compliance with O.C.G.A § 40-6-241.2 and in compliance with the ***Hands Free Georgia Act,*** which was effective July 1, 2018.

Rev. 10/18

8. Drivers shall only use cell phones while driving in compliance with the ***Hands Free Georgia Act***, which was effective July 1, 2018.

9. Drivers or attendants must properly identify and announce their presence at the entrance of the building at the specified pick-up location if a curbside pick-up is not apparent.

10. Drivers or attendants must exit the vehicle to open and close vehicle doors when passengers enter or exit the vehicle and provide assistance as necessary to or from the main door of the place of destination.

11. Drivers shall confirm, prior to vehicle departure that the delivered passenger is inside the destination.

12. Drivers or attendants, while on board, must assist the passengers in the process of being seated, including the fastening of the seat belts. Children under the age eight must be properly secured in a child safety seat or booster seat in compliance with O.C.G.A § 40-8-76 (b). Drivers shall confirm, prior to allowing any vehicle to proceed, that wheelchairs and wheelchair passengers are properly secured and that all passengers are properly belted in their seat belts.

13. Drivers must provide support and oral directions to passengers. Such assistance shall also apply to the movement of wheelchairs and mobility-limited persons as they enter or exit the vehicle using the wheelchair lift. Such assistance shall also include stowage by the driver of mobility aids and folding wheelchairs.

14. Driver shall regulate heat and air inside the van during operations at a temperature level suitable to the climate conditions outside for passenger comfort.

REV. 04/20

15. Drivers who have had within the last five (5) years or currently have suspended or revoked driver's licenses, commercial or other, are prohibited from driving for any purpose under the NEMT program. Driver's whose cause for license suspension is for non-payment of child support will be removed from driving under the NEMT program

and reinstated only once the courts 1) release the individual and such release can be verified; and 2) the individual remains in good standing for a minimum of ninety (90) days after the release.

REV. 10/17

16. Drivers with one confirmed incident of failure to properly secure a member's wheelchair must be removed from providing services until such time as the NEMT Provider submits documentation to the Broker to support that the Driver has been properly trained in the use of securement devices.

17. Drivers or attendants shall not be responsible for passenger's personal items.

REV. 01/21

18. CMS requires Long-Term Care (LTC) Facilities to test drivers for COVID-19 based on parameters set forth within the Community COVID-19 activity level. All nursing home drivers must adhere to the requirements of Antigen testing for COVID-19 before transporting a nursing home resident. Directives in accordance with CMS guidelines and CDC recommendations www.cdc.gov.

REV. 01/21

19. According to OSHA and CDC recommendations to minimize the spread of COVID-19 and other infectious diseases, the Broker/transportation providers maintain regular housekeeping practices, ensure drivers are wearing the appropriate PPE wipe down the seats, the doorknobs, and inside windows after every trip when all members have exited the vehicle. Frequent and thorough hand washing is required. If soap and running water are not immediately available, alcohol-based hand rubs containing at least 60% alcohol is recommended.

Section 300.6 Vehicle Requirements

The Broker must assure that all transportation providers maintain all vehicles and vehicle equipment adequately to meet the requirements of the NEMT program. Vehicles and all components must comply with or exceed the manufacturers, State and federal, safety and mechanical operating and maintenance standards for the vehicles and models used for the NEMT program. Vehicles must comply with all applicable federal laws including the Americans with Disabilities Act (ADA) regulations. Any vehicle found non-compliant with the Georgia Department of Motor Vehicles Services (DMVS) licensing requirements, safety standards, PSC or ADA regulations, or NEMT/Broker contract requirements, that vehicle must be removed from service immediately if this discrepancy creates a health or safety hazard for vehicle occupants. Discrepancies shall be defined by DCH in its Policies and Procedures for Non-Emergency Medical Transportation (NEMT) Broker Services manual, as shall discrepancies related to passenger discomfort or inconvenience, and administrative requirements. All vehicles must meet the following requirements:

1. The transportation provider must provide and use a two-way communication system linking all vehicles used in delivering NEMT services with the transportation provider's major place of business. The two-way communication system shall be used in such a manner as to facilitate communication and to minimize the time in which out-of-service vehicles can be replaced or repaired. Pagers are not an acceptable substitute. A vehicle with an inoperative two-way communication system must be placed out-of-service until the system is repaired or replaced.

2. All vehicles must be equipped with adequate heating and air conditioning for driver and passengers. Any vehicle with a non-functioning climate control system must be placed out-of-service until appropriate corrective action is taken.

3. All vehicles must have functioning, clean and accessible seat belts for each passenger seat position and shall be stored off the floor when not in use. Each vehicle must utilize child safety seats when transporting children under the age of eight (8). Each vehicle shall have at least two (2) seat belt extensions provided. Additionally, each vehicle shall be equipped with seat belt cutter(s), mounted above the driver's door, for use in emergency situations.

4. All vehicles must have a functioning speedometer and odometer.

5. All vehicles must have functioning interior light(s) within the passenger compartment.

6. All vehicles must have adequate sidewall padding and ceiling covering.

7. All vehicles must be smooth riding, so as not to create passenger discomfort.

8. All vehicles must have two exterior rear view mirrors, one on each side of the vehicle.

9. All vehicles must be equipped with an interior mirror, which shall be either clear-view laminated glass or clear-view glass bonded to the back, which retains the glass in the event of breakage. This interior mirror shall be for monitoring the passenger compartment.

10. The vehicle's interior and exterior must be clean and have exteriors free of broken mirrors or windows, excessive grime, rust, chipped paint or major dents, which detract from the overall appearance of the vehicles.

11. The vehicle must have passenger compartments that are clean, free from torn upholstery or floor covering, damaged or broken seats, and protruding sharp edges and shall also be free of dirt, oil, grease or litter.

12. The vehicle floor must be covered with commercial anti-skid, ribbed rubber flooring or carpeting. Ribbing shall not interfere with wheelchair movement between the lift and the wheelchair positions.

13. All vehicles must have the transportation provider's name, vehicle number, and the Broker's phone number prominently displayed within the interior of each vehicle. This information must also be available in written form on each vehicle for distribution to riders on request.

14. All vehicles must have the name and other identifying information of the transportation provider displayed on the exterior of the vehicle in accordance with the Georgia Department of Public Safety requirements.

15. All vehicles must have the following signs posted in all vehicle interiors, easily visible to the passengers:

    a. no smoking, eating or drinking; and
    b. all passengers must use seat belts.

16. All vehicles must be equipped with one or more functional fire extinguishers at least 2.5 pounds each in size, with a combined capacity totaling at least 5.0 pounds in size (preferably ABC or Halon-type), and shall display a current inspection tag or sticker. The fire extinguisher shall be secured within reach of the driver and visible to passengers for use in emergencies when the driver is incapacitated.

17. All vehicles, except stretcher vans, that require a step up for entry, must include a retractable step, or a step stool as approved by DCH to aid in passenger boarding. The step stool shall be used to minimize ground-to-first-step height, should have four legs with anti-skid tips, sturdy metal with non-skid tread, with a height of 8 and 1/4", a width of 15" and a depth of 14" or an equally suitable replacement. Under no circumstances will a milk crate or similar substitute be considered a viable alternative for a step stool and will not be permitted on any vehicle.

18. All vehicles must have on board three (3) portable triangular reflectors mounted on stands. Use of flares is prohibited.

19. All vehicles must include a vehicle information packet to be stored in the driver compartment, or securely stored on or in the driver's side visor. This packet will include:

    a. vehicle registration;
    b. insurance card; and
    c. accident procedures and forms.

20. All vehicles must be provided with a fully equipped first aid kit and a "spill kit" including: liquid spill absorbent, latex gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.

21. All vehicles must contain a map of the applicable NEMT Regions with sufficient detail to locate members and medical destinations. Maps must be approved by DCH.

Section 300.7 Wheelchair Van Requirements

All vehicles used to transport wheelchair passengers must comply with the ADA requirements in effect at the time of the vehicle's construction. Vehicles used to transport wheelchair passengers must meet ADA requirements, including but not limited to the following:

1. must maintain a floor-to-ceiling height clearance of at least fifty-six (56) inches in the passenger compartment;

2. must have an engine-wheelchair lift interlock system, which requires that the vehicle's transmission be placed in park, and the emergency brake engaged to prevent vehicle movement when the lift or ramp is deployed;

3. full size wheelchair vans or buses must have wheelchair lift – a hydraulically or electro-mechanically powered wheelchair lift mounted so as not to impair the structural integrity of the vehicle;

4. wheelchair accessible mini-vans with a lowered floor and fold out ramp must meet ADA requirements;

5. Wheelchair Restraint System – for each wheelchair position, a wheelchair securement device (or "tiedown") shall be provided that complies with applicable ADA standards; and,

6. The system utilized may accommodate scooter-type wheelchairs. However, passengers utilizing these devices shall be requested to dismount from the device and be seated in a passenger seat.

Section 300.8 Vehicle Inspections

The Broker must develop and implement an annual inspection process, which will occur twice per year (every six (6) months), to verify that all vehicles meet the requirements of **Section 300.6 and Section 300.7** and that safety and passenger comfort features are in good business order (e.g., brakes, tire tread, turn signals, horn, seat belts, air conditioning/heating, etc.). The Broker shall conduct these biannual inspections using its own staff or an alternate method approved by DCH.

Prior to the execution of a service agreement between the Broker and a transportation provider, the Broker shall conduct a completed satisfactory initial inspection of all the transportation provider's vehicles, when applicable, prior to but no earlier than sixty (60) days, before the provider enters any vehicles into service. Subsequent inspections must be completed no later than six (6) months after the most recent inspection. Records of all inspections must be maintained as described in **Section 400.5 and Section 400.6**.

Section 300.9 Prohibition of Smoking

Smoking is prohibited on the vehicles while performing service for DCH. "No Smoking" signs shall be visible to all passengers. Broker shall require that drivers and attendants contact Broker immediately if passengers fail to comply with this prohibition. This prohibition applies to passengers, attendants, and all service providers.

Section 300.10 Backup Service

Broker shall be responsible for retaining and arranging for back-up vehicles or personnel or both when notified by a member, a provider or DCH that a vehicle is excessively late, is otherwise unavailable for services or when specifically requested by DCH. The vehicle is excessively late if it is twenty (20) minutes late in meeting its assigned schedule.

A back-up vehicle for an excessively late vehicle or an otherwise unavailable vehicle must be in place within thirty (30) minutes after a vehicle has been deemed unavailable for service for whatever reason.

Section 300.11 Removal of Vehicle from Service

Any vehicle found not in compliance with the required vehicle standards or any State or federal standards must be removed from service immediately until DCH certifies, in writing, that it may be returned to service.

Any vehicle receiving two (2) or more complaints from passengers concerning cleanliness, heating, air conditioning deficiencies, or other deficiencies within a five (5) day period must be inspected and appropriate corrective actions taken. Such actions must be documented and become a part of the vehicle's permanent record.

Section 300.12 Driver Qualifications

The Broker shall have written oversight procedures for ensuring that transportation providers meet all driver qualifications as well as deliver the required NEMT services. The Broker may establish additional qualifications, which shall be approved by DCH prior to implementation.

The Broker shall assure that an oversight procedure is in place to determine that all drivers, at all times during their employment, be legally licensed by the State of Georgia or other valid state issued driver's license, to operate the transportation vehicle to which they are assigned; be competent in their driving habits; be courteous, patient and helpful to all passengers; and be neat and clean in appearance.

