

Medicaid's Non-Emergency Medical Transportation Benefit:

Stakeholder Perspectives
on Trends, Challenges,
and Innovations

PREPARED FOR
THE MEDICAID AND CHIP PAYMENT
AND ACCESS COMMISSION

BY
SHARON SILOW-CARROLL
KATHY GIFFORD
CARRIE ROSENZWEIG
KATHY RYLAND
ANH PHAM

HEALTH MANAGEMENT ASSOCIATES



About Health Management Associates

Health Management Associates (HMA) is an independent, national research and consulting firm specializing in publicly funded health care and human services policy, programs, financing, and evaluation. We partner with government, public and private providers, health systems, health plans, community-based organizations, institutional investors, foundations, and associations to improve health care and social services. Drawing knowledge from the frontlines of health care delivery and reform, we work with our clients to explore innovative solutions to complex challenges. HMA has more than 20 offices and over 300 multidisciplinary consultants coast to coast. Learn more at healthmanagement.com/.

About the Authors

Sharon Silow-Carroll, MSW, MBA, Principal, has more than 30 years of experience in health care policy research and analysis, focusing on innovative initiatives to enhance health care system quality, access, value, and coverage. Her areas of interest include Medicaid managed care, maternal and reproductive health, children and youth with special health care needs, and long-term care.

Kathy Gifford, JD, Principal, is a Medicaid expert who advises clients on the challenges, opportunities and complexities that arise in a program designed and administered differently in every state. Before joining HMA in 2002, she served as director of the Indiana Medicaid program.

Carrie Rosenzweig, MPP, Senior Consultant, is an experienced policy analyst and qualitative researcher who has focused her career on issues related to coverage and access to health services for vulnerable populations. Her primary areas of interest include Medicaid managed care as well as family planning and reproductive health.

Kathy Ryland, former Managing Principal (retired), has more than 30 years of health care experience, focused on managed care, Medicaid, provider networks, and rural health care issues.

Anh Pham, Consultant, is an adept health care policy quantitative and qualitative researcher. Her primary areas of interest include the intersection of health and human services, as well as behavioral health.

Julie George, JD, Consultant, assisted with the research for this study.

Acknowledgments and Interviewees

HMA gratefully acknowledges the Medicaid and CHIP Payment and Access Commission (MACPAC) for supporting this study. The authors would like to thank Kacey Buder, Senior Analyst, and Aaron Pervin, Senior Analyst, at MACPAC for their guidance on this project. We also greatly appreciate the following individuals and representatives of stakeholder organizations for sharing their perspectives and experiences regarding NEMT:

Michael Adelberg, Principal, Faegre Drinker Consulting

Alex Bond, Analyst, Office of the Secretary, U.S. Department of Transportation

Scott Borgen, Executive Director, Community Transportation Association of America (CTAA)

Rachelle Brill, Senior Policy Analyst, Center for Consumer Engagement in Health Innovation

Megan Callahan, Vice President of Healthcare, Lyft

Linda Cherrington, Research Assistant, Texas A&M Transportation Institute

Laura Colbert, Executive Director, Georgians for a Healthy Future

Nicole Cooper, Head of Healthcare Policy, Lyft

Albert Cortina, Senior Advisor, LogistiCare

Lexa Galanti, Transportation Data Analyst, Federal Transportation Authority, U.S. Department of Transportation

Sofia Gallo, Special Assistant for Policy, Office of the Secretary, Department of Transportation

Sheri Gaskins, Technical Director, Division of Benefits and Coverage, Centers for Medicare & Medicaid Services

Paula George, Human Service Transportation Coordinator, Cape Code Regional Transit Authority

William Halsey, Director of Integrated Care, Connecticut Department of Social Services

Joey Herrera, Manager, Managed Care Compliance and Operations, Texas Health and Human Services Commission

Tim Hoitink, Assistant General Counsel, Massachusetts Executive Office of Health and Human Services

Kirsten Jensen, Director, Division of Benefits and Coverage, Centers for Medicare & Medicaid Services

Alison Kirchgasser, Deputy Policy Director for Federal Policy, Massachusetts Office of Medicaid/MassHealth

Vera Kirrane, Transportation Program Coordinator, Massachusetts Human Service Transportation Office

Joshua Komenda, President and Principal, Veyo

Linda Landry, Cape Code Regional Transit Authority

Kate Layman, Manager, Medicaid and CHIP services, Policy and Program Development, Texas Health and Human Services Commission

Lindsey Lux, Chief of Staff, Indiana Family and Social Services Administration

Valerie Mayes, Senior Policy Advisor, Texas Health and Human Services Commission

Kimberly McKnight, NEMT Manager, Georgia Department of Community Health

Andi Mullin, Director, State and Local Advocacy, Center for Consumer Engagement in Health Innovation

Mark Ordeman, Staff Vice President, National Contracting, Centene

James Peoples, Director of Provider Services, Georgia Department of Community Health

Robert Pittman, VP of Government Affairs, LogistiCare

Alexander Poirot, FTA Director of Government Affairs, U.S. Department of Transportation

Priscilla Portis, Director, FFS Provider Network, Massachusetts Office of Medicaid/MassHealth

Chris Priest, VP, Medicaid Solutions, Medicaid and Complex Care Product Oversight, Centene

Christina Quast, Operations Administrator, Arizona Health Care Cost Containment System (AHCCCS)

Akriti Rai, Market Operations Manager, Veyo

Stacey Ramirez, State Director, The ARC of Georgia

Lynnette Rhodes, Executive Director, Medical Assistance Plans, Georgia Department of Community Health

Kimberly Roop, MD, President, Indiana Medicaid, Anthem Blue Cross and Blue Shield

Shelli Silver, Deputy Director, Health Plan Operations, Arizona Health Care Cost Containment System (AHCCCS)

Marsha Simon, President, MJ Simon & Co.

Jennifer Sisto Gall, Senior Business Development Manager, Lyft

Loren Smith, Deputy Assistant Secretary for Policy, U.S. Department of Transportation

Karren Sondrini, Director, Way2Go, CICOA Aging & In-Home Solutions

Stephanie Stephens, State Medicaid Director, Texas Health and Human Services Commission

Marianne Stock, Division Chief, Rural and Targeted Programs, Office of Program Management, Federal Transit Administration, U.S. Department of Transportation

Anthony Ta, Policy and Program Development Manager, Massachusetts Human Service Transportation Office

Madison Tallant, Program and Policy Coordinator, Center for Consumer Engagement in Health Innovation

Sarah Titzer, Planning and Performance Director, Indiana Medicaid, Anthem Blue Cross and Blue Shield

Katie Zito, Sr. Government Relations Director, Anthem, Inc.

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Summary

As of December 27, 2020, federal statute requires states to provide non-emergency medical transportation (NEMT) to Medicaid beneficiaries who have no other means of transportation to medically necessary health care services. Within federal guidelines, states have discretion in how they provide NEMT and use a variety of delivery system models and reimbursement approaches. Prior to December 2020, this requirement was contained in federal regulations only and consumer advocates and many policymakers raised concerns about proposals to make the NEMT benefit optional to states. This report about NEMT trends, challenges, and innovations draws from a 50-state scan of NEMT programs and interviews with NEMT stakeholders. Interviewees included federal officials; Medicaid officials from six select states (study states); NEMT brokers and providers including transportation network companies (TNCs); managed care organizations (MCOs); beneficiary advocates; and subject matter experts. Key findings include:

NEMT Populations and Utilization

Populations with the highest NEMT utilization are persons with disabilities and individuals attending medical appointments multiple times per week, such as trips for dialysis, Medication for Opioid Use Disorder (MOUD), cancer treatment, or adult day health programs. However, NEMT utilization patterns and controls vary across states. All study states reported a significant utilization decline at the start of the COVID-19 pandemic. They noted that even with telehealth playing a greater role, a significant number of Medicaid beneficiaries will continue to need transportation assistance in the future.

Variation in Modes of Transportation

Geographic variations within a state affect the availability and utilization of different modes of transportation, with fewer options in rural areas. Many NEMT programs have adopted strategies to accommodate individuals with specific conditions and needs, such as pregnant or postpartum women, bariatric members, or individuals with intellectual and developmental disabilities (I/DD), end-stage renal disease (ESRD), or substance use disorders (SUD).

NEMT Delivery System Model Variations, Advantages, and Challenges

Each state Medicaid program has the flexibility to design its NEMT delivery system to accommodate its operational, demographic, and geographic needs and characteristics. States use a variety of delivery system models including administering the benefit directly “in-house,” carving the benefit into its managed care arrangements, and contracting with a transportation broker on either a fee-for-service (FFS) or capitated basis. Stakeholders described advantages and disadvantages to each approach. For example, compared to the in-house model, adopting a broker model may allow a state to access greater NEMT expertise and specialized technology but may reduce the incentive to coordinate with other federally assisted transportation programs. Also, carving the NEMT benefit into a managed care arrangement may enhance care management and coordination efforts but could result in administrative inefficiencies when multiple MCOs in a state individually subcontract with brokers.

NEMT Complaints, Performance Issues, and Innovation

NEMT complaints from beneficiaries, health care providers, and MCO care managers are primarily related to late pick-ups and no-shows. Interviewees in some of the study states reported collaborative efforts across NEMT stakeholders to address NEMT performance issues and implement innovative approaches to improve member safety and experience. Interviewees also viewed technologies, such as GPS tracking, as key to improving timeliness, efficiency, and beneficiary satisfaction and noted that states, brokers, and MCOs are increasingly specifying required technologies in their broker and NEMT provider contracts.

Performance Improvement, Oversight, and Program Integrity

While contracts for brokers, MCOs, and transportation providers often include NEMT performance standards and incentives, some advocates interviewed expressed frustration about the adequacy of state oversight and enforcement, stressing the need for greater consumer feedback and involvement. Most interviewees did not perceive NEMT fraud, waste, and abuse to be a significant problem, particularly with the shift to broker models and new technologies.

Transportation Network Challenges and Increasing Role of TNCs

NEMT programs often face significant challenges maintaining an adequate transportation network, particularly in rural areas. Interviewees cited the high cost of insurance as a substantial barrier to NEMT provider participation. States and brokers have taken a variety of approaches to enhance NEMT provider capacity, including, in recent years, use of TNCs such as Uber and Lyft. Interviewees reported that TNCs offer several advantages and opportunities for supplementing NEMT supply for able-bodied, independent beneficiaries but agreed that TNCs are not appropriate for a large segment of the NEMT population, including those who have physical or intellectual and developmental disabilities. While a growing number of states have authorized the use of TNCs in their Medicaid programs, state regulatory approaches vary. Several interviewees suggested establishing specific training requirements and additional federal guidelines for TNCs providing NEMT.

Coordination Across Federally Assisted Transportation Services

While federal transportation policy encourages coordination across federally funded transportation services and programs, there is variation and generally not a large degree of coordination in most study states. States routinely promote the use of public transportation for NEMT, but these options are not appropriate for all Medicaid beneficiaries and their availability is usually limited to urban areas. There are also a variety of obstacles to coordination across programs, including differences in the needs and characteristics of beneficiaries served by different programs, differences in geographic footprints and hours of operation, and different rules for scheduling. Some interviewees also reported that sharing rides among beneficiaries of different programs is inhibited by the need for complex cost allocation capabilities to comply with the requirement that Medicaid only reimburse for transporting a Medicaid-eligible beneficiary to a medically necessary medical service.

Stakeholders' View on the Value and Role of NEMT

All interviewees emphasized the importance of the NEMT benefit in helping Medicaid beneficiaries access the health care they need. Several highlighted the value or potential value of NEMT in improving health outcomes and reducing disparities, and some interviewees opined that NEMT would offer even greater value if beneficiaries and health care providers received more education about the benefit. There is some data, although limited, on NEMT's return on investment and long-term savings, and stakeholders have called for more research in this area. As the interviews for this study were conducted prior to the codification of the NEMT requirement into statute, interviewees had different views when asked how states would respond if NEMT became an optional benefit. Most agreed that reducing or eliminating the benefit would have a negative effect on access to services and health outcomes. Furthermore, multiple stakeholders suggested that codifying the NEMT benefit into the federal Medicaid statute requirement could facilitate important NEMT policy discussions regarding the value of NEMT and its role in improving health outcomes.

Background

States must provide non-emergency medical transportation (NEMT) to medically necessary health care services for Medicaid beneficiaries who have no other means of transportation – a requirement that sets Medicaid apart from most health insurance.¹ In December 2020, following the completion of the interviews for this study, Congress added a requirement for states to provide NEMT to the Social Security Act (the Act) through the Consolidated Appropriations Act of 2021 (P.L. 116-260). Previously, the NEMT requirement was not specified in federal statute, unlike other Medicaid mandatory benefits. Instead, NEMT was mandated by federal regulations that require states to “ensure necessary transportation” for Medicaid beneficiaries to assure access “to and from providers” (42 CFR 431.53). States must also use the most appropriate form of transportation for the beneficiary and provide transportation assistance to children and their families as part of Medicaid’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit (42 CFR 441.62).

Because they were not codified in statute until December 2020, federal NEMT regulations were more vulnerable to change through administrative action, a path the Trump Administration explored. Former President Trump’s budget proposals for federal fiscal years (FFY) 2019, 2020, and 2021 called for making NEMT an optional benefit.² CMS has already waived the NEMT benefit requirement for expansion adults (who gained coverage under the Affordable Care Act) and other low-income adults not eligible for Medicaid on the basis of disability in a small number of states through Section 1115 Medicaid Demonstration waivers. States seeking these waivers argue that excluding transportation makes coverage for this group more consistent with benefits offered through private health insurance.

Within federal guidelines, states have discretion in how they deliver NEMT and typically use a variety of transportation modes including wheelchair and standard vans, taxis and limousines, public transportation, ambulances, volunteer drivers, and personal vehicles (e.g., providing mileage reimbursement to beneficiaries or their family members or friends). More recently, some states have expanded their NEMT options to include transportation network companies (TNCs), such as Uber and Lyft. To control utilization of the NEMT benefit, states may impose copay or prior authorization requirements or place limits on the number of covered trips. States typically require the use of the least expensive mode of transportation available to the beneficiary that is also appropriate to their needs (in alignment with federal regulations³), and sometimes restrict NEMT services to the nearest qualified provider.

States use a variety of NEMT delivery system models and reimbursement approaches. These include: managing the benefit in-house (i.e., within the Medicaid agency) and paying for NEMT on a fee-for-service (FFS) basis; contracting with transportation brokers on a capitated or FFS basis (e.g., trip cost plus administrative fee) to manage all or some aspects of NEMT on a state’s behalf; and carving the NEMT benefit into a capitated managed care arrangement with a Medicaid managed care organization (MCO) that either administers the benefit directly or subcontracts with a broker. Approximately a dozen states use more than one model, using, for example, different models for different Medicaid populations or for different geographic areas.

