STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 10,060
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the Department of Social Welfare's denial of her application for Medicaid transportation services.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who is in her fourth month of pregnancy. She lives in Brattleboro but travels to Greenfield, Massachusetts, some twenty miles from her home, for routine prenatal care visits with an obstetrician. The doctor's fees are paid through the Medicaid program. Thus far, she has been transported to Greenfield by her father, but the petitioner states he will not be able to do so in the future. She does not drive herself.

2. In late September of 1990, the petitioner requested medical transportation services for her next obstetrician's appointment through SEVCA, a non-profit organization which is authorized to provide Medicaid transportation services. Because the request was for transportation to an out of state provider, the request was referred to the head of the Medicaid Transportation Program in the central DSW office. That request was denied by the Department on October 3, 1990

because "appropriate medical services are available within a shorter distance than that requested."

3. Under procedures adopted by the Department in 1986, transportation costs will be provided to medical appointments anywhere within the "hospital service area" in which the applicant lives as set forth in its regulations. No inquiry is usually made as to the actual medical necessity of the service as long as the trip is within the service area. A copy of the service area map is attached hereto as Exhibit 1. If a request is made for transportation outside of the service area, it will only be paid for if it is for a service which is medically necessary and unavailable in the service area.

4. The petitioner's service area contains seven counties in the southeast corner of the state. However, in those seven counties, there is only one obstetrics practice, (with three doctors), which is located in the town of Brattleboro. The petitioner chooses not to patronize the Brattleboro practice because she has had negative experiences with the prenatal care she has received there in the past and believes that one of the physicians in the practice may have endangered herself or her child and no longer trusts him or his partners. She has not, however, filed any civil lawsuit or complaint with the medical licensing Board with regard to the services she received and

there is no evidence that the physician has refused to take her as a patient.

5. Both parties agree that many persons who live in the Brattleboro area commonly seek medical care in Greenfield, Massachusetts. The petitioner's Greenfield physician alone sees over 700 patients from the Brattleboro area. The Department regularly pays for transportation to that town for medical services which are unavailable in the Brattleboro hospital service area and currently provides trips there about three times per week.

6. The "hospital service area" criteria was adopted by the Department in an attempt to define the medical community in which the applicant lives in a uniform manner for the use of private brokers who actually take applications and obtain transportation services for Medicaid recipients through a contract with the Department's agent, Vermont Public Transportation.

ORDER

The Department's decision is reversed.

REASONS

The Social Security Act requires each state which participates in the Medicaid program to formulate a plan which:

> Provides such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.

42 U.S.C. ∋ 1396a(a)(19)

That language has been interpreted by the agency charged with the administration of Medicaid, the Health Care Financing Agency (HCFA), as requiring that a state provide transportation services when it is necessary in order for a recipient to receive medical care:

> A State plan must--
>
> > (a) Specify that the Medicaid agency will assure necessary transportation for recipients to and from providers; and
> >
> > (b) Describe the methods that will be used to meet this requirement

42 C.F.R. ∋ 431.53

Pursuant to federal law and regulations, the Vermont Department of Social Welfare has adopted a transportation regulation as part of its Medicaid plan which reads as follows:

> M755 Transportation
>
> Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.
>
> The following limitations on coverage shall apply:
>
> > 1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)
> >
> > 2. Transportation is not otherwise available to the Medicaid recipient.
> >
> > 3. Transportation is to and from necessary medical services.
> >
> > 4. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at

> unusual or exceptional cost in order to meet a recipient's personal choice of provider.
>
> 5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.
>
> 6. Reimbursement for the services is limited to enrolled transportation providers.
>
> 7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
>
> 8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

The Department does not itself provide transportation services but instead contracts with Vermont Public Transportation (VPT) for their provision. VPT in turn contracts with local community service agencies to take applications and provide the transportation services. In order to provide those "brokers" with guidelines to determine eligibility under paragraph four of the transportation regulation (see above), the Department has published the following procedures:

> Verifying Eligibility Factors
>
> . . .
>
> How do brokers establish that transportation is to a service generally available to and used by the community in which the recipient resides?
>
> The brokers must first distinguish between services for goods as provided by pharmacists and durable medical equipment suppliers and treatment services as provided by physicians and other licensed practitioners.
>
> With services for goods, it is generally believed

that there is no difference in the provision; for example, a prescription for a particular item would result in the same item no matter who dispensed it. Thus, any transportation would be limited to the nearest available provider.