Drivers shall not engage in any behavior practices that will subject the State or the Broker to charges against protected groups. All drivers employed by transportation providers through service agreements with the Broker to deliver transportation services shall meet the following conditions.

Rev. 10/20

1. All drivers must be at least twenty-one (21) years of age and have a current valid state issued driver's license.

Rev. 10/15

2. All drivers and attendants must have no prior convictions for a sexual crime or crime of violence.

Rev. 10/15

3. The transportation provider shall not utilize drivers who have been convicted of driving under the influence of alcohol, narcotics or drugs/medications within the last five years prior to date of employment. If the transportation provider suspects a driver to be driving under the influence of alcohol, narcotics or drugs/medications that would endanger the safety of members, the transportation provider shall immediately remove the driver from providing service to Medicaid members. Any person who has been convicted of a felony during the last five (5) years will drive and/or attend passengers only after satisfactory review by the Broker and DCH or its agent.

4. Individuals who have had within the last five (5) years or currently have suspended or revoked driver's license, commercial or other, are prohibited from driving under the

NEMT program. This excludes individuals whose cause for license suspension is for non-payment for child support, once the courts release the individual and such release can be verified and the individual remains in good standing for a minimum of ninety (90) days. At any point the individual's status changes and he or she is in arrears of child support payment(s) said driver's approval would be revoked permanently.

5. Drivers who receive citations and are convicted of two (2) moving violations and/or accidents where the driver was at fault, must be removed from service.

Section 300.13 Driver, Attendant, and Service Personnel Training

The Broker may establish and implement its own Driver, Attendant and Service Personnel Training standards in lieu of the standards established in the following paragraphs of this section, subject to advance review and approval of the Department.

Drivers: All drivers must have successfully completed driver training, first aid training and training in the use of a spill kit and the removal of biohazards *prior to driving under the NEMT program*. Certifications in these areas must be maintained for each driver. Training shall include:

1. a passenger assistance orientation program;

2. an on-going safety and sensitivity program to ensure a safe operating environment;

3. a defensive driving training.

Any driver who has not previously completed the training required must satisfactorily complete the required training within ninety (90) days of assignment.
Attendants. All Attendants used by transportation providers must have successfully completed an Attendants training program prior to riding with transportation providers under the NEMT program. Certifications in these areas must be maintained for each attendant. Attendant training shall include at a minimum:

1. first aid training;
2. a passenger assistance orientation program; and

3. an on-going safety and sensitivity program to ensure a safe operating environment.

Service Personnel. The Broker shall provide a program of service personnel training prior to permitting any personnel to have public contact or answer scheduling lines. Training shall include sensitivity components dealing with:

1. the aged and disabled persons;

2. cultural diversity;

3. handling hostile callers;

4. public contact; and

5. communicating with hearing or speech-impaired individuals through a service such as Georgia Relay.

Service personnel, including scheduling personnel, must be trained and knowledgeable in all aspects of transportation service operations including Broker reservation procedures. The Broker shall provide a written comprehensive training plan for all service personnel. Any changes to this plan must be approved by DCH prior to implementation. Changes must be submitted to DCH no later than thirty (30) days prior to requested implementation.

Section 300.14 Orientation for Transportation Providers

The Broker shall provide an orientation program for all transportation providers with which it has entered a service agreement. At a minimum, the orientation program must include:

1. overview of NEMT Program and division of responsibilities between Broker and transportation provider;
2. vehicle requirements;
3. procedures for handling accidents, moving violations and vehicle breakdowns;
4. driver qualifications;
5. driver conduct;
6. the use of attendants and/or companions;
7. scheduling procedures during regular operating hours, including criteria for determining the most appropriate mode of transportation for the member;
8. *after-hours* scheduling procedures;
9. procedures for handling requests for "urgent care";
10. criteria for trip assignment;
11. dispatching and delivery of services;
12. procedures for obtaining reimbursement for authorized trips;
13. driver customer service standards and requirements during pickup, transport and delivery;
14. record keeping and documentation requirements for scheduling, dispatching and driver personnel, including completion of required logs;
15. procedures for handling complaints and incidents from members or providers;
16. procedures for notifying members when services are denied or terminated by the Broker;
17. criteria and procedures for documenting and notifying members when services are denied or terminated by the transportation provider.

Section 300.15 Operational Procedures Manual

The Broker must develop an *Operational Procedures Manual* detailing all procedures to be used in the scheduling and delivery of transportation services. This manual must be submitted to DCH for review and approval at least forty (40) calendar days prior to the start of operations. The Broker must incorporate modifications required by DCH within ten (10) business days of notification. In no case will a Broker be allowed to begin operations without an approved operational procedures manual.

The Operational Procedures Manual must be incorporated into all training programs for new employees. The manual must also be provided to all transportation providers with whom the Broker has entered into a service agreement. The manual must be utilized in an orientation program to be provided by the Broker to transportation providers.

The operational procedures manual must be reviewed and updated annually and whenever changes in the operation of the business are made. Updates to the manual must be approved by DCH before distribution. DCH reserves the right to require modifications to the manual. Required updates must be submitted to DCH for approval within ten (10) business days of the request.

The operational procedures manual developed will become the property of DCH, which reserves the right to share selected text with Brokers in other regions for the purposes of improving all such manuals.

Section 300.16 Member Appeals

The Broker is responsible for notifying members of the right to appeal when a trip is denied, suspended or terminated.
The Broker must provide a written notice to the member within three (3) business days of the day a trip is denied, suspended or terminated. The notice must include the specific reason for the denial, suspension or termination and an explanation of the member's appeal rights. The original letter must be mailed or handed to the member, and a copy maintained in the Broker's member file. The Broker must use the notice of appeal letters developed by DCH **(see Appendix F Member Appeal Notices)**.

The member will be allowed thirty (30) calendar days to appeal the initial decision. Failure to appeal within thirty (30) calendar days waives the member's right to further appeal. Upon receipt of a timely appeal, the Broker has thirty (30) calendar days to complete the appeals process. The Broker will continue to provide transportation during the appeals process. If the appeal is a result from uncooperative or abusive behavior and the member continues to demonstrate documented behavior that is unacceptable and/or unsafe, even during the appeals process, transportation may be discontinued until a final court order overturning DCH's termination decision or settlement agreement between the parties is executed.

In the event the Broker is unable to resolve the dispute, the member must be given written, final notice informing the member of his/her right for further appeal to the DCH Client Appeals Unit. The Broker agrees to defend its decision, if necessary, at the time of any administrative hearing on the matter and without cost to DCH. All initial and final notices of appeal must be approved by DCH for content and format prior to program operation. If the member submits an appeal to

the Client Appeals Unit, the Broker, upon request from the DCH, must submit copies of the notices to the Appeals Unit within two (2) business days of the request.

At the conclusion of the appeals process, the Broker must implement any corrective action within ten (10) business days following notification by DCH. Corrective action may result in a change of policy or procedures regarding delivery of services.

The Broker must establish and maintain a member file whenever a complaint or appeal is filed by or on behalf of a member. These files must be available upon request of DCH or its agent within three (3) business days of the request.

Rev. 10/17

Section 300.17 Complaints and Incidents

The Broker shall be responsible for recording and responding to all complaints and incidents regarding the delivery of services, and then reporting all such complaints and incidents to DCH. Complaints and incidents may be reported by Medicaid members and/or their representatives, providers, DCH or its agent, or any individual or group who contacts the Broker. Resolutions and corrective actions taken by the Broker to address these complaints and incidents are subject to review and may be overridden by DCH. Upon review, DCH may require the Broker to implement new measures and/or submit proof of any corrective actions (including any policy or procedure changes) to improve service delivery. The Broker shall establish and maintain standardized written procedures to address all complaints and incidents. Such procedures must at a minimum, include those currently outlined in this Section.

For purposes of this program, the Broker shall consider a ***complaint*** and/or ***incident*** to be different.

The Broker shall consider a complaint as a general expression of dissatisfaction with service delivery, and /or the behaviors of other person(s) associated with the delivery of NEMT services. This can include, but not be limited to; dissatisfaction with the appearance, cleanliness or function of a vehicle; dispatching of inappropriate modes of transportation; dissatisfaction with interaction with members and drivers during transportation, dissatisfaction with the performance of Broker or provider personnel; regulatory or statutory violations, acts of moral turpitude or any other act, or behavior that adversely affects the health, safety or well-being of the member and/or person(s) associated with the NEMT program. All complaints must be reported to DCH monthly and include the requirements as outlined in this Section as well as **Section 500.8** of this manual.

The Broker shall consider an incident as a distinct piece of action, allegation, or occurrence that is noteworthy. This shall include, but not be limited to: a Code of Conduct breach, injury, accident, theft, property/equipment damage, sexual harassment or lewd conduct, alcohol/drug use, verbal/physical abuse, moral turpitude or other act; any inappropriate behavior adversely affecting the health, safety, and well-being of Medicaid members and/or person(s) associated with the NEMT program. All incidents must be reported to DCH immediately upon discovery whether the Broker perceives the incident valid or not.

The Broker shall respond verbally to the complainant within twenty-four (24) hours of receiving the complaint and/or incident and indicate on file that contact was made with the complainant within the required timeframe. Also, the Broker must provide to DCH a written record of the

investigative findings and/or resolutions along with any corrective actions taken or to be taken within five (5) business days of receiving the complaint and or incident.

The Broker may be required to remove any transportation provider, including drivers, and/or service personnel immediately upon discovery of non-compliance with NEMT policy for purposes of investigations, retraining applicable to the type of complaint or incident, or other corrective action as determined by DCH.

The Broker shall compile a report that analyzes the complaints and incidents on a monthly basis for the purposes of determining the quality of services, particularly noting any patterns or trends, to ensure services conform to NEMT requirements. The complaints and incidents received will be submitted to DCH by region and on a monthly basis and will include:

1) the complainant filing the complaint and/or incident;
2) the name of Medicaid member being transported;
3) the dates of service;
4) a brief description of complaint and/or incident;
5) the assigned transportation provider; and,
6) the Broker's corrective actions or resolutions to the complaint and/or incident.

The report shall be in accordance with the specifications and format approved by DCH.

The Broker shall designate an individual(s) within its organization to serve as liaison to DCH to ensure proper handling, resolution and/or corrective action to complaints and incidents.

The Broker must maintain records of complaints and incidents and their resolutions including a brief description of any corrective action taken. Copies of these records must be submitted within three (3) business days upon request by DCH.

Section 300.18 Performance Monitoring

DCH reserves the right to conduct a review of the Broker's records or to conduct an on-site review at any time to ensure compliance with these requirements.

1. Broker agrees to make all records related to services available for such reviews by DCH. DCH or its agent shall monitor the Broker's performance by telephone contact, record reviews, and other means.

2. DCH reserves the right to audit the Broker's records to validate service delivery reports and other information.

3. DCH staff or their official agent may ride on trips to monitor service. All of the transportation provider's vehicles must be made available to DCH or its agent(s) for inspection at any time.

4. DCH staff or its official agent will review reports of complaints and incidents from members, providers, or any individual or group who contacts the Broker regarding the delivery of services.

5. DCH or its official agent will maintain a toll-free telephone number to receive service complaints and incidents from members and healthcare providers. The Broker's project manager or a designee must be available to respond to DCH concerning these complaints and incidents within a thirty (30) minute response time.

6. Brokers must contract with an independent agent to conduct annual customer service satisfaction/member surveys. The methodology for administering the survey is subject to DCH approval. Copies of the report results and methodology for analyzing the data are due to DCH by July 31st each year following the end of the State fiscal year.

