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**SMD# 23-006**

**RE: Assurance of Transportation:  
A Medicaid Transportation  
Coverage Guide**

September 28, 2023

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance, the Medicaid Transportation Coverage Guide, to serve as a consolidated and comprehensive compilation of both current and new Medicaid transportation policy, providing a one-stop source of guidance on federal requirements and state flexibilities. In addition, the issuance of this guidance addresses the statutory requirements outlined in the Consolidated Appropriations Act (CAA), 2021, Division CC, Title II, Section 209(a)<sup>1</sup> (section 209(a)), and responds to the recommendation from the U.S. Government Accountability Office (GAO) to the Secretary of the Department of Health and Human Services (HHS) that CMS assess current Medicaid non-emergency medical transportation (NEMT) guidance and update it as needed.<sup>2</sup> Most importantly, this guidance addresses requirements and flexibilities regarding Medicaid's transportation assurance so states are better able to provide beneficiaries greater access to Medicaid benefits.

This Medicaid Transportation Coverage Guide addresses the transportation assurance requirement in section 1902(a)(4)(A) of the Social Security Act (the Act), and includes new guidance to improve access to necessary transportation services in more complex scenarios, including where beneficiaries may encounter extended wait times and need to make long-distance trips. The guidance also provides references and greater context on certain overlapping requirements so states are better able to navigate complex issues and consider impacts across their Medicaid programs.

Medicaid transportation is a critical service that assists beneficiaries with accessing covered Medicaid services and has a direct impact on health outcomes. CMS encourages states to consider how to fully operationalize the transportation assurance and to ensure it is regularly monitored and considered for improvements. CMS is part of the Coordinating Council on Access and Mobility (CCAM),<sup>3</sup> working with the Federal Transit Administration on ways to

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<sup>1</sup> Consolidated Appropriations Act, 2021 Division CC, Title II, Section 209(a) (Public Law 116-260): <https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf>.

<sup>2</sup> Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States, GAO-16-238 (Washington, D.C.: Feb. 2, 2016) <https://www.gao.gov/products/gao-16-238>.

<sup>3</sup> For more information about the CCAM, please visit: <https://www.transit.dot.gov/coordinating-council-access-and-mobility>.

coordinate Medicaid and public transit programs. In addition, CMS encourages states, managed care plans, and transportation providers to work collaboratively to ensure beneficiaries are educated and informed about transportation options available to them.

All references to the Medicaid program in this letter and the accompanying Medicaid Transportation Coverage Guide encompass Medicaid expansion Children's Health Insurance Programs (CHIP). In general, this guidance does not apply to separate CHIPs, except those that provide the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Those separate CHIPs should follow the guidance about EPSDT in this guide (see 42 C.F.R. § 457.496(b)). We also remind states that all separate CHIPs must provide emergency services pursuant to 42 C.F.R. § 457.410(b)(3).

CMS encourages states to follow this document as a guide to developing and updating appropriate policies and procedures that facilitate robust transportation programs. While states can engage vendors and managed care plans, and can delegate the many aspects of the operation of transportation programs to other entities, the single state Medicaid agency ultimately is responsible for ensuring transportation that meets all statutory and regulatory requirements, regardless of whether the beneficiary receives necessary transportation through a Medicaid fee-for-service or managed care delivery system, and whether transportation is offered as an optional medical service or an administrative activity.

CMS is eager to work with states to assure transportation and ensure access to care. For additional information about this letter, or for states requesting technical assistance, please contact Kirsten Jensen, Director of the Division of Benefits and Coverage, at [kirsten.jensen@cms.hhs.gov](mailto:kirsten.jensen@cms.hhs.gov).

Sincerely,

Daniel Tsai  
Deputy Administrator and Director

**Medicaid Transportation Coverage Guide**

**2023**

## Executive Summary

### *Overview of the Assurance of Transportation*

The Medicaid transportation assurance encompasses both emergency transportation and non-emergency medical transportation (NEMT) when necessary to enable the beneficiary to access a covered service.<sup>4</sup> The assurance of transportation is not a requirement for states to pay for a ride, but rather a requirement to make certain that every Medicaid beneficiary who has no other means of transportation has access to transportation needed to receive covered care. Accordingly, it is a critical part of access to care for many beneficiaries, and has a key role in health equity by ensuring beneficiaries can attain the highest level of health and have a meaningful opportunity to attain optimal health regardless of race, ethnicity, disability, sex (including sexual orientation and gender identity),<sup>5</sup> socioeconomic status, geography, preferred language, and other factors that can affect access to care and health outcomes.<sup>6</sup>

### *Medicaid Transportation Background*

Historically, the transportation assurance was based on the principles identified in section 1902(a)(4)(A) of the Social Security Act (the Act), which requires that state plans “provide such methods of administration... as are found by the Secretary to be necessary for proper and efficient operation of the plan” and was promulgated in regulation in 42 C.F.R. § 431.53. This regulation established the transportation assurance as a state plan requirement, providing that the plan must “[s]pecify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers;” and “[d]escribe the methods that the agency will use to meet this requirement.”

Recently, the Consolidated Appropriations Act (CAA), 2021, Division CC, Title II, Section 209<sup>7</sup> (section 209), codified in statute at section 1902(a)(4) of the Act<sup>8</sup> the longstanding regulatory interpretation described above, adding a statutory requirement that state plans must include “a specification that the single State agency...will ensure necessary transportation for beneficiaries under the State plan to and from providers and a description of the method that such agency will use to ensure such transportation.”

Together, the new statutory and existing regulatory construct for and approach to defining transportation as an administrative activity or optional medical service remain the same. When provided pursuant to 42 C.F.R. § 431.53, transportation is covered as an administrative activity under the state plan and is matched at the standard 50 percent Federal Financial Participation (FFP) rate provided under section 1903(a)(7) of the Act for administrative expenditures. However, the transportation assurance may also be covered as an optional medical service under

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<sup>4</sup> Throughout this guide, the terms medical services and covered services include all physical health, mental health, and substance use disorder services that Medicaid covers under the state plan.

<sup>5</sup> See <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>

<sup>6</sup> <https://www.cms.gov/files/document/health-equity-fact-sheet.pdf>.

<sup>7</sup> Consolidated Appropriations Act, 2021 Division CC, Title II, Section 209 (Public Law 116-260): <https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf>.

<sup>8</sup> Section 1902(a)(4) of the Act (42 U.S.C. 1396a(a)(4)): [https://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

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42 C.F.R. § 440.170(a), which is based on section 1905(a)(31) of the Act.<sup>9</sup> When provided as an optional medical service, transportation expenditures are matched at the state's applicable Federal Medical Assistance Percentage (FMAP).

In section 209, Congress also made corresponding amendments to section 1937(a)(1) of the Act, adding a new subparagraph (F) and applying substantially the same assurance of transportation requirements for benchmark and benchmark-equivalent coverage, also known as Alternative Benefit Plan (ABP) coverage. Prior to this amendment, the assurance of transportation in ABPs was required by regulation under 42 C.F.R. § 440.390, which references the state plan assurance of transportation requirement in 42 C.F.R. § 431.53. Additionally, section 1903(i) of the Act was amended to include a new paragraph (9), providing that, “with respect to any amount expended for non-emergency transportation authorized under section 1902(a)(4),” no payment may be made “unless the State plan provides for the methods and procedures required under section 1902(a)(30)(A).”

In addition to the new statutory requirements, section 209 obligated CMS to perform the following required activities<sup>10</sup>:

- Convene a series of meetings with interested parties to obtain feedback and facilitate discussion on, and to enable shared learning of, the leading practices for improving Medicaid program integrity with respect to NEMT to medically necessary services, taking into account the unique considerations of specific groups of Medicaid beneficiaries, such as American Indians, individuals who reside and/or seek services on Tribal lands, and individuals with disabilities who need special accommodations (section 209(b)(2));
- Assess CMS' guidance issued to states<sup>11</sup> relating to federal Medicaid requirements under Title XIX of the Act for NEMT to medically necessary services and update such guidance as necessary to ensure states have appropriate and current guidance in designing and administering coverage of NEMT (section 209(b)(3)); and
- Submit a report to Congress on recommendations for Medicaid coverage of NEMT to medically necessary services based on an analysis of the nation-wide data set under the Transformed Medicaid Statistical Information System (T-MSIS) (section 209(b)(5)).

To meet the requirements of section 209(b)(2), CMS held a series of listening sessions for interested parties between March and May of 2022 to obtain input and facilitate shared learning about the leading practices for improving Medicaid program integrity for NEMT. A total of four public and five focused listening sessions were held on various topics with specific groups,

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<sup>9</sup> Section 1905(a)(31) of the Act provides the Secretary the authority to include in the definition of medical assistance “any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.”

<sup>10</sup> In addition to assuring transportation and performing the required activities, section 209(b)(4) established provider and driver requirements and provided that states that establish an NEMT brokerage may consult with relevant interested parties. CMS issued a CMCS Informational Bulletin summarizing all the requirements in 2021: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf>.

<sup>11</sup> State refers to U.S states, territories, and the District of Columbia.

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including state associations, advocates, providers, drivers, government entities, managed care plans, broker organizations, the Tribal Technical Advisory Group, public transit agencies, beneficiaries, members of the public, and others. Prior to each session, CMS encouraged interested parties to bring forward suggestions, recommendations, and innovations that could improve NEMT for Medicaid beneficiaries. These listening sessions provided insight into which policy topics were confusing or difficult to navigate, illuminated operational challenges, and highlighted effects of these issues on beneficiaries' experiences and access to care as well as the experiences of NEMT providers and medical service providers.

This Medicaid Transportation Coverage Guide serves to satisfy the requirements of section 209(b)(3) and has been informed by feedback from interested parties as discussed above, technical assistance requests from states, and other inquiries submitted to CMS. We have considered the questions and concerns we have heard, as well as the best practices, recommendations, and innovative approaches that have been shared, in developing this updated guidance as a comprehensive compilation of information on Medicaid transportation and related policies. This guide is also designed to help states better understand transportation federal requirements and available flexibilities, and to inform state operational and policy decisions. Topics that were discussed in the listening sessions are indicated by an asterisk (\*) throughout the guide. Throughout the listening process, CMS also identified key areas where new policy was needed to help bolster access to care regarding wait times, long-distance trips, and transportation for the direct benefit of an EPSDT-eligible beneficiary.

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### ***Assurance of Transportation***

The assurance of transportation is an essential feature of the Medicaid program that ensures beneficiaries' access to health care. The transportation assurance includes non-emergency and emergency transport provided through multiple modes of transportation. CMS recognizes variation across states in the type of terrain and geography through which transportation occurs, such as air, water, roadways, rough land terrain, subway, and other environments. For purposes of this Medicaid Transportation Coverage Guide (Coverage Guide), the term "vehicle" is used. It should be noted that a vehicle can include anything used to provide transportation such as car, plane, bus, train, subway, specialized vehicles, or other mode of transport.

#### Assuring Access to Necessary Transportation\*

States are required to assure that beneficiaries have transportation necessary to access covered medical services. This assurance is not a requirement to pay for a ride, but rather a requirement to make certain that every beneficiary who has no other means of transportation has access to transportation needed to receive covered care. States' implementation of the required assurance of necessary transportation can take into account operational limitations and parameters, such as describing when air travel may be considered, but limitations must be reasonable in meeting the needs of the beneficiary and cannot be so restrictive as to conflict with the state's responsibility to assure necessary transportation so that a beneficiary can access a covered service.