With treatment services, it is recognized that the provision may vary depending on the provider. Thus, the brokers may consider areas that service the recipient's town of residence as follows:

a. Communities that share the same hospital service or catchment area as the town of residence (see Appendix F).

   The expression "hospital service area" refers to a designation applied by the Department of Health. It defines which communities are assigned to which hospitals for purposes of determining the size of the populations served, in the process of establishing rates of reimbursement for hospital beds.

b. Communities that are in contested or border areas of the hospital service or catchment area that serves the town of residence (see Appendix F). [Attached hereto as Exhibit One]

c. Communities in other hospital service or catchment areas as long as the cost of transportation to these communities would be no greater than the cost of transportation to a community within the hospital service or catchment area of the recipient's town of residence (see Appendix F).

d. Communities outside the hospital service or catchment area of the recipient's town of residence but within the state of Vermont or in areas served by Vermont Medicaid approved "border hospitals" (see Appendix G) when the recipient's attending physician refers the recipient to that service. In certain cases the reason for the referral is readily apparent; e.g., chemotherapy, kidney dialysis, etc. and only needs to be documented. In all other cases, verification of the referral must be obtained in writing.

e. Communities outside the state of Vermont and not served by Vermont Medicaid approved

> "border hospitals" (see Appendix G) when the recipient's attending physician refers the recipient to that service and the Medicaid Division has approved the trip. In these cases, verification of the physician's referral must be obtained in writing.
>
> In any case, a recipient's personal choice may not be the only factor determining whether transportation may be provided to a service.
>
> Brokers may request written or verbal verification of any information they may consider questionable.
>
> Medicaid Transportation Procedures December 24, 1986, pages 408 and 409.

The petitioner in this case was denied transportation assistance for a medically necessary service based on the above regulation because she sought transportation to a physician who does not practice in her hospital service area when a physician who can provide that same service is in her area. The petitioner asserts that the Department's decision denies her the freedom to choose her health care provider which is guaranteed by federal law. The Department takes the position that under federal law it has the discretion to choose the methods for providing transportation to medical services and has adopted a reasonable method of providing transportation where it is medically necessary. It further takes the position that "freedom to choose" a health care provider is not a factor in determining whether transportation services must be provided--medical necessity is the sole consideration.

There is no disagreement between the parties that a Medicaid recipient is guaranteed the right to choose the health care professional who will provide her covered

services by federal law. The state plan must:

> (23) except as provided in subsection (g) of this section and in section 1396n and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title.
>
> "Freedom of Choice"
> 42 U.S.C. ∋ 1396a(a)(23)

The federal regulations also reflect that Right:

Free Choice of providers.

> (a) Basis and purpose. This section implements section 1902(a)(23) of the Act, which provides that recipients may obtain services from any qualified Medicaid provider, and section 1915 of the Act, which provides that a State shall not be found out of compliance with section 1902(a)(23) solely by reason of certain specified allowable restrictions of this free choice (see paragraph (c) of this section and ∋ 431.54 and which authorizes the Secretary to waive the requirements of section 1902(a)(23), and other provisions of the Act, in certain circumstances (see ∋ 431.55).
>
> (b) State plan requirement. Except as provided in paragraph (c) of this section, a State plan (except in Puerto Rico, the Virgin Islands, and Guam) must provide that any recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or

arranges for their availability on a prepayment basis.