CHAPTER 400 – BUSINESS REQUIREMENTS

Section 400.1 Staffing Requirements

The Broker shall appoint and maintain, subject to DCH approval, a Project Director for the NEMT program who has sufficient authority for resource control to manage the allocation of resources to meet all program requirements without service interruption to Medicaid members. The Project Director must be committed to this program for a minimum period of six (6) months following contract award. The Project Director must be on-site within the Broker's region full-time during implementation and the first six (6) months of operation and then at least fifty percent (50%) of regular operating hours each month. Supervisory personnel must be available to Broker staff in person or by telephone within a thirty (30) minute response time during all hours of operation.

The Broker must maintain sufficient levels of supervisory and support staff with appropriate training and work experience that reflects the population being served in each region to perform all program requirements on an ongoing basis. DCH shall have the right to require reassignment or removal from the NEMT program of any staff or personnel found unacceptable.

Section 400.2 Equal Employment Opportunity Plan

The Broker's staffing must demonstrate a commitment to minority participation on the Georgia project. The Broker must develop an *Equal Employment Opportunity Plan* in compliance with the Equal Employment Opportunity Act (Public Law 92-26) of 1982 and submit it to DCH for review and approval at least thirty (30) days prior to the start of operations. The Broker must incorporate modifications required by DCH within ten (10) business days of notification. In no case will a Broker be allowed to begin operations without an approved Equal Employment Opportunity Plan.

The Broker shall review and identify updates to the Plan on an annual basis by July 1st (or alternate dated approved in writing by DCH). The Broker shall submit all proposed updates to the Plan to DCH for review and approval prior to implementing. If there are no changes, the Plan must still be submitted and indicate no changes and dated for the current year's submission.

Section 400.3 Central Business Office

The Broker must establish a non-residential central business office within the service region for which it has responsibility. If the Broker is successful in more than one (1) region, then there can be one (1) central business office and an additional non-residential satellite business office

servicing the other region(s). This business office must be centrally located within the region in an accessible location for foot and vehicle traffic. The Broker may establish more than one (1) business office within the region, but one regional non-residential business office must be designated as the central business office.

All documentation must reflect the address of the location identified as the legal, duly licensed Central Business Office. This business office must be open from 8:00 A.M. to 5:00 P.M. Eastern Time, Monday through Friday. DCH does not require the Project Director and scheduling staff to be located in the Central Business Office in each NEMT region. Scheduling staff must be at the office from 7:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday.

The Broker must have the capacity to send and receive facsimiles at the central business office at all times during business hours. The Broker must provide an administrative telephone number that will enable DCH staff to reach the Project Director directly, without going through the scheduling staff. The Broker must also have the capacity to reproduce documents upon request by DCH and at no cost to DCH.

Section 400.4 Meetings

The Broker may meet with DCH representatives quarterly or upon request by DCH via conference call or at a mutually agreed upon location to discuss the NEMT program for their regions and to answer pertinent inquiries regarding the program, its implementation and its operation.

The Broker must establish an Advisory Committee in each region. The Committee shall consist of representatives from a nursing home, dialysis center, hospital, transportation provider(s) and the member community. The Advisory Committee must meet quarterly of each calendar year and the Broker must provide DCH with a copy of the minutes from each meeting within ten (10) business days of that meeting.

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Section 400.5 Record Retention

The Broker shall maintain detailed records evidencing the administrative costs and expenses related to the NEMT program, the provision of services, and complaints and incidents, for the purposes of audit and evaluation by the Department and other federal or State personnel.

All records, including training records, must be readily retrievable within two (2) business days for review at the request of DCH and its authorized representatives.

All records shall be maintained and available for review by authorized federal and State personnel.

The Broker shall preserve and make available all its records pertaining to the performance for a period of five (5) years from the date of final payment under the NEMT/Broker contract, and for such period, if any as is required by applicable statue or by any other section of the NEMT/Broker contract. If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of seven (7) years from the date of termination or of any resulting final settlement. Records that relate to appeals, litigation, or the settlement of claims arising out of the performance of this contract, or costs and

expenses of any such agreements as to which exception has been taken by the Broker, or any of its duly authorized representatives shall be retained by Broker until such appeals, litigation, claims or exceptions have been disposed of.

Section 400.6 Transportation Provider Records

The Broker must establish, maintain and provide upon request, the following records and related information in its files for each non-public transportation provider with which the Broker has entered a Service Agreement:

1. copy of Broker's executed service agreement for each transportation provider;

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2. copy of transportation provider's registration with the Georgia Department of Public Safety;
3. vehicle records, including at a minimum the following documentation for each vehicle:
    a. manufacturer and model;
    b. model year;
    c. vehicle identification number;
    d. odometer reading at the time the vehicle entered service;
    e. type of vehicle (minibus, wheelchair van or stretcher van);
    f. capacity (number of passengers);
    g. license tag number; insurance certifications; Unified Carrier Registration (UCR) and vehicle stamp;
    h. special equipment (lift, etc.); and
    i. date, odometer reading and description of inspection activity (e.g., verification that vehicle meets program vehicle requirements, inspection of equipment such as brakes, tire tread, turn signals, horn, seat belts, air conditioning and/or heating, etc.);

4. records must be maintained of the initial inspection and all subsequent inspections;

5. driver records, including at a minimum the following documentation for each driver:

    a. driver's name, date of birth and social security number;
    b. copy of the driver's license;
    c. prior driving record for previous three (3) years obtained from Georgia State Patrol;
    d. documentation of background checks conducted by Broker to determine if the driver can provide services;
    e. first aid training certificates;
    f. driver training course certificate; and
    g. documentation of any complaints and incidents received about the driver and any accidents or moving violations involving the driver.

Section 400.7 Services Provided

The Broker must maintain such records as are necessary to fully disclose the extent of services provided and to furnish DCH with information regarding services as may be periodically requested. Required records include completed vehicle manifests.

Vehicle manifests are to be completed by each vehicle driver daily and must contain the following information:

1. transportation provider name;
2. vehicle number;
3. vehicle operator name;
4. member name;
5. member Medicaid number;
6. time of medical appointment (if applicable);
7. pick up point;
8. destination;
9. scheduled pick up time;
10. actual arrival time at pick-up point;
11. actual departure time from pick-up point;
12. actual return time from drop off point;
13. odometer reading at point of pick-up;
14. odometer reading at point of drop-off;
15. name of escort and relationship to member;
16. date of service; and
17. name of Broker-provided attendant (if applicable).

Section 400.8 Business Continuity and Disaster Recovery Plan

The Broker must develop and maintain a Business Continuity and Disaster Recovery Plan designed to minimize any disruption to transportation services caused by a disaster at the Broker's central business office or other facilities. It is the sole responsibility of the Broker to maintain adequate backup to ensure continued scheduling and transportation capability.

The Plan must be submitted to DCH for review and approval thirty (30) calendar days prior to the start of operations. The Broker must incorporate modifications required by DCH within ten (10)

calendar days of notification. In no case will a Broker be allowed to begin operations without an approved Business Continuity and Disaster Recovery Plan. The Broker shall submit an updated Plan on an annual basis by July 1st (or alternate date approved in writing by DCH). If there are no changes, the Plan must still be submitted and indicate no changes and dated for the current year's submission. In addition, the Broker must complete interim updates within ten (10) business days of change in procedures.

The Broker shall conduct on an annual basis a Disaster Recovery Plan Review and exercise/drill at the Broker's own expense. The Broker must notify DCH five (5) business days at a minimum of the date of the exercise/drill. A written report of the findings must be delivered to DCH within fifteen (15) calendar days of the date that the test is conducted.

At a minimum, the Plan must include the following components:

1. measures taken to minimize the threat of a disaster at the Broker's central business office and other facilities, including physical security and fire detection and prevention;

2. provisions for accepting member telephone calls and scheduling transportation in the event of a disaster at the Broker's central business office or the failure of the Broker's telephone system;

3. procedures utilized to minimize the loss of required records in the event of fire, flood or other disaster; and

4. off-site storage.

Section 400.9 Turnover/Transition Task

Prior to the conclusion or non-renewal of the NEMT/Broker contract, or in the event of a termination for any reason, the Broker shall assist when turning over the Broker functions to DCH or its agent, as specified in Section 400.10 Turnover/Transition Plan.

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Within thirty (30) calendar days after the NEMT/Broker contract is awarded the successful Broker shall submit a *Turnover/Transition Plan* to DCH for approval. Thereafter, the Broker shall submit an updated Plan on an annual basis by January 1 (or alternate date approved in writing by DCH) throughout the life of this contract to reflect any changes that may impact transition activities. The Broker shall incorporate any modifications required by DCH within ten (10) business days of notification. If there are no changes, the Plan must still be submitted and indicate no changes and dated for the current year's submission.

The Plan shall include:

1. a proposed approach to turnover, in paragraph form, along with a work plan, including the tasks and time line schedule for the turnover;

2. an estimate of the number of full-time equivalents (FTEs) and type personnel needed to operate all functions of the Turnover/Transition Plan. The statement shall be separated by service area and by type of activity of the personnel;

3. a statement of all facilities and resources currently required to operate the Broker functions, including, but not limited to:

    a. data processing equipment;
    b. reservation/scheduling software;
    c. system and special software (data base and telecommunications);
    d. other equipment;
    e. office space;
    f. transport and service provider network; and
    g. a statement indicating that DCH would have license to utilize the Broker's software until a new Broker can be selected and become operational in that NEMT service region.

The statement of resource requirements shall be based on the Broker's experience in the operation of the Broker functions and shall include actual Broker resources devoted to the operation of all tasks required.

Turnover/Transition Services. The Broker will provide to DCH or its agent by a turnover date to be determined by DCH, all current, updated and accurate reference files, and all other records required by DCH or its agents to perform the duties of: recruiting and negotiating with transportation providers; payment administration; gatekeeping; reservations and trip assignments; quality assurance, and administrative oversight/reporting.

The Broker will also submit to DCH any inventory of training manuals, operational procedures manuals, brochures, pamphlets, and all other written materials developed in support of this contract activity.

The Broker will, upon request by DCH, begin training the staff of DCH or its designated agent in the required Broker operations. Such trainings must be completed at least one month prior to the end of this contract or on a date specified by DCH.

Turnover/Transition Deliverables. The Broker will provide an initial Turnover/Transition Plan on a date approved by DCH for DCH's review and approval and will also provide annual updates to the Plan on a schedule to be established by DCH.

Section 400.11 Quality Assurance Plan

The Broker must develop and maintain an ongoing quality assurance plan to support the provision of high-quality transportation services to the Medicaid member community. At a minimum, the Quality Assurance Plan must include the following elements:

1. key indicators of quality related to scheduling and delivery of transportation services;

2. a description of how the Broker plans to monitor these key indicators;

3. a description of how the Broker will develop, implement, and evaluate corrective actions or modifications to overall operations as necessary to address quality concerns;

4. a description of the Broker monitoring procedures to safeguard against fraud and abuse by transportation providers and members;

5. a description of how the Broker will monitor the quality of the transportation providers;

6. a description of how the Broker will ensure that all NEMT services paid for are properly authorized and rendered;

7. a description of how the Broker will ensure that transportation providers and Independent Drivers within their network meet standards for driver qualifications, training and vehicle maintenance and inspections;

8. a description of the staffing resources responsible for the quality assurance plan and quality assurance activities; and

9. samples of all reports related to quality assurance and performance monitoring, along with descriptions of their use and who is responsible for reviewing them.