#### Emergency Medical Transportation

The federal Medicaid transportation assurance requirement does not recognize emergency medical transportation (EMT) services separately from the overall assurance of transportation requirement. Under section 1902(a)(4) of the Act and implementing regulations, including 42 C.F.R. § 431.53, states must ensure both emergency and non-emergency medical transportation where necessary for the beneficiary to receive covered services. Additionally, though there may be state regulations or policy restricting transportation to an alternate destination, federal Medicaid law and regulations do not specify that emergency transportation must be to an emergency department of a hospital. Examples of alternative destination locations may include urgent care, freestanding behavioral health facilities, group practices, ambulatory care settings, crisis centers, and community clinics.

### ***Transportation Authorities: Flexibilities Under the State Plan***

States have considerable flexibility in the design and operation of the assurance of transportation. Generally, states may assure transportation as an administrative activity, as an optional medical service, or a combination of these. Regardless of whether transportation is claimed as an administrative activity, optional medical service, or as a combination in different circumstances, matching funds may not be claimed for direct expenditures for transportation infrastructure (e.g., roads, rails, purchase of vehicles, etc.). The following sections provide guidance on how states may effectuate different transportation flexibilities within the state plan.

### Transportation Provided as an Optional Medical Service

Transportation can be assured as an optional medical service if included in the state's approved state plan, but only when provided by a provider to whom a direct vendor payment can be made by the Medicaid agency, as required under 42 C.F.R. § 440.170(a)(2). States can receive the state's regular FMAP rate for NEMT and EMT when furnished as an optional medical service under an approved state plan, which may be higher than the administrative claiming rate.

As an optional service, the NEMT and/or EMT must meet the definitions outlined in Medicaid regulations at 42 C.F.R. § 440.170(a) and all other requirements relating to Medicaid medical services. These include the beneficiary freedom of choice requirement (section 1902(a)(23) of the Act and 42 C.F.R. § 431.51), which permits a beneficiary to obtain services from any qualified and willing Medicaid provider; the comparability requirement (section 1902(a)(10)(B) of the Act and 42 C.F.R. § 440.240), which specifies that services available to any categorically needy beneficiary under the plan may not be less in amount, duration, and scope than those services available to any other categorically needy beneficiary or to a medically needy beneficiary (and any services available to a medically needy group may not be less in amount duration, and scope than those services available to any other covered medically needy group); and the statewideness requirement (section 1902(a)(1) of the Act and 42 C.F.R. § 431.50), which indicates that a state plan must be in effect throughout the state. If covered under the state plan as an optional medical service, states cannot pay beneficiaries directly for transportation as required under 42 C.F.R. § 440.170(a)(2).

### Transportation Provided as an Administrative Activity

Administrative claiming provides states with greater flexibility in designing their transportation program because state plan requirements for medical services, such as freedom of choice, comparability, statewideness, and direct vendor payment, do not apply. Instead, states are allowed to provide payment for transportation services directly to the beneficiary under this authority. States that elect to provide NEMT, EMT, or both, as an administrative activity may need to submit and have approved a Medicaid Administrative Claiming Plan depending on the complexity of the state's program. Regardless, states must include transportation in their Public Assistance Cost Allocation Plans (45 C.F.R. 95 Subpart E) if they intend to claim transportation as an administrative expenditure. In addition, the state plan (in Attachment 3.1-D "Assurance of Transportation") must describe the methods the state will undertake to meet this assurance, whether as an administrative activity or as a medical service or both. Transportation as an administrative activity allows the state to claim FFP at the 50% administrative claiming rate.<sup>12</sup> Note states may also claim FFP in administrative expenditures for assisting an individual to obtain transportation to Medicaid covered services or arranging for transportation for beneficiaries (separately from any Medicaid expenditure for the transportation itself).

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<sup>12</sup> Section 1903(a)(7) of the Act.

Providing Transportation as Both an Administrative Activity and Optional Medical Service

There is nothing in federal Medicaid law or regulation that would preclude a state from providing NEMT or EMT as a medical service in one area of the state and claiming it as an administrative activity in another part of the state. However, providing transportation as a medical service requires that it be offered in compliance with the basic Medicaid tenets, including statewideness, comparability, and freedom of choice of provider, as discussed above. States may seek a waiver of one or more of these requirements described in the preceding sentence under section 1915(b) or section 1115 of the Act, which must be approved by CMS. Providing transportation as a medical service also requires direct vendor payment. Due to this requirement, states must claim any direct payment to beneficiaries as an administrative activity as required under 42 C.F.R. § 440.170(a)(2).

Broker as an Optional Medical Service \*

Section 1902(a)(70) of the Act provides state plan authority to establish an NEMT brokerage program and receive the state's regular FMAP rate for medical assistance. This authority allows states to amend their Medicaid state plans to include an NEMT brokerage program without regard to the statutory requirements for comparability, statewideness, and freedom of choice of provider, without the need for waivers under section 1915(b) or section 1115 of the Act. Regulations at 42 C.F.R. § 440.170(a)(4) further define this state plan option.

Broker as an Administrative Activity \*

It should be noted that expenditures for broker-arranged NEMT can also be claimed as an administrative activity.

***Transportation Authorities: Other Flexibilities in the Medicaid Program***

In addition to the state plan authorities described above, there are other authorities under which states cover transportation for certain beneficiaries.

Alternative Benefit Plan

While section 1937(a)(1)(A) of the Act provides for an "Alternative Benefit Plan" to the traditional state plan governed by section 1902, this does not absolve the state of its existing obligation to provide coverage of emergency and non-emergency transportation to beneficiaries receiving Medicaid services in Alternative Benefit Plans. See section 1937(b)(5) of the Act and implementing federal regulations at 42 C.F.R. § 440.390 requiring the provision of emergency services and an assurance of NEMT. The assurance of necessary transportation under this authority can include limitations and restrictions on amount, duration, and scope, but limitations must be reasonable in meeting the needs of the beneficiary and cannot be so restrictive as to conflict with the state's responsibility to assure transportation.

Managed Care Authorities\*

States may cover transportation as an optional medical service under managed care authorities, such as a section 1932(a) State Plan Amendment (SPA), section 1915(b) waiver, or section 1115 demonstration authority under the Act. If the service is covered under the State plan as a medical service, this service can be included in the Medicaid managed care

capitation rates per 42 C.F.R. § 438.3(c)(1)(ii). The foregoing managed care authorities can be used to waive freedom of choice of provider, statewideness, and/or comparability requirements. Section 1932(a) SPAs are approved for an indefinite period, but states generally may not require certain beneficiaries, including Medicare beneficiaries, American Indians, and certain children with special needs, to enroll in a managed care plan established under this authority. Section 1915(b) waivers are initially approved and renewed for two-year periods, unless the covered population includes dually eligible beneficiaries, in which case the program can be approved for an initial period of up to five years and renewed for up to five years. Transportation delivered through managed care as an optional medical service must follow applicable Medicaid managed care rules in 42 C.F.R Part 438 and must be included in an actuarially certified capitation rate if included in a managed care plan's risk contract.

If transportation is not covered under the State plan as a medical service, the managed care plan could voluntarily choose to cover transportation as an additional benefit, consistent with 42 C.F.R § 438.3(e)(i), although the cost of the service could not be included when developing the capitation rates. Like other services, states may choose to carve transportation out of a managed care delivery system. If the State only covers transportation as an administrative activity, the State could enter into a separate arrangement with a managed care plan to provide it as an administrative activity as an administrative service organization.

### Home and Community-Based Services (HCBS) and Non-Medical Transportation\*

HCBS are designed to meet the medical and non-medical needs of people who prefer to receive long-term services and supports in their home or community, rather than in an institutional setting. Transportation to access state plan medical services provided to HCBS participants is provided through the state's transportation program. In addition, states have the option to cover *non-medical* transportation to enable HCBS participants to access community services, activities, and resources when other options are unavailable. At the state's discretion, non-medical transportation services may be covered separately under a section 1915(c) waiver, a section 1915(i) SPA, a section 1915(j) SPA, a section 1915(k) SPA, or a demonstration project under section 1115 of the Act. For additional information on how Medicaid may pay for non-medical transportation for HCBS participants, please refer to the section 1915(c) HCBS waiver technical guide<sup>13</sup> and State Health Official Letter (SHO)# 21-001.<sup>14</sup>

### ***Transportation as a Medicaid Program Requirement***

The assurance of transportation is mandatory in Medicaid and the methods a state uses to meet this requirement must be described in the state plan. While some states delegate some transportation functions to external entities, the state is ultimately responsible for ensuring that beneficiaries are able to access necessary transportation to enable them to receive covered services.

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<sup>13</sup> [https://wms-mmdl.cms.gov/WMS/help/35/Instructions\\_TechnicalGuide\\_V3.6.pdf](https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf).

<sup>14</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

### Transportation is an Underlying Medicaid Program Component\*

Transportation is a Medicaid program component and providers who furnish transportation services are directly or indirectly<sup>15</sup> Medicaid providers through fee-for-service and managed care. This is true whether transportation organizations and drivers are enrolled as individuals or, for provider types not eligible to enroll under the state plan, furnishing services through another enrolled provider such as a vendor or a county authority, or another organization, entity, or individual.

Whether transportation organizations and drivers are enrolled as participating providers through a provider agreement, or, if not eligible to enroll directly, are furnishing services under the auspices of another enrolled provider, states are responsible for ensuring Medicaid program requirements are met. This includes; for instance, availability of necessary transportation for all beneficiaries<sup>16</sup> including those living with disabilities,<sup>17,18</sup> free from discrimination;<sup>19,20</sup> availability of clear procedural steps related to filing grievances and appeals and beneficiary right to a fair hearing;<sup>21</sup> prohibition on balance billing;<sup>22</sup> language assistance for individuals with Limited English Proficiency (LEP),<sup>23,24</sup> and, an expectation of courteous, respectful, and professional behavior<sup>25</sup> and cultural competency.<sup>26</sup>

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<sup>15</sup> The term “indirect” refers to providers who are not a provider type eligible to enroll with the state Medicaid agency, but regardless of enrollment status, deliver direct services to Medicaid beneficiaries.

<sup>16</sup> See 42 C.F.R. § 431.53.

<sup>17</sup> Section 504 of the Rehabilitation Act of 1973 requires that “no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under” any program or activity that either receives Federal financial assistance.

<sup>18</sup> Title II of the Americans with Disabilities Act of 1990 at 42 U.S.C. § 12132 requires that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”

<sup>19</sup> See section 1557 of the Patient Protection and Affordable Care Act. Additional information found at: <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>.

<sup>20</sup> For additional requirements for managed care, see 42 C.F.R. § 438.3(d)(4) and 42 C.F.R. § 438.206(c)(2).

<sup>21</sup> Section 1902(a)(3) of the Act requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. See 42 C.F.R. § 431 Subpart E, and 42 C.F.R. § 438 Subpart F for more information related to grievances, appeals, and fair hearings.

<sup>22</sup> See 42 C.F.R. § 447.15.