Prior to the passage of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), states needed a Medicaid waiver to contract with an NEMT broker unless the state was willing to provide NEMT as an administrative service, which is subject to a lower federal matching rate in most states. The DRA, however, created a new State Plan option to establish an NEMT brokerage program and receive the higher medical services matching rate, subject to certain requirements. In general, under this option NEMT brokers can be public or private entities and must be selected through a competitive bidding process. As of 2018, twenty states operated their NEMT broker program under the State Plan option or a combination of the State Plan option and a waiver.⁴

Compared to other medical services, administering the NEMT benefit presents unique challenges to states. Each state must consider available financial and staff resources, its geography and population density (urban, rural, frontier), and availability of transportation providers. Certain factors affecting NEMT performance, however, are outside a state's control, such as weather, traffic and road conditions, and fuel and insurance prices. Federal authorities have identified other ongoing challenges including contracting with and overseeing vendors, maintaining program integrity, customer service concerns, transportation shortage areas, and data collection and reporting. Federal requirements to utilize the lowest cost mode of transportation available and the nearest health care provider also affect state policy decisions.

Objectives & Methodology

The Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Health Management Associates (HMA) to conduct research on the range of approaches and trends in the provision of the NEMT benefit to Medicaid enrollees across the United States.⁵ HMA used three methods to achieve the study's objectives: an environmental scan, stakeholder interviews, and a synthesis of the findings. HMA conducted an environmental scan of state documents and materials related to NEMT for all 50 states and the District of Columbia and collected state-level data about the percentage of rural population, managed care penetration rate, and Medicaid expansion status. The environmental scan included a high-level assessment of the following features of each state's NEMT program: NEMT delivery system model(s) used, use of TNC providers, copay requirements, benefit limits and exclusions, geographic variation, coordination of NEMT with other transportation programs, program integrity and quality strategies, significant programmatic changes, and notable innovations.

Based on a set of criteria including variation in NEMT delivery system models, geographic diversity, innovations, and notable quality requirements, HMA and MACPAC selected six states for further study: Arizona, Connecticut, Georgia, Indiana, Massachusetts and Texas.

HMA conducted 21 individual and group interviews involving 51 individuals that included federal officials from CMS and the Federal Transit Administration (FTA), state Medicaid officials, NEMT providers, transportation broker representatives, MCO representatives, beneficiary advocates, and NEMT subject matter experts. The interviews were conducted using a set of standardized questions related to key policy issues (e.g., NEMT delivery system model differences, coordination, value and efficiency, use of TNCs, innovations, oversight). The findings of the stakeholder interviews and

document review were then analyzed and synthesized to respond to MACPAC's key policy questions and create the state profiles included in the current report. A list of stakeholder interviewees and organizations is contained in Appendix H: Stakeholder Interviewees/ Acknowledgements.

Findings

NEMT Populations and Utilization

Several interviewees reported that the populations with the highest NEMT utilization are persons with disabilities and individuals attending medical appointments multiple times per week, such as trips for dialysis, Medication for Opioid Use Disorder (MOUD), cancer treatment, or adult day health programs. Interviewees identified as frequent users individuals with physical disabilities, intellectual or developmental disabilities (I/DD), end-stage renal disease (ESRD), mental health needs, and substance use disorders (SUD); the elderly; residents in nursing facilities who require transportation to and from their medical appointments; individuals undergoing cancer treatment; and parents or caregivers accompanying a child to medical appointments.

States' NEMT utilization patterns and controls vary. Several interviewees noted NEMT utilization changes in recent years (pre-COVID-19) attributed, in part, to changes in Medicaid eligibility and covered services. For example, the number of NEMT trips increased in states that implemented the Affordable Care Act adult Medicaid expansion and the number of NEMT trips to methadone clinics increased when MOUD became a covered service. Interviewees in Connecticut and Indiana also identified bariatric surgery patients as a small, but growing population of NEMT users.

To manage NEMT utilization, some states require prior authorization for all rides or under certain conditions (e.g., for trips over a specified mileage threshold). MCOs report overriding state trip limits or other utilization controls when appropriate, emphasizing the value of members receiving needed medical services. Among the study states, only Indiana requires copays for some populations and requires prior authorization when a beneficiary exceeds 20 one-way trips per 12-month period. An Indiana Medicaid official reported that the state has submitted a State Plan Amendment to CMS to eliminate prior authorization requirements for beneficiaries exceeding 20 one-way trips and for one-way trips that are 50 miles or more, but still plans to evaluate each trip to ensure it is to an Indiana Medicaid participating provider/location prior to the trip. Indiana also requires prior authorization for interstate or out-of-state transportation, train services, bus services of 50 miles or more one-way, and airline or air ambulance services.

While the COVID-19 pandemic significantly reduced NEMT utilization and may have long-term effects on NEMT service demand, many beneficiaries will continue to need transportation assistance. State interviewees in all six study states reported that the pandemic had significantly decreased NEMT utilization. The demand for rides declined as a result of stay-at-home orders, medical facility closures, risks of contagion (through public transportation and shared rides), patient and health care provider cancellation or postponement of nonemergency and noncritical appointments, and the shift to virtual telemedicine/telehealth visits. The availability of NEMT providers also initially declined because

providers and drivers lacked personal protective equipment (PPE). The pandemic has also affected the mix of transportation modes used for NEMT; for safety reasons, shared rides and public transportation declined significantly, with greater interest in demand-response transit (i.e., flexible modes based on passenger requests) and TNCs.

Interviewees relayed that some NEMT brokers, providers, and states quickly adapted. In Connecticut, a large livery provider outfitted its cars with plexiglass and driver PPE and contracted with two urban areas to provide safe transportation including rides for COVID-positive individuals. In addition, the state NEMT broker, Veyo, contracted with their Independent Drivers to provide NEMT rides to individuals who were COVID-19 positive. In addition, Veyo reported using NEMT providers to deliver Meals on Wheels and PPE to Medicaid beneficiaries, which also helped to maintain their network. Massachusetts Medicaid and the state's transportation office implemented additional safety measures such as telephonic pre-screening for symptoms at the time of scheduling, minimizing shared ride groupings, social distancing on larger vehicles, and enhancing vehicle cleaning schedules. PPE has been provided to drivers transporting individuals with known or suspected COVID-19.

State interviewees reported that NEMT utilization has been increasing in recent months, but most suspect the pandemic will have a lasting effect on NEMT to the degree telehealth continues to play a significant role in health care. However, interviewees noted that a substantial number of Medicaid beneficiaries – including those requiring dialysis, MOUD, adult day health, and many chronic care services – will continue to need transportation assistance.

Modes of Transportation

Geographic variation within the state affects the availability and utilization of different modes of transportation, with fewer options in rural areas. In urban areas, beneficiaries often rely more heavily on public transportation. For instance, buses have the highest NEMT utilization in Connecticut, which has as rural population of only 12 percent. Urban areas also have a greater supply of private transportation providers that contract to provide NEMT, such as livery services, wheelchair-enabled vans, taxis, and TNCs. In contrast, beneficiaries in rural areas with limited or no public transit options tend to rely more heavily on taxis or mileage reimbursement to friends or family members, for example, who are willing to drive beneficiaries to their medical appointments.⁶

In Arizona, which is predominantly rural, taxis are the most common mode of transportation due to a lack of public transportation in many regions, although some rural counties receive funding from the FTA to operate county-based public transportation (described further in the section, *Transportation Network Challenges*). Where public transportation is an option, high summer temperatures can prevent many individuals from waiting at outdoor bus stops.

Unique state geographic features also affect the NEMT options offered to beneficiaries. For instance, a Massachusetts broker reported contracting with a public steamship authority to transport beneficiaries between the area's islands and the Massachusetts mainland. Similarly, Arizona offers non-ambulance air transport to serve beneficiaries living in or near the Grand Canyon, where ground transportation is not possible. Texas, a large state with vast rural areas, also permits the use of commercial air transportation.

Many NEMT programs have adopted strategies to accommodate individuals with specific conditions and needs, such as pregnant or postpartum women, bariatric surgery or dialysis patients, and individuals with I/DD, ESRD, or SUD. For example, Massachusetts implemented a Critical Care Model for members receiving life sustaining services, such as dialysis or cancer treatment, that utilizes a specially trained network of transportation vendors who are familiar with these populations. Georgia, which otherwise only allows one escort to accompany a member when medically necessary, allows the children of pregnant or postpartum women to accompany their mothers on their NEMT trips.

Brokers also reported special accommodations in their scheduling software to better meet member needs. For example, a multistate broker (LogistiCare) has initiated a program in several states that matches transportation providers' performance with specific facility/treatment type destinations, such as dialysis clinic trips. The program relies on "champion" transportation providers who are educated on the medical conditions treated at the assigned sites and the conditions of the recipients in need of such services. This broker maintains a similar program in Florida for children that is designed to dispatch transportation providers and additional care attendants that understand children's behavioral issues and are best equipped to handle their needs. This broker also reported that it records the specialty needs of each member, such as behavioral health or cultural needs, in its system and checks those entries before assigning a trip. For example, some female beneficiaries are not comfortable with a male driver. Brokers also report upgrading members from the least cost transportation option (e.g., public transit) to a higher cost option based on specific needs or circumstances, such as for people with I/DD.

NEMT Delivery System Model Variations, Advantages, and Challenges

Each state Medicaid program has the flexibility to design its NEMT delivery system to accommodate its operational, demographic, and geographic needs and characteristics. The six study states employ a variety of NEMT delivery system models, and some have made recent model changes or are planning to do so. (Table 1: Study State Medicaid NEMT Delivery System Models and Changes).

Table 1: Study State Medicaid NEMT Delivery System Models and Changes

State	Model/Risk Arrangement ⁷	Recent or Planned Changes
Arizona	MCO Carve-In/MCOs at risk In-house for American Indian/Alaska Native (AIAN) individuals not enrolled in MCOs/State at risk	N/A
Connecticut	Statewide Broker/Broker at risk	2018: Shifted Broker Model from FFS to capitation
Georgia	Regional Brokers/Brokers at risk	N/A
Indiana	MCO Carve-In/MCOs at risk Statewide Broker for FFS population/ Broker at risk	2018: Transitioned FFS population from in-house to broker model
Massachusetts	Regional Brokers coordinating with human service transportation/State at risk	2021: New contracts will reduce number of brokers, increase performance incentives
Texas	Regional Brokers/Brokers at risk In-house for one region/State at risk	2021: Shift from regional brokers ⁸ to MCO carve-in model

When deciding on an NEMT delivery system model or model change, state officials reported that their design choices were influenced by a variety of factors including:

- **The state's available financial and staff resources.** Georgia officials, for example, reported that the state originally adopted a broker model, in part, to streamline and reduce the NEMT administrative burden on the state.
- **The need to accommodate known patterns of care.** Massachusetts officials reported that in July 2021, the state will reduce the number of regional NEMT brokers (currently six different brokers in nine regions) to no more than three brokers and expand those brokers' geographic footprint to increase efficiency. They explained that a significant portion of the Medicaid population travels eastward to Boston for medical visits, with NEMT providers currently passing through multiple NEMT regions.
- **A plan to promote coordination with existing managed care delivery systems.** Texas is currently in the process of transitioning from a regional broker model to an MCO carve-in model. State officials reported that the change was intended to reduce overall costs and streamline administration by making MCOs responsible for both NEMT and medical services. The state is also expecting to see improved member outcomes, as the MCOs will have greater control, care coordination processes,

and incentives to assure members get to their appointments. Arizona officials reported that the state's MCO carve-in model dates to the inception of the Arizona Medicaid program as a fully capitated managed care program in the early 1980s.

- **A priority to promote coordination with other human services transit programs.** The Massachusetts Human Service Transportation (HST) office coordinates transportation for a number of health and human service agencies and programs, including MassHealth (the Massachusetts Medicaid program). Massachusetts interviewees reported that the state's approach was chosen to reduce overall administrative overlap and duplication across the component agencies.
- **The desire to incentivize targeted outcomes (e.g., improved quality of care and/or reduced incidents of fraud and abuse).** Indiana reported moving from an in-house administrative model to a statewide broker model for its Medicaid FFS population in 2018, in part, to ensure proper oversight of the NEMT network and reduce fraud, waste, and abuse, while strengthening the network and ensuring appropriate access to transportation consistently across the state. Connecticut reported switching from an FFS broker arrangement to a capitated broker arrangement to provide more flexibility to the broker to implement pay-for-performance incentive arrangements for NEMT providers.

While CMS officials interviewed for this study observed that many states have adopted the State Plan broker option (first available in 2006) or have moved to an MCO carve-in model, these officials indicated that CMS does not favor or prefer one NEMT delivery system model over another. Rather, officials noted that all options are available for states to consider based on their needs. Interviewees cited a number of advantages and potential challenges that each major NEMT delivery system model offers, summarized in

Table 2: Comparison of NEMT Delivery System Models.

Table 2: Comparison of NEMT Delivery System Models

Advantages	Potential Challenges
In-house Management Model	
<ul style="list-style-type: none"> • State retains control over NEMT policies and operating practices and a direct link to Medicaid beneficiaries regarding the NEMT benefit • State retains direct relationship and communications with NEMT providers • May facilitate greater coordination with other federally-assisted transportation programs 	<ul style="list-style-type: none"> • State retains NEMT administrative burden (e.g., network maintenance, call center operations, service authorization, etc.) • State may lack necessary expertise or specialized technology (e.g., global positioning system (GPS) tracking) • May offer less flexibility to create variable fee schedules or pay-for-performance incentives (when administered as a medical benefit) • Potentially higher risk for fraud and abuse • Potentially higher burden on the beneficiary to identify and schedule an NEMT provider
Broker Model	
<ul style="list-style-type: none"> • May provide greater NEMT expertise and opportunities to implement specialized technology • Provides cost predictability, particularly if broker contract is capitated • Compared to in-house model, decreases state's administrative burden • Potentially lowers risk for fraud and abuse and may generate efficiencies • Enables all beneficiaries in a region (if one broker per region) or statewide (if one statewide broker) to call the same phone number to arrange NEMT services (compared to states with multiple MCO carve-in arrangements covering the same region) 	<ul style="list-style-type: none"> • NEMT services are not integrated with entity responsible for medical benefit and care/case management responsibilities • Potential disincentive to authorize trips under a capitated contract • May reduce incentive to coordinate with other federally-assisted transportation programs
MCO Carve-In Model	
<ul style="list-style-type: none"> • Integrating NEMT with other MCO covered services may enhance care management and coordination efforts, generating cost savings due to improved health outcomes • Provides greater flexibility to override state limits or provide transportation to additional services when deemed to add value and promote member health • To the extent the MCO subcontracts with a broker, may gain greater NEMT expertise and specialized technology • Provides cost predictability when included in MCO capitation rate • May decrease state NEMT administrative burden • May lower risk for fraud and abuse • MCOs potentially more likely to seek beneficiary input 	<ul style="list-style-type: none"> • May result in administrative inefficiencies as multiple MCOs in a state individually subcontract with brokers

NEMT Complaints and Performance Issues

NEMT complaints from beneficiaries, health care providers, and MCO care managers are primarily related to late pick-ups and no-shows. A few interviewees noted that the rate of beneficiary NEMT complaints is very small (sometimes less than 1 percent of riders), but they acknowledged that even one missed ride to a critical medical appointment is a serious problem. A broker noted that the number of complaints could be large when ride volumes are high as there are many points of the NEMT request-to-ride process where things can go wrong, from service failures, such as incorrect pick-up information, late pick-up, or missed trip, to unforeseen incidents, such as flat tires, vehicle breakdown, or driver errors. In addition to late pick-ups and no-shows, other common complaints relate to vehicles that are not appropriately equipped, safe, or accessible, especially for wheelchairs; the behavior of other passengers in the vehicle; language barriers; and poor customer service and call center responsiveness. Advocates expressed concern that complaints made by beneficiaries often go unresolved or are not addressed adequately by the entity responsible. For example, a broker might consider a complaint about a pick-up that is hours late as resolved if the beneficiary was eventually picked up, according to the advocate.