(c) Limitations on applicability. Paragraph (b) of this section does not prohibit the agency from--

(1) Establishing the fees it will pay providers for Medicaid services;

(2) Setting reasonable standards relating to the qualifications of providers; or

(3) Restricting recipients' free choice of providers in accordance with one or more of the exceptions provided for under ə 431.54, or under a waiver as provided for under ə 431.55.

(d) Certification requirement. If a State implements a project under one of the exceptions allowed under ə 431.54(d), (e) or (f), if must certify to HCFA that the statutory safeguards and requirements for an exception under section 1915(a) of the Act are met. The certification must be submitted prior to instituting the project in the case of an exception under ə 431.54(d), for which the Secretary must make certain findings before the project may be initiated.

42 C.F.R. ə 431.51

The federal regulations also require states to pay for providers who are out of state in certain circumstances:

Payments for services furnished out of State.

(a) Basis and purpose. This section implements:

(1) Section 1902(a)(16) of the Act, which authorizes the Secretary to prescribe State plan requirements for furnishing Medicaid to State residents who are absent from the State; and

(2) Section 1902(a)(10)(A) of the Act, which requires a State plan to provide for Medicaid for all individuals receiving assistance under the State's title IV-E plan.

(b) Payment for services. A State plan must provide that the State will furnish Medicaid to:

(1) A recipient who is a resident of the State while that recipient is in another State, to the same extent that Medicaid is furnished to residents in the State, When:

(i) Medical services are needed because of a medical emergency;

(ii) Medical services are needed because the recipient's health would be endangered if he were required to travel to his State of residence;

(iii) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State; or

(iv) It is general practice for recipients in a particular locality to use medical resources in another State; and

(2) A child for whom the State makes adoption assistance or foster care maintenance payments under title IV-E of the Act.

(c) Cooperation among States. The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan.

42 C.F.R. ∋ 431.52 (emphasis is added)

The regulations (as opposed to the procedures) adopted by the Department covering transportation services (see M ∋ 755, paragraph 3 above) state that one of the criteria for providing transportation is that it be "to or from necessary medical services." Although the Department

relies upon that language to deny transportation to the petitioner, there is no evidence that the Department is denying the petitioner because the service at issue, i.e. prenatal care, is not medically necessary. The real issue here is whether the Department's regulation assuring transportation must, and if it must, does, in fact, take into account the petitioner's right to choose her provider. For reasons sets forth below, it is concluded that "freedom of choice" must be a factor in determining whether to provide transportation and that the Department's regulations, though not its procedures, reflect that requirement.

While the Department has broad discretion in administering its transportation assistance plan, it is required to "provide such safeguards as may be necessary to assure that . . . such care and services will be provided, in a manner consistent with simplicity of administration and in the best interests of recipients." 42 U.S.C. ə 1396a(a)(19). The transportation plan cannot be counterproductive to the medical well-being of the recipient and must bear a rational relationship to the underlying federal purpose. See Budnicki v. Beal, 450 F. Supp. 1013 (SD. N.Y. 1984); White v. Beal 555 F. 2d 1146 (3d Cir. 1977).

The federal law and regulations cited above include a clearly expressed goal of assuring personal choice (within some financial constraints) of health care providers to

Medicaid recipients. This goal cannot be frustrated by the state's refusal to provide transportation services which "give effect to the plaintiffs' right, under 42 U.S.C. ə 1396a(a)(23) and 42 C.F.R. ə 431.51, to free choice among qualified providers." Morgan v. Cohen 665 F.Supp. 1164, 1176 (E.D. Pa. 1987) HCFA, the agency charged with the administration of the Medicaid program, has adopted guidelines which address the issues of freedom of choice and transportation:

> If it is apparent to a state that the number of choices of any particular type of provider is significantly limited, the state may authorize transportation to allow a reasonable selection of appropriate providers. . . . Freedom of choice does not require a state to provide transportation at unusual or exceptional cost to meet a recipient's personal choice of provider.
>
> HCFA State Medicaid Manual, Section 2113, as reprinted in C.C.H. ə 14,605, Section 89, p. 6309