<sup>23</sup> Considerations for individuals with LEP include availability of qualified interpreters and translators (including the availability of telecommunication devices), or having state websites, emails, and documents made available in languages other than English. Additional resources are included in Appendix B.

<sup>24</sup> HHS, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons found at <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-vi/index.html>.

<sup>25</sup> The Medicaid Non-Emergency Medical Transportation Booklet for Providers includes information about Program integrity, including the expectation for courteous and respectful behavior and professional drivers. <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf>.

<sup>26</sup> See requirements at 42 C.F.R. § 440.262 indicating states must “have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. These methods must ensure that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs.”

### Access and Availability of Services\*

Medicaid operates as a partnership between states and the federal government, through which states have broad latitude and flexibility in operationalizing the delivery of Medicaid services and setting payment rates. For transportation provided as an optional medical service, section 1902(a)(30)(A) of the Act generally requires the state plan to provide methods and procedures as may be necessary to ensure that “payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[.]” Under section 1903(a)(7) of the Act, transportation provided as an administrative activity must be provided in a manner consistent with “the proper and efficient administration of the State plan.” When determining and updating state plan rates for transportation, states should evaluate and set the rates so that beneficiaries will have access to transportation at least consistent with the availability of transportation services to non-Medicaid individuals in geographic areas of the state. For states that use a managed care delivery system, 42 C.F.R. § 438.206(a) requires that each state ensure that all services covered under the state plan are available and accessible to enrollees of managed care plans<sup>27</sup> in a timely manner. As such, if states include transportation as a covered service in a managed care contract, states should carefully analyze their contracts and capitation rates to ensure that they provide for adequate access and availability of services and require compliance with all applicable provisions in 42 C.F.R. part 438.

### Ensuring Transportation Means States Have Oversight Responsibilities and Accountability\*

Each state administers its Medicaid program in accordance with a CMS-approved state plan. Although the state has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements. These requirements include but are not limited to the requirement to ensure that its provider agreements require that providers of services maintain records to fully disclose the extent of services provided to Medicaid beneficiaries<sup>28</sup> and that transportation services for which Medicaid payment is made are furnished only to eligible beneficiaries when necessary to allow the beneficiary to travel to and from a provider to receive a covered service.<sup>29</sup> Additionally, state claims for transportation services must be in accordance with all state requirements. States may delegate or contract for the operation of the NEMT program to another governmental entity, such as a state transportation board or a county government, or a non-governmental entity, provided it complies with applicable state and federal requirements.

For more information about oversight of transportation provided through other vendors, managed care plans, brokers, or other entities, please refer to the “Oversight of Transportation Services for Beneficiaries” section.

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<sup>27</sup> The term “managed care plans” includes managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans as defined in 42 C.F.R. § 438.2 unless otherwise noted.

<sup>28</sup> See 42 C.F.R. § 431.107.

<sup>29</sup> See 42 C.F.R. § 431.53.

### ***Transportation Access Requirements***

Medicaid transportation has two main requirements to ensure it is the most suitable and economic means of providing transportation when there is no other option available to the beneficiary: (1) that it is the least costly and most appropriate mode suited to the needs of the beneficiary, and (2) that it provides transport to the nearest qualified provider. Transportation is covered only when it is necessary. States may impose additional processes to navigate provider and beneficiary relationships, but those processes must be reasonable so as not to restrict access.

#### Least Costly/Most Appropriate\*

The requirement for the least costly and most appropriate ride was first stated in a March 7, 1991 State Medicaid Director (SMD) letter, which interpreted the provision in section 1902(a)(4) of the Act that the plan must provide for methods of administration as found necessary by the Secretary for the proper and efficient operation of the plan to require the state to first attempt to use any available free services (for example, access to a ride from family, friends, etc.) to satisfy a beneficiary's transportation needs.<sup>30</sup> This letter also interpreted this statutory provision to require that, when several modes of transportation are available, states must use the least costly mode that is appropriate for the physical and emotional condition of the beneficiary. States should note that the least costly and most appropriate mode must continue to ensure quality of services. Please refer to the "Americans with Disabilities Act (ADA) and Paratransit," "Beneficiaries with Disabilities," and "Beneficiaries with Behavioral Health Needs" sections for additional information.

#### Nearest Qualified Medical Provider\*

In general, it is not proper and efficient<sup>31</sup> to transport a beneficiary a lengthy distance to see a provider when there are closer qualified participating providers. For that reason, unless there is a medical need to see a more distant provider, the state generally must ensure the availability of necessary transportation to the nearest qualified provider of the services the beneficiary needs. However, it is important to note that there are circumstances when the state could be in violation of the freedom of choice requirement if it holds too closely to this concept. For example, if the state denied transportation to the participating provider of choice when the cost of the ride is equal to the cost of a ride to a closer provider, or varies by only a *de minimis* amount, it could be a violation of the freedom of choice of provider requirement.<sup>32</sup> Additionally, if preserving a beneficiary's relationship with the distant provider is necessary because leaving that provider would harm the beneficiary or the provider has special capabilities/capacities that are necessary for the beneficiary's care, denial of transportation to that provider may also violate freedom of choice or could constitute denial of the underlying medical service itself where other providers lack the special capabilities/capacities necessary for the beneficiary's care.

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<sup>30</sup> SMDL guidance on payment for of transportation and the assurance of transportation issued March 7, 1991.

<sup>31</sup> Section 1902(a)(4)(A) of the Act requires that "A State plan for medical assistance must...provide...such methods of administration...as are found by the Secretary to be necessary for the proper and efficient operation of the plan."

<sup>32</sup> See section 1902(a)(23) of the Act.



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When transportation is denied to a particular provider because there are closer qualified providers, assistance should be given by the state to identify which additional providers are available in closer proximity to the beneficiary. The state should determine a geographic distance within which transportation is generally provided along with any criteria for extenuating circumstances when transportation will be covered outside the usual geographic distance. The state should also have a review process for requests for transport to providers whose distances are beyond the transport zone.

### Necessary Transportation

States are generally granted considerable flexibility in meeting the assurance of necessary transportation. Ensuring necessary transportation to and from services does not mean that the state must provide transportation without considering if a beneficiary has a personal vehicle available. A general expectation that a beneficiary uses their own personal vehicle for transportation is permissible as long as the individual's circumstances would not preclude the use of their own personal vehicle. Circumstances such as maintenance and fuel costs may impede use of the beneficiary's vehicle as a transportation option. States have an obligation to ensure that payment is made only where transportation is not otherwise available to the beneficiary to access Medicaid-covered services.

### Processes to Improve Passenger and Provider Relations

The assurance of transportation to enable beneficiaries to reach their Medicaid providers is not a requirement to pay for a ride but rather a requirement to ensure that every beneficiary, regardless of additional needs or challenges, is able to access transportation to Medicaid-covered services. A negative transportation experience can have a direct impact on both a driver's willingness to accept a passenger and a beneficiary's willingness to accept a ride. To ensure transportation providers, such as drivers, have the necessary tools to engage beneficiaries and ensure a positive experience, CMS recognizes there may be a need for additional steps to help manage the transportation provider-beneficiary relationship.

For instance, a driver may be scheduled to transport a beneficiary for whom a ride has been arranged, needing no accommodation for physical or behavioral health. The passenger may have exhibited past conduct which impacted a driver's ability to drive safely or without distraction, or may have not been respectful.

To address this situation, the state may need to implement processes to prepare beneficiaries for their transportation pickup appointments or otherwise take steps to promote a positive and effective transportation provider-beneficiary relationship when relationships may be a barrier to a driver providing future services. Examples include, but are not limited to:

- Restricting beneficiaries to a single provider who may accommodate additional passenger challenges when there are no other willing transportation providers;
- Requiring beneficiaries to be transported in a "specialized transport" appropriate for the beneficiary's behaviors and needs;
- Requiring the beneficiary to follow special prior authorization procedures, as warranted, to arrange for transportation;
- Allowing beneficiaries to arrange their own ride as reasonable accommodations; or

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- Consulting with a beneficiary’s treating practitioners, including physical and behavioral health providers, on how to best serve the individual.

Beneficiaries may not receive necessary care when appointments are missed. To ensure a beneficiary’s receipt of medical services is not hindered or discouraged, states may not deny transportation due to beneficiary no-shows or lateness, even if frequently occurring. States and providers may also not impose a charge on a beneficiary for no-shows.<sup>33,34</sup> However, CMS recognizes there may be a need for additional steps in scheduling and confirming a ride for passengers who exhibit chronic lateness or no-shows, such as, but not limited to:

- Counseling the beneficiary;
- Requiring the beneficiary to confirm the ride the morning of or the night before, or the ride will not be provided;
- Requiring the beneficiary to use a single provider who is assigned by the state and then requiring the beneficiary to confirm the ride shortly before it is to be provided or the ride will not be provided; or
- Allowing the beneficiary to arrange their own transportation which the state will reimburse or make other payment arrangements, as appropriate. States can offer this option but cannot force beneficiaries to arrange their own transportation.

It is important to note that before implementing any action to limit transportation in any way, states should send a letter to the beneficiary documenting the efforts made to accommodate the beneficiary, along with the behaviors that have resulted in the additional process.

Transportation experiences can have an impact and influence on the decision a beneficiary makes in scheduling a service and the frequency of scheduling. Beneficiaries who have a negative experience may see obstacles related to transportation as a deterrent to receiving medically necessary care. Improving the experience in being informed and educated about transportation, arranging for transportation, ride experience, interaction with customer service representatives, ease in scheduling, and clear processes in rescheduling are all important considerations. As with other Medicaid services, rescheduling is a common part of service delivery and can be related to factors such as illness, another life event, or a provider scheduling conflict. It is important that the scheduling and rescheduling process for the beneficiary is administratively simple and that any arising provider and driver issues are regularly monitored and managed by the transportation provider and the state, as appropriate. Please refer to the “Beneficiary Support” section for additional information on Oversight of Transportation Services for Beneficiaries, Scheduling Assistance, and No-show Providers, Replacements, and Reschedules.

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<sup>33</sup> FFP is not available for the cost of transportation to a beneficiary who does not appear for their ride (referred to as a no-show beneficiary).

<sup>34</sup> <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/1995%2520-%2520billing%2520%26%2520missed%2520appointments.pdf>.

### ***Consideration for Special Populations\****

States may experience unique challenges in providing transportation to specific groups of Medicaid beneficiaries, including but not limited to American Indian and Alaska Native (AI/AN) beneficiaries, beneficiaries with disabilities, and, more generally, beneficiaries living in rural areas.<sup>35</sup> States should design a transportation program that ensures each beneficiary can access medical care and in a manner that optimizes adherence to treatment regimens. The following policies may help states in the development and administration of their assurance of transportation to address the challenges faced by special populations.

#### **Beneficiaries with Disabilities\***

Beneficiaries with disabilities may require alternative modes of transportation to meet their unique needs and, in many cases, require more than curb-to-curb services. States must consider a beneficiary's support needs in determining the most appropriate mode of transportation. For example, if a beneficiary uses a wheelchair, then the state must ensure that the transportation provider transports the beneficiary in a wheelchair-accessible vehicle. In addition, states must ensure oversight of the transportation entities that provide or coordinate transportation to ensure beneficiaries with disabilities are provided with modes of transportation that meet their needs.