Some beneficiary populations have unique concerns and challenges. For example: sharing rides is unsafe for beneficiaries that are immunocompromised; individuals with I/DD often face difficulties if they cannot bring a caregiver; parents may not be permitted to bring siblings of the child with a medical appointment along for the NEMT ride, resulting in childcare challenges; riders with behavioral health needs sometimes encounter drivers lacking sensitivity and training; and school-aged children can miss a full day of school when they have a medical appointment if the state policy does not allow for pick-ups or drop-offs at a school.

Many factors contribute to NEMT performance issues. Interviewees noted many factors that can cause delays and other NEMT performance issues such as: traffic and construction-related detours; long distances between beneficiaries' homes and health care providers in rural areas and in large states; and increases in daily MOUD trips to methadone clinics, particularly from rural areas, that can strain network capacity. Other factors mentioned by interviewees include:

- Dispatch communication failures (e.g., a driver given the wrong address)
- NEMT providers given insufficient information about the beneficiary's medical needs (e.g., uses a wheelchair), requiring the need to divert a second vehicle that is more appropriate
- Driver given insufficient information about correct entrances in large medical complexes
- Riders not ready for the pick-up, resulting in delays that affect subsequent trips
- Drivers accepting more trips than they can handle
- Bad weather
- Unexpected vehicle breakdowns

These factors are more likely to cause performance issues when the NEMT provider network is strained, and there are limited vehicles available for recovery trips (discussed further below).

States, brokers, and MCOs in some of the study states reported collaborative efforts across NEMT stakeholders to identify performance issues and implement innovative approaches that improve

member safety and experience. For example, the Massachusetts HST has ongoing working relationships with large medical facilities and, together with the regional broker, meets with these facilities to discuss the transportation process. The regional brokers regularly visit facilities in person to identify the best pick-up and drop-off points to make the process more seamless for beneficiaries. HST also advises brokers to book trips with a 15-minute buffer to account for traffic delays. In Georgia, when wheelchair safety became an issue in one region, the Medicaid agency and the regional broker identified inadequate training as the root cause, and the broker retrained its wheelchair transportation providers on the correct way to secure the wheelchairs. Since then, the number of wheelchair securement incidents has decreased. An advocacy coalition representing seniors in Georgia reported that positive conversations with the state's Medicaid program led to policy changes to better enforce the Door-to-Door Policy. This policy requires drivers to assure the rider actually enters the day center or medical office and is not just dropped off at the curb. Multiple state agencies and brokers also noted that they remove drivers that have repeat issues or complaints.

Performance Improvement, Oversight, and Accountability

Contracts for brokers, MCOs, and transportation providers often include NEMT performance standards and incentives. Several interviewees discussed the importance of strong contract provisions for promoting performance across brokers, MCOs, and providers. A review of state contracts with transportation brokers and MCOs found requirements around: performance metric reporting on timeliness of pick-ups, call center activity (such as average speed to answer, call abandonment rates, average hold time), and beneficiary complaints; vehicle standards; driver training and credentials; and penalties for non-compliance. Also, three of the six study states use performance-based incentive payments for NEMT brokers:

- Connecticut's statewide broker can earn up to five percent of the contract price if they meet quality metric thresholds related to call center performance, on-time pick-ups, complaint rates, and satisfaction survey results.
- Since 2009, Massachusetts has used shared cost-savings incentives whereby brokers are rewarded for reducing trip expenses and improving efficiency. The broker must reinvest these incentive payments into the brokerage to, for example, upgrade software, buy new computers, or hire additional staff.
- Indiana's broker for the FFS population can earn an incentive payment by meeting a 99.5 percent trip fulfillment metric. (A state official reported that the state is amending the contract to also provide a partial incentive payment for meeting a lower metric.) The broker contract also requires a performance withhold of 3 percent of the broker's capitation, which can be earned back based on the broker's score card performance.

Some brokers are also using performance-based incentives with transportation providers and drivers. For example, a multistate broker described that in some states they assess liquidated damages on providers having performance problems, which they use to create a bonus pool to reward other providers whose drivers demonstrate high performance. These incentives reportedly keep

transportation providers focused on improvement and encourage them to closely monitor their drivers. Other brokers described rewarding high-performing providers and drivers with more trips.

Despite performance improvement efforts, some interviewees expressed frustration about the adequacy of state oversight and enforcement. Advocates stressed that NEMT performance metrics and contract standards are only meaningful if there is effective performance reporting from brokers and sufficient monitoring by the state. Pointing to states shifting NEMT administrative responsibility to and contracting with brokers or MCOs, one advocate noted that “the ‘sign it and forget about it’ strategy has failed.” This interviewee claimed that some NEMT brokers do not share rider complaints or on-time performance data, which they argue should be reported to the state and made publicly available.

Another advocate opined that states may be hesitant to penalize under-performing brokers because there is a limited number of brokers competing for state contracts. Similarly, brokers may be hesitant to reprimand or end a contract with an under-performing transportation vendor because they are already struggling to maintain network adequacy. Other advocates commented on the lack of state staff to sufficiently oversee brokers.

Beneficiary advocates expressed that consumer feedback and involvement in oversight are essential for improving performance, but opportunities for such consumer input may be limited. Advocates felt that states and MCOs with consumer advisory councils, stakeholder committees that include patients, and offices that closely monitor complaints have more successful NEMT programs because consumers provide critical insight into the program’s problems. They posited that any of the NEMT delivery system models can function effectively with proper state oversight and mechanisms to obtain consumer input. They added that some Medicaid MCOs have been more receptive to feedback from consumers than brokers or state Medicaid agencies. However, this varies across states and Medicaid MCOs.

The role of the federal government in NEMT administration is relatively limited, focused mainly on ensuring regulatory compliance and responding to state inquiries. Public officials from CMS’ Division of Benefits and Coverage (the CMS division responsible for NEMT administration) described the division’s role as reviewing State Plan Amendments to ensure that they meet the federal regulatory requirement to provide necessary transportation to medical services, responding to state queries, and providing technical assistance.

CMS does not steer states toward any particular delivery system model or policies.⁹ It may, however, connect states interested in adopting similar NEMT policies or approaches. For example, CMS reportedly connected state officials interested in incorporating TNCs into their program with Medicaid officials in other states that had experience using TNCs. CMS has not recently issued formal guidance on NEMT, but has released several FAQs related to administration of the NEMT benefit during the COVID-19 pandemic (e.g., ability to use the NEMT benefit to deliver meals to vulnerable populations, and availability of a streamlined process for TNCs to enroll as Medicaid providers during the public health emergency via section 1135 flexibility).¹⁰ Officials also noted plans for CMS to issue guidance related to TNCs in NEMT, although they did not share a timeline for this guidance.

Stakeholders interviewed for this study suggested the following opportunities for federal government action that could help improve NEMT quality and performance:

- Proactively share states' NEMT strategies, for example by hosting a forum of Medicaid NEMT directors to discuss best practices related to TNCs, technologies, etc.
- Provide guidance on using TNCs in NEMT programs by providing minimum standards (for example, related to use of closest providers) that states could augment as they deem appropriate
- Establish national standards and performance measurements for NEMT quality that apply to all states and NEMT delivery system models
- Offer NEMT reinsurance programs and federal incentives to rural areas to enhance NEMT reimbursement and expand rural provider networks
- Develop a national database for NEMT (for example, collecting utilization and cost data) to compare different states' NEMT programs and different NEMT delivery system models, and support research on quantifying transportation's contribution to improved health quality and related cost savings.

Program Integrity

Despite concerns about fraud and abuse in NEMT programs in the past, many interviewees did not perceive this fraud or abuse to be widespread or significant. Federal oversight authorities have found that NEMT has high risk for fraud and abuse, describing concerns related to verification of eligibility and the need for NEMT services, enrollment of providers, and program inefficiencies.^{11,12} Audits in multiple states have found a lack of compliance with federal and state requirements around NEMT billing and claims.¹³ However, Medicaid officials in most study states and other interviewees suggested that while occasional instances of fraud or misuse by beneficiaries and providers may occur, they are not prevalent problems and are appropriately addressed through regulation and oversight. Some observed that NEMT misuse has declined with the shift in NEMT administration from Medicaid agencies to brokers, who typically have closer connections with providers and greater capacity for managing the network.

Interviewees viewed technology as key tool to address NEMT fraud, as brokers can electronically verify if a person was in a vehicle and whether the trip was completed. Examples of efforts to promote program integrity and reduce fraud and misuse include:

- The MassHealth program integrity unit conducts automated checks (for example, to identify if a beneficiary was in the hospital when the invoiced trip occurred). Recent HST contract amendments allow brokers to call providers to confirm suspicious appointments scheduled to occur at off/odd times to make sure the individual is going to an appointment, which state officials viewed as a successful deterrent against fraud. They noted that the mileage reimbursement component of the NEMT benefit is more susceptible to misuse and challenging to manage.
- Indiana desired to improve oversight of the NEMT benefit, and an audit revealed NEMT fraud in its program such as billing for trips that did not take place or rides to non-medical or non-verified services. As a result, the state shifted from in-house administration to a broker. Interviewees report that this resulted in greater rigor around claims submission, significant reduction in per-member per-month costs and average mileage per trip, and more stringent vehicle and driver credentialing, with providers who were unable to meet safety standards discontinued from the program.

- A multistate broker reported they require signatures from riders completing a trip, verify through GPS that the drivers use the shortest distance from pick to drop-off, and compare trip authorizations with completed transport data.

Innovation and Technology

New technologies are viewed as key to improving timeliness, efficiency, and beneficiary satisfaction.

Brokers have introduced technologies that are reportedly enhancing NEMT program administration and performance in several ways. All types of interviewees described increasing use of GPS, electronic scheduling software, and other forms of advanced technology or ‘digitization’ that can:

- Verify beneficiary eligibility and that the requested trip is for an approved, valid medical purpose
- Assign the trip to a transportation provider qualified to offer the appropriate level of service at the lowest cost
- Document the date, time, and location for each NEMT encounter and completion in real time
- Schedule NEMT trips with one call or ‘click’
- Track driver location in real time, view when a driver is running late and might cause a missed appointment, and send a new driver
- Provide real-time information and updates to riders about late pick-ups
- Track and report transportation performance metrics (specifically on-time performance)
- Connect transportation and health care datasets to help measure the impact of NEMT on health outcomes

Interviewees across all the study states shared examples of the way they are leveraging new technologies within NEMT provider networks:

- Connecticut Medicaid is developing a dashboard that will verify performance indicators and launching a debit card that the broker can load remotely so beneficiaries can more easily purchase public transportation.
- In Texas, Mobile Data Terminals (MDTs), computerized devices used in public transit and other vehicles, enable real-time communication between the broker’s dispatcher, driver, and rider.
- Indiana’s broker for the Medicaid FFS population provides GPS-equipped iPads to NEMT providers so the broker can monitor their location. The broker also offers a mobile app that enables drivers to input trip information for scheduling and submitting claims, a provider portal that allows drivers to reconcile claims, and an electronic claims dispute process. In March 2020, the broker implemented automated reminder phone calls to beneficiaries about their scheduled trip. The broker also uses an auto-router system that allows beneficiaries to select a preferred provider, facilitating development of relationships with drivers who understand the patient’s needs.

State, MCO, and broker contracts increasingly require the use of specific NEMT technologies. For example, Massachusetts’ new NEMT contract procurement will require brokers to use standardized GPS tracking, smart phone applications, and web-based scheduling. According to a multistate broker, including technology requirements in state broker contracts also enables the broker to include the same

requirements in its provider credentialing and recruiting policies. For example, the broker may specify software vendors that its network providers must use in its NEMT provider contracts.

While some states and brokers are equipping or encouraging transportation providers to adopt GPS, electronic invoicing, and other technologies, some interviewees noted that equipment costs were a barrier to universal use, especially for small transportation companies with low profit margins. Similarly, lack of smartphones, computers, or broadband internet access may prevent some beneficiaries from taking advantage of NEMT apps and portals that would enhance communication and simplify NEMT requests. Additionally, one beneficiary advocate commented that technology is not a solution to all problems related to NEMT: “You still need oversight, good contracts, and good feedback. The problems you need to solve are the human problems.”

Transportation Network Challenges

NEMT programs often face significant challenges maintaining an adequate transportation network due to provider shortages, particularly in rural areas. Broker, MCO, and provider interviewees agreed that maintaining a sufficient number of vehicles and drivers is challenging. Provider shortages are especially pronounced in rural areas where NEMT providers are in even shorter supply, and vehicles must travel longer distances to complete trips, but they can also affect large cities and urban areas. For example, one broker interviewee and one MCO interviewee reported that a declining supply of traditional taxi cabs in recent years, likely related to the growth in TNCs such as Uber and Lyft, has significantly challenged the NEMT provider network. Provider shortages are also common with respect to specialty vehicles required for members with complex needs such as wheelchair and stretcher vans.