The Quality Assurance Plan must be submitted to DCH for review and approval at least forty (40) calendar days prior to the start of operations. The Broker must incorporate modifications required by DCH within ten (10) business days of notification. In no cases will a Broker be allowed to begin operations without an approved quality assurance plan. Thereafter, the Quality Assurance Plan must be reviewed and submitted on an annual basis by July 1st or alternate date approved in writing by DCH. If there are no changes, the Plan must still be submitted and indicate no changes and dated for the current year's submission. Any revisions must be submitted to DCH for review and approval at least thirty (30) calendar days prior to implementation.

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Section 400.12 Security Plan

The Broker shall develop and implement a written Security Plan which details how it will comply with the Administrative, Technical, and Physical Security Standards and Requirements specified in the HIPAA Security Rule, the eRFP, and the NEMT/Broker contract, including, but not limited to, NIST Computer Security Controls, the GTA Security Standard and Access Management protocols, and any updates thereto. The Security Plan shall provide contact information for individuals with responsibility for securing State data.

In accordance with Section 4.B.i.c(5) of the NEMT/Broker contract, the Broker shall review and update the Plan on an annual basis by June 1st of each year for all contract renewals and within thirty (30) Calendar Days in advance of any changes to the Plan or such other frequency as determined by the DCH Project Leader. If there are no changes, the Plan must still be submitted and indicate no changes and dated for the current year's submission. Any Broker-proposed updates to the Plan shall be submitted to the DCH Project Leader for prior review and approval at least thirty (30) Calendar Days in advance of any changes to the Plan.

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Section 400.13 Independent Service Auditor's Report

In accordance with Section 34.E of the NEMT/Broker contract, the Broker shall submit by July 15th of each year (or alternate date approved in writing by DCH) an Annual Independent Assessment of the Organization's Financial Controls that meets all standards and requirements of the most current version of the American Institute of Certified Public Accountants ("AICPA") SAE 18, SOC-1 (Type II) and an Annual Independent Assessment of the Service Organization's HIPAA Security Controls and Safeguards that meets all standards and requirements of the most current version of the National Institute of Standards and Technology ("NIST") Special Publication SP800-53 Moderate-Impact-Baseline Security Controls published by the NIST, to include a Security Assessment Report and Gap Analysis ("SAR Report") and a Plan of Action and Milestones Report ("POAM Report") that details the Service Organization's Remediation Plan for any reported findings which were identified as a result of the Independent Assessment. If there are no changes, the Plan(s) must still be submitted and indicate no changes and dated for the current year's submission. The Broker shall bear the cost of obtaining the report.

The Broker shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the audit and shall submit an acceptable proposed CAP to DCH where required. The Broker shall implement the CAP within thirty (30) Calendar Days of its approval by DCH or as specified in DCH's approval.

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Section 400.14 License, Permit and Certification Requirements

The Broker must assure that transportation providers maintain current licenses, permits or certifications as required by all levels of government in Georgia for the operation of necessary vehicles.

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Section 400.15 Computer Requirements

The Broker shall assist DCH in its efforts to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its amendments, rules, procedures and regulations. The Broker's system shall conform to HIPAA standards for information exchange. The Broker shall be able to transmit and receive all applicable transactions required by HIPAA regulations in the version deemed by DCH. The Broker must have a system that is flexible and can accommodate changes needed based on federal, state, or local government mandates as well as changes needed to support DCH policy changes. The Broker must comply with the implementation timeline established by DCH.

The Broker must maintain in the central business office sufficient computer hardware and software to support automated call intake, eligibility verification, needs assessments and trip reservations, as well as to meet the monthly reporting requirements established under the NEMT/Broker contract.

The Broker may use one (1) of two (2) options available to verify member eligibility.

1. The Broker may access this information via the web portal at the following address http://www.mmis.georgia.gov; or

2. The Broker may use the Medicaid Eligibility Inquiry System (MEIS).

MEIS can be accessed with a touch-tone telephone by dialing 770-325-9600 or 1-800-766-4456 twenty-four (24) hours a day (except between the hours of 6:00 PM on Sundays to 6:00 AM on Mondays). Additionally, the Broker may contract with a MEIS agent or use of the web portal to verify eligibility. However, the Broker must insure that they can verify eligibility at all times.

The Broker must accept and load in a computer database, on a monthly basis, Medicaid member files for use in identifying members assigned to their region. The Broker must demonstrate the ability to accept, load and utilize the member file during operational readiness testing. DCH or its fiscal agent will provide the format and specifications of the member file download.
The reservation/scheduling NEMT software utilized by the Broker must have the following capabilities:

1. maintain a database of transportation providers with which the Broker has service agreements, including reimbursement and other information needed to determine trip assignments;

2. automatic address validations, distance calculations and trip pricing, if applicable; and

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3. standing order trips and random trip reservations capability. The Broker must update or confirm existing standing order every 30 days from its effective date.

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Section 400.16 Disclosure of Ownership and Control Statement

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The Code of Federal Regulation (42 CFR 455.105(b)) states in part that, upon request, providers furnish to the state or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. DCH requires business transaction disclosure information to be submitted by the NEMT Broker on an annual basis no later than January 31st. If the request for disclosure information is made prior to or subsequent that date, the Broker is required to submit that information within 35 days of the date of request. The Broker must immediately resubmit a new or updated disclosure form should there be any changes in information by the subcontractor on previously submitted forms.

This form is available on-line at www.mmis.georgia.gov under "*Provider Enrollment*", select "*Enrollment Forms*" (Disclosure of Ownership and Control Interest Statement – Contractors Only – NEMT). Brokers are required to submit forms electronically.

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The Broker must provide reports and summaries upon request and as specified by DCH. DCH will provide the Broker with a copy of each of the required reporting formats upon final execution of the NEMT/Broker contract. The Broker must provide reports by the 30th calendar day of the month following the month of Broker payment to direct service providers or as otherwise noted by DCH in the below sections of this chapter. Reports shall include all data specified for which payment was made to a direct service provider and shall be reported by month of service. The final report is due by the 30th calendar day of the month following the month of termination of the NEMT/Broker contract. If the Broker has been awarded more than one (1) region, reports must reflect each region separately. Reports include but are not limited to those named in **Section**

500.1 through Section 500.13 below. For a summary detail of required reports in this manual, please see **Appendix P Reporting Requirements Matrix.**

Section 500.1 Driver Report

The Broker shall provide DCH, on hard copy and on CD or in electronic format, a listing of entities providing transportation services on behalf of the Broker and a roster of all drivers before the start of operations. Drivers must be listed separately for each transportation provider. The roster shall indicate, at a minimum, the driver's name, driver's license number, and social security number. The carrier listing and driver roster shall be updated to reflect additions and deletions in carriers and personnel, and delivered to DCH each calendar quarter. This roster is due by the 30th calendar day of the month following the end of the reporting quarter.

Section 500.2 Vehicle Report

The Broker shall provide DCH with a listing of all vehicles placed in service for the performance of obligations before the start of operations. The list shall include for each vehicle:

1. name of transportation provider;
2. manufacturer and model;
3. model year;
4. vehicle identification number; and
5. type of vehicle (minibus, wheelchair van or stretcher van).

The roster shall be updated to reflect vehicle additions and deletions, and delivered to DCH each calendar quarter. This roster is due by the 30th calendar day of the month following the end of the reporting quarter.

Section 500.3 Transportation Services Encounter Data Report

The Broker shall collect and submit to the Department or its agent detailed encounter data on each trip made in behalf of a Medicaid member residing in the Broker's area. The transactions must comply with HIPAA regulations in the version deemed by DCH. The data will be processed by the Department in a manner similar to claims processing, with the exception that no payment per claim will be generated. All other costs, including telecommunications equipment and expense, computer hardware and software associated with collecting and transmitting encounter data to the Department shall be the responsibility of the Broker.

The encounter data are due thirty (30) calendar days following the month of payment by the Broker and shall be reported by month of service. The electronic media must be supported by a summary report, as described in the following section. Totals included in the summary report must balance to the detail reporting information or both the detail and summary reporting will be rejected by DCH and corrected reports required.

Section 500.4 Transportation Services Summary Reports

The following summary reports must be submitted on paper or acceptable electronic media as approved by DCH and in the quantity specified by DCH.

Transportation Services Monthly Report. Shows the number of trips, number of unduplicated members, and the total number of miles, broken out by mode of transportation service provided. This report is due by the 30th calendar day of the month following the month of payment by the Broker and shall be reported by month of service. The report must balance to the detail reporting information described in **Section 500.3 Transportation Services Detail Reporting via Encounter Data** or both the detail and summary reporting will be rejected by DCH and corrected reports required.

Annual Transportation Services State Fiscal Year Report. Shows the number of trips, number of unduplicated members, and the total number of miles, broken out by mode of transportation service provided. This report shall also include the total number of calls received, number of calls answered, number of calls abandoned and the year average hold time. This report is due by July 31st each year following the end of the State fiscal year.

Section 500.5 Accidents and Moving Violations Report

The Broker shall notify DCH or its agent immediately of any accident resulting in driver or passenger injury or fatality while delivering services. The Broker shall file a written accident report with DCH within ten (10) business days of the accident and will cooperate with DCH during any ensuing investigation. Please see **Appendix I Accidents and Moving Violations Report**. A police report is also required as supporting documentation. The Broker shall notify DCH immediately of any moving violations. The Broker must provide a copy of the police report within ten (10) business days of the moving violation.

The Broker shall maintain copies of each accident and moving violations report in the files of both the vehicle and the driver involved. Police reports associated with moving violations must be maintained in the file of the responsible driver.

The requirements of this section must be incorporated in all service agreements between the Broker and transportation providers.

Section 500.6 Telecommunications System Report

On a monthly basis, the Broker must provide reports produced by the telephone system used in scheduling appointments to DCH or its agent. The following information must be included in this report:

1. number of calls received;
2. number of calls answered;
3. number of calls placed on hold;
4. average hold time for calls placed on hold;

5. number of abandoned calls;

6. average calls handled per Hour/Agent;

7. average occupancy percentage;

8. abandon calls as a percent of total calls received;

9. average speed of answer;

10. average talk time; and

11. number of telephone operators by time of day/day of week.

This report is due by the 30th calendar day of the month following the month of the telephone activity.

Section 500.7 Annual Certified Financial Audit Report

Certified Financial Audit. This report must include financial margins of profit and financials must be certified by an independent Certified Public Account (CPA), or comparable as determined by DCH, for the Georgia-held book of business and Georgia's book of business only.

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The Broker must submit this report within three (3) months following the end of the DCH fiscal year and no later than September 30th of that year.

Section 500.8 Complaint and Incident Report

As described in **Section 300.17 Complaints and Incidents**, the Broker must compile and analyze complaints and incidents on file on a monthly basis. A written summary must be sent to DCH by the 30th calendar day of the month following the month of activity. The report shall include the date of the incident, complainant, and number of complaints and incidents by type, a description of corrective actions taken and percentage of complaints and incidents by category.

Section 500.9 Member No-Show Report

As described in **Section 100.2 Payment Administration** Number 5, the Broker will pay the provider for the "A leg" of a trip in the instance where a member fails to board the vehicle for a trip (a.k.a. "member no-show") within the time frame prescribed in Section **300.3 Pick-up and Delivery Standards**. Also, the scheduled provider must have arrived to pick up the member on time described in **Section 300.3**.