#### **Beneficiaries with Behavioral Health Needs\***

Beneficiaries with behavioral health needs (mental health conditions and substance use disorders), especially those experiencing a behavioral health crisis, may require alternative modes of transportation to meet their particular needs. States must consider a beneficiary's behavioral health needs in determining the most appropriate mode of transportation. States are encouraged to cover transportation services specifically tailored for beneficiaries with behavioral health needs. For example, a state may cover behavioral health transportation services and require transportation providers that provide those services to be trained and credentialed in serving beneficiaries with behavioral health needs.

#### **Tribal Transportation\***

Health programs operated by the Indian Health Service (IHS) or operated by Tribes and Tribal Organizations under the Indian Self-Determination and Assistance Act can provide Medicaid covered services, including transportation, to American Indian and Alaska Natives (AI/AN) if they generally meet the state's qualifications for providing these services (they are not, however, required to obtain a state license).<sup>36</sup> If qualified, Urban Indian Organizations can also provide these services. We refer to health programs operated by Indian Health Service, Tribes, and Urban Indian Organizations collectively as I/T/Us. Many AI/AN Medicaid beneficiaries face difficulties in accessing transportation and as a result, may not receive needed medical services. For example, there may be barriers unique to Tribal communities, such as not having formal street addresses (which may make it more difficult for a provider to find the beneficiary's residence), homes that are isolated from roadways, and unpaved and rugged roadways that cannot be traveled without special

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<sup>35</sup> These sub-populations were frequently mentioned in the listening sessions.

<sup>36</sup> See 42 C.F.R. § 431.110. This regulation also explains that when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure.

vehicles. Many Tribal communities located on tribal land may be situated in mountainous regions that are difficult to navigate in inclement weather.

States have flexibility to design methods of administering the transportation assurance to meet the unique needs of beneficiaries, including AI/AN beneficiaries, who are experiencing these barriers. For example, drivers can use odometer readings or GPS coordinates to navigate to a location and calculate mileage if there is no street address. In some instances, because of the time and distance to medical care, it may be necessary to authorize overnight stays (including meals and/or lodging).<sup>37</sup>

Tribes and Tribal organizations may have unique experience in navigating these barriers. Additionally, 42 C.F.R. § 440.170(a)(4) permits governmental entities to serve as transportation brokers, including Tribes and Tribal organizations. States are encouraged, where possible, to use existing providers servicing Tribal areas including I/T/Us. Each state Medicaid agency has an internal Tribal liaison who state agency staff can consult and whom an I/T/U and individual AI/AN Medicaid beneficiaries can contact if they need assistance with accessing transportation. CMS also encourages states to consult with Tribes and Tribal organizations as they review their policies and procedures and evaluate rate methodologies that recognize the unique transportation issues faced by Tribal transportation providers.

### Rural Areas\*

States face unique challenges in meeting their obligation to assure transportation for beneficiaries residing in rural areas. More time and distance are generally needed to provide transportation services, as public transportation is generally absent or difficult to access and communication methods may be more limited than in urban areas. For example, a transportation provider may travel many miles to transport a beneficiary to a covered medical service, and the time required to travel this distance may mean that the transportation provider is unable to transport any other beneficiaries on that day. Additionally, beneficiaries who do not show up for the ride may be more costly for rural transportation providers than those in urban or suburban areas, given the long distances and time that can be involved. CMS strongly encourages states to evaluate rate methodologies that recognize the unique transportation issues faced by rural transportation providers. States have the flexibility to set higher base rates or establish supplemental payments for transportation providers to recognize the higher cost of doing business in rural areas. Please refer to the following sections: “Related Travel Expenses,” “Long Wait Times,” “Long-Distance Trips,” “No Load Miles or Unloaded Miles,” and “Flexibilities for Coverage of Wait Times and Long Distances” for additional information.

### ***Transportation Under Specific Circumstances***

The following guidance provides information about federal policies regarding transporting for specific trips or under certain conditions or circumstances.

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<sup>37</sup> See policy regarding Related Travel Expenses for more information.

### Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Transportation\*

The EPSDT benefit mandates Medicaid coverage of services described in section 1905(r) of the Act for EPSDT-eligible beneficiaries,<sup>38</sup> including medically necessary medical, dental, mental health, substance use disorder, personal care, and long-term services and supports, regardless of whether the particular services are covered under the state plan. Transportation is an essential part of making medically necessary health care available to children. Beyond the general transportation assurance requirement, the Medicaid EPSDT benefit further specifies in 42 C.F.R. § 441.62 that states must offer and provide beneficiaries of EPSDT services with “necessary assistance with transportation as required under § 431.53[.]” As required under EPSDT,<sup>39</sup> states must inform beneficiaries and families in a clear and nontechnical manner that necessary assistance with transportation is available. In determining what constitutes necessary transportation for children under 21, the state should consider the needs and best interests of the child when providing additional assistance with transportation to covered services. If, in order to effectuate transportation for the child, the child needs to be accompanied to their medical services(s), the state must cover the cost of transportation for the person accompanying the child. Transportation for the person accompanying the child includes coverage for trips to and from the service (e.g., roundtrip for admission, roundtrip for discharge), including in cases of out-of-state trips.

### Transportation for the Direct Benefit of Children Under 21

The goal of the EPSDT benefit is to ensure that children under 21 receive timely access to medically necessary section 1905(a) services. CMS issued prior guidance<sup>40</sup> that linked the medically necessary treatment services provided for the direct benefit of the child with the child’s parent(s), family member(s), or caregiver(s) in order to play an integral role in effectively treating the child. However, if the participation of a parent, family member, or other caregiver is necessary to a child’s care and such caregiver cannot access the child to participate in the care, then the Medicaid program cannot ensure that the child is receiving the necessary care. For example, where a child is receiving residential or facility-based care (e.g., inpatient, neonatal intensive care unit (NICU), psychiatric residential treatment facility (PRTF), etc.) and the presence of the parent, family member, or other caregiver is necessary so that they can actively participate in the treatment/intervention for the direct benefit of the child, then state may pay for transportation for the parent, family member, or caregiver in order to ensure the child’s medically necessary services are provided (e.g., to provide breast milk or breastfeed, participate in family therapy, medical decision making and consent for surgery, etc.).

Alternatively, the cost of transportation could be considered part of the cost of the medical service (e.g., inpatient hospital benefit, etc.) and included in another service payment, rather than paid separately as a distinct service. For example, if a child is admitted to a facility to obtain treatment and it is medically necessary for the parent, family member, or other

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<sup>38</sup> EPSDT-eligible beneficiaries include, but may not be limited to, all beneficiaries under age 21 who are eligible for a categorically needy eligibility group.

<sup>39</sup> Section 1902(a)(43) of the Act and implementing regulations at 42 C.F.R. § 441.56 require states to inform eligible Medicaid beneficiaries under the age of 21 and their families about EPSDT, generally within 60 days following an eligibility determination. This is known as the informing process.

<sup>40</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>.

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caregiver to participate in receipt of the treatment, then parent, family member, or other caregiver's transportation could be included in the payment for the institutional services as a component of the facility service provided to the child.

### Transportation for Visitation\*

Transportation for parents, family members, or other caregiver(s), referred to as "visitors" in this context, who are visiting a beneficiary who is hospitalized or otherwise receiving residential or facility-based treatment (in-state or out-of-state) generally is not necessary for the beneficiary to receive the covered medical service and is thus not part of the assurance of transportation requirement. Visitor transportation is not eligible for Medicaid coverage, regardless of whether the state is ensuring necessary transportation as an administrative activity or as an optional medical service.

### Transportation for Optional Benefits\*

Transportation must be assured for both mandatory benefits and optional benefits that the state has chosen to cover. For instance, while the prescribed drug benefit is an optional state plan benefit, if the state chooses to cover prescribed drugs, it must also assure that beneficiaries have necessary transportation to pick up covered prescriptions. In this specific example, however, since NEMT should be cost efficient, a state may adopt a policy of not providing NEMT to a pharmacy location when there is an available pharmacy mail order program or an available pharmacy with timely delivery service that is able to reliably deliver prescriptions directly to the beneficiary. Whenever possible and to the extent it would promote efficiency and economy, state programs should attempt to combine a return trip from a provider when the beneficiary has received a prescription with a stop at the nearest participating pharmacy to fill (or at least drop off) the new prescription before returning the beneficiary home. Please refer to the "Flexibilities for Coverage of Wait Times and Long Distances" section for additional information.

### Transportation for Beneficiaries Dually Eligible for Medicaid and Medicare\*

Medicare is the primary payer for services that are payable by both Medicare and Medicaid. However, Medicare has a limited non-emergency ambulance transportation benefit. If a full benefit dually eligible individual<sup>41</sup> is obtaining a Medicaid-coverable service for which Medicare is the primary payer, the state must ensure necessary transportation to the medical service.

If the beneficiary is obtaining a non-Medicaid coverable service that is covered by Medicare, the state has the option to cover transportation to that service. For example, states have the option (by specifying in the state plan) to cover transportation for full benefit dually eligible beneficiaries to the pharmacy to obtain Part D drugs, if it would be cost effective to do so. The transportation to obtain Part D drugs is optional because Part D drugs are expressly excluded from coverage in Medicaid under section 1935(d)(1) of the Act. Because Part D drugs are expressly not covered by Medicaid, the transportation to obtain these drugs

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<sup>41</sup> Full benefit dually eligible individuals are those individuals enrolled in the Qualified Medicare Beneficiary Plus (QMB Plus), Specified Low Income Medicare Beneficiary Plus (SLMB Plus), and Full Benefit Dual Eligible (FBDE) Medicaid options.

becomes optional. Please see the section titled “Coverage of Transportation to Services not Provided by a Medicaid Provider” for additional information.

### School-Based Transportation

As a general rule, ordinary transportation of Medicaid beneficiaries to school is not covered by Medicaid because education is the primary purpose of attending school, even when a Medicaid-covered health service is provided in the school. However, Medicaid payment is available for transportation to onsite school-based services for children receiving services under the Individuals with Disabilities Education Act (IDEA).

Section 1903(c) of the Act provides that states may not be “prohibited or restricted from receiving payment... for medical assistance for covered services... because such services are included in the child’s Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).” When specialized transportation is necessary primarily to ensure the child’s medical needs are met and the need for such specialized transportation is specified in a child’s IEP, then Medicaid payment is available for specialized transportation to and from school for days when the child receives a Medicaid-covered service (see “Medicaid Payment for Services Provided without Charge (Free Care)” SMD letter #14-006<sup>42</sup>, the school-based health services manual<sup>43</sup>, and a 1999 SMDL<sup>44</sup>). CMS policy related to payment for specialized transportation expressed in prior guidance remains unchanged. Non-specialized transportation and transportation not specified in an IEP is not covered because the primary benefit from ordinary school transportation is for school attendance. Ordinary school transportation is not targeted to address the student’s medical needs and is not covered by Medicaid. The fact that a provider was at the school and provided care to a Medicaid-covered student does not create the need for Medicaid non-emergency medical transportation.