Interviewees also attributed provider shortages to high operating costs and low Medicaid payments, which limit provider profitability. They noted that low and fixed Medicaid reimbursement rates for NEMT services are not adequate to cover the variable and increasing costs to providers for gas, vehicle maintenance, driver wages, and insurance. One broker interviewee pointed out that some current state contracts are based on procurements conducted several years prior, and the rates in those contracts are now outdated. The same interviewee recommended annual or biannual rate reviews, pointing to several states, including Texas, Missouri, Maine, and Oklahoma, that conduct a thorough review with input from brokers before they develop a rate. Although labor intensive, frequent rate updates allow the broker to support a healthier network.

A state Medicaid official commented that NEMT providers lose drivers to companies that can offer more competitive wages, such as UPS and Amazon, particularly in rural areas where there is a more limited workforce. An advocate interviewee discussed strategies to address network development and maintenance issues in rural areas such as enhanced payment rates or other provider incentives.

Nearly all interviewees identified the high cost of insurance for NEMT providers as a central challenge to maintaining an adequate network. Interviewees reported that insurance requirements can vary dramatically across states and MCOs, with annual premiums ranging from \$500,000 to \$5 million per provider. They noted that states often require NEMT providers to purchase higher levels of insurance than common carriers, such as taxi companies or TNCs, because NEMT serves vulnerable populations with associated higher risk – citing a \$1 million differential in one state. Insurance rates are also higher

for certain vehicles such as wheelchair and stretcher vans. One broker interviewee explained that for an average provider operating four to five vehicles, the insurance requirements can be unaffordable. An interviewee representing an NEMT provider commented that insurance requirement changes made during their state's transition to a broker model caused many small "Mom and Pop" transportation providers to close down because they could not afford the insurance.

At the same time, state Medicaid officials and brokers commented on the increasing difficulty in finding private insurance companies that are comfortable underwriting these high-risk policies. For example, one broker interviewee recounted a time period when three of the six largest underwriting companies went bankrupt, and the broker had to help about 200 providers find new coverage. In Indiana, the Medicaid agency has begun to engage the state's Department of Revenue (that certifies motor carriers) regarding the department's insurance requirements. They also requested that the state's NEMT brokers collect insurance prices and quotes from their providers and forward them to the Indiana Department of Insurance for evaluation of whether they are equitable and appropriate.

States and brokers have taken a variety of approaches to enhance capacity where provider networks are strained. Stakeholders described numerous strategies to maintain an adequate supply of NEMT providers including:

- **Promoting mileage reimbursement and volunteer drivers, especially in rural and remote areas.** Most states will reimburse beneficiaries, or their friend, family member, or volunteer driver, who uses their personal vehicle to drive a beneficiary to their Medicaid eligible appointment at the standard IRS mileage rate for each trip. Texas officials interviewed reported that mileage reimbursement accounted for up to 30 percent of NEMT utilization in some rural areas compared to a little as 10 percent in more urban areas.
- **Reliance on county transit programs (e.g., non-medical transportation, ADA transport).** An NEMT expert interviewed for this study discussed the importance of the FTA's Formula Grants for Rural Areas (referred to as the "Section 5311 Program") that funds transportation in remote areas without many transportation providers.^{14,15} To assure NEMT access, state Medicaid agencies, brokers, and MCOs often include public transit agencies that operate rural demand-response public transportation services in their NEMT networks. This interviewee commented on the mutual dependence of rural public transit programs and Medicaid NEMT programs. Transit programs provide NEMT access in rural areas where there would otherwise be limited transportation providers but also rely on Medicaid NEMT payments to support their operations.
- **Use of broker-owned vehicles when there is a surge in demand and limited capacity to meet it.** Brokers noted they are often limited in their ability to use their own vehicles to supplement the provider network due to federal and state regulations that restrict a broker from directly providing transportation themselves in order to prevent a conflict of interest.¹⁶ Federal regulations provide for exceptions when there is insufficient capacity to meet the existing need, particularly in rural areas or when there is a specialized need that only the broker can fill.¹⁷ For example, LogistiCare reported that they are permitted to run some of their own vehicles in rural, Northern Maine to ensure there is sufficient coverage.

- **Negotiating with NEMT companies for service expansions into NEMT shortage areas.** One broker interviewee reported that they partner with the highest quality and efficient NEMT providers in their network to expand operations into areas where there is a dearth of providers. The broker noted that this type of engagement in long-term planning with NEMT companies for service expansions has been a highly successful strategy to address capacity issues.
- **Incorporating TNCs, such as Uber and Lyft, into the provider network.** Some brokers have augmented their networks with TNCs in states that permit this mode as an NEMT option (discussed further in the next section, *Experience with Transportation Network Companies*).

Experience with Transportation Network Companies

Transportation network companies, such as Uber and Lyft, are playing an increasing role in NEMT.

TNCs are generally defined as an entity that uses a digital network to enable a passenger to prearrange a trip with a driver in exchange for compensation. Broker interviewees envision TNCs becoming a larger part of the NEMT provider network over time and plan to encourage and promote their adoption in additional states. The number of states in which TNCs are currently operating in the NEMT program is difficult to pinpoint because TNCs may participate at different levels, and the environment is changing rapidly. According to this study's state environmental scan (conducted in April and May 2020), approximately 15 states have authorized or are in the process of authorizing TNCs for Medicaid.¹⁸ According to Lyft, 14 States and Washington, DC have adopted comprehensive policies that incorporate TNCs into their Medicaid NEMT programs, and in some other states TNCs can be used only as a backup.¹⁹ LogistiCare reports using TNCs to some extent in 25 states.²⁰

While a growing number of states have authorized the use of TNCs for NEMT, state regulatory approaches vary. Some states require TNCs to enroll as Medicaid providers while others permit brokers to use TNCs only on a limited recovery basis when other options have been exhausted, or the traditional provider does not show up. In all cases, the member's condition must be an appropriate fit. Other states have approved the use of TNCs without requiring them to meet the same driver and vehicle standards as other NEMT providers. All six study states either currently permit or are in the process of allowing or expanding TNCs as NEMT providers. They share an overall objective to expand supply and access to transportation, though the specific impetus and regulatory requirements vary:

- **Georgia** was an early adopter of TNCs in 2017, initially for backup when other NEMT transportation providers were not available. TNCs are not required to enroll as Medicaid providers that meet Medicaid-specific training and standards. However, Georgia restricts the use of TNCs to members who do not need physical assistance, when no traditional transportation provider is available to transport the member, or if requested by the member and approved by the broker.
- **Arizona** authorized the use of TNCs through a broker contract beginning in May 2019, in part to respond to the surge in demand for transportation during the winter tourist season. The state's policy created a new provider type for TNCs and reduced training requirements for TNCs compared to traditional NEMT providers.²¹
- **Massachusetts'** 2020 broker procurement creates a Ride Hail pilot (expected to begin in fiscal year (FY) 2022) to increase capacity to meet last-minute, urgent transportation needs; state officials do

not expect to see significant cost savings from the pilot. TNCs may only provide rides to MassHealth members with an urgent request for transportation, who only require curb-to-curb transportation (not door-to-door level of service), are 18+ years old, and have opted into the service based on the informed and meaningful understanding that Ride Hail trips have a different set of transportation provider standards than other transportation providers.

- **Indiana** reported plans to begin to enroll TNCs as Medicaid providers beginning in August 2020, noting that the needed system changes were “fast-tracked” early in the COVID-19 pandemic due to the potential for emerging NEMT network shortages.
- **Texas** is in the midst of implementing new legislation²² to increase TNC participation in the NEMT program so that Medicaid members have access to the same modernized modes of transportation as anyone else to the extent appropriate, according to Texas Medicaid officials. The law removes the requirement that TNCs enroll as Medicaid providers and bars the Texas Health and Human Services Commission (HSSC) or brokers from imposing additional regulations on TNCs beyond what is required for TNCs to operate commercially in the state. Minimum standards for NEMT providers related to vehicle maintenance and safety, driver background checks, and training requirements will not apply to TNCs.²³
- **Connecticut’s** NEMT broker, Veyo, maintains a Medicaid-specific Independent Driver Provider (IDP) network, in which independent contractors use their own vehicles to provide NEMT to eligible Medicaid members, similar to the ridesharing/TNC model. According to public documents, the state expects IDPs to improve quality, achieve efficiencies, and enhance utilization administration. IDPs are required to meet standards and undergo specialized training.²⁴ Veyo also contracts with Aryv, a TNC specifically focused on NEMT.

Interviewees agreed that TNCs offer several advantages and opportunities for the NEMT program.

NEMT stakeholders highlighted the following benefits for Medicaid NEMT programs offered by TNCs:

- **Increased NEMT supply and expanded access.** Overall, interviewees agreed that TNCs’ ability to provide on-demand, same-day, or next-day transportation, especially during surge or peak periods, is valuable to the NEMT program. Brokers emphasized that this flexibility enables them to more easily scale their network to meet changing demands without having to carry that capacity and associated expense throughout the entire week. Fixed commercial fleets cannot adjust in the same way, and with the decline in traditional taxi companies, brokers find it vital to have a network of providers who can “log on” to respond to requests when demand exceeds supply. State Medicaid officials also noted that TNCs are useful to expand access in shortage areas and for longer trips that traditional NEMT providers do not want, or trips that take place at certain times of the day (for example, a late-night hospital discharge when other NEMT providers are not operating).
- **Improved member satisfaction.** Many state Medicaid officials, MCOs, brokers, and providers interviewed also view TNCs as a way to improve member satisfaction. For example, one MCO interviewee expects that incorporating TNCs into the provider network will generate improvements in flexibility, reliability, and timeliness, and ultimately translate to fewer complaints and grievances. There is some data to support this. For example, a white paper published by Lyft and *FierceHealthcare* showed that Centene’s Lyft pilot program resulted in a 66 percent reduction in

member-rider complaints and a 21-minute reduction in average wait time for Medicaid, Medicare, Exchange, and Dual-Eligible beneficiaries utilizing Lyft compared to traditional NEMT rides.²⁵

Similarly, several state officials felt that the use of TNCs will modernize and normalize medical transportation which might encourage more people to use the benefit. They noted that TNCs may better reflect member preferences, increase privacy, and remove the stigma associated with some traditional NEMT vehicles, particularly for those who have daily trips.

- **Innovative technology solutions.** Interviewees indicated that TNCs, specifically Lyft and Uber, have set the standard for transportation technology solutions, such as GPS tracking to monitor the location of the vehicle and real-time text notifications to the beneficiary about the status of the pick-up. One MCO commented that these technologies are the “greatest innovation for timeliness.” As noted above, states, MCOs, and brokers are promoting greater adoption of these technologies among other types of NEMT providers.
- **Cost efficiencies.** State Medicaid officials also expect the incorporation of TNCs into provider networks to generate cost efficiencies. One broker reported that TNCs in their network have a lower cost per mile than a traditional NEMT provider with significant overhead expenses, offering savings they can pass onto Medicaid payers. The FierceHealthcare and Lyft study found that AmeriHealth Caritas DC saw a 40 percent decrease in ER use and a 12 percent decrease in ambulance use among the 11,400 members who used Lyft services, based on claims analysis conducted 4 months before and after Lyft became accessible to riders.²⁶ The study also found that Alameda Health System achieved \$400,000 in cost-savings with the use of Lyft compared to using taxi vouchers.²⁷ Interviewees also asserted that Medicaid agencies would see a reduction of fraud, waste, and abuse as a result of TNCs’ innovative technologies such as GPS tracking.

TNCs may not be appropriate for a large segment of NEMT beneficiaries. Interviewees agreed that TNC drivers generally do not have the specialized Medicaid or NEMT training required to meet the complex social, medical, and mobility needs of the highest NEMT utilizers (e.g., certain individuals with I/DD or high physical or behavioral health needs). Moreover, many of these individuals may not have the functional ability to identify the car or walk to the car. Some states have established restrictions on the types of NEMT beneficiaries that may use TNCs. Georgia’s Medicaid agency developed guidance for NEMT brokers that stipulates that only ambulatory individuals who require no physical assistance may use TNCs. Georgia Medicaid officials reported that the utilization of TNCs has declined since they implemented these policy restrictions and as the brokers built up their traditional NEMT networks.

For able-bodied, independent individuals, TNCs can be a viable option. However, some interviewees still had concerns about the appropriateness of TNCs. One interviewee representing a broker believed that even though the vast majority (80 percent) of their trips are for ambulatory members, drivers would still require education and training to assist Medicaid beneficiaries for at least half of those trips. They clarified that it is difficult to identify the cases that need additional assistance because members do not always self-identify as having a disability or needing assistance, and beneficiaries’ conditions can change rapidly. For example, an individual can go in for a minor procedure and afterwards may require assistance from the driver. Another broker highlighted that TNCs cannot provide the continuity of care important for beneficiaries who are using NEMT services daily or multiple times a week, such as

beneficiaries going to dialysis or SUD treatment. Some NEMT contracts require that the driver wait 10-15 minutes for the beneficiary, which is something TNCs may not be used to doing with their commercial clients.

Interviewees noted the importance of specific training or guidelines for TNCs providing NEMT.

Advocates suggest one strategy to address these concerns would be to create a separate TNC driver pool for NEMT that would be held to the same training and requirements as NEMT providers. Veyo's IDP model offers this hybrid approach. Their IDP drivers are required to meet the same state and federal laws that apply to NEMT providers, complete 5-8 hours of training specific to the transportation needs of Medicaid members including ADA Sensitivity, Cultural Competency, cardiopulmonary resuscitation (CPR)/First Aid, Health Insurance Portability and Accountability Act (HIPAA), Blood-borne Pathogens, Defensive Driving, and working with individuals with I/DD, physical disabilities, and behavioral health needs.²⁸

Lyft reported that they are investing in Medicaid NEMT and trying to address concerns by adapting their platform to meet the needs of the NEMT population. Lyft requires that the Medicaid beneficiaries they serve meet a set of criteria including that they are cognitively and functionally capable and can identify, walk to, and get in and out of the car independently. In addition, they reported that all of their drivers must complete extensive sensitivity training and are educated about the needs of members with limited hearing, vision, or mobility; however, this training is not specific to the NEMT population. They also conduct automated voice calls to notify riders of their trip details, which they report is important for the elderly population, and identify custom pick-up and drop-off locations for large hospital campuses or medical buildings.