The Broker shall submit to the Department a monthly report containing member no-show data. The *Member No-Show Report* and the methodology used to capture the member no-show and how the Broker will pay the provider for the "A leg" in the event of a member no-show, must be submitted to DCH for review and approval thirty (30) calendar days prior to the start of operations. The Broker must incorporate modifications required by DCH within ten (10) calendar days of notification. In no case will a Broker be allowed to begin operations without an approved Member No-Show Plan. Updates to the existing Plan must be submitted to DCH for

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review and approval at a minimum of five (5) business days prior to execution. Implementation of any revisions will not be effective until DCH has given Broker written approval of any proposed revision. This report must be submitted to DCH thirty (30) calendar days following the month of payment by the Broker to direct service provider.

Section 500.10 Transportation Denied by Reason Report

The Broker shall submit to the Department a monthly report of the number of requests for transportation denied by reason. The written summary must be sent to DCH by the 30th calendar day of the month following the month of activity. The report shall include the reporting month, subtotal, total for fiscal year and percentage of denials by reason.

Section 500.11 Late Percentage Summary Report

The Broker shall submit to the Department a late percentage monthly report. The written summary must be sent to DCH by the 30th calendar day of the month following the month of activity. The report shall include for the reporting period the total number of trips, “A leg" late trips, “B leg" late trip, total late trips and the percentage of late trips.

Section 500.12 Staff Roster Report

The Broker must submit a staff roster every ninety (90) calendar days. The employee listing shall be updated to reflect changes in staffing. DCH shall have the right to require the reassignment or the removal of any staff or personnel without cause at the sole discretion of DCH.

NEMT APPENDICES

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APPENDIX A

GEORGIA MEDICAID COVERED AND NON-COVERED SERVICES

Medicaid is a health insurance program that pays medical bills for eligible low-income families including pregnant women and women with breast or cervical cancer, foster and adoptive children and for eligible aged, blind and/or those who have disabilities whose income is insufficient to meet the cost of necessary medical services.

Services Covered by Georgia Medicaid

With **applicable service limitations**, the following is a list of services covered by Georgia Medicaid.

1. Physician Services
2. Dental Services
3. Oral Surgery Services
4. Podiatric Services
5. Orthotic and Prosthetic Services
6. Durable Medical Equipment Services
7. Inpatient and Outpatient Hospital Services
8. Laboratory and Radiological Services
9. Pharmacy Services
10. Home Health Services
11. Rural Health Clinic/Community Health Center Services
12. Physician's Assistant Services
13. Family Planning Services
14. Nurse Midwifery Services
15. Mental Health Clinic Services
16. Non-Emergency Medical Transportation Services
17. Ambulatory Surgical Services
18. Hospice Services
19. Dialysis Services
20. Childbirth Education Services
21. Nurse Practitioner Services
22. Psychological Services
23. Vision Care Services

24. Intermediate Care for the Mentally Retarded Facility Services
25. Swing Bed Services
26. Children's Intervention Services
27. Health Check (Early and Periodic Screening, Diagnostic and Treatment) Services
28. Nursing Facility Services
29. Diagnostic, Screening and Preventive Services (Health Department)
30. Targeted Case Management Services
    a. Adults with AIDS
    b. Children at Risk of Incarceration
    c. Chronically Mentally Ill
    d. Early Intervention
    e. Perinatal
    f. Adult and Child Protective Services
31. Waiver Services

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There are services which are covered by Georgia Medicaid, but may not be allowed or appropriate for NEMT. For example, transportation of medically fragile children or adults along with the necessary life-sustaining medical equipment may or may not be appropriate for NEMT. If the member's condition is stable (which shall be determined by the member's physician and/or healthcare team) NEMT may be appropriate. However, medically fragile children are required to travel with an escort who can assist the member in and out of the vehicle and manage or maintain the medical equipment needed by the member during transport.

Some medical equipment that may be required for this population during transportation may include but not be limited to:

1. portable oxygen tank or nasal cannula;
2. IV fluids with measured or calibrated IV equipment;
3. portable ventilator (must be fully charged);
4. Suction equipment that is portable or Endotracheal Tube;
5. Enteral Feeding Tube (nutrition fed through a tube placed in the nose, the stomach or the small intestine.);
6. Cardiorespiratory Monitoring equipment;
7. Urinary Catheterization tube or portable bag
8. Renal or Abdominal Dialysis Equipment;
9. Ministrations imposed by tracheotomy, colostomy, Ileostomy, or other medical surgical procedures;
10. (TPN Dependent) Total Parenteral Feeding.

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It should be noted that transportation providers are only responsible for the member's transportation. NEMT vehicles/drivers are not equipped or trained to manage or maintain any type of medical equipment. If applicable, equipment must be fully charged and operable at the time of transport.

In the case of an emergency, the transportation provider (driver) will call 911 for assistance for the member.

Services Not Covered by Georgia Medicaid

There are certain items and services that Georgia Medicaid does not cover. Services not covered by Georgia Medicaid include but are not limited to:

1. inpatient hospital services for persons in institutions for treatment of mental diseases or special disorders, such as tuberculosis. (Crisis Stabilization Units [CSU] and Psychiatric Residential Treatment Facilities [PRTF] are not considered hospitals);
2. services given by a relative or a member of an individual's household;
3. cosmetic surgery;
4. orthopedic shoes for persons over twenty-one (21) years of age unless attached to a brace;
5. routine foot care except for children under twenty-one (21) years of age;
6. abortions, unless the person's life is at risk or in cases of reported rape or incest;
7. over-the-counter drugs, except insulin;
8. disposable or over-the-counter medical supplies, such as bandages, adult diapers, rubbing alcohol, and cotton;
9. chiropractic services unless the individual is covered by Medicare;
10. experimental items or services;

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11. dentures and eyeglasses for persons over twenty-one (21) years of age (transportation is covered for pickup of dentures and eyeglasses).
12. transportation for educational purposes, except childbirth and parenting classes (currently, transportation to parenting classes is limited to hospital outpatient services only);
13. vocational training;
14. transportation to attend amusement parks, sporting events, and other social functions;
15. transportation to pick up Women, Infant and Children (WIC) vouchers;
16. transportation to Alcoholic Anonymous (AA) meetings; and,
17. transportation to Narcotic Anonymous (NA) meetings.

APPENDIX B

VEHICLE REQUIREMENT CATEGORIES

NEMT vehicle requirements, specified in Section 300.6, are classified in one of three categories, "health and safety hazards", "passenger comfort and convenience", or "administrative". The categories are listed below:

Health and Safety Hazards Requirements	**Passenger Comfort and Convenience Requirements**	**Administrative Requirements**
Functional fire extinguisher(s) at least two 2.5 pounds in size or one 5 pounds in size mounted within reach of the driver	Adequate heating and air-conditioning for driver and passenger	Transportation provider's name, vehicle number, and the Broker's phone number prominently displayed inside the vehicle
Functioning seat belts for all passengers	Functioning interior light	Vehicle information packet containing vehicle registration, valid proof of insurance, original PSC cab card (form G), and accident procedures and forms maintained in the vehicle
Two seat belt extensions	Adequate sidewall padding and ceiling covering	Map of NEMT Region in the vehicle
Seat belt cutters mounted above the driver's door	Interior mirror for monitoring the passenger compartment	
Spill kit: containing liquid spill absorbent, latex gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer	Interior and exterior free from hazardous debris or unsecured items	
First aid kit: containing band aids, gauze, sterile gauze pads, antiseptic pads, scissors, tweezers, latex gloves, antibiotic cream, instant cold pack, and first aid tape	Rubber mat or carpet on floor of passenger compartment	
Three portable triangular reflectors mounted on stands	Operable two way Communication System	

Health and Safety Hazards Requirements	Passenger Comfort and Convenience Requirements	Administrative Requirements
Hydraulic or electro-mechanical wheelchair lift installed (wheelchair van)	Smooth riding vehicle	
Retractable step or step-stool (except emergency ambulance vehicles)	Sign posted in all vehicle interiors, easily visible to passengers: “No smoking, eating or drinking” and “All passengers must use seat belts”	
Reasonable means to secure wheelchairs or stretchers, if applicable.	Passenger compartment must be clean, free from torn upholstery or floor covering, damaged or broken seats and protruding sharp edges, and shall be free of dirt, oil, grease or litter	
Child safety seats when transporting		
Two exterior rear view mirrors one on each side of the vehicle		
Current PSC registration		
Functioning speedometer and odometer		

APPENDIX C

NEMT REGIONS & COUNTIES SERVED

Region	NEMT Broker & Phone Number	Counties Served
North	**Southeastrans** *Toll free* 1-866-388-9844 *Local* 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	**Southeastrans** 404-209-4000 *Note: For Georgia Families 360°* 1-866-991-6701	Fulton, DeKalb and Gwinnett
Central	**ModivCare** ***(Formerly LogistiCare)*** *Toll free* 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	**ModivCare** ***(Formerly LogistiCare)*** Toll free 1-888-224-7988 *Note: For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities* 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	**ModivCare** ***(Formerly LogistiCare)*** Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX D

NEWBORN MEDICAID CERTIFICATION (TEMPORARY)

NEWBORN MEDICAID CERTIFICATION
(TEMPORARY)

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Division of Public Health

Please mail completed form to

GHP
P.O. Box 105209
Tucker, GA. 30085-5209

NEWBORN MEDICAID ID NUMBER
Certifying provider must contact GHP to obtain a newborn I.D.

NEWBORN'S NAME *First* *MI* *Last* *Suffix*

DATE OF BIRTH **SEX** Male ☐ Female ☐

Mother's Medicaid ID No. *Mother's Social Security No.* *Is the mother a U.S. Citizen?* YES ☐ NO ☐

MOTHERS NAME *First Name* *MI* *Last*

MAILING ADDRESS *Number and street* *City* *State* *Zip* *County* *Telephone Number*

Date of Request *Parent/Relative Signature*

COMPLETED BY *Please Print*

TITLE *Please Print*

PROVIDER NAME *Please Print*

TELEPHONE

PROVIDER SIGNATURE

By signing, I certify to the best of my knowledge that the information above is verified and accurate

DATE COMPLETED

PROVIDER NO.

Please contact GHP to verify the mother's Medicaid eligibility for the month of the newborn's birth, and to obtain the newborn's Medicaid I.D. number.

DMA-550 REV. (07/10)

APPENDIX E

MEMBER COVERAGE GROUPS AND CERTIFICATION DOCUMENTS

Eligibility for Medicaid is determined by the Social Security Administration or by the Department of Human Services, Division of Family and Children Services. There are currently 1.8 Million Medicaid members in Georgia. There are over forty (40) different coverage groups available through the eligibility process. All eligibility for Medicaid, except that for Supplementary Security Income, and Presumptive Eligibility, is determined by the Division of Family and Children Services.