FFP may be claimed for the cost of transportation services when the Medicaid-eligible child must leave the school and go into the community to receive medical services covered and paid for under Medicaid. FFP is available for the cost of transporting the child from school to the community provider and back to school or home and for transporting the child from the home to the provider and then to school. This includes the cost of transporting an attendant when an attendant is necessary to accompany the child.<sup>45</sup>

School-based specialized transportation is transportation to a medically necessary service (as outlined in the IEP of an enrolled Medicaid beneficiary) provided in a specially adapted vehicle that has been physically adjusted or designed to meet the needs of the individual student (e.g., special harnesses, wheelchair lifts, ramps, specialized environmental controls, specialized suspension systems etc.) to accommodate students with disabilities in the school-

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<sup>42</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

<sup>43</sup> “Medicaid and School Health: A Technical Assistance Guide,” August 1997.

<sup>44</sup> State Medicaid Director Letter, May 21, 1999.

<sup>45</sup> Please note a transportation attendant is not the same as a personal care attendant/aide. If a personal care aide is provided as a covered service to the beneficiary and will accompany the beneficiary on a medical appointment, including during transport, then an additional transportation attendant is not necessary.

based setting. Note: the presence of only an aide (on a non-adapted bus/vehicle) or simple seat belts do not make a vehicle specially adapted. In all cases, the medical need for physical or environmental adaptations during transport from home to school and back home (or to an alternative site to receive the IEP service) must be identified in the IEP. FFP is not available for the cost of transporting a student who rides a physically adapted bus or other vehicle, but does not have a medical reason documented in an IEP to make use of the particular bus/vehicle adaptation. For a more complete discussion on Medicaid services in schools, see: “[Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, 2023.](#)”<sup>46</sup>

### Coverage of Emergency Transportation for Individuals with Unsatisfactory Immigration Status

Section 1903(v)(2) of the Act requires that payment be made for care and services necessary for the treatment of an emergency medical condition for individuals who are otherwise eligible for Medicaid in the state, but who do not have a satisfactory immigration status. These emergency medical conditions include medical conditions that could endanger the beneficiary’s health/life (including the cost for emergency labor and delivery) and services could include provision of EMT.

### Coverage of Transportation to Services not Provided by a Medicaid Provider

States may choose to cover transportation to access otherwise covered services paid for by other payers and/or services provided by non-participating providers, when it is cost effective to do so. States may choose to exercise this option because it could be more cost effective and efficient to cover an individual’s transportation to an otherwise covered medical service when the medical service is not paid for by Medicaid. For example, a state may choose to cover trips to otherwise covered services furnished by the Department of Veteran’s Affairs (VA) for a beneficiary who is a veteran and enrolled in VA health care, because the beneficiary’s obtaining the service from the VA without charge to the Medicaid program is cost effective and efficient.

### Ground Emergency Medical Transportation (GEMT)

The cost of fire and rescue personnel and their equipment is generally not related to Medicaid covered services. As such, Medicaid cost identification methodologies that inappropriately allocate costs associated with fire and rescue personnel and their equipment could be unallowable under the federal cost allocation requirements. Similarly, costs associated with other emergency response personnel, vehicles, and equipment that are not involved in the provision of a Medicaid-covered service, such as police and their vehicles and equipment, should not be included in GEMT cost identification and allocation methodologies for Medicaid payment, and potentially would be unallowable. CMS encourages states to look to the current federal cost allocation regulations to appropriately and accurately define and allocate costs to the relevant Medicaid cost objectives, which are costs incurred for the purpose of delivering allowable Medicaid services to Medicaid beneficiaries. For example, costs associated with fire and rescue personnel who do not provide Medicaid covered

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<sup>46</sup> <https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf>.



services to Medicaid beneficiaries on the scene of an emergency but who are present during the emergency as required by state law or local code would potentially be unallowable. However, all personnel who meet applicable Medicaid provider qualifications (such as Medicaid-participating, licensed or certified emergency medical technicians) and provide Medicaid-covered services at an emergency site to beneficiaries may be included in the GEMT cost allocations, provided the unit of government can identify the portion of costs properly allocable to the provider's furnishing of Medicaid-covered services (as opposed to conducting other duties or functions that do not constitute a Medicaid-covered service) and allocate that portion of costs to the Medicaid program. The CMS Informational Bulletin titled "Applicable Federal Cost Principles for Ground Emergency Medical Transportation (GEMT)" provides additional information related to coverage of GEMT.<sup>47</sup>

### Treatment at the Scene without Transport\*

When no transportation occurs, such as when any necessary treatment is provided at the scene of an accident or medical event, states cannot claim FFP for the treatment as a transportation service. Whether claimed as an optional medical service or as an administrative activity, transportation necessarily requires transport of a Medicaid beneficiary to a provider site for the receipt of a covered Medicaid service, and when no transportation of a beneficiary has occurred, Medicaid payment for transportation is not available. States have the flexibility to cover services provided at the scene (with no transport) under various Medicaid coverage authorities.

A number of states have used section 1905(a)(6) of the Act, sometimes referred to as the "other licensed practitioner" benefit, to cover the services of certain professionals, such as paramedics, typically associated with the provision of emergency services rendered on the scene. Other licensed practitioner services, defined at 42 C.F.R. § 440.60, are "... medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practices as defined under State law." States could consider submitting a SPA to cover the services of licensed paramedics under section 1905(a)(6) of the Act in order to make payment for services furnished on the scene when no transport takes place. This benefit can also include the services of unlicensed professionals who furnish covered services under the supervision of licensed practitioners. In these instances, states should assess the type of professionals furnishing services and their qualifications to determine the appropriate coverage authorities. For more information about treatment at the scene and an example model for aligning service delivery and transportation at the scene, please see "Medicaid Opportunities in the Emergency Triage, Treat, and Transport (ET3) Model" issued on August 8, 2019.<sup>48</sup>

### Law Enforcement as a Mode of Transportation\*

Section 1902(a)(4) of the Act requires that states provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the State plan. While states and localities may require particular vehicles and/or equipment (e.g., fire trucks, police, and ambulance) to be dispatched to the scene of an emergency, Medicaid FFP is not

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<sup>47</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib08172022.pdf>

<sup>48</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080819-3.pdf>

available in expenditures for personnel, vehicles, or equipment not directly involved in the provision of Medicaid-covered services. In circumstances where law enforcement personnel transport Medicaid beneficiaries to a provider of covered services, they typically do so only incidentally to their law enforcement activities, which are the primary purpose for their dispatch to and presence on the scene. In general, costs of law enforcement personnel and equipment are not directly involved in the provision of a Medicaid-covered service, and Medicaid payment for them would not be consistent with the proper and efficient operation of the plan or with applicable cost allocation principles. Additionally, if transportation is claimed as an optional medical service, section 1902(a)(23) of the Act would apply. This section provides that beneficiaries may obtain services from any willing and qualified Medicaid provider that undertakes to provide the services to them. When law enforcement transports an individual, the individual is typically taken involuntarily or without an opportunity to select another qualified and willing provider. Since individuals in these circumstances are not given their free choice of provider, Medicaid payment for transportation by law enforcement as an optional medical service would be inconsistent with section 1902(a)(23) of the Act. Please refer to the “Ground Emergency Medical Transportation (GEMT)” section for more information.

### Transportation Network Companies (TNCs) Also Known as Ridesharing Organizations\*

TNCs, also known as ridesharing organizations, are a type of transportation provider. The state has flexibility in determining and designing how it will provide and pay for transportation services in accordance with the transportation regulations described in 42 C.F.R. § 431.53 and 42 C.F.R. § 440.170(a). In implementing TNCs as an option, states must be cognizant of the Medicaid policy that requires that the ride be the least costly, most appropriate ride that meets the medical needs of the beneficiary. Furthermore, payment for a ride must be consistent with efficiency, economy, and quality of care. As applied to TNCs, this means the state would need to account for the medical appropriateness of the ride and the financial efficiency of using a TNC to furnish Medicaid-covered transportation (e.g., including any economies of scale that might be realized through a contractual agreement with a TNC).

### ***Broker***

Under section 1902(a)(70) of the Act and implementing regulations at 42 C.F.R. § 440.170(a)(4), states may establish a broker program to ensure necessary NEMT. The following sections seek to clarify broker requirements and states’ obligations.

### Competitive Bidding\*

Regulations at 42 C.F.R. § 440.170(a)(4) require that a broker contract be competitively bid and awarded based on a state's evaluation of the broker's experience, performance, references, resources, qualifications, and costs. In addition, it must include oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous. State and local entities that wish to serve as brokers may compete on the same terms as non-governmental entities.

## Medicaid Transportation Coverage Guide

### Broker Conflict of Interest and Exception Requests\*

42 C.F.R. § 440.170 (a)(4)(ii) provides that, in general, brokerage contracts must prohibit the broker (including certain related parties) from providing transportation under the contract with the state, and the broker may not refer or subcontract to a transportation service provider with which it has a financial relationship, unless certain exceptions as discussed below are approved through the SPA process.

CMS may grant an exception for a non-governmental broker to provide transportation services under three circumstances per 42 C.F.R. § 440.170(a)(4)(ii)(B):

- The transportation is provided in a rural area, and there is no other available Medicaid-participating provider or other qualified provider except the non-governmental broker;
- The transportation is so specialized that there is no other Medicaid-participating provider or no other qualified provider except the non-governmental broker; or
- Except for the non-governmental broker, the availability of other Medicaid-participating providers or other qualified providers is insufficient to meet transportation need.

If a state wishes to implement one of the exceptions to the broker conflict of interest rules, the state must submit a SPA proposal to implement the exception, which must include documentation to support that the criteria for the exception are met. States must be able to show precise, up-to-date, and accurate statistical data to support the need for the broker to transport in each county or subdivision in which the state is requesting to effectuate the exception. States should also consider including the following in the documentation submission:

- What steps have been taken by the relevant transportation broker(s) to contract with an adequate supply of network providers, and what barriers prevent the broker(s) from contracting with an adequate number of network providers? States should include the estimated timeframe needed for the broker(s) to contract with adequate providers, as well as the timeframe the state is requesting to apply the exception.
- How would the state ensure the broker(s) only supplement available transportation from network providers as necessary, and do not supplant or diminish the available pool of qualified providers who contract with the broker(s)?
- What metrics will the state use to determine that the exception sought is no longer necessary?

If an exception is granted, the state should contractually require its broker(s) to limit the use of these vehicles to only those trips for which an appropriate contracted transportation network provider is not available.

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### Public/Governmental Entities as Brokers\*

A broker that is a public/governmental unit<sup>49</sup> (e.g., regional transportation authority, state department of transportation (DOT), or transit agency) must competitively bid to become a Medicaid NEMT broker. When the governmental entity also provides transportation services, or arranges for NEMT by referring to or subcontracting with another government-owned or operated transportation provider (e.g., public transit providers), it is exempted from the conflict of interest prohibition when certain requirements are met, which ensure an arm's-length transaction. These include:

- The contract with the governmental broker provides for payment that does not exceed the actual costs calculated as though the broker were a distinct governmental unit (excluding from payments any personnel or other costs shared with or allocated from parent or related entities); the governmental broker must maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program;
- The broker documents that the governmental provider was the most appropriate and lowest cost alternative for each individual trip, in consideration of the beneficiary's specific needs; and
- The broker documents that Medicaid is paying for
  - i. *public fixed route transportation* at a rate that is no more than the rate charged to the general public; and
  - ii. *ADA paratransit* and *demand response* at a rate that is no more than the rate charged to any other state human services agencies for comparable services.

