PO Box 12000 | Syracuse, NY 13218
medanswering.com

3/12/2019

To: **All Ambulette Transportation Providers**

From: **MAS on behalf of NYSDOH Bureau of Medicaid Transportation**

Subject: **Ambulette Preferred Provider Opportunity for New York Presbyterian Lower Manhattan Hospital; 170 Williams St, NY, NY 10038**

The New York State Department of Health has analyzed data collected by MAS and is offering an **Ambulette** Preferred Provider Opportunity (PPO) for **New York Presbyterian Lower Manhattan Hospital; 170 Williams St, NY, NY 10038.**

The PPO includes non-emergency Ambulette transportation for Medicaid enrollees for discharge trips.

One transportation provider will be selected to fulfill the responsibilities of the PPO. The transportation provider will receive a flat rate per enrollee for each trip leg the enrollee is transported. The PPO rate is inclusive of all services associated with the defined modality, according to NYS DOH Policy.

In order to be eligible for a NYS DOH Preferred Provider Opportunity, the transportation provider must have a fully operational API connection providing MAS all pertinent information fields (including but not limited to GPS information). For more information on API connections please contact your county Field Liaison.

The transportation provider must at all times comply with New York State rules & regulations. Please note the following additional operating guidelines for this Preferred Provider Opportunity;

Please complete and email the attached proposal document by the required return date.

Attached is a three-month trip sample. The data does not guarantee future trip volume.

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PROPOSAL TO THE

NEW YORK STATE DEPARTMENT OF HEALTH

BUREAU OF MEDICAID TRANSPORTATION

AMBULETTE PREFERRED PROVIDER OPPORTUNITY

New York Presbyterian Lower Manhattan Hospital; 170 William St, NY, NY 10038

Please complete, sign and return via email to: ppo@medanswering.com. All proposals are due by 4 PM on **4/1/2019**.

Transportation Company Name _____ Owner/General Manager _____

Email _____ Provider ID _____

SECTION 1: Proposed Charge Per Person Per Trip Leg

Flat rate _____

SECTION 2: Required Information

Do you have a Medicaid Compliance Program as required by NYS Office of Medicaid Inspector General?
Yes _____ No _____

Does your company have a fully operational API connection that provides information to MAS on all information fields?

Yes _____ No _____

Are all vehicles used by your company for transporting Medicaid enrollees properly owned/leased, registered and insured as Ambulette vehicles according to NYSDOH Policy?

Yes _____ No _____

How many vehicles properly owned/leased, registered and Insured as Ambulette vehicles in your fleet are available for transporting Medicaid enrollees?

Number of Vehicles? _____

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SECTION 3: Required Performance Standards.

1. Assigned trips may not be refused.
2. Assigned trips may not be reassigned
3. The Transportation Provider (TP) will be available 24 hours a day 7 days a week, 365 days a year.
4. TP must accept all trips assignments electronically via the MAS Medicaid Transportation Management System (MAS System). There will be no calls or faxes from MAS.
5. For all scheduled trips the TP must be on time for pick-ups & drop offs (within 15 minutes of the scheduled time).
6. All immediate trip requests must be picked up within 60 minutes of the MAS trip assignment.
7. TP leadership must attend all pre and post meetings/conference calls with DOH, MAS and **New York Presbyterian Lower Manhattan Hospital**.
8. In order to meet the high-quality expectations of the NYSDOH and **New York Presbyterian Lower Manhattan Hospital**, the TP will commit to honoring agreements between the two that ensure high quality results. Such agreements may Include on-time performance, dress code/company Identification, employee ID, pick up & drop off locations & protocols, quick and easy mutual access to organizational leadership to address both real-time problem solving & long-term planning.
9. Additional guidelines as agreed to by **New York Presbyterian Lower Manhattan Hospital** and the transportation provider.

PRINT NAME _____

SIGNATURE AND DATE _____