In Georgia, the following groups of individuals may be eligible to receive Medicaid benefits:

1. persons receiving cash assistance as members of Supplementary Security Income (SSI), Mandatory State Supplement (MSS) or Temporary Assistance to Needy Families (TANF) benefits;

2. children and their families who meet the Aid to Family with Dependent Children (AFDC) requirements that were in effect prior to the Welfare Reform Act of 1996 which separated AFDC and Medicaid. This group was formally AFDC, but is now known as the Low Income Medicaid (LIM) group;

3. aged, blind or disabled individuals residing in nursing facilities who meet certain income criteria;

4. aged, blind or disabled individuals who meet certain income criteria and are in need of nursing facility care but have chosen to remain at home and receive community-based health care services through a Medicaid Waiver Program;

5. children under age 18, including those in two-parent households, whose income and resources are below the AFDC or Medically Needy Standards;

6. aged or disabled individuals who are covered by Medicare Part A insurance. Reimbursement is limited to Medicare cost-sharing expenses. See Subsection **Qualified Medicare Beneficiaries (QMB)** coverage for details of coverage for Qualified Medicare Beneficiaries (QMB);

7. certain qualified disabled and working individuals (QDWIs) who are eligible to enroll in Medicare Part A insurance (due to the severity of their disability) and whose income is below 200% of the FPL and whose resources are less than twice the SSI standards. Medicaid benefits are limited to the payment of only Medicare Part A insurance premiums;

8. pregnant women, whether married or not, whose family income does not exceed 200% of the FPL for the family size. This coverage group is called "Right from the Start Medicaid for Pregnant Women" (RSM). Once eligibility is established for those pregnant women, they remain Medicaid eligible without regard to changes in family income through the two

months following the month in which the last day of pregnancy falls. There is no resource limit for this coverage group;

9. children age 1 through age 5 whose family income does not exceed 133% of the FPL for their family size. This coverage is also called RSM Child. When these children reach the maximum age for RSM coverage, their eligibility terminates under this coverage group unless they are receiving a Medicaid covered inpatient service from a Medicaid provider. There is no resource limit for this coverage group;

10. children ages 6 (six) to age nineteen (19) whose family income does not exceed 100% of the FPL for their family size. This coverage is also called RSM Child. There is no resource limit for this group;

11. children ages 0 (zero) to age 1 (one) whose family income does not exceed 185% of the FPL for their family size. This coverage is also called RSM Child. There is no resource limit for this group;

12. pregnant women whose family income does not exceed 200% of the FPL may receive all Medicaid services, except inpatient hospital and delivery services, as presumptively eligible until a formal eligibility determination is made by RSM Project or County Department of Family and Children Services (DFCS) Medicaid Eligibility Specialists. Presumptive eligibility determinations based on income, pregnancy and citizenship only are made by providers certified to perform this activity. These providers are County Departments of Health;

13. terminally ill individuals who meet certain income criteria and have agreed to receive hospice care services;

14. pregnant women, children, aged, blind or disabled individuals whose incomes are above the monthly cash assistance limit, but who incur medical expenses to offset the excess income in order to become Medicaid eligible (Medically Needy Medicaid);

15. children under age 18 for whom an adoption assistance agreement is in effect or for whom foster care maintenance payments are being made under Title IV-E of the Social Security Act;

16. individuals who would be eligible except for citizenship requirements, may be eligible for Emergency Medical Assistance (EMA); and

17. Medicaid eligibility is available to children under age 18 who are not eligible for SSI in their own homes because of the parents' income and/or resources. This type program, called the TEFRA/Katie Beckett Deeming Waiver program (Katie Beckett), allows the State to disregard parents' income and resources in the determination of Medicaid eligibility. Once determined eligible under the Deeming Waiver program, these children are eligible for the full range of Medicaid services.

Three Months Prior Coverage

Individuals included in any of these groups (except QMBs) also may be eligible for Medicaid coverage for the three months immediately preceding the month of application. This coverage may be granted in combination with on-going benefits or as a single period of coverage.

Eligibility Begin Date

Medicaid coverage is available for the month of application for those individuals and families who meet the eligibility standards. This does not include QMBs whose coverage begins the month following the month of application.

Additionally, children under age 18, pregnant women and aged, blind or disabled individuals whose income is above the Medically Needy Income Level (MNIL) may become eligible by incurring medical expenses equal to their excess income under the Medically Needy program. Eligibility begins on the day their excess income is spent down by incurred medical expenses. Individuals who receive Medicaid benefits under the Medically Needy program must reapply every six months in order to continue their eligibility.

Home and Community Based Waivers

Medicaid coverage is available to certain individuals with special conditions through waiver programs approved by the federal government. These individuals are eligible for nursing facility, ICF-MR or hospital care but have chosen to remain at home and receive services in the community and in the most integrated setting. Eligibility is determined by using SSI criteria and/or a special income limit set by the State. Most waivers provide for a broad array of services to fully support the individual's health, well-being, independence, and productivity.

Waivers

GAPP/Georgia Pediatric Program Waiver coverage is available to medically fragile children under 21 years of age, and who require private duty nursing and/or medical day care services.

New Options Waiver and Comprehensive Waiver (NOW and COMP) serve Medicaid eligible individuals with a mental retardation diagnosis who meet an Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care.

The *Independent Care Waiver Program (ICWP)* is also available to severely, physically disabled adults who meet nursing home or hospital levels of care but are medically stable and able to live in the community with special service supports.

The Elderly and Disabled Program Waiver serves individuals of all ages who meet a nursing facility level of care through two programs: the Community Care Services Program (CCSP) or the SOURCE (Service Options Using Resources in Community Environments). This waiver program provides a range of services including adult day health care which works with NEMT for provision of transportation to and from the facility.

Qualified Medicare Beneficiaries (QMB) Coverage

Aged or disabled individuals who are receiving Medicare Part A insurance and whose income is below 100% of the FPL and whose resources are below twice the SSI standards are eligible for limited Medicare cost-sharing expenses.

Benefits for individuals eligible for QMB coverage are limited to Medicaid reimbursement for Medicare premiums, coinsurance, and deductibles.

No other services are included for Medicaid reimbursement.

QMB coverage is available the month following the month of the eligibility determination to those individuals who meet the QMB standards. There is no QMB coverage available for months immediately preceding the month of application.

DCH will continue to provide reimbursement for services rendered to those individuals who receive the full range of Medicaid and Medicare services. Persons wishing to apply for QMB coverage should be referred to the DFCS office in their county of residence for an eligibility determination.

Qualified Disabled and Working Individuals (QDWI) Coverage

Certain qualified disabled and working individuals who are eligible to enroll in Medicare Part A due to the severity of their disability, whose income is below 200% of the FPL, and whose resources are less than twice the SSI standards are eligible for limited Medicaid benefits.
Benefits for individuals eligible for QDWI coverage are limited to payment of their Medicare Part A premiums.

QDWI coverage is available the month of eligibility determination to those individuals who meet the QDWI standards. QDWI coverage is also available for three months immediately preceding the month of application. QDWIs will not receive a Medical Assistance Eligibility Certification (Medicaid card).

Persons wishing to apply for QDWI should be referred to the DFCS office in their county of residence for an eligibility determination.

APPENDIX F

MEMBER APPEAL NOTICES

INITIAL DECISION LETTER

_____

(Date Notice Mailed)

Name of Member Medicaid ID #:_____
Mailing Address

Dear _____:

Your request for non-emergency transportation (NEMT) for a date of service of _____ has been initially denied. The reason for this initial denial is:

_____

_____

_____

If you disagree with this decision to initially deny you non-emergency transportation, you have the right to request a review (reconsideration) of this denial. If you request a review, you must do so no later than thirty (30) calendar days from the date at the top of this notice. You may request a review by calling us at _____ or writing us at_____

_____

_____

If your review is successful, you will receive transportation. If you again are denied transportation after the review is completed, you will receive a final decision and information on how to request a fair hearing through the Department of Community Health. Please remember that in order to request a fair hearing, you must first request a review of the initial denial as described above. If you do not request a review of the initial denial, then you do not have a right to a fair hearing.

Sincerely,

(Broker)

FINAL DECISION LETTER

_____

(Date Notice Mailed)

Name of Member Medicaid ID #:_____
Mailing Address

Dear _____:

This notice is about your request for a review (reconsideration) of the denial of non-emergency transportation (NEMT) for a date of service of _____. We have reviewed your request for NEMT and we are now issuing a final denial. The reason for this final decision to deny you non-emergency transportation is:

_____

_____

_____

. If you disagree with this decision to deny you non-emergency transportation, you have the right to request a fair hearing through the Georgia Department of Community Health. If you request a fair hearing, you must do so no later than thirty (30) calendar days of the date at the top of this notice. You would send your written request for a fair hearing to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

You have the right to legal representation at the fair hearing. If you want to know about legal assistance available, you may contact the GA Legal Services Program (*except for counties served by Atlanta Legal Aid)* or Atlanta Legal Aid (*if member resides in DeKalb, Gwinnett, Cobb, Fulton, or Clayton Counties)* office in your area by calling _____. Your request for a fair hearing to the Client Appeals Unit, GA Department of Community Health will be forwarded to the Office of State Administrative Hearings for processing.

If you do not request a fair hearing within thirty (30) calendar days from the above date, then you do not have the right to further appeal.

Sincerely,

(Broker)

NO MEMBER APPEAL LETTER

Date

Member Name
Address
City, State, Zip

Dear

Your request for non-emergency transportation (NEMT) for date(s) of service *(insert date)* to *(insert location)* has been denied. The reason for this denial is:

The medical appointment requested, (*insert medical appointment),* is not covered by Georgia Medicaid.

Georgia Medicaid will only pay for your non-emergency transportation if the service is a covered medical service by the Medicaid program. If you have questions about what services are covered, please contact our Member Services line at 1-866-211-0950.

There are no member appeal rights when transportation service is denied under these circumstances.

Sincerely,

(Broker)

cc: Department of Community Health

APPENDIX G

NEMT Gatekeeping Policy

1. The Broker shall accept requests for transportation directly from members, adult family members on behalf of minor members, guardians responsible for members, and licensed healthcare professionals on behalf of members who are residents of a nursing facility or other residential care facility, or who are otherwise unable to communicate for themselves.

Rev. 1/15

2. The Broker is not obligated to provide transportation for, and is not capitated for, Qualified Medicare Beneficiaries (QMBs) only.

3. The Broker should assure that the member is a resident of a county in the Broker's region and is currently Medicaid eligible, either listed as on file, either in the Broker's database or through an available eligibility verification system, or in possession of a temporary proof of Medicaid eligibility (forms 962 or 964).

4. The Broker shall attempt to determine if the member has his/her own or other means of transportation available. If the member's own means of transportation is available **and** the member is capable of driving, the Broker may deny trip request. The Broker cannot deny non-emergency medical transportation solely based upon member owning a vehicle or there being a vehicle in the household.

Rev. 1/15

Rev. 7/16

The Broker shall use its discretion to offer fuel assistance as necessary for transportation provided to the member by a friend or relative. Fuel assistance is not offered to the Medicaid member.

5. The Broker may require the use of public transportation, where available and appropriate, for ambulatory members who are able to understand common signs and directions and who indicate familiarity with the use of public transportation.

6. The Broker shall not require any member who is pregnant or has more than two children under age of 6, also traveling to utilize public transportation.

7. The Broker must provide fare, if requested, in a timely manner for a member and escort if applicable, when referring the member to public transportation.

8. The Broker must determine if the member is ambulatory, requires a wheelchair, or requires a stretcher for transport. Members unable to walk, even with assistance, from their door to the vehicle must be transported via wheelchair or stretcher as appropriate. Members who are routinely confined to a wheelchair or bed must be transported in vehicles appropriate to the level of confinement.

9. The Broker must inquire whether the member requires assistance in walking after receiving treatment. If the member requires assistance, and no escort is available, the Broker must provide an attendant to render that assistance, or transport by wheelchair or stretcher van, as appropriate.

10. The Broker must allow for extenuating circumstances in applying the three (3) day advance application requirement for transportation. Such extenuating circumstances shall include, but not be limited to, such situations as requirement for post-operative or follow-up appointments in less than 3 days; urgent care requirements as claimed by the member, adult family members on behalf of a minor, elderly or disabled members, guardians responsible for members, and licensed healthcare professionals on behalf of members who are residents of a nursing facility or other residential care facility, or who are otherwise unable to communicate for themselves; hospital and emergency room discharges; and transportation to appointments made to replace appointments missed because of failed transportation arranged by the Broker.