For a more complete discussion about Governmental Entities as Brokers, please refer to the preamble to 73 FR 77519.<sup>50</sup> Please also refer to the "Fixed Route Public Transit" section.

### Broker Payments to Providers\*

States that contract with a broker to assure necessary transportation are still obligated to ensure beneficiary access to necessary transportation services under section 1902(a)(70) of the Act. States may direct brokers to use specific provider payment methodologies to help ensure beneficiary access to necessary transportation services. States are also expected to provide sufficient oversight to ensure that when contracting with transportation providers the broker does not offer payment that is so low that local transportation providers are unwilling to participate, thus creating a need for the broker to provide transportation. States have the flexibility to explore a broad array of innovative payment models.

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<sup>49</sup> For more information about distinct governmental units please refer to the preamble 73 FR 77521 at <https://www.govinfo.gov/content/pkg/FR-2008-12-19/pdf/E8-29662.pdf>.

<sup>50</sup> Id.

### ***Beneficiary Support***

As in all Medicaid services, the delivery of transportation services should be person-centered. In order for the transportation assurance to serve its intended purpose, the state must have in place a reasonable process for providing and managing transportation. While some of these functions are often delegated, the state has ultimate responsibility to provide oversight. Interested parties who participated in the section 209 listening sessions emphasized the importance of state oversight, as well as more reasonable processes to avoid having to reschedule medical appointments, which can impact health outcomes.

#### Oversight of Transportation Services for Beneficiaries\*

States have ultimate oversight responsibility to monitor beneficiary access and complaints, ensure transportation is timely, and ensure that transport personnel are licensed, qualified, competent, and courteous. States have a responsibility to ensure beneficiaries are aware of the processes and policies regarding accessing transportation, filing complaints and grievances, and requesting a fair hearing. State Medicaid agencies should have in place robust oversight programs that include conducting regular audits to ensure all state and federal Medicaid law, regulations, and policies are followed. States also have an obligation of oversight for all Medicaid-covered transportation, including where transportation is arranged by local jurisdictions.

The state, the broker, and the transportation company should monitor any complaints made by beneficiaries related to transportation access and quality including, but not limited to, courteous and respectful drivers and scheduling staff, clean vehicles, timely rides, etc., and hold accountable the operational organizations that administer day-to-day transportation, such as transportation companies, brokers, counties, managed care plans, and drivers.<sup>51</sup> Most importantly, state Medicaid agencies must ensure the adequacy of beneficiary access to covered medical care and services.

#### Scheduling Assistance\*

As stated previously, states are required to assure that beneficiaries who have no other means of transportation have access to necessary transportation to and from Medicaid-covered services. Also, states should inform Medicaid beneficiaries of available services, and states should provide information to beneficiaries about assistance with necessary transportation. States are expected to provide clear and effective communication with beneficiaries and providers to ensure beneficiaries do not miss appointments and avoid long wait times, to accommodate adjustments in appointment times, and to efficiently match beneficiaries with appropriate transportation. States may need to replace and/or reschedule rides for many reasons, including to accommodate beneficiary needs. In general, states should have processes in place to ensure timeliness, effective communication, and efficient resolution for unanticipated interruptions in services. Please refer to the “Processes to Improve Passenger and Provider Relations” section for additional information.

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<sup>51</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.

### No-show Providers, Replacements, and Reschedules\*

Providers who do not arrive for a pick-up (referred to as no-show providers) affect a state's ability to assure necessary transportation to covered services for beneficiaries with no other means of transportation. No-show providers lead to missed medical appointments, which impact beneficiary health and outcomes. States and their Medicaid transportation partners must have adequate oversight and processes in place to ensure that scheduled transportation is furnished as arranged. As such, states should have mechanisms in place to monitor performance to reduce the number of no-show providers and allow for replacement transportation providers with short notice. Beneficiaries should also be informed about and have ready access to information on how to report a no-show and arrange for a replacement provider.

FFP is not available in payments for no-show providers as no Medicaid-covered service is delivered or activity performed in the case of a no-show provider. States have the responsibility to take any necessary oversight actions to help prevent future no-shows and to ensure impacted beneficiaries are able to access necessary transportation.

### ***Provider and Vehicle Requirements***

Transportation to medical services is vital to ensure that individuals can receive covered services needed to improve or maintain their health status. States must establish qualifications and safety standards for drivers, use appropriate screening and credentialing methods, and ensure that Medicaid-covered transportation is appropriately accessible, including during disasters.

### State Driver and Vehicle Standards\*

Section 209 added section 1902(a)(87) to the Act<sup>52</sup> and requires that states provide for a mechanism, which may include attestation, that ensures that, with respect to any provider (including a transportation network company) or individual driver of nonemergency transportation to medically necessary services receiving payments under such plan (but excluding any public transit authority), at a minimum—

- (A) each such provider and individual driver is not excluded from participation in any Federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the HHS Inspector General;
- (B) each such individual driver has a valid driver's license;
- (C) each such provider has in place a process to address any violation of a state drug law; and
- (D) each such provider has in place a process to disclose to the State Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider, including any traffic violations.

Beyond the requirements at 1902(a)(87) of the Act, Federal Medicaid law does not establish additional basic driver and vehicle standards. Instead, these standards are generally determined by state agencies responsible for motor vehicle management. Drivers must have the appropriate, current licenses for the types of vehicles they drive when transporting others.

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<sup>52</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf>.

For example, states may require a chauffeur's license (or equivalent) for taxis and vans. A state Medicaid agency may also require additional qualifications for drivers to ensure that Medicaid beneficiaries receive high-quality transport. Standards might include limiting the number of penalty/violation points drivers can have against their license, certifying the health of a driver, carrying vehicle liability insurance, and complying with state safety and inspection standards.

### Provider Enrollment, Screening and Background Checks\*

Sections 1902(a)(77) and (kk) of the Act require that states comply with the process for screening providers and suppliers, and section 1902(a)(78) requires enrollment of all providers furnishing items or services under the state plan. These statutory provisions are implemented by regulations at 42 C.F.R. § 455 Subpart E, which require states to enroll and screen providers according to categorical risk level, including at a minimum verifying compliance with state and federal requirements and conducting certain licensure and database checks. Section 1902(a)(27) of the Act and the regulation at 42 C.F.R. § 431.107 also require an agreement between the Medicaid agency and each provider or organization furnishing services under the state plan.

States have discretion to require enrollment of transportation providers at the organizational or individual level<sup>53</sup> or to add additional screening requirements,<sup>54</sup> but must be consistent in application of such requirements. However, if states recognize drivers as a provider type eligible to enroll, individual drivers must be enrolled, even if the organization is also required to be enrolled. States may also impose additional requirements, such as provider and driver standards to assure that drivers are qualified and appropriate. For instance, states may elevate the risk level for this provider type from the minimum "limited" level to "moderate" or "high," which incurs additional screening such as site visits and/or a fingerprint-based criminal background check, or impose additional background checks on drivers regardless of whether or not transportation is ranked as "high" risk. States can also add additional vehicle requirements, inspections, and other Medicaid provider enrollment policies.

As discussed in State Medicaid Director Letter (SMDL) #09-001,<sup>55</sup> transportation providers are also required to screen their employees to ensure they are not excluded, regardless of whether the state chooses to enroll the organization or individual drivers within the organization. Additionally, section 209 added section 1902(a)(87) to the Act, which requires states to attest in the state plan that any provider, including TNCs and individual drivers, meet specific minimum requirements regarding exclusions, licensure, violation of drug law, and disclosures.<sup>56</sup> Please refer to the "Attachment 3.1-D Page - Section 209 Attestation" section for additional information about the section 209 provider and driver requirements.

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<sup>53</sup>See page 43 of the Medicaid Provider Enrollment Compendium (MPEC)  
<https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf>.

<sup>54</sup> See 42 C.F.R. § 455.452.

<sup>55</sup> <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf>.

<sup>56</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf>.

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### Disaster Policy\*

Regulations at 42 C.F.R. § 431.53 require that states must ensure necessary transportation for beneficiaries to and from providers of covered services. During a disaster, it may be necessary to move Medicaid beneficiaries from one location to another so that they can receive covered services. For example, if the beneficiary is residing in a nursing facility or any other medical facility within an area that is impacted by a disaster, NEMT is available to move the beneficiary from a nursing facility or other medical facility that is no longer safe to another nursing facility or other medical facility not rendered unsafe or unavailable by the disaster, even when the closest available facility is out of state. The state must cover the transportation of a beneficiary from one nursing facility to another nursing facility to obtain services, or from a nursing facility to a community setting where the beneficiary can continue to receive services, when necessary, even when the placement is in another state. However, NEMT is not available to move a beneficiary from one community setting to another for personal reasons such as because the beneficiary would like to be closer to family or friends.

### *Payment*

When covering necessary transportation, states must pay for the least costly mode of transportation that most appropriately meets the needs of a beneficiary to access covered services. However, states must also ensure that payment is adequate to ensure beneficiary access to covered services. The following sections provide guidance on which are covered transportation services, and new policy on wait times and long-distance trips.

### No Load Miles or Unloaded Miles\*

The terms “no load miles” or “unloaded miles” refer to the mileage the driver travels without a Medicaid beneficiary in the vehicle. This situation includes the driver’s return trip in the case of beneficiaries who do not appear for their ride (referred to as beneficiary no-shows). Generally, no load miles cannot be paid as a direct service or administrative activity. Recognizing that no load miles result in significant costs to transportation providers and failure to account for them would negatively affect potential transportation providers’ willingness to transport Medicaid beneficiaries, states may build the cost of no load miles and beneficiary no-shows into their transportation payment methodology. States may also separately cover no load miles in limited circumstances if they exercise the flexibilities described in the section below, titled “Flexibilities for Coverage of Wait Times and Long Distances.”

### Long-Distance Trips\*

Drivers, especially in rural areas and Tribal lands, sometimes travel many miles away from their operational base or standard travel routes to take beneficiaries to covered medical services. In instances of overnight long-distance trips, states are required to cover related travel expenses. Please refer the Flexibilities for Coverage of Wait Times and Long Distances section below for additional information.

### Long Wait Times\*

Beneficiaries, especially those with complex medical needs, may need to travel to covered medical services that take hours to complete (e.g., dialysis treatment, outpatient surgery, etc.). Drivers who are also providing the beneficiary’s return transportation may experience



long wait times when transporting beneficiaries to and from such covered medical services. Generally, states may not cover long wait times as a distinct service, as the assurance of transportation is intended to assure transportation for beneficiaries to access medically necessary covered services, thus a beneficiary must be present with the driver. Additionally, it may not be consistent with economy and efficiency for a driver to wait for a beneficiary to finish receiving a covered service, as opposed to the first driver leaving and a second driver providing the beneficiary's return transportation after the covered service is finished. However, in some cases, even a long driver wait time may be the most economic and efficient means to provide a return trip to the beneficiary, and such wait times involve significant costs to the transportation provider that must be considered in establishing adequate transportation payment methodologies and rates. Consistent with the above guidance on no load miles, states may build the cost of long wait times into their transportation payment methodology. States may separately cover wait times as a travel expense in limited circumstances if they exercise the flexibilities described in the section below titled "Flexibilities for Coverage of Wait Times and Long Distances."