Coordination Across Federally Assisted Transportation Services

Federal transportation policy encourages coordination across federally assisted transportation services, including Medicaid NEMT. Since the creation of the federal Coordinating Council on Access and Mobility (CCAM) by Executive Order in 2004,²⁹ this federal interagency partnership has issued policy recommendations and implemented activities to improve the efficiency of transportation for older adults, people with disabilities, and low-income individuals. In response to coordination requirements included in the 2015 federal transportation reauthorization bill (the "FAST Act"),³⁰ CCAM has:

- Distributed pilot program grants to be used for capital projects to improve the coordination of NEMT transportation-disadvantaged populations
- Developed a new strategic plan to advance federal transportation coordination efforts
- Convened three federal work groups to identify and address barriers to coordinated transportation
- Facilitated focus groups to identify coordination challenges at the state and local level
- Published the Federal Fund Braiding Guide (addressing when federal funds may be used to fulfill the local match requirement of another federal grant)
- Developed the CCAM Program Inventory (identifying CCAM agency programs that fund transportation for people with disabilities, older adults, and individuals of low income)

- Developed the CCAM Cost-Sharing Policy Statement that includes information and resources for grantees on vehicle and ride sharing and federal fund braiding.³¹

Despite these and other efforts of CCAM and its interagency partners, many stakeholders described barriers to coordinating publicly assisted transportation programs.

States vary in the extent to which they coordinate their NEMT programs with other federally funded transportation programs. Medicaid officials in half of the six study states reported coordination as a policy priority. Georgia officials indicated that the Georgia Department of Community Health, which administers Medicaid, has standing meetings with the state’s Department of Transportation and Department of Human Services to work together to coordinate transportation programs and to share policies and data. Texas officials reported that Medicaid takes advantage of the FTA-funded rural transit districts and the public transportation services they provide. In Massachusetts, HST manages transportation for six state agencies or programs: MassHealth, Department of Developmental Services, Department of Public Health’s Early Intervention Program, Massachusetts Rehabilitation Commission, Massachusetts Commission for the Blind, and Department of Mental Health.³² State officials interviewed indicated that the extensive coordination efforts under the HST Office have reduced costs by allowing shared rides across these agencies and programs. The HST Office also performs provider background checks and helps the agencies it serves to implement universal provider standards, although some agencies impose additional standards (e.g., TB tests for drivers transporting small children).

A CCAM representative interviewed for this study also cited Medicaid NEMT programs in Pennsylvania and Vermont for successfully promoting coordination across programs. Pennsylvania’s counties are responsible for coordinating Medicaid NEMT and other human services transportation programs in many parts of the state. In Vermont, the Department of Vermont Health Access contracts with the Vermont Public Transportation Association (VPTA) that serves as the statewide NEMT broker. VPTA then subcontracts with local public transit operators who coordinate NEMT with other public transit in the area. Other interviewees, however, reported limited or no coordination across federally assisted transportation programs and cited a range of barriers and challenges, described further below.

Obstacles to coordination across federally-assisted programs include differences in beneficiary needs, geographic footprints, hours of operation, and lead times required to schedule a ride. One regional broker that serves multiple human services transportation programs described two operating models used for both Medicaid and non-Medicaid beneficiaries: the “program-based” model and the “demand-response model.” The program-based model is used to transport individuals to the same program or facility on a regular basis, including, for example, day habilitation programs, early intervention programs, supported employment and day services programs for persons with I/DD, and certain mental health programs. Consumers in these programs are assigned to established routes and share rides with other consumers going to the same program – generally having similar needs and characteristics. The “demand-response” model is used for trips to medical appointments for Medicaid beneficiaries and certain limited trips for consumers of other human services programs.³³ Because of differing requirements and needs, this broker does not intermingle riders between programs or with Medicaid beneficiaries going to medical appointments and noted that it did not see any advantages to

coordinating rides across human services programs. Another broker stated they often contract with county transportation providers, especially when building up a network in new areas. However, they reported that county providers do not provide 24/7 access to transportation on weekends and after hours, so they are often not able to accommodate the different streams of ridership and populations required for coordination.

An interviewee from an organization that provides transportation for seniors and persons with disabilities noted that the state's NEMT broker allows Medicaid members to schedule rides 48 hours (or more) in advance, but felt this timeframe was too short. This provider reported that it schedules rides for other programs as far as 30 days in advance and often fills up and cannot accommodate NEMT requests with only 48 hours' notice.

Sharing rides among beneficiaries of different programs can be inhibited by the need for complex cost allocation capabilities to comply with the requirement that Medicaid only reimburse for transporting a Medicaid-eligible beneficiary to a medically necessary medical service. When a Medicaid beneficiary is transported in a shared trip with individuals covered under other programs, Medicaid can pay for the Medicaid eligible portion of that Medicaid beneficiary's transportation, but not additional costs that arise from a shared trip, such as costs associated from longer trip times.³⁴ This requires cost allocation capabilities that equitably and appropriately apportion the shared costs across the relevant programs. According to interviewees, the complexity of such cost allocation has inhibited ride sharing across programs. One interviewee observed that Medicaid would rather pay more for on-demand trips than a more cost-effective monthly transit option to avoid paying for trips for non-medical purposes. To help other federally-assisted transportation programs with Medicaid billing, a Department of Transportation official reported that CCAM is currently developing a cost allocation tool, to be completed in 2021, that will allow the NEMT provider or transit agency to identify and bill Medicaid for the specific costs of a Medicaid eligible beneficiary taking a specific trip, even if the Medicaid beneficiary shared the ride with an individual from another program.

While states routinely promote use of public transportation options where available, these options are not appropriate for all Medicaid beneficiaries and are usually limited to urban areas. The ability to leverage public transportation such as fixed-route buses and subways for NEMT is limited. Even in cities, bus stops may be too far away from the beneficiary's home or destination, inaccessible for a beneficiary with mobility or cognitive limitations, and may entail substantial rider wait times. Coordinating NEMT with fixed-route or demand-response paratransit options also presents barriers. A broker interviewee noted that paratransit companies sometimes have capacity challenges that make strategic partnerships with NEMT more difficult. A state official and a broker reported that despite their past efforts to better align Medicaid NEMT and paratransit options, results were at best mixed, and few NEMT members used paratransit.

Stakeholders' View on Value and Role of NEMT

All interviewees emphasized the importance of the NEMT benefit in helping Medicaid beneficiaries get the care they need. Transportation assistance was cited as particularly critical for people living in rural areas with long travel distances to medical services and where public transportation options are limited or nonexistent, as well as for people with disabilities who do not drive. An MCO representative also reported that NEMT is instrumental in combatting the opioid epidemic by getting beneficiaries to needed MOUD and SUD services, further commenting: "NEMT is the difference between a member getting lifesaving daily dialysis or getting placed in the hospital for a kidney transplant. For opioids, it's either getting MOUD or relapsing." The interviewee viewed NEMT as an essential tool for helping people achieve and maintain recovery.

Most interviewees highlighted the value or potential value of NEMT in improving health outcomes and reducing disparities. Medicaid officials expressed belief that NEMT is cost-effective, pointing out that individuals who regularly attend their well visits are less likely to use more costly emergency and hospital services. A broker representative pointed out that other agencies and organizations, including the Veterans Administration, Accountable Care Organizations, Medicare Advantage plans, and a large commercial insurance carrier, have begun to offer transportation to their beneficiaries based on their belief that the benefit will ultimately result in savings. MCOs also expressed their understanding of NEMT's value proposition. For example, one MCO reported offering an enhanced value-added benefit beyond the state's 20 trip per member per 12-month period limit for members who need rides to medical services, as well as for transportation to job interviews, WIC offices, job fairs, or the pharmacy.

Medicaid officials and advocates stated that NEMT is critical for reducing racial and ethnic disparities in health outcomes and emphasized the need to improve access to NEMT in poor, rural areas.

There is some data, although limited, on NEMT's return on investment and long-term savings. Some interviewees pointed to research examining the direct effects of NEMT on costs and health outcomes. One MCO study found that care quality increased and hospital admissions per 1,000 members decreased where NEMT was available. Another study, carried out by the Medical Transportation Access Coalition (MTAC), found a significant return on investment for NEMT to dialysis for kidney disease, wound care for diabetes, and treatment for SUD.^{35,36} However, interviewees also noted that measuring the benefits of transportation is difficult, and studies have generally been limited in scope and conducted by organizations that have an interest in maintaining the benefit or policy organizations that oppose the benefit.

Some interviewees felt that the NEMT benefit would offer even greater value with more education of beneficiaries and health care providers. An NEMT researcher noted that many older adults and individuals with low income are not aware of the NEMT benefit, and as a result may not receive the Medicaid health care available to them. A state Medicaid official similarly pointed to the need for greater education for beneficiaries about the NEMT benefit, particularly when transitions in NEMT administration occur. Indiana Medicaid officials reported a large increase in NEMT utilization following a shift to a broker model for the FFS population, which they credit to better and more frequent member education and increased awareness of the benefit.

Medicaid officials and other stakeholders differed in their views of how states would react if NEMT were to become an optional benefit. Although the NEMT benefit was codified into statute in December 2020, at the time of the interviews it was still required by federal regulations. Three of the study states' Medicaid representatives believed that their states would keep the NEMT benefit if it became optional, either because of the value of the benefit or because the backlash from removing it would be harsh. Another state official said that while Medicaid agency staff believe the benefit is important, lawmakers may be looking for opportunities to reduce spending in light of the impact of COVID-19 on the economy – challenges likely to persist beyond FY 2021. Other stakeholders posited that states' decisions about keeping or dropping NEMT would fall along partisan political lines. Advocates predicted that many states would eliminate or reduce the benefit if given the option and that most states would at least consider doing so given the challenging budget environment. It is important to note that three study states (Indiana, Massachusetts, and Georgia) either proposed or received approval to exclude NEMT from the benefits for their Medicaid expansion populations and other low-income adults. Indiana (as well as Iowa) has implemented Medicaid Section 1115 waivers that exclude the NEMT benefit for most Medicaid expansion beneficiaries (with the exception of pregnant beneficiaries and beneficiaries determined to be medically frail). Georgia received CMS approval of a similar waiver application on October 15, 2020, while Massachusetts policymakers withdrew the waiver request they made in 2017.

Most interviewees agreed that reducing or eliminating the benefit would have a negative effect on access to services and health outcomes. As discussed above, all of the stakeholders interviewed emphasized the importance of NEMT in accessing medical services, particularly for more vulnerable or frail beneficiaries. By extension, they posited that eliminating the benefit would adversely affect health outcomes and called for additional research to fully assess the relationship between the benefit, health outcomes, and long-term costs.^{37,38,39,40} One advocate expressed that eliminating NEMT would further exacerbate current racial and geographic health disparities. In addition, because rural county transit providers can use Medicaid NEMT funds to leverage federal transit funding (described in the section, *Coordination Across Federally Assisted Transportation Services*), scaling back NEMT would have an amplified negative effect on all mobility in rural communities, according to two stakeholders.

Multiple stakeholders interviewed suggested that an NEMT benefit requirement should be codified into law. At the time of the interviews for this study, the requirement to provide NEMT was not included in federal statute, unlike other mandatory Medicaid benefits, but rather was required by Medicaid regulations. In light of policy discussions at the federal level about making NEMT an optional benefit, one consumer advocate opined that Congress should mandate NEMT as an essential and valuable Medicaid benefit. Another public transportation advocate commented that codifying the NEMT benefit would facilitate important NEMT policy discussions regarding the value of NEMT, its role in improving health outcomes, and strategies for addressing NEMT fraud, waste, and abuse concerns. As mentioned above, NEMT became a mandatory benefit required by federal statute in December 2020.

Conclusion

This report synthesizes perspectives on Medicaid NEMT administration and delivery from select state and federal officials, transportation brokers and providers, MCOs, beneficiary advocates, and experts. It highlights the diversity in states' approaches to managing their Medicaid NEMT programs and the delivery of transportation services. The report summarizes common challenges to administering NEMT, as well as changing technologies and innovations that have implications for NEMT performance, beneficiary satisfaction, oversight, cost, and efficiency. Along with recent changes to NEMT utilization (and overall health care delivery) resulting from the COVID-19 pandemic as well as the new statutory language codifying the NEMT benefit into law, states and other NEMT stakeholders are considering how to shape the NEMT benefit in this dynamic environment. The 2020 Act codifying the benefit also calls for new studies and guidance on NEMT, particularly related to program integrity. It will be important to monitor and assess the impact of all of these changes on the quality and accessibility of NEMT for the individuals who depend on this benefit.

Appendix

Appendix A. Arizona NEMT Profile: Managed Care Carve-In, Plus In-House Fee-for-Service

NEMT Delivery System Model
<p>Arizona’s Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), carves NEMT into capitated contracts with MCOs. One of the largest MCOs in Arizona (Mercy Care) manages the benefit and contracts directly with transportation providers. All other MCOs contract with a transportation broker to administer NEMT services.</p>
<p>AHCCCS administers the NEMT benefit for tribal members not enrolled in an MCO through the fee-for-service (FFS) American Indian Health Program (AIHP) and Tribal Arizona Long Term Care System (ALTCS).⁴¹ Among 22 tribes in the state, approximately 121,000 American Indian/Alaska Native (AIAN) people are enrolled in AIHP, and about 2,500 are enrolled in Tribal ALTCS as of October 1, 2020, which accounts for about 6-6.5% of the AHCCCS population according to state officials.</p>
<p><u>Significant Changes</u></p>
<p>In October 2018, Arizona integrated behavioral health and physical health under the same MCOs. The MCOs are responsible for providing the NEMT benefit for both behavioral and physical health services. Prior to integration, NEMT was “split” between physical health MCOs and behavioral health MCOs, with many behavioral health outpatient providers running vans and other types of transports.</p>
State Characteristics ⁴²
<ul style="list-style-type: none"> • Medicaid Managed Care: 84.4% (AIAN beneficiaries may switch between MCOs and AIHP at any time) • Medicaid Expansion: Yes • Rural Population: 10.2%
Copay Requirements, Benefit Limits, and/or Benefit Exclusions
<ul style="list-style-type: none"> • No copay required • Prior authorization required for AIHP/Tribal ALTCS trips more than 100 miles • NEMT covers transport to pharmacies, but in two counties (Maricopa and Pima), there is a 15-mile limit for pharmacy trips • NEMT covers transportation to local community-based support programs (e.g., various drug and alcohol support groups, National Alliance on Mental Illness (NAMI) Programs)⁴³
Transportation Modes and Variation
<p>Taxis are the primary mode of NEMT. According to state officials, among MCOs, there were 1,633,000 taxi claims for 130,000 members in CY19, followed by mini-bus mountain transport (353,000 claims) and wheelchair van (211,000 claims). There was lower utilization of mileage reimbursement, bus ticket/passes, and TNC rides, according to AHCCCS. Some outpatient health providers such as dialysis centers have vans and arrange transportation for patients.</p>
<p>Interviewees report that there are no significant differences in transportation mode in the rural areas, except that last year AHCCCS added specific allowances for non-ambulance air NEMT in the Grand Canyon.</p>

Because tribes determine who has rights of entry onto tribal lands, AIHP NEMT providers must have a business license with the tribe of the members they serve on tribal land, if required. Tribal members must often travel long distances to access services, according to interviewees.