11. The Broker shall provide transportation only to a Medicaid billable service, or one that would be a Medicaid billable service if the provider were enrolled in the Medicaid program.

12. Some nursing facilities, group homes and personal care homes have one or more vehicles, which are intended to facilitate the general administration of the facility and not necessarily to provide for resident transportation. The Broker cannot deny service based on the mere existence of a vehicle. The availability of a vehicle for resident transportation must be determined on a case basis. If the vehicle is not available for resident transportation at the time required, as represented by the nursing facility manager or director of nursing, as applicable, such vehicle must be excluded from considerations of other available transportation.

13. The Broker shall consider in good faith information presented by or on behalf of a member relative to the need for NEMT services upon **each such request** for transportation, regardless of the member's having been previously denied NEMT services.

14. The Broker may require that a member and associated escort be picked up from, and returned to, a common address.

15. Foster children shall be transported to access Medicaid services upon request of the foster parent, without regard to any transportation resources that may be available in the foster care household.

16. The Broker may opt to expand the mileage limits for transportation without a healthcare provider's referral per region however, at a minimum transportation shall be provided for Medicaid members within the following general geographic access standards for health care services:

    a) 30 miles Urban;
    b) 50 miles Rural;
    c) 15 miles Adult Day Health Care Urban, and 30 miles Rural;
    d) 15 miles Pharmacies Urban, and 30 miles Rural.

17. Transportation outside the general geographic access standard for health care services is to be provided only when sufficient medical resources are not available in the member's service area or when a healthcare provider has referred the member to medically necessary health care services outside of the geographic access standard. The Broker shall not

arbitrarily deny services, but may require as a condition for approval of NEMT services, a written referral signed by a licensed healthcare provider attesting to the medical necessity for out-of-area service.

18. Members enrolled in managed care health plans are obligated to use providers participating in the managed care health plan. Travel for such managed care plan enrollees shall be considered the same as travel based on a healthcare provider's referral.

19. **Grandfather Clause**: Applicable only to those Medicaid members who have had a standing order in effect at an Adult Day Health (ADH) facility prior to July 1, 2012. "Grandfathered" is the term identifying these members and allows them to continue attending that ADH facility and exempts them from the Geographic Considerations policy outlined in Section 100.9 of this manual. Members attending an ADH facility and have a standing order in effect after July 1, 2012, will be subject to the Geographic Considerations policy stated above. Any "Grandfathered" member changing their residence, regardless of the circumstance, and moving outside of the current geographical standards in place after July 1, 2012, will no longer be considered "grandfathered" and will be subject to the Geographic Considerations policy requirements.

APPENDIX H

IMPLEMENTATION CHECKLIST

NEMT REGION: _____

Implementation Task or Deliverable	Proportion Complete	Complete	Date	Initial
Office Space				
Files/Furniture				
Computer System:				
Hardware installed				
Software installed				
Eligibility Verification System installed				
Staff Training				
Telephones:				
Equipment installed				
Staff Training				
Multilingual capabilities				
Personnel Recruiting and Staff Employed:				
Project Director				
Supervisory Staff				
Support Staff				
Transportation Service Provider Recruitment:				
Development of model service agreement				
Signing of all service agreements				
Verification that vehicles meet RFP standards				
Verification that drivers meet RFP standards				
Training:				
Broker's staff				
Transportation service providers				
Drivers				
Attendants				
MEMBER Education and Application for Services:				
MEMBER education plan				
MEMBER education notices				
MEMBER application for service process				

Implementation Task or Deliverable	Proportion Complete	Complete	Date	Initial
MEMBER Education and Application for Services (*cont'd)*:				
MEMBER for handling urgent care				
Denial process/documents				
Computerized MEMBER worksheet				
Development of required deliverables:				
Operational Procedures Manual				
Quality Assurance Plan				
Plan for handling backup service				
Appeals and complaints process in place				
Business Continuity and Disaster Recovery Plan				
Record retention system in place				
Driver report format				
Vehicle report format				
Detailed report of transportation services format				
Accident and moving violation report format				
Telephone system report format				
Broker Monitoring Plan:				
Plan for monitoring driver qualifications/conduct				
Plan for monitoring vehicle requirements				
Operational Readiness Testing:				
Telephone system fully operational				
Computer system fully operational				
Staffing in compliance with RFP and proposal				
All deliverables available for review				
Readiness of central office operations				
Readiness of MEMBER application process				
Readiness of scheduling process				
Readiness of denial process				
Readiness of quality assurance procedures				
Readiness of appeal process				
All service agreements signed/available				

APPENDIX I

ACCIDENT AND MOVING VIOLATIONS REPORT

SECTION I

Name of Broker: _____ Date of Occurrence: _____

Time of Occurrence: _____

Transportation Provider: _____ Date Reported to Broker: _____

Contact Person: _____

Address: _____

_____ Name of Vehicle Driver: _____

Telephone #: _____ Driver's License #: _____

Fax #: _____ Vehicle Tag #: _____

SECTION II

Detailed Description of Occurrence: (attach additional pages if necessary)

_____

_____

Check all that apply (attach additional pages if necessary)

Injuries: No ___ Yes ___ Minor ☐ Serious ☐ Fatal ☐

Injured Member(s) _____ Driver _____ Attendant ____ Escort ____ Other _____

Name #1: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene ☐ Medical Facility ☐ Name of Facility: _____

Brief Description of Treatment: _____

Name #2: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene ☐ Medical Facility ☐ Name of Facility: _____

Brief Description of Treatment: _____

Name #3: _____ Medicaid #: _____ Phone #: _____

Address: _____

Description of Injury: _____

Treated at: Scene ☐ Medical Facility ☐ Name of Facility: _____

Brief Description of Treatment: _____

SECTION III

Were emergency services called? 911 ☐ Police ☐ Ambulance ☐ Tow Truck ☐ No ☐

If motor vehicle accident, who was charged? NEMT Transportation Provider ☐ Other ☐

Attached: Police Report _____ Other _____

Immediate corrective action taken by carrier/broker: _____

Report Submitted By: _____ Phone #: _____

Print/Type Name

_____ Date: _____

Authorized Signature

Instructions for Completing the Non-Emergency Medical Transportation Broker Accident and Moving Violations Report Form

All accidents and moving violations that occur while delivering NEMT services must be reported to the DCH on the Non-Emergency Medical Transportation Broker Accident and Moving Violations Report Form (DMA-5/99). This form must be completed and submitted to DCH within ten (10) business days of the accident or moving violation. Please attach additional pages if necessary.

SECTION I

This section must be completed to reflect the name of the Broker and the name, contact person, address, telephone number, and fax number of the transportation service provider.

Please specify the date and time when the accident/incident occurred.

The date reported to the Broker must reflect the date that the provider informed the Broker of the accident/incident.

List the name and driver's license number of the individual driving the vehicle involved in the accident/incident and the tag number of the vehicle involved in the accident/incident.

SECTION II

This section must be completed to reflect a detailed description of the accident/incident, whether or not any injuries occurred, the nature of each injury and list each person injured (member, driver, escort, attendant, other). Attach additional pages as needed.

If member, the member Medicaid ID number must be given for each person.

If the injured person is treated at a medical facility, the name of the medical facility must be given.

Provide a brief description of each injury and indicate where treated - at the scene of the accident/incident or a medical facility.

SECTION III

Emergency services - Please check all applicable boxes.

If motor vehicle accident, indicate who was charged, the NEMT transportation vehicle driver or the driver of the other vehicle(s).

List any immediate corrective actions taken by the carrier and the Broker.

Person authorized to complete form must print or type their full name and telephone number. Their signature and date must also be completed.

DMA 5/99

APPENDIX J

REV.
10/17

GEORGIA RELAY

Georgia Relay is a FREE public service provided by the State of Georgia to make communicating by telephone easy, accessible and reliable for everyone, including people who are deaf, hard of hearing, deaf-blind or have difficulty speaking.

Available 24 hours a day, 365 days a year, Georgia Relay allows users to stay connected through a variety of Traditional Relay and Captioned Telephone services to include:

TTY (Text Telephone)

Voice Carry-Over (VCO)

Hearing Carry-Over (HCO)

Speech-To-Speech (STS)

Video Relay Service (VRS)

CapTel®

Spanish Relay

For more information, please visit www.GeorgiaRelay.org or call or call one of the toll free numbers below:

TTY: 800-255-0056

Voice: 800-255-0135

Mobile Caption Service: 800-855-9111

Speech to Speech: 888-202-4082

Spanish to Spanish: 888-202-3972
(Includes Spanish-to-Spanish and translation from English to Spanish)

APPENDIX K

CHILD SEAT REQUIREMENTS

Rev. 10/17

The Brokers must ensure that a sufficient number of transportation providers within its provider network have appropriate child safety seats for transporting children. The Broker cannot deny transportation to a Medicaid member because the member does not have a car seat available for the child.

The Broker is responsible for assuring that all transportation providers are in compliance with all applicable laws including Georgia Section 40-8-76 G.

APPENDIX L

MEMBER ABUSE OF PROGRAM/WARNING LETTERS

In the instance where a member has on at least two (2) occasions no showed, been late for pick-up or canceled a reservation at the time of pick-up, the Broker shall send a warning letter to the member via certified mail (See Member Warning Letter – Letter A).

After receiving a complaint regarding a member's abusive behavior or misconduct, the Broker shall send a warning letter to the member via certified mail (see Member Warning Letter – Letter B).

After two warnings the Broker shall send a letter of denial, via certified mail, informing the member of 1) his/her continued actions that have resulted in the denial of service; and 2) their right to request reconsideration/review by the Broker. The letter must include the member appeal process (See Member Denial Letter – Letter C).

If member requests the Broker to review/reconsider their decision of denial and the non-emergency medical transportation request is again denied after the Broker review is completed, the Broker must send a *Final Decision Letter* (see Appendix F-2).

Rev. 10/15

The Broker will continue to provide transportation during the appeals process. If the appeal is a result from uncooperative or abusive behavior and the member continues to demonstrate documented behavior that is unacceptable and/or unsafe, even during the appeals process, transportation may be discontinued until a final court order overturning DCH's termination decision or settlement agreement between the parties is executed.

MEMBER WARNING LETTER

Letter A

Date

Member Name
Address
City, State, Zip

Dear Member:

You requested non-emergency transportation from (*insert Broker name)* for the following date(s): *insert date.* On each occasion, when the vehicle arrived to transport you, you were *(insert one: not at the residence, not at scheduled pick-up location, or cancelled at the time of pick-up).*

If you do not need transportation for the date requested, you must contact (*insert Broker name*) at (*insert phone number*) to cancel the trip. Please call the day before the scheduled pick-up time or immediately on the day of travel, but no later than one (1) hour before your scheduled pick-up time to cancel transport. Failure to notify (*insert Broker name*) of the cancellation may result in denial of non-emergency transportation services in the future.

This letter serves as formal notice that if this happens again, steps will be taken to suspend, deny, or terminate non-emergency transportation services. Always contact (*insert Broker name*) whenever there is a change in your schedule.

If you have any questions, you may contact *(insert Broker phone number)*.

Sincerely,

(insert Broker information)

cc: Department of Community Health

MEMBER WARNING LETTER

Letter B

Date

Member Name
Address
City, State, Zip

Dear Member:

You requested non-emergency transportation services from (*insert Broker name*) for the following dates: *(insert dates)*.