### Related Travel Expenses\*

As described in regulations at 42 C.F.R. § 440.170(a), transportation includes travel related expenses determined to be necessary by the agency to secure covered services. Related travel expenses include the cost of meals, lodging, and the cost of a transportation attendant<sup>57</sup> when necessary, as well as the potential to cover wait times if states exercise the flexibilities described in the section below titled "Flexibilities for Coverage of Wait Times and Long Distances." The cost of a transportation attendant may include transportation, meals, lodging, and if the attendant is not a family member, salary. Coverage of related travel expenses, when necessary for accessing covered services, is required regardless of whether the state is providing transportation as an optional medical service or as an administrative activity.

### Flexibilities for Coverage of Wait Times and Long Distances\*

CMS recognizes that beneficiaries may live in areas without sufficient medical providers and may require long-distance transportation to access covered services, and some beneficiaries' locations may be so remote that travel distance and travel times make it economically infeasible to enlist an adequate network of transportation providers when transportation payment rates and methodologies do not account for the unusually high costs of transporting these beneficiaries. CMS interprets the definition of transportation as an optional medical service at 42 C.F.R. § 440.170(a) to include related travel expenses determined to be necessary by the state to secure medically necessary services for the beneficiary. Consistent with the historical application of least costly, most appropriate transportation and coverage of other related travel expenses, such as meals and lodging, during long-distance trips, we interpret necessary transportation to include, in the limited circumstances described below, wait time and/or unloaded mileage. Under section 1903(a)(7) of the Act, this policy applies in the case of transportation provided as an administrative activity as necessary "for the proper and efficient administration of the State plan."

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<sup>57</sup> Attendant refers to transportation attendant as described in 42 C.F.R. § 440.170(a)(3)(iii) and not an attendant provided through another section 1905(a) benefit under the Act, such as personal care.

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Effective on the date of issuance of this Coverage Guide, wait times and/or unloaded mileage expenses can be covered at the state's option, while the beneficiary is not in the vehicle, solely under these circumstances:

- For wait time, the travel distance and transport time (for trips to and from services) make it more economically feasible for the transportation provider to remain at the medical provider while the beneficiary receives covered services, and
- For unloaded mileage, the most appropriate and economical transportation provider must incur extraordinary costs for time and/or mileage to pick up or drop off the beneficiary for the beneficiary to receive covered services. This means the expense of the unloaded portion of the trip that is not accounted for in the state's usual transportation payment rate or methodology would be prohibitive for the transportation provider, and the transportation provider is the most economical available resource capable of providing appropriate transportation.

States must submit a state plan amendment (SPA) with coverage and payment pages before claiming FFP for expenditures that require these flexibilities. Coverage pages should indicate which flexibilities the state is implementing under their description of related travel expenses. Payment pages should include the methodologies states will use for payment using these flexibilities. While not required in the state plan, states should develop operational criteria under which the flexibilities would apply.

Consistent with section 1902(a)(30)(A) of the Act, CMS will review proposed SPAs modifying Medicaid transportation payment methodologies for consistency with the requirements of efficiency, economy, quality of care, and sufficient access to providers, when the state is paying for transportation as an optional medical service. When the state is paying for transportation as an administrative activity, we will review related SPAs for consistency with the proper and efficient administration of the plan, as specified in section 1903(a)(7) of the Act. Please refer to the "General Payment" and "Cost Principles" sections for more information.

Driver shortages impact access to care for beneficiaries who need in-person services. These policy updates are intended to increase access to care and to alleviate some of the concerns related to driver retention and workforce development that may negatively affect beneficiaries' ability to access transportation to and from needed services.

### General Payment

Section 1902(a)(30)(A) of the Act requires Medicaid state plans to provide for methods and procedures relating to the utilization of, and payment for, Medicaid-covered services as may be necessary to safeguard against unnecessary utilization and to assure that payments are consistent with efficiency, economy, and quality of care. Further, state payment rates or methodologies must be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. These state plan requirements apply when transportation is covered as an optional medical service. When a state covers transportation as an administrative activity, section 1903(a)(7) of the Act requires that expenditures for

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transportation must be “as found necessary by the Secretary for the proper and efficient administration of the State plan.” Within these parameters, states have considerable flexibility to establish their payment methodologies and rates for transportation.

As with most non-institutional Medicaid services, there is no applicable upper payment limit (UPL) for payment for these services. The following are a few examples of ways that states may pay for transportation:

- States can adopt Medicare rates, or a percentage thereof, when a comparable Medicare rate exists;
- States may set their own rates (i.e., state-developed fee schedule rates) based on their own unique circumstances; and
- States may also elect to use an interim payment methodology that is reconciled to the provider’s final actual costs of providing transportation.

The suggested coverage flexibilities in this guidance allow for states to similarly apply this flexibility to the manner in which states pay for transportation to the location of the beneficiary, otherwise referred to as unloaded miles, and wait times associated with the driver waiting for the patient while the patient is in their appointment for a covered Medicaid service. In setting a rate for these circumstances, states must consider appropriate methods of payment, and may rely upon existing rate structures when doing so. For example, the Internal Revenue Service establishes a federal mileage rate for determining deductible cost associated with transportation.<sup>58</sup> Likewise, Medicare establishes a mileage rate for ambulance providers, which is geographically adjusted on Medicare’s published fee schedules.

### Cost Principles

The cost principles associated with transportation services were described in detail in the CMCS Informational Bulletin, “Applicable Federal Cost Principles for Ground Emergency Medical Transportation (GEMT).”<sup>59</sup> While the guidance provided herein addresses transportation generally (not limited to ground emergency medical transportation), the federal regulations associated with cost identification are the same.

In order to be approved, as required by regulations at 42 C.F.R § 430.10 and § 447.201 and as described in the above referenced informational bulletin, a SPA must comprehensively describe payment methodologies and contain all information necessary for CMS to determine whether it can be approved to serve as a basis for FFP. The regulations further require that a state plan describe the policies and methods to be used to set payment rates for each type of service included in the state’s Medicaid program. Accordingly, for an allowable cost identification methodology that includes an interim payment methodology with cost reconciliation, a payment SPA must comprehensively describe the cost identification and

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<sup>58</sup> Internal Revenue Service Standard Mileage Rates: <https://www.irs.gov/tax-professionals/standard-mileage-rates>.

<sup>59</sup> CMCS Informational Bulletin “Applicable Federal Cost Principles for Ground Emergency Medical Transportation (GEMT).” Aug. 17, 2022. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib08172022.pdf>.

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reconciliation methodology that will be used to determine interim and final payments to providers. Such a transportation payment SPA must describe:

- The interim rate that will be paid to providers during the cost reporting period;
- The allowable direct and indirect costs associated with furnishing Medicaid-covered transportation services;
- The cost identification and allocation processes used to determine the portion of provider costs claimed for Medicaid payment; and
- The procedures and timing for cost report completion and submission, and cost reconciliation with the providers.

For activities beyond the transportation of a beneficiary to a covered service, states will be required to develop allocation statistics to account for the time the driver of a vehicle spent driving to or from the beneficiary's location as well as the time spent waiting for the appointment to be completed. States could use mileage as a statistic in this instance to allocate a portion of the allowable costs of the unloaded mileage, and could use time, collected through a worker log, to identify the amount of time spent on site with the patient in order to create reasonable allocation statistics, if the state chooses to pursue including these activities in the overall reconciled cost methodology. Please refer to the section below titled "Flexibilities for Coverage of Wait Times and Long Distances" for an additional option for states.

As always, the state's cost identification procedures and associated state-developed cost report templates and instructions must be consistent with federal cost allocation regulations under 45 C.F.R. part 75. CMS reviews the state's cost report template and instructions prior to approving proposed SPAs to ensure that they are consistent with the applicable federal cost regulations; however, it is incumbent upon states to ensure that reported costs and associated claims for FFP are accurate and represent only costs associated with the provision of Medicaid-covered services. Costs that are claimed improperly may be subject to federal financial reviews and/or audit findings and place states at financial risk of liability to repay the federal share of any identified overpayments.

To properly allocate transportation costs to the Medicaid program, states must rely on data that appropriately apportion costs to the Medicaid transportation cost objective, and then allocate only those transportation costs to the Medicaid program according to the Medicaid program's share of the provider's total services - that is, allocate only the proportion of the provider's activities that benefitted the Medicaid program. Federal regulations at 42 C.F.R. § 431.107(b) require that "[a] State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to: (1) Keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries; (2) On request, furnish to the Medicaid agency, the Secretary, or the state Medicaid fraud control unit (if such a unit has been approved by the Secretary under § 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan[.]" CMS has advised states to use such relevant documentation in assigning costs to Medicaid for cost-based payment methodologies. For instance, localities that operate NEMT providers and wish to claim

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payment from payers, including Medicaid payment, must gather claims data by payer status for all individuals who receive NEMT services from the locality-operated provider during the cost reporting period.

Additionally, documentation of transportation services is useful not only when billing for services, but also in the event that an audit takes place. Consistent with 42 C.F.R. § 433.32(a), states must maintain an accounting system and supporting fiscal records to assure that claims for federal funds are made in accordance with applicable federal requirements. The main goals of documentation are to support that submitted claims represent necessary transportation furnished to a beneficiary to transport the beneficiary to and/or from covered services. To meet these goals, records should be accurate and complete.

### NEMT Cost Sharing

Cost sharing is permitted for NEMT only if covered as an optional medical service under the state plan, consistent with all applicable federal requirements for cost sharing for covered services. Any Medicaid cost sharing assessed must be nominal and comply with requirements at sections 1916 and 1916A of the Act and regulations at 42 C.F.R. § 447.50-57, including mandatory exempted populations. Providers may not deny services to an eligible individual on account of the individual's inability to pay the cost sharing, unless the individual has family income above 100 percent of the Federal Poverty Level (FPL) and the individual is not part of an exempted group, as described at 42 C.F.R. § 447.52(e)(1). Additionally, Medicaid cost sharing and premiums incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income pursuant to 42 C.F.R. § 447.56(f). Cost sharing is not permitted for NEMT claimed as an administrative activity.<sup>60</sup>

### Payment for Transportation During Retroactive Eligibility Periods

States must process and pay claims for covered services received by a beneficiary who is found eligible during the retroactive eligibility period, including for necessary transportation, regardless of whether transportation is furnished as an administrative activity or as a medical service. This requirement includes scenarios for which services have already been paid. Operationalizing this process may require the provider to first return any money collected from the beneficiary/family and then submit a claim to the state for the unpaid service. No payment is required when the transportation is available without cost to the beneficiary, such as from family, friends, or other public agencies.

### Costs that are Not Part of Medicaid Transportation\*

The cost of transportation for a provider of medical services, such as a paid personal care attendant, case managers or nurses conducting home visits, or a provider traveling to a rural area, is not coverable under the assurance of transportation.<sup>61</sup> Transportation is only available to assist a beneficiary who has no other means of transportation to access a medical service.

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<sup>60</sup> Under sections 1902(a)(14), 1916 and 1916A of the Act, Medicaid cost sharing is only permitted for services covered under the state plan. Administrative activities are not a coverable Medicaid service and therefore cost sharing is not authorized.