Primary Populations and Utilization Trends

Interviewees reported that prior to the COVID-19 pandemic, NEMT utilization was stable.

Impact of COVID-19

The increase in telehealth and telephonic health care delivery during the pandemic reduced demand for NEMT. Interviewees noted that this may be temporary depending on the degree to which telemedicine continues after the public health emergency.

Experience with Transportation Network Companies (TNCs)

Arizona added TNCs as approved Medicaid transportation providers effective May 2019, allowing for TNCs to provide NEMT services through an NEMT broker pursuant to a contract with an MCO. According to interviewees, the state hoped to increase transportation capacity during high tourism months (December through April) when taxi drivers often prefer tourists to NEMT riders. AHCCCS also expects additional cost efficiencies by implementing TNCs. Interviewees noted that TNC utilization has been low, and AHCCCS planned to explore the reasons for low utilization. However, these plans were put on hold when the COVID-19 pandemic struck.

Performance, Challenges, and Improvement

According to interviewees, most beneficiary complaints include those related to missed appointments, late arrivals to appointments, customer service representatives, and driver performance.

State MCO contracts require MCOs to track timeliness of pick-ups and conduct quarterly performance audits to evaluate compliance with standards (e.g., member does not have to wait more than one hour after treatment for transportation home) for all subcontracted transportation vendors/brokers. If standards are not met, MCOs must require corrective action and establish processes to monitor and reduce the appointment no-show rate.⁴⁴

In addition, AHCCCS monitors compliance reports, identifies regularly occurring complaints, and follows up with the MCOs on issues of concern. AHCCCS can issue compliance, administrative, or monetary (penalties) actions with MCOs if necessary.

To minimize fraud and misuse of NEMT in the FFS program, AHCCCS requires trip tickets with member signatures on all trips, and prior authorization for trips greater than 100 miles.

Technology and Innovation

Introduction of TNCs brought GPS technology to NEMT.

Coordination with other Federally-Supported Transportation Programs

The MCOs provide bus tickets and passes for members to use public transit in urban areas. However, due to very high temperatures during the summer season, public transit requiring waiting outdoors is not frequently used. There are reportedly no policies regarding coordination between NEMT and other federally funded transportation programs.

Appendix B. Connecticut NEMT Profile: Statewide Broker

NEMT Delivery System Model
<p>Connecticut's Medicaid agency, the Department of Social Services (DSS), contracts with a statewide broker, Veyo/Total Transit (Veyo), using a shared risk model.</p> <p><u>Significant Changes</u></p> <p>In January 2018, DSS shifted its statewide broker model from a fixed fee-for-schedule (FFS) contract with a broker to a primarily capitated contract with another multistate broker, Veyo. An interviewee reported that through the new capitation plus administrative fee arrangement, DSS sought greater broker accountability, flexibility for the broker to create pay-for-performance incentives for NEMT providers, and greater cost control for the state (though CT has since increased the administrative payment, and broker profit and loss caps are in place).</p> <p>An interviewee reported that DSS remains very involved in overseeing the program. They have a director and five full-time staff focused on NEMT and hold weekly meetings with the broker.</p>
State Characteristics ⁴⁵
<ul style="list-style-type: none"> • Medicaid Managed Care: 0% • Medicaid Expansion: Yes • Rural Population: 12.0%
Copay Requirements, Benefit Limits, and/or Benefit Exclusions
<ul style="list-style-type: none"> • No copay required • Prior authorization is required • NEMT is not provided for pharmacy trips or Durable Medical Equipment (DME) services, unless the DME needs to be adjusted to fit the individual
Transportation Modes and Variation
<p>Primary NEMT modes are: (1) Public transportation (64%), (2) mileage reimbursement, (3) mileage reimbursement for homemaker/companion agency staff, (4) taxi/livery, (5) wheelchair accessible taxi/livery, (6) invalid coach (licensed by the Department of Public Health), (7) air and ground ambulance, (8) commercial air, (9) group or share ride vehicles, except for members who are immunocompromised or for whom this is otherwise not medically appropriate, (10) independent driver-providers (IDPs), and (11) other modes may become available and upon mutual agreement of DSS and the Contractor.⁴⁶ The mode used for each NEMT ride depends on the rider's needs, according to interviewees.</p>
Primary Populations and Utilization Trends
<p>An interviewee stated that common NEMT users are people with behavioral health needs (e.g., drug rehab, substance use, mental health), nursing home residents going to doctor appointments, dialysis patients (using repeat trips), and a small group of bariatric patients.</p> <p>Interviewees reported that prior to the COVID-19 pandemic, NEMT utilization was increasing, with growth in on-demand, bus pass, and livery utilization, and a larger number of individuals using the benefit.</p> <p><u>Impact of COVID-19</u></p> <p>NEMT utilization dramatically declined when the pandemic began, according to interviewees. Both demand and supply decreased as beneficiaries stopped going to most appointments, telehealth increased, and independent drivers sought other jobs. A large livery provider outfitted its cars with</p>

plexiglass and driver PPE and contracted with two urban areas to provide safe transportation including rides for COVID-positive individuals. In an effort to maintain its network, Veyo used NEMT providers to deliver Meals on Wheels and PPE to Medicaid beneficiaries, paid for by state dollars. NEMT utilization has started to rebound, but interviewees noted it is not clear whether it will fully return to prior levels.

Experience with Transportation Network Companies (TNCs)

To help meet demand for NEMT rides, Veyo supplements its network of traditional NEMT providers with Independent-Driver Providers (IDPs), independent contractors who use their own vehicles to provide NEMT (similar to Uber/Lyft). Veyo trains and credentials IDPs for Medicaid.⁴⁷ Veyo also contracts with Aryv, a TNC specifically focused on NEMT.

IDPs comprised about 5% of NEMT rides in 2019⁴⁸, and interviewees reported that this proportion is growing.

Performance, Challenges, and Improvement

According to interviewees, most beneficiary complaints are related to late pick-ups and driver no-shows, and these remain a challenge. To help address performance issues, a director-level position at DSS now oversees the NEMT program, and they have been developing a dashboard intended to validate performance data.

In addition to numerous reporting and program integrity requirements (e.g., pre-trip and post-trip review and verifications) and performance standards (e.g., the waiting time for a scheduled pick-up should not exceed 15 minutes after the scheduled pick-up time), the state contract includes performance incentives tied to call center measures, on-time performance, complaints, and satisfaction⁴⁹ where the broker can earn up to 5% of the “performance band.” The broker reported using incentives with its contracted providers, adjusting drivers’ trip volume based on their on-time performance or no-show rate. Interviewees expressed that performance measures and incentives motivate improvement.

In addition, interviewees reported that DSS and the broker are trying to address performance issues through greater use of the GPS-enabled app, corrective action plans for transportation providers who misuse the app, and identification of nursing homes that do not have people ready for their pick-up and drivers with chronic no-shows or late pick-ups. To address complaints from beneficiaries going to dialysis regularly, the broker reported using a small subset of NEMT providers for those trips so individuals are familiar with their drivers and can call them directly for the return leg of the appointment. To address wheelchair safety issues, the broker conducted trainings for providers on securing a wheelchair in the vehicles.

Technology and Innovation

Veyo is requiring their providers to use GPS-enabled apps that track location and facilitate DSS monitoring of on-time performance. Despite initial concerns about the cost, providers only incur the cost of the data used by the app on their phone. GPS technology also helps the broker identify fraud and misuse through real-time verification of drop-offs, pick-ups, and routes. According to an interviewee, the broker’s front desk staff use their “ride view” platform to see the vehicle on a map and better manage trips, improving accountability and reliability.

Veyo is launching a debit card that they can load remotely so beneficiaries can more easily purchase public transportation.

Coordination with other Federally-Supported Transportation Programs

CT requires the use of public transit as the lowest cost, most appropriate mode if a member lives within a certain distance of public transportation stop, is on a viable route, and does not have a medical condition preventing them. As a result, public transit (primarily buses) is the largest NEMT mode of transportation. Some beneficiaries reportedly require education on how to use public transit, and some prefer that option because they can qualify for a monthly bus pass that they can also use for other transportation needs.

The broker contract requires that the broker coordinates with local programs to avoid duplication; however, DSS, Veyo, and the Department of Transportation explored whether they could align NEMT with paratransit⁵⁰ and found that there is little member crossover between the two programs and did not further pursue coordination, according to interviewees.

Appendix C. Georgia NEMT Profile: Regional Brokers

NEMT Delivery System Model
<p>Georgia’s Medicaid agency, the Department of Community Health (DCH), contracts with two transportation brokers to administer NEMT in five regions. LogistiCare covers three regions, and Southeastrans covers two regions. DCH uses full-risk capitation payments.⁵¹</p>
State Characteristics ⁵²
<ul style="list-style-type: none"> • Medicaid Managed Care: 68.8% • Medicaid Expansion: No • Rural Population: 24.9%
Copay Requirements, Benefit Limits, and/or Benefit Exclusions
<ul style="list-style-type: none"> • No copay required • Rides are limited to 30 miles in urban areas, and 50 miles in rural areas (with exceptions if medically necessity) • Populations not eligible for the NEMT benefit include Qualified Medicare Beneficiaries (QMBs), CHIP (PeachCare) members, Planning for Healthy Babies waiver members, and Emergency Medical Assistance recipients.
Transportation Modes and Variation
<p>Passenger vans and public transit are generally used for ambulatory beneficiaries. Wheelchair transportation and stretcher vans are common for beneficiaries with physical limitations. At their discretion, brokers also use TNCs and may offer taxis or gas reimbursement to beneficiaries or to friends/family who drive them for urgent care and/or back-up services when necessary.</p> <p>While the brokers are prohibited from being NEMT transportation providers themselves, the state requires the broker to have available “shooter vans,” vehicles to be used in the event the scheduled transportation provider is unavailable for transport or if there are no other qualified providers available to provide the transportation.⁵³</p>
Primary Populations and Utilization Trends
<p>NEMT in Georgia is most often used to bring beneficiaries to and from mental health/behavioral health services, adult day health services, dialysis appointments, and between their nursing home and medical appointments. Brokers are required to transport an escort or attendant with riders with I/DD. Brokers may allow new mothers to use TNCs, which can accommodate the woman’s other children.</p> <p>Prior to the pandemic, NEMT utilization was increasing due to: aging of the state’s population, preference to avoid driving in the increasing amount of traffic, more appointments resulting from more health care providers accepting Medicaid patients, increases in adult day facilities, and more people accessing behavioral health and substance use disorder treatment related to the opioid epidemic.</p> <p><i>Impact of COVID-19</i></p> <p>NEMT utilization decreased as beneficiaries did not want to ride in vehicles with other people, telehealth replaced in-person visits, and health providers cancelled nonessential appointments. DCH has been meeting with the brokers more frequently during the pandemic, working with them to ensure drivers have PPE, and receiving daily NEMT reports.</p>
Experience with Transportation Network Companies (TNCs)

One broker began using TNCs in 2017, primarily for backup when other NEMT transportation providers were not available. Both brokers currently contract with and reimburse Lyft and independent drivers directly.

Because TNCs are not required to enroll as Medicaid providers (and thus, are not required to meet Medicaid-specific training and standards), DCH developed policies to identify which beneficiaries are appropriate for ride sharing. For example, TNCs may not be used for individuals with I/DD. Interviewees reported that TNCs currently comprise about 20-25% of NEMT trips, but utilization declined slightly as these policy restrictions were established and as the brokers built up their networks. Interviewees noted that TNCs are especially helpful for late night hospital discharges, longer trips, and mothers with multiple children.

Performance, Challenges, and Improvement

No-shows and late pick-ups are common complaints. Riders' concerns also include the need to bring family members with them to appointments, ensuring accessibility with appropriate vehicles, and the safety and securing of wheelchairs, according to interviewees.

DCH requires from the brokers monthly, quarterly, and annual reports documenting NEMT performance and works with its Vendor Management Unity to monitor complaints. DCH issues corrective action requests to address issues (e.g., if a certain region has a large number of missed appointments). One of the brokers uses performance incentives to reward providers with greater trip volume if they perform well.

Brokers are required to develop and maintain an ongoing quality assurance plan that must be reviewed at least annually. Any revisions must be submitted to DCH for review and approval. The brokers are also required to develop safeguards against fraudulent activity by transportation service providers and Medicaid beneficiaries.⁵⁴ DCH's Office of Inspector General plays a critical role in managing fraud, waste, and abuse, according to interviewees.

Technology and Innovation

Both brokers have reportedly upgraded their technology to expand the use of GPS and mobile apps. These technologies track and monitor trips, helping to ensure members are getting picked up and dropped off on time, according to interviewees.

Coordination with other Federally-Supported Transportation Programs

The Policy Manual states that brokers are encouraged to utilize federally funded and public transportation whenever possible if it is cost-effective and to negotiate service agreements with such entities when appropriate.⁵⁵ According to interviewees, DCH would like to see greater use of public transit. In the urban areas, public transit utilization is 15-20% of NEMT utilization, but there is less public transit in rural areas.

DCH has standing meetings with Georgia's Department of Human Services (DHS) and Department of Transportation (DOT) in an effort to coordinate their transportation programs. They share their experiences, policies, and data, but interviewees noted challenges to coordination (e.g., different needs of the Medicaid and DHS members, rural transit vehicle capacity limitations). DCH refers their members that do not qualify for the NEMT benefit to DHS.

Appendix D. Indiana NEMT Profile: Managed Care Carve-In plus Statewide Broker for Fee-for-Service Population

NEMT Delivery System Model

NEMT services are carved into capitated MCO arrangements for beneficiaries enrolled in one of the state's Medicaid managed care programs — Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and PACE (about 77% of total enrollees). The MCOs subcontract with transportation brokers to manage the NEMT benefit. Indiana's Medicaid agency, the Family and Social Services Administration (FSSA), contracts with a statewide broker to manage the NEMT benefit for the fee-for-service (FFS) population (about 23% of the Medicaid population), which includes all dual-eligible populations, foster and adopted populations, HCBS waiver recipients, and institutionalized Medicaid beneficiaries.

Significant Changes

In July 2018, FSSA transitioned management of the FFS population from an in-house NEMT management model to a capitated statewide broker contract (with a risk corridor) with Southeastrans. According to an FSSA interviewee, the transition was primarily driven by a desire for enhanced program integrity (after an audit revealed fraud, waste, abuse in the system) and to ensure proper oversight of the transportation network so members have access to a reliable and safe network of providers.

