MAS

PO Box 12000 | Syracuse, NY 13218
medanswering.com

September 25, 2020

To: **All Ambulance Transportation Providers**

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

Subject: **Ambulance Preferred Provider Opportunity**

The New York State Department of Health (DOH) is pleased to offer an Ambulance Preferred Provider Opportunity (PPO) for trips being arranged for eligible NYS Medicaid enrollees to/from Health + Hospitals/Gotham Health & Post-Acute Care Ambulance Micro-Network 2. (For listing of facilities, please reference the Ambulance Micro-Network 2 Facility Transport Summary)

There will be one transportation provider (TP) selected to fulfill the responsibilities associated with this PPO. The selected TP 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 in accordance with DOH Policy.

The selected TP must be an approved NYS Medicaid Transportation Provider and comply with New York State's rules and regulations. Due to the current pandemic multi-loading and/or grouped rides are currently prohibited by NYS Department of Health. In addition, TP's are expected to follow all routine cleaning and sanitizing protocols listed on the DOH website. This is to ensure safe and healthful transport conditions for all NYS Medicaid enrollees.

Interested TPs must complete and submit the attached proposal by the required due date.

Please note MAS reserves the right to contact the TP for clarification on questions regarding the PPO application.

A three-month trip sample is provided for your review, however, please understand this data does not guarantee future trip volume.

AMBULANCE PREFERRED PROVIDER OPPORTUNITY
HEALTH + HOSPITALS/GOTHAM HEALTH & POST-ACUTE CARE

AMBULANCE MICRO-NETWORK 2

PROPOSAL

*All proposals must be completed, signed, scanned to: ppo@medanswering.com by 4 PM on **10/9/20**.*

Transportation Provider Company: _____

Provider ID: _____

Owner/General Manager: _____

Email: _____

SECTION 1: Proposed Flat Rate Charge Per Person/Per Trip Leg

Flat rate (Single Load): _____

SECTION 2: Required Information

1. Do you have a Medicaid Compliance Program as required by NYS Office of Medicaid Inspector General?

   Yes _____ No _____

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

   Yes _____ No _____

3. How many properly owned/leased, registered and insured Medicaid Ambulance vehicles are in your fleet?

   Number of Vehicles: _____

4. If your company is not currently providing service 24 hours/day, 7 days/week, 365 days/year, is your company able to provide 24/7/365 service for this PPO?

   Yes _____ No _____

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SECTION 3: PPO Requirements

1. Assigned trips may not be refused.
2. Assigned trips may not be reassigned.
3. TP will be available 24 hours/day, 7 days/week, 365 days/year.
4. TP must accept all trips assignments electronically via the MAS System Online. 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 and/or conference calls with DOH, MAS and NYC Health + Hospitals.
8. In order to meet the high-quality expectations of the DOH and NYC Health + Hospitals, the TP will commit to honoring agreements between these two entities to ensure exceptional results. Such agreements may include, but not be limited to, on-time performance, proper dress code, company identification, employee ID, pick up and drop off locations, adhering to protocols, quick and easy mutual access to organizational leadership in order to address real-time problem solving and long-term planning.
9. Additional guidelines as agreed to by NYC Health + Hospitals and the TP.

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PROPOSAL

SECTION 4: Additional Information

In the box below, please include any additional comments relative to the services you provide that should be considered by NYC Health + Hospitals and NYSDOH during the selection process.

_____

PRINT NAME (Owner/General Manager)

_____ _____

SIGNATURE (Owner/General Manager) **DATE**