<sup>61</sup> Depending on the 1905(a) benefit, these costs may be able to be factored into rates for particular services.

State employees using their private vehicle to provide transportation to beneficiaries can be a Medicaid-covered activity. If the beneficiary is being transported for more than one reason, then there must be an allocation of the transportation cost to assure that the Medicaid agency is paying only for the portion of the transportation expenditure allocable to transportation to a Medicaid-covered service. States paying for necessary transportation as an administrative activity in this scenario may claim FFP at the 50% administrative activity rate for a payment made directly to the employee for transportation provided to the beneficiary to access covered Medicaid services.

FFP is not available for the advance of capital funds to providers for the purchase of transportation vehicles. Under section 1903(a) of the Act, FFP is limited to expenditures specifically authorized by Title XIX for medical assistance and administrative activities necessary for the proper and efficient administration of the plan. Advanced funds for the purchase of capital assets is not within the definition of a covered medical assistance service or an allowable administrative activity. States may consider the costs of capital assets properly attributable to Medicaid-covered services and administrative activities in determining payment methodologies and rates for necessary transportation.

### ***Public Transit Agencies***

Public transit agencies are often utilized in state Medicaid transportation programs and recognized as one of the least costly options. State departments of transportation (DOTs) and Medicaid agencies should explore partnerships to better serve the Medicaid population.<sup>62</sup> This section clarifies the requirements related to the identification of the least costly and most appropriate transportation and public transit costs, to ensure states and other interested parties understand when and how public transit agencies may be used to provide transportation to beneficiaries.

#### Americans with Disabilities Act (ADA) Paratransit\*

As noted previously, the assurance of transportation to Medicaid providers is not a requirement to pay for a ride but rather a requirement to ensure that every beneficiary, regardless of support needs, or travel distance, is able to access transportation to Medicaid providers to receive covered services. If using paratransit, states should ensure that the paratransit agency provides sufficient reliability and timeliness to allow Medicaid beneficiaries to access Medicaid providers and receive covered services.

The ADA requires public transit agencies that provide fixed route services to provide “complementary paratransit” services to people with disabilities when these individuals cannot use the fixed route bus or rail service because of their disability. However, states should ensure that the fiscal burden of transporting beneficiaries is not unfairly placed on paratransit services. Recognizing the higher costs of operating a paratransit system, Medicaid may pay more than the rate charged to individuals with disabilities for a paratransit

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<sup>62</sup> States should consider how public providers and Medicaid agencies can work together to understand transit and Medicaid policies and definitions.

ride. The rate paid for paratransit trips must represent a reasonable amount and be no more than the rate paid for similar paratransit trips paid by other state human services agencies.

### Fixed Route Public Transit\*

States may set rates for transportation services in a manner that is determined to be economic and efficient to enlist enough providers so that care and services are available to Medicaid beneficiaries in the same manner as they are available to the general population (section 1902(a)(30)(A) of the Act) or necessary for the proper and efficient operation of the state plan (section 1903(a)(7) of the Act), as applicable. Other third-party payers (for example, state human service agencies) often cover and pay for similar trips for their clients but generally pay the same amount that the public is charged for these rides. States using fixed route public transit for the provision of Medicaid should not include payment for:

- public fixed route transportation at a rate that is more than the rate charged to the general public; and
- ADA paratransit and demand response at a rate that is more than the rate charged to any other state human services agencies for comparable services.

The state Medicaid agency is only required to pay for necessary transportation when the beneficiary has no other means to access a covered service. Thus, when there are other non-Medicaid resources available to assist the beneficiary, then the Medicaid program is not required to pay for a ride.

### Public Transit Passes\*

States may utilize public transit passes and claim FFP for the cost of bus, rail, ferry, or other public transit passes as long as the cost of the pass is consistent with section 1902(a)(30)(A) or section 1903(a)(7) of the Act, as applicable, as discussed above. As described in a December 26, 1996, SMDL letter titled “Non-emergency Transportation,”<sup>63</sup> determination of cost effectiveness requires that the cost of the public transit pass for the individual be no more than the cost of other payment methods for the trips. The costs of the public transit pass (whether monthly or other basis) must, therefore, be compared to the cost of single trips the beneficiary would make to Medicaid providers to obtain medical service. The cost of a monthly public transit pass should not exceed the cost of the individual trips taken during that month.

For example, the cost of a public transit pass where a beneficiary lives is \$40 per month for unlimited rides or \$10 for each round trip. If the beneficiary has four scheduled medical appointments, during the month for which transportation was needed (and the appointments were verified as being scheduled), the total cost for the individual trips would also be \$40 (\$10 x 4=\$40). In this scenario, the cost of the public transit pass would not be greater than the cost of the individual rides taken that month so the public transit pass would be an economic and efficient means to ensure necessary transportation for the beneficiary to access covered services for that month. Whether the beneficiary uses the pass for non-medical-related trips would not be relevant because the cost of the individually purchased trips to and from covered services was not less than the cost of the pass. This applies to all modes of public transit whether it is a bus, rail, ferry, or other public transit.

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<sup>63</sup> <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/Non-EmergencyTransportation.pdf>.

### Coordination of Transportation\*

State Medicaid agencies and public transit agencies have opportunities to partner and dialogue about transportation on an ongoing basis to further collective understanding and help to serve beneficiaries who will utilize public transit to access Medicaid services and care. State Medicaid agencies may participate in efforts to coordinate the use of transportation resources as long as those efforts recognize the Medicaid program's responsibility is limited to ensuring necessary transportation for beneficiaries to and from covered services. NEMT services may be provided through a brokerage program under contract with individuals or entities selected through a competitive bidding process (as specified in the broker rules at 42 C.F.R. § 440.170(a)(4)). States may utilize public transit agencies to coordinate NEMT in order to provide the services more efficiently and cost effectively as long as there is no conflict with the policies and rules of the Medicaid program. As such, public transit agencies must be selected through a competitive bidding process.

It is important to note that Medicaid is the payer of last resort. In terms of financing, Medicaid is not responsible for the general operation or deficit financing of public or private transportation programs or providers. Federal funds may not be used as the non-federal share of Medicaid expenditures unless there is express authority under federal law for the federal funds to be used as the non-federal Medicaid share. Medicaid may be used to pay for a ride but may not be used to purchase or subsidize the transportation infrastructure (e.g., purchase a vehicle). Medicaid-paid transportation should only be used when there are no other means for the beneficiary to be transported to their medical appointment. For additional information, please refer to the section "Costs that are Not Part of Medicaid Transportation."

### ***SPA Content Requirements***

Regulations at 42 C.F.R. § 430.10 describe the state plan as a comprehensive written statement submitted by the state Medicaid agency describing the nature and scope of its Medicaid program. The state plan contains all the information necessary for CMS to determine whether the plan can be approved to serve as a basis for FFP. When a state is planning to make a change to its program policies or operational approach, states send SPAs to CMS for review and approval. The following are descriptions of what is needed in the state plan.

### Transportation State Plan Pages\*

The state plan pages describe, in sufficient level of detail, the methods the state will employ to ensure necessary transportation. Current federal guidelines related to the assurance of transportation require the state plan to:

- Specify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers of covered services and describe the methods that the agency will use to meet this requirement (42 C.F.R. § 431.53);
- Effectively inform all EPSDT eligible individuals (or their families) that necessary transportation and scheduling assistance under EPSDT is available upon request and provide necessary assistance with transportation when requested (section 1905(r) of the Act and 42 C.F.R. § 441.62);
- Identify how the state will pay for necessary transportation; and



- Include the section 1902(a)(87) of the Act required provider and driver attestations.

The items below describe where these descriptions are typically located in the state plan.

### Attachments 3.1-A and 3.1-B

If states elect to claim NEMT or EMT as an optional medical service, all the requirements at 42 C.F.R. § 440.170, as well as comparability, statewideness, and freedom of choice, would apply. As with all optional medical services, states are to describe the amount, duration, and scope of services on the 3.1-A/3.1-B pages. The state may include operational limitations and parameters, such as describing when air travel may be considered, but any limitations must be reasonable in meeting the needs of the beneficiary and cannot be so restrictive as to conflict with the state's responsibility to assure transportation.

### Attachment 3.1-D Page(s) - Methods of Transportation

States should list on the state plan 3.1-D pages the transportation delivery model for both NEMT and EMT. These pages describe, in a logical flow, the types of transportation provided and how they are made available to beneficiaries, the types of providers (e.g., a broker, vendor(s), managed care plan(s), or private contracted or independent network of drivers) that provide the service, and any combination of providers that will be used. These pages essentially provide the narrative story of how the state assures and ensures transportation. Detail must be sufficient to understand what the state Medicaid program offers to beneficiaries as options for transportation when a ride is needed. If transportation is provided under managed care authority or under section 1115 demonstration authority, a general description should be included in the 3.1-D pages, but content should also indicate where precisely to look by referencing those approved authorities for more detailed information on how transportation is provided through the authorities other than the state plan.

These pages also describe how the state will claim for expenditures for transportation, whether it will be an administrative activity, medical service, or both. States are to clearly describe the delivery model used to assure transportation to and from services on the 3.1-D page. The state may contract with individuals, corporations, taxicab, bus companies, airlines, etc. to provide transportation to eligible individuals.

### Attachment 3.1-D Page - Section 1902(a)(87) Attestation

Section 1902(a)(87) of the Act, requiring the Medicaid state plan to provide for a mechanism that may include an attestation that ensures any provider, including transportation network companies and individual drivers, meet specific minimum requirements. States must include an attestation that all the minimum requirements outlined in section 1902(a)(87) of the Act are met on the 3.1-D page.<sup>64</sup> This attestation is usually a separate page as part of the state plan 3.1-D pages. Specifically, states must attest that they ensure any provider (including a transportation network company or individual driver) of NEMT to medically necessary services receiving payments under the plan (but excluding any public transit authority) meets specified minimum requirements that:

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<sup>64</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf>.

## Medicaid Transportation Coverage Guide

- Each provider and individual driver are not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and are not listed on the exclusion list of the HHS Inspector General;
- Each such individual driver has a valid driver's license;
- Each such provider has in place a process to address any violation of a state drug law; and
- Each such provider has in place a process to disclose to the state Medicaid program the driving history, including any traffic violations, of each such individual driver employed by such provider.

### Attachment 4.19-B Page(s)

As with all other benefits in the state plan, states must provide detail on provider payments. This includes the rate methodology as well as the cost reporting methodology, as applicable, for transportation services as described in the 3.1-A and 3.1-B pages.

Please note that prior to this Coverage Guide, in the case of a state plan broker that is operating under regulations at 42 C.F.R. § 440.170(a)(4), payment of such broker was described in the coverage pages. For new state plans submitted after issuance of this guidance, states are required to submit a comprehensive transportation methodology in the 4.19-B pages to be consistent with non-broker transportation SPA pages.

**Appendix A: Additional Resources for Meeting the Needs of Medicaid Beneficiaries with Limited English Proficiency**

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: <https://thinkculturalhealth.hhs.gov/clas>.
- CMS Guide to Developing a Language Access Plan to help providers consider the specific needs of individuals with limited English proficiency at <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf>.
- Introduction to Language Access Plans free training available to states and transportation providers to consider how best to meet the transportation and communication needs of individuals with limited English proficiency: <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining>.