We have received a complaint from the assigned transportation provider about your behavior during the above scheduled date(s) of service. The provider stated that you were verbally abusive and/or physically abusive to other passengers and/or driver during this trip.

Please note that a transportation provider has a right to refuse service to unruly individuals and eventually refuse to accept the trip request from (*insert Broker name*).

This letter serves as formal notice that if this happens again, steps will be taken to suspend, deny, or terminate non-emergency transportation services.

Sincerely,

(*insert Broker information)*

cc: Department of Community Health

MEMBER DENIAL LETTER
Letter C

Date

Member Name
Address
City, State, Zip

Dear Member:

On *(insert dates of previous warning letters)*, (*insert Broker name*) notified you that your behavior may result in denial of non-emergency transportation services. Please see copies of warning letter(s) attached.

On *(insert date)*, a transportation provider was dispatched to your address as scheduled to transport you to your medical appointment. You *(insert member's non-compliance with policy)*. As a result of your actions and previous warnings, non-emergency transportation for you through our current provider network has been suspended.

If you find another transportation provider willing to transport you, (*insert Broker name*) may be able to provide payment to that provider if provider meets certain guidelines and standards required by (*insert Broker name*). Please have provider contact us at *(insert Broker contact*).

If you feel this decision is wrong and you wish to have your case reconsidered, you must contact (*insert Broker name*) at below information within thirty (30) calendar days from the date of this letter.

insert Broker Contact Information

If your review is successful, your non-emergency transportation will be resumed. If your review is unsuccessful, you will receive a *Final Decision* letter including information on how to request a fair hearing through the Department of Community Health (DCH) only after your appeal to (*insert Broker name*). If you do not request a review/reconsideration by the (*insert Broker name*) you do not have the right to a fair hearing through DCH.

Please contact us for any questions you may have regarding this letter.

Sincerely

(*insert Broker information)*

cc: Department of Community Health

APPENDIX M

NEMT ENCOUNTER CLAIMS SPECIFICATIONS

The 837 Professional transaction is the only acceptable format for electronic NEMT claims submission to the Department of Community Health. The technical requirements for transmission of claims are available in the GAMMIS Non-Emergency Medical Transportation (NEMT) Companion guide (837P) on the web portal site http://www.mmis.georgia.gov.

NEMT program specific required information for NEMT encounter claims processing are as follows:

A. Modifiers must be reported with each procedure code billed for Non-Pharmacy origin and destinations. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit. Values of allowable modifiers are:

Modifier Code	Modifier Code Description
D	Diagnostic or Therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, Domiciliary, Custodial Facility (other than an 1819 Facility (SNF)
H	Hospital
J	Dialysis Facility
N	Nursing Home Facility
P	Physician's office (includes HMO no-hospital facility, clinic, etc.
R	Residence

For example: If a member is transported from their residence (R) to a physician's office (P) the modifier will be (RP). The return trip from the physician's office to the member's residence will be (PR).

B. For Pharmacy Initial/Return Trip the allowable modifiers are:
   U1: Initial Trip
   U2: Return Trip

C. Valid Procedure Codes

Procedure Code	Procedure code Description
A0120	Non-Emergency Medical Transport Ambulatory Van
A0130	Non-Emergency Medical Transport Wheelchair Van
T2005	Non-Emergency Medical Stretcher Van
A0110	Non-Emergency Medical Transport Bus (public transportation)
A0080	Non-Emergency Transport by Volunteer (Independent Driver)
A0100	Non-Emergency Medical Transport Taxi

D. The Appointment Time, Scheduled Pickup Time, Actual Pickup Time and Actual Drop Off Time is required when procedure code A0120, A0130, T2005 or A0080 are billed.

1. Appointment Time: 4 position value (hour/minutes) preceded by a qualifier of AT, (ATHHMM)
2. Scheduled Pickup Time: 4 position value (hour/minutes) preceded by a qualifier PT, (PTHHMM)
3. Actual Pickup Time: 4 position value (hour/minutes) preceded by a qualifier PA, (PAHHMM)
4. Actual Drop Off Time 4 position value (hour/minutes) preceded by a qualifier DA, (ADHHMM)

Note: 0000 is a valid value within the HHMM

Example of four values being billed: AT1400, PT1230, PA000, AD1330
Example of singe value being billed: AT0800

National Correct Coding Initiative (NCCI)

The Center for Medicare and Medicaid Services (CMS) has directed all State Medicaid agencies to implement the National Correct Coding Initiative (NCCI) as policy in support of Section 6507 of the Patient Affordable Care Act of March 23, 2010.

Georgia Medicaid uses NCCI standard payment methodologies. NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUEs) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

For additional questions regarding the NCCI or MUE regulations, please see the CMS website: http://www.cms.gov/.

General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing

requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 (02-12) forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 (02-12) claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

APPENDIX N

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)
Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the healthcare providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work

247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child

446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTHCARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact GAINWELL at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. GAINWELL will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL in error:

GAINWELL will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and re-credentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time-period for providers to receive credentialing and re-credentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and re-credentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or re-credentialing decision. The credentialing decision is provided to the CMOs.

GAINWELL provider reps will provide training and assistance as needed. Providers may contact GAINWELL for assistance with credentialing and re-credentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to GAINWELL in error:

GAINWELL will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach State website, or the Peach State provider manual.	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

How often can a patient change his/her PCP?

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections • PCP moves, retires, etc.	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	**PBM**	**BIN #**	**PCN**
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan	Envolve Pharmacy Solutions (PBM) Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through GAINWELL by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. GAINWELL will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**

No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

APPENDIX O

Information for Providers Serving Medicaid Members
in the Georgia Families 360°SM Program

Georgia Families 360°SM, the state's managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the **Georgia Families 360°SM** Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360°SM Every member in **Georgia Families 360°SM** is assigned a Care Coordinator who works closely with them to ensure access to care and ensure that appropriate, timely, and trauma informed care is provided for acute conditions as well as ongoing preventive care. This ensures that all medical, dental, and behavioral health issues are addressed. Members also have a medical and dental home to promote consistency and continuity of care. The medical and dental homes coordinate care and serve as a place where the child is known over time by providers who can provide holistic care. DFCS, DJJ, foster parents, adoptive parents, and other caregivers are involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements. Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management programs are in place to focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD as well as other behavioral health prescribed medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations Representative.

To learn more about DCH and its dedication to *A Healthy Georgia*, visit www.dch.georgia.gov.

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APPENDIX P

Reporting Requirements Matrix

This Matrix provides a quick reference for submission deadlines for required reports. This matrix may not include all required reports of the NEMT/Broker contract; however, it is the Broker's responsibility to ensure that required reports are submitted timely and within required time frame. Please reference each applicable Section for additional reporting requirements.

Name of Report	Days	Monthly	Quarterly	Annually	Fiscal Year	Requirements
Section 300.18 Customer Service Satisfaction/Member Survey					**X**	Report results and methodology for analyzing the data are due to DCH by July 31st each year following the end of the State fiscal year.
Section 400.2 Equal Employment Opportunity Plan				**X**		Must be revised on an annual basis and resubmitted for DCH approval no later than July 31 of each year.
Section 400.8 Disaster Recovery Plan Review/Exercise/Drill				**X**		A written report of the findings must be delivered to DCH within fifteen (15) calendar days of the date that the test is conducted.
Section 500.1 Driver Reports			**X**			This roster is due by the 30th calendar day of the month following the end of the reporting quarter.
Section 500.2 Vehicle Report			**X**			This roster is due by the 30th calendar day of the month following the end of the reporting quarter.
Section 500.3 Transportation Services-Via Encounter Data		**X**				This roster is due thirty (30) calendar days following the month of payment by the Broker.
Section 500.4 Transportation Services Monthly Report		**X**				Due by the 30th calendar day of the month following the month of payment by the Broker and shall be reported by month of service.
Transportation Services State Fiscal Year					**X**	**Due by July 31st each year** following the end of the State fiscal year.

Name of Report	Days	Monthly	Quarterly	Annually	Fiscal Year	Requirements
Section 500.5 Accidents and Moving Violations Report	**X**					Any injury or fatality shall be reported immediately. The Broker shall file a written accident report with DCH within ten (10) business days of the accident along with a police report documentation.
Section 500.6 Telecommunications System Report		**X**				This report is due by the 30th calendar day of the month following the month of the telephone activity.
Section 500.7 Certified Financial Audit					**X**	Report through the close of each State fiscal year, calendar year, or tax reporting year are due to DCH within six (6) months of the close of the year's end.
Quarterly Financial (Unaudited)			**X**			This report is due forty-five (45) calendar days following the end of each quarter of the Broker's reporting year.
Section 500.8 Complaint and Incident Report		**X**				This report is due by the 30th calendar day of the month following the month of activity.
Section 500.9 Member No-Show Report		**X**				Data due by the 30th calendar day of the month following the month of payment by the Broker.
Section 500.10 Transportation Denied by Reason		**X**				The written summary must be sent to DCH by the 30th calendar day of the month following the month of activity.
Section 500.11 Late Percentage Summary		**X**				The written summary must be sent to DCH by the 30th calendar day of the month following the month of activity.
Section 500.12 Staff Roster			**X**			This roster is due by the 30th calendar day of the month following the end of the reporting quarter.

APPENDIX Q
NEMT Physician's Medical Necessity Certification

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Physician's Medical Necessity Certification
Non-Emergency Transportation Broker Program

This form serves to provide medical necessity for the provision of transportation services for the eligible Medicaid member indicated below. Pursuant to **Section 100.9 Geographic Considerations** of the Georgia Department of Community Health's *Non-Emergency Transportation (NET) Broker Program Policies and Procedures Manual*, transportation required for a specific Medicaid reimbursable service located outside of the general geographic access standard for health care services must be medically necessary. After completion and/or review by the attending physician, the physician must sign and date below. Upon proper completion and attestation of this form, no further documentation of medical necessity shall be required by the broker.

Medicaid Member's Information

Name: Date of Birth: Medicaid ID #:		
Address:		Apartment:
City:	State:	Zip:

Medical Provider to Be Transported To

Physician / Facility:			Facility Type:	
Address:			City & Zip Code:	
Length of time care needed:	Permanent [ ] Yes [ ] No	Temporary [ ] Yes [ ] No	Months Estimated _____	GA Medicaid Provider #:

Medical Necessity for Transport

1	This is the closest facility/physician that can provide this treatment/service because the member has one or more of the following needs: (please explain if applicable). Skilled service _____ _____ Language _____ _____ Behavior _____ Treatment _____ Other: _____	[ ] Yes	[ ] No
2	This member has a condition that prevents them from being treated by a nearer physician/facility (i.e., specialty).	[ ] Yes	[ ] No
3	Other (explain)_____ _____ _____		
4	I am unable to attest to medical necessity for the above indicated Medicaid Member to receive treatment at the facility/physician indicated above.	[ ] Yes	

Physician Attestation and Signature/Date

This is to certify that I am a duly licensed physician and that in my professional judgment it is medically necessary for the above Medicaid Member to travel to the above facility/physician for the reasons indicated. I further certify that the medical necessity information above is true, accurate and complete to the best of my knowledge and that this information will be used by The Georgia Department of Community Health and its authorized agent to support the determination of medical necessity to receive NET services outside the geographical access standards for health care services. I understand that any falsification or omission of material fact stated may subject me to penalties by DCH when submitting letters of medical necessity related to the NET program.

_____
Physician's Name (printed)

_____ _____
Physician's Signature **Date**

DCH-NET LOMN 10/1/13