Following implementation of the statewide broker contract, an independent evaluation found that the broker transition caused significant disruption to the system due to increased demand for trips and new requirements imposed on transportation providers.⁵⁶ The FSSA interviewee reported that the number of unique members served increased from 3,000 to 11,000-13,000 per month after implementation of the broker contract, attributed to greater member education and public awareness of the NEMT benefit, and reduced burden on the member to arrange a trip.⁵⁷ The FSSA interviewee also commented that some NEMT providers were unable to meet the more stringent vehicle and driver credentialing standards and therefore could not continue to provide services.

Despite the initial challenges faced during the transition to the broker model, the broker contract has reportedly generated significant cost savings. According to the FSSA interviewee, per member per month (PMPM) costs have decreased from \$10.30 PMPM under the in-house model to \$5.98 PMPM under the broker arrangement, the cost per mile has been reduced by \$0.20, and the mileage per trip had been reduced by 26%, which the interviewee suggested is an indicator of less fraud, waste, and abuse.

State Characteristics⁵⁸

- Medicaid Managed Care: 77.1%
- Medicaid Expansion: Yes
- Rural Population: 27.6%

Copay Requirements, Benefit Limits, and/or Benefit Exclusions

NEMT is not covered (per Section 1115 waiver authority) for expansion adults enrolled in the Healthy Indiana Plan, except beneficiaries who are pregnant and those who have been determined to be medically frail.

FSSA began covering pharmacy-only trips for the FFS population on June 1, 2018. MCOs can choose to offer transportation to a pharmacy in addition to other enhanced transportation arrangements such as to attend member education workshops.^{59,60}

Copays are required for both FFS and managed care beneficiaries, except for Hoosier Healthwise members.

- Copay requirements for individuals in the FFS population based on NEMT service cost (405 IAC 5-30-2):
 - \$10 or less: \$0.50 copay each one-way trip
 - \$10.01 to \$50: \$1.00 copay each one-way trip
 - \$50.01 and up: \$2.00 copay each one-way trip
 - No copay required for any accompanying parent or attendant
 - Copay exemptions apply to persons age 18 and under, pregnant women, patients in a medical institution, enrollees in the Breast and Cervical Cancer Program, and American Indian or Native Alaskan enrollees.
- Copay requirements for Hoosier Care Connect: \$1.00 each one-way trip
- Copay requirements for Hoosier Healthwise: none (except CHIP \$10 ambulance copay)

Prior authorization is required in the following circumstances, and when trip limits for the FFS and managed care populations are exceeded:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions
- Trips of 50 miles or more one way
- Interstate transportation or transportation services rendered by a provider located out-of-state in a non-designated area
- Train or bus services
- Airline or air ambulance services

An FSSA interviewee reported that FSSA has submitted a State Plan Amendment to CMS to eliminate the prior authorization requirement for beneficiaries who exceed 20 one-way trips and for trips that are 50 miles or more one-way, but the broker will continue to complete an authorization on all trips to verify it is to an Indiana Medicaid participating provider/location prior to the trip.

Transportation Modes and Variation

Transportation modes include ambulance, air ambulance, bus, taxi, ambulatory and non-ambulatory common carriers, a family member's personal vehicle, and nursing home transportation.⁶¹ Community Transportation Providers (organizations that receive FTA 5310/5311 funding), and for-profit County Transportation Companies also reportedly provide NEMT services in the state.

According to interviewees, mileage reimbursement accounts for only 2% of utilization in the FFS population. They cite barriers to usage such as the 20-page provider enrollment application an individual transporting a member must complete. Although FSSA reduced the application length in August 2020, interviewees reported that it remains a barrier. However, an online portal is under development, which individuals can use to enroll as a "provider" for gas mileage reimbursement.

An FSSA interviewee reported that public transit accounts for about 1% of total NEMT utilization.

Primary Populations and Utilization Trends

According to an FSSA interviewee, NEMT is used widely across all aid categories and Medicaid programs (except the expansion adults who are excluded). The interviewee specifically noted that nursing facility residents and dialysis patients are high utilizers of NEMT. Other populations using NEMT services in the FFS population are wards and foster children as well as individuals with lower level disability such as those receiving waiver services.

The FSSA interviewee stated that a large share of trips is “on-demand trips” such as to primary care appointments and “subscription trips” for recurring appointments to services such as SUD/MOUD, dialysis, and cancer treatment. NEMT utilization increased significantly following the shift to a broker model for the FFS population due to increased member education and awareness and has remained relatively stable since then. According to interviewees, NEMT utilization increased among individuals accessing SUD services once MOUD became a covered benefit in late 2017. A recent assessment of the statewide broker contract noted: “More than half of the enrollees are over the age of 50. Less than 20 percent are under the age of 18. As a result, the FFS population has significantly higher complex needs than the managed care population.”⁶²

Impact of COVID-19

Early in the COVID-19 pandemic, FSSA saw a 40% reduction in transportation requests. At the time of the FSSA interview (early July 2020), transportation requests had rebounded but remained at about 20% below pre-pandemic levels. The FSSA interviewee reported that some NEMT providers had temporarily discontinued their services and that FSSA had made several NEMT policy changes as a result of the pandemic, which were also adopted by the MCOs. For example, FSSA mandated that Emergency Medical Services (EMS) be used to transport COVID-positive members since they have the proper PPE. FSSA also waived the requirement that members sign the iPad upon completion of the trip. One broker delayed implementation of these changes, which reportedly negatively affected their member satisfaction and customer service. FSSA anticipates lasting effects to the NEMT program due to the increased use of telemedicine, which was approved for several additional services due to COVID.

Experience with Transportation Network Companies (TNCs)

At the time of the FSSA interview, TNCs were not yet an approved NEMT provider type in Indiana, but work on system changes to add them was underway. When the COVID-19 crisis began, FSSA fast-tracked these system changes to allow enrollment of TNCs to address shortages in the NEMT provider network. As of November 13, 2020, FSSA reported the state’s NEMT broker for the FFS population, Southeastrans, is now using Lyft as a provider of last resort when the member meets qualification requirements and consents to the use of a TNC, but MCOs have not yet activated TNCs in their networks.

Performance, Challenges, and Improvement

Interviewees reported that beneficiary complaints focus on timeliness and the behavior of passengers and drivers. The shift to a broker model for the FFS population created a centralized place for members to make complaints, which did not exist previously. Brokers must report no-shows, complaints, utilization/rides, call-center statistics, claim information, program integrity referrals, grievances and appeals, and requirements for handling complaints and developing remediation plans.

The broker contract for the FFS population includes a performance withhold in which 3% of the broker’s remuneration is withheld contingent on the broker’s score card performance. In addition, FSSA interviewees reported that the current broker contract includes an incentive payment whereby the broker must meet a 99.5% trip fulfillment metric to be eligible (which has not yet been earned). FSSA amended the contract to add a comprehensive Pay for Performance section with several performance requirements and corresponding earning levels in year three.

MCOs and brokers contracts have robust program integrity and utilization management requirements to investigate fraud, waste, and abuse related to the delivery of NEMT services and identify instances

of over- and under-utilization of emergency room services and other health care services. MCOs must have “policies and procedures for conducting both announced and unannounced site visits and field audits to providers defined as high risk including transportation services to ensure services are rendered and billed correctly.”^{63,64,65}

Technology and Innovation

FSSA provides an iPad to FFS NEMT providers so they can input trip information. The iPads are equipped with GPS so the Broker can monitor them on the backend. Members are required to sign the iPad upon completion of trip.

FSSA’s FFS broker, Southeastrans, has a variety of technologies to simplify and streamline NEMT processes. For example, their auto-router system enables members to select a preferred transportation provider so that when a member requests a trip, the request is sent first to the preferred NEMT provider, which can either accept or decline the trip. If it is declined, it is routed to a different NEMT provider. They also have a provider app used for trip scheduling and claims submission and a provider portal where providers can reconcile claims. In March 2020, Southeastrans implemented automated reminder phone calls to members about their scheduled trip.

Coordination with other Federally-Supported Transportation Programs

There is no required coordination with other federally-supported transportation programs. FSSA does coordinate with the Department of Aging to provide education for HCBS waiver providers that provide transportation services about how to enroll as an FSSA provider type so that they are eligible for gas mileage reimbursement, according to interviewees.

FSSA officials noted that member reluctance to use public transit because of uncertainty around wait times, schedules, and distances from bus stops presents a significant challenge to coordination with public transit systems. They noted, however, that they continue to work with public transit systems in an effort to expand network access for members.

Appendix E. Massachusetts NEMT Profile: Regional Brokers

NEMT Delivery System Model

In 2001, the Massachusetts Executive Office of Health and Human Services (EOHHS), which oversees Medicaid (MassHealth) and a number of other agencies, established the Human Service Transportation (HST) Office to coordinate transportation for six human service agencies including Medicaid.⁶⁶ This coordinated approach was chosen for efficiency and to reduce overlap between agencies that serve different populations accessing the same services, according to interviewees.

HST operates a non-risk regional broker model for NEMT. HST currently contracts with six Regional Transit Authorities (RTAs) that are paid an administrative management fee to provide brokerage services in nine regions (one RTA covers four regions) throughout the state. Medical “demand-response” trips (comprising the majority of Medicaid NEMT) are bid on a low-cost, most-appropriate basis, and brokers are paid based on a monthly average trip cost. HST also operates a program-based model for members going to programs on a regular, high-frequency schedule; payment is based on a per-route or per-trip basis.⁶⁷ Non-emergency ambulance and certain wheelchair van NEMT services are reimbursed on a FFS basis directly by EOHHS.

Significant Changes

Under a new contract starting July 1, 2021, Massachusetts will select one statewide broker or up to three regional brokers to manage transportation services and consolidate the nine regions into three HST Service Areas. Non-emergency ambulance transportation and wheelchair van transportation for members in rehabilitation and nursing facilities or who need mobility assistance from transportation provider personnel to exit their residences or to move from their residences to the vehicle will be integrated into broker services to provide a more unified service offering. The new arrangement prioritizes consumer safety and experience. The new broker contract(s) will expand the pool of eligible bidders and take advantage of technologic advances to improve ease of use and ensure timely service, including self-service options through web and mobile app portals, ride hail services through TNCs, and GPS vehicle tracking. The new arrangement is intended to consolidate data reconciliation, which HST interviewees reported is challenging with six different brokers for nine regions.

In addition, the program-based model (serving a small portion of the Medicaid population) is switching to capitated payments under the new contracts to increase cost savings and encourage brokers to find more efficient ways to transport people to programs with more frequent and predictable routes.

State Characteristics⁶⁸

- Medicaid Managed Care: 45.4% in acute comprehensive managed care plans, 65% in all managed care entities
 - Medicaid Expansion: Yes
 - Rural Population: 8.0%
-
- No copay required
 - Excludes trips within 0.75 miles if able to ambulate, and excludes pharmacy trips to obtain medication
 - Prior authorization of Provider Request for Transportation (PT-1) form required for HST Brokered transportation, and medical necessity form by medical provider for FFS wheelchair van and non-emergency ambulance

Transportation Modes and Variation

According to interviewees, HST does not purchase public transit directly, but the MassHealth agency offers public transit reimbursement to Medicaid beneficiaries who submit required documentation. Private transportation providers include intercity bus carriers, ferries, shuttle services, and wheelchair vans. The most common mode is sedan transport fulfilled by local livery companies through selective contract with a regional HST broker.

Primary Populations and Utilization Trends

Interviewees reported that a main focus of HST's NEMT program is individuals with behavioral health and substance use disorders. HST also has a program called the Critical Care Model for members who receive life sustaining services such as dialysis, chemotherapy, or radiation. The model uses a specific pool of vendors that specialize in understanding and meeting the needs of that population. For example, drivers are taught the importance of arriving on time to an appointment, the need for flexible pick-up times as appointments may run long, and that patients leaving specific treatment types may require varying levels of assistance. HST also undertook a SUD treatment initiative, conducting onsite presentations, which included an overview of the transportation services, with every methadone clinic in the state. Interviewees reported that Medicaid expansion in 2014 was last time there was a significant change in NEMT utilization.

Impact of COVID-19

NEMT utilization has decreased significantly due to medical and program-based facility closures and increased use of telehealth. HST interviewees reported they are operating at 50% of their pre-pandemic levels; however, since more outpatient medical facilities have begun to reopen, they have seen utilization increase slightly. HST and MassHealth have a standing weekly meeting and a weekly meeting with brokers to exchange status updates, monitor utilization, and assess the lasting effects of the pandemic such as increased telehealth visits. HST and MassHealth have implemented additional safety measures in response to the COVID-19 pandemic such as telephonic pre-screening for symptoms at the time of scheduling, minimizing shared ride groupings, social distancing on larger vehicles, and enhancing vehicle cleaning schedules. Through the Massachusetts Command Center, PPE has been provided to providers transporting individuals with known or suspected COVID-19. One local broker, whose trip volume has reportedly decreased 80%, has made changes to their operations including providing PPE to their drivers, minimizing shared rides as much as vehicle supply will allow, and retrofitting their vehicles with plastic partitions.

Experience with Transportation Network Companies (TNCs)

With the new 2021 broker contracts, HST will create a pilot in which certain MassHealth beneficiaries may opt into on-demand "Ride Hail" Services. Under the new program, brokers must make their best efforts to contract with one or more TNC to meet the demand for same-day and next-day urgent transportation requests. According to interviewees, the COVID-19 pandemic may affect the timing of the pilot rollout, given that there are more telehealth visits and fewer urgent requests.

Performance, Challenges, and Improvement

Interviewees report that member complaints focus on on-time performance and are sometimes related to weather or traffic. HST interviewees described their ongoing working relationships with larger medical facilities, such as Massachusetts General Hospital, to streamline and improve the NEMT process. For example, HST facilitates meetings with larger medical facilities and the region's broker representative to discuss the NEMT process and identify pick-up and drop-off points to make

the experience seamless for beneficiaries. HST also advises brokers to book trips with 15 minutes of extra time buffer for routes that often experience delays and traffic.

Introduced in 2009, shared cost-savings incentives built into broker contracts allow brokers to share in cost savings with HST that result from reduced trip expenses and overhead and improved overall efficiency.⁶⁹ The savings must be reinvested in the brokerage service to upgrade software, buy new computers, and hire additional staff.⁷⁰ The 2021 broker contracts will include new performance incentives, whereby the broker can earn up to 1.5% of the state's total quarterly contract expenditures, demand-response trip expenditures, and (three) monthly installment payments of the broker management fee. Incentive payments will be contingent upon call center performance, on-time arrival pick-up performance, customer satisfaction, and percentage of shared trips.⁷¹

MassHealth has a program integrity unit that conducts automated checks to identify potential misuse of NEMT services. Brokers are required to perform on-site service inspections at consumer destination facilities (e.g., clinics, doctor offices, program sites, etc.) and must report any credible evidence of fraud or abuse to HST.⁷² HST confirms compliance with vehicle maintenance, driver qualifications, insurance compliance, timely payment of vendors, and other areas for broker performance. HST made amendments in recent contracts that allow brokers to call providers to confirm suspicious appointments outside of normal operating hours to verify the individual is going to an appointment.