The Department's own regulations reflect the concerns and mimic the language in HCFA's manual. The regulations restrict the payment of transportation expenses to necessary medical services for which no other transportation is available. The regulation nowhere restricts payment to the "nearest available provider", a standard urged by the Department as part of its "medically necessary" argument. Paragraph four of the regulation is very close to the language in the HCFA manual:

> (4) The medical service is generally available to and used by other members of the community or locality in

> which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.
>
> M. ∋ 755

The use of the word "medical service" is somewhat confusing, since services are provided based on medical necessity, not on general availability to the community. However, a common sense reading of that regulation and one which comports with federal law and regulation is that the medical service provider is generally available to and used used by other members of the community. The further restriction in that section also implies what is not explicitly stated, that freedom of choice is a factor, although not an over-riding factor, in determining whether to pay a transportation expense.

Based on the above, the Department's assertion that its regulations do not and are not required to reflect the right of freedom of choice is erroneous. In its memo, the Department relies upon a statement in HCFA's State Medicaid Manual to support its contention: "Since the free-choice provision applies only to providers of medical services, transportation services for which a state claims reimbursement as an administrative expense are not subject to the freedom-of-choice provision." However, an examination of that section shows that statement applies to how transportation services are provided, not whether they are to be provider. That section goes on to say:

. . .

> For such transportation, a state may designate allowable modes of transportation or arrange for transportation on a prepaid or contract basis with transit companies. Transportation for which a state claims reimbursement as a medical expense (e.g., ambulance service) must be considered within the free-choice rights of the recipient. A state may enter into contractual arrangements for "medical transportation" and inform recipients of the availability of this service. Also, a state may establish allowable payments for private "medical transportation" not to exceed the costs which would have been incurred under the contract, for comparable services. However, a state must not limit "medical transportation" to its contractual arrangements.
>
> HCFA State Medicaid Manual, Section 2113, as reported in C.C.H. ∋ 14,605, Section 89, p. 6309

The Department unquestionably has the discretion to determine how to provide the actual transportation and may take cost into consideration. The Department's regulations also specifically limit freedom of choice by refusing to pay "unusual or exceptional costs". No doubt, it makes sense financially to place some restrictions on personal choice as long as the Medicaid recipient has access to providers "generally available to and used by others in the community." But that ability to restrict may not be used to totally destroy any meaningful range of choice.

Both federal and state law and regulations, therefore, guarantee that a petitioner in need of a necessary medical service will be transported, in a manner seen fit by the Department, to any qualified provider generally available to and used by other members of the community or locality

in which the recipient is located so long as the cost is not unusual or exceptional. In the instant case, the petitioner, who has no other transportation, has asked for transportation to an out-of-state provider for necessary medical care and has shown that both the provider and this area are generally used by other community members of Brattleboro to obtain medical services. The evidence shows that the Department regularly pays for visits to this area, as often as three times per week and, there is nothing unusual or exceptional about the cost of the twenty mile trip. In addition, if the petitioner is not provided transportation to that out-of-state physician, she is forced to use the only physician in her "service area" and is totally deprived of any choice. This result is directly contrary to one of the stated goals of the Social Security Act which is to ensure that no individual is forced to use a particular health care provider.

To the extent that the Department's procedures set out above do not allow for an analysis of the choice issue, they must be found to conflict with the state and federal regulations. While such guidelines may contribute to administrative simplicity and may be essential for the use of non-agency personnel who take applications for this program, those guidelines must allow ultimately for some agency discretion to approve transportation outside the hospital catchment area where a reasonable range of freedom of choice is not provided in the service area. The

procedures on their face do not appear to be unduly restrictive since they allow transportation services throughout a wide geographical area. However, as medical services exist or change in a community, those regulations may be too restrictive as applied to an individual. That was true in this case, as only one provider existed in the designated area. The petitioner cannot be forced, through a lack of transportation, to see a particular provider when providers who are commonly used by other community members are available within a reasonable transporting distance.

# # #