The HST office has also expanded its Compliance and Quality Assurance Department to address questions or concerns from customers and ensure safe delivery of services. Routine site inspections are done to ensure that vendors and brokers are complying with contractual contracts and that members are transported to their medical appointments safely and securely. The Compliance and Quality Assurance Department also ensures that there is appropriate and timely resolution to customer complaints by improving the process of gathering feedback and responding accordingly.

One local broker interviewee reported using Trapeze Medical Transportation software to monitor all trips, transportation provider responses, and billing. Some vehicles are equipped with mobile data computers which require the drivers to record their arrival and drop-off times. The broker also sends written surveys on a monthly basis to collect feedback from 10-15% of members.

Technology and Innovation

HST reports GPS offers a "cleaner approach to quality assurance" by providing an opportunity to validate pick-ups and drop-offs and review complaints or disputes. Although some vehicles used by brokers currently have GPS, HST will reportedly create universal technology standards for the brokers under the new contracts. The 2021 broker contracts include provisions to incorporate GPS tracking of all vehicles to improve on-time performance and reliability and introduce a web/mobile app for riders to request transportation and reduce call wait times.

Coordination with other Federally-Supported Transportation Programs

Massachusetts has a fully coordinated human services transportation program, with HST and the regional brokers coordinating transportation for six health or human services agencies and programs: MassHealth, the Departments of Developmental Services and Mental Health, the Massachusetts Rehabilitation Commission and Commission for the Blind, and the state's Early Intervention Program. Under the 2021 contracts, HST plans to work collaboratively with the Massachusetts Department of Transportation to implement the program in the most efficient and effective manner.⁷³

HST and Medicaid official interviewees reported significant benefits to coordination. Because many beneficiaries are eligible across multiple HST programs, HST can ensure that billing goes to the correct

agency, enable shared rides, eliminate multiple broker fees, and reduce costs. HST is also able to implement universal provider standards for each HST agency and offer universal checks and balances such as statewide sex offender registry checks and largescale national background checks for fingerprinting. A National Academy study found the use of RTAs to broker coordinated human services transportation helped contain costs per trip and ensure service quality.⁷⁴

Interviewees noted challenges to coordination, including differing consumer requirements, performance standards, vehicle requirements, and agency-specific driver standards.

Appendix F. Texas NEMT Profile: Regional Brokers (plus One In-House Region), Shifting to Managed Care Carve-In

Note: This description is based primarily on an interview with Texas HHSC officials; interviewees did not reply to requests to review this section as of the December 2020 submission to MACPAC

NEMT Delivery System Model

Texas' Health and Human Services Commission (HHSC), which operates the state's Medicaid program, contracts with transportation brokers to administer NEMT in 12 regions using capitated payments. In the Dallas/Fort Worth and Houston areas, HHSC contracts with two full-risk brokers (FRBs), LogistiCare and MTM, to manage the NEMT benefit. The state contracts with Managed Transportation Organizations (MTOs) in the 10 remaining regions (5 regions held by LogistiCare, 1 region held by Project Amistad, 2 regions held by American Medical Response, and 2 regions held by MTM). Texas Medicaid officials noted that the FRBs, which were originally created through a rider that expired, have identical requirements to MTOs as of September 1, 2016.

In Region 4, which covers the North Texas region, HHSC administers NEMT "in-house," contracting directly with transportation providers on a fee-for-service (FFS) basis following the termination of the region's broker contract in 2015.

Significant Changes

The Texas Legislature passed HB 1576 in 2019,⁷⁵ which required NEMT to be carved into MCO contracts by September 1, 2020. The timeline for implementation was delayed due to COVID-19, and the NEMT benefit will now be fully carved in by June 1, 2021. The state plans to transition the benefit in two phases:

- Phase 1 – As of January 2020, a limited number of MCOs with existing state contracts were required to provide nonmedical transportation (NMT) as a value-added service to their members. NMT is "curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle" scheduled with less than 48 hours' notice for specific circumstances such as a pharmacy pick-up, hospital discharge, or an urgent care need.
- Phase 2 - As of June 1, 2021, NEMT will be a required benefit for all MCOs and NMT value-added services will be expanded statewide.

According to Texas HHSC interviewees, the NEMT managed care carve-in was motivated by a desire to reduce overall costs and increase efficiencies. They believe that it will be administratively easier for the MCOs to manage both the medical and transportation benefits and expect to see improved member outcomes as a result. There is also a focus on encouraging the participation of TNCs in the program to increase access to more modern, on-demand modes of transportation for Medicaid beneficiaries. They noted that at least some MCOs plan to subcontract with current NEMT brokers.

State Characteristics⁷⁶

- Medicaid Managed Care: 92.4%
- Medicaid Expansion: No
- Rural Population: 15.3%

Copay Requirements, Benefit Limits, and/or Benefit Exclusions

- No copay required
- Prior authorization is required

- Excluded populations: Individuals residing in a nursing facility or ICF/MR, unless the beneficiary requires transportation to renal dialysis treatment

Transportation Modes and Variation

According to interviewees, 90% of NEMT utilization is comprised of demand-response transportation services such as taxis or wheelchair vans and mileage reimbursement to beneficiaries or their family, friend, or neighbor who drives them to the medical service.⁷⁷ Mass transit accounts for the remaining 10% of NEMT utilization, including commercial air, intercity and intracity buses, and the Advanced Plus program, which provides mileage reimbursement, meals, and/or lodging to eligible children and their attendants.⁷⁸ Individuals are eligible for intercity and intracity mass transit if they live, and their appointment is located, within a quarter (1/4) mile from a public fixed-route (bus) stop.

Primary Populations and Utilization Trends

STAR plus members, which include the elderly and adults with disabilities, are reportedly the highest utilizers of NEMT.

In June 2019, the Texas legislature passed a bill that requires HHSC, in collaboration with the Texas Maternal Mortality Task Force, to implement a pilot program for providing medical transportation program services to pregnant women and new mothers who are enrolled in Medicaid (Texas Code, Sec. 531.024141). The pilot leverages TNCs to allow mothers to travel with their children directly to and from prenatal and postpartum appointments, without stopping or sharing the trip with other beneficiaries. In addition, the pilot will allow rides to be scheduled with less than 48 hours advance notice, a departure from current rules. By September 1, 2020, the pilot must start in at least one HHSC managed care service area and would be optional for MTOs.⁷⁹ The state plans to evaluate the program to determine the extent to which it is “cost-effective; improves the efficiency and quality of services provided under the NEMT program; increases access to prenatal and postpartum health care services; reduces pregnancy-related complications; and decreases the rate of missed appointments for covered health care services.”⁸⁰

Impact of COVID-19

NEMT utilization decreased as telehealth replaced in-person visits and as health care providers cancelled nonessential appointments, according to interviewees.

Experience with Transportation Network Companies (TNCs)

Regional contracted brokers may subcontract with a TNC to provide NEMT services to Medicaid beneficiaries.⁸¹ Interviewees noted that TNCs must enroll as Medicaid providers under current rules.

HB 1576 directs HHSC to allow TNCs to participate in the NEMT program without enrolling as a Medicaid provider and bars HHSC or the regional broker from imposing additional requirements beyond those in the existing state TNC Occupations Code. By implementing these changes intended to expand TNC participation, HHSC officials report the state hopes to increase their transportation provider base, modernize the NEMT program, and more easily accommodate urgent and last-minute requests for transportation.

Performance, Challenges, and Improvement

HHSC created a centralized office to oversee NEMT, the Texas Medical Transportation Program (MTP). MTP uses on-site and desk reviews as part of its oversight of driver compliance with training requirements and criminal history checks, vehicle standards, call metrics, and quality and timeliness

of the delivery of transportation services. Corrective action plans and assessments of liquidated damages are available remedies for failure to comply with contract requirements.⁸²

Regional Contract Specialists (RCS) are located throughout the state and are responsible for ensuring that regional contracted brokers comply with terms and conditions of their contract, including vehicle maintenance and inspections and driver compliance with state and federal laws and agency rules. RCSs are also responsible for educating contracted vendors about any new or changes to existing policies.

On a quarterly basis, HHSC matches transportation claims with medical claims data and returns unmatched claims to the associated MTO to investigate for potential fraud or misuse, according to interviewees. The state also created a quality performance matrix to track and enforce quality in the transportation benefit, triggering monetary penalties against brokers when specific performance standards are not met.

Technology and Innovation

Interviewees reported that some current brokers and providers utilize GPS tracking, which has been a valuable tool, though some do not due to the expense. They also commented that mobile data terminals (MDTs), which some brokers are also using, help with real-time communication between the client, dispatcher, and driver during a trip.

Coordination with other Federally-Supported Transportation Programs

State statute requires the regions to develop coordinated human services public transportation plans.⁸³ According to interviewees, HHSC coordinates with 21 out of 36 rural transit districts (covering about 61% of counties in the state), which receive funding from the FTA and Texas Department of Transportation.

Appendix G: Fixing America's Surface Transportation (FAST) Act (Pub. L. 114-94) Section 3006(c)

(c) Coordinated Mobility.--

- 1) Definitions.--In this subsection, the following definitions apply:
 - A. Allocated cost model.--The term "allocated cost model" means a method of determining the cost of trips by allocating the cost to each trip purpose served by a transportation provider in a manner that is proportional to the level of transportation service that the transportation provider delivers for each trip purpose, to the extent permitted by applicable Federal laws.
 - B. Council.--The term "Council" means the Interagency Transportation Coordinating Council on Access and Mobility established under Executive Order No. 13330 (49 U.S.C. 101 note).
- 2) Strategic plan.--Not later than 1 year after the date of enactment of this Act, the Council shall publish a strategic plan for the Council that--
 - A. outlines the role and responsibilities of each Federal agency with respect to local transportation coordination, including nonemergency medical transportation;
 - B. identifies a strategy to strengthen interagency collaboration;
 - C. addresses any outstanding recommendations made by the Council in the 2005 Report to the President relating to the implementation of Executive Order No. 13330, including--
 - i. a cost-sharing policy endorsed by the Council; and
 - ii. recommendations to increase participation by recipients of Federal grants in locally developed, coordinated planning processes;
 - D. to the extent feasible, addresses recommendations by the Comptroller General concerning local coordination of transportation services;
 - E. examines and proposes changes to Federal regulations that will eliminate Federal barriers to local transportation coordination, including non-emergency medical transportation; and
 - F. recommends to Congress changes to Federal laws, including chapter 7 of title 42, United States Code, that will eliminate Federal barriers to local transportation coordination, including nonemergency medical transportation.
- 3) Development of cost-sharing policy in compliance with applicable federal laws.--In establishing the cost-sharing policy required under paragraph (2), the Council may consider, to the extent practicable--
 - A. the development of recommended strategies for grantees of programs funded by members of the Council, including strategies for grantees of programs that fund nonemergency medical transportation, to use the cost-sharing policy in a manner that does not violate applicable Federal laws; and
 - B. incorporation of an allocated cost model to facilitate local coordination efforts that comply with applicable requirements of programs funded by members of the Council, such as--
 - i. eligibility requirements;
 - ii. service delivery requirements; and
 - iii. reimbursement requirements.

- 4) Report.--The Council shall, concurrently with submission to the President of a report containing final recommendations of the Council, transmit such report to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate.

Endnotes

¹ National Academies of Sciences, Engineering, and Medicine. (2018). *Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination*. Washington, DC: The National Academies Press. Retrieved October 30, 2020, from: <https://www.nap.edu/catalog/25184/handbook-for-examining-the-effects-of-non-emergency-medical-transportation-brokerages-on-transportation-coordination>.

² U.S. Department of Health & Human Services. (2020). *Putting America's Health First* (Rep.). Retrieved November 4, 2020, from: <https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf>

³ 42 CFR 440.170 includes the following requirements: (ii) The broker documents that, with respect to the individual's specific transportation needs, the government provider is the most appropriate and lowest cost alternative; and (iii) The broker documents that the Medicaid program is paying no more for fixed-route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for comparable services.

⁴ The National Academies of Sciences, Engineering, and Medicine. (2018). *State-by-State Profiles for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination* (Rep.). Retrieved October 21, 2020, from: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_202_companion.pdf

⁵ This work is part of a larger MACPAC study on Medicaid NEMT being conducted in response to a request from the Senate Appropriations Committee.

⁶ Indiana Medicaid officials reported that mileage reimbursement accounts for only 2% of utilization among the population enrolled in FFS, citing a burdensome application the driver must complete and other barriers. FSSA modified the application process in August 2020, hoping to increase gas mileage reimbursement where appropriate. Most Medicaid beneficiaries in Indiana are enrolled in managed care organizations, which are responsible for their members' NEMT and may have different rules about mileage reimbursement.

⁷ Risk Arrangement indicates whether an entity is financially responsible for changes in trip volume and costs. An MCO or broker receiving capitated, per-member-per-month payments is considered "at risk." A state that pays directly for transportation services or pays a broker on a per-ride basis is "at risk."

⁸ Exception: NEMT is administered by the state in one region.

⁹ Other divisions of CMS are involved with potential NEMT policy changes. The State Demonstrations Group makes decisions about state requests to remove the NEMT benefit through Section 1115 demonstration authority and is currently developing monitoring and evaluation requirements for such demonstrations.

¹⁰ Centers for Medicare & Medicaid Services (CMS). (2020). *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*. Retrieved October 22, 2020, from: <https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf>

¹¹ Medicaid and CHIP Payment and Access Commission (MACPAC). (2019). *Medicaid Coverage of Non-Emergency Medical Transportation* (Issue brief). Retrieved October 21, 2020, from: <https://www.macpac.gov/wp-content/uploads/2019/05/Medicaid-Coverage-of-Non-Emergency-Medical-Transportation.pdf>

¹² CMS. (2016). *Medicaid Non-Emergency Medical Transportation Booklet for Providers*. Retrieved October 22, 2020, from: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>

¹³ MACPAC. (2019). *Medicaid Coverage of Non-Emergency Medical Transportation* (Issue brief). Retrieved October 21, 2020, from: <https://www.macpac.gov/wp-content/uploads/2019/05/Medicaid-Coverage-of-Non-Emergency-Medical-Transportation.pdf>

¹⁴ The Section 5311 Program provides capital, planning, and operating assistance to states and federally recognized Indian tribes to support public transportation in rural areas with populations less than 50,000, where many residents often rely on public transit to reach their destinations. It also provides funding for state and national training and technical assistance through the Rural Transportation Assistance Program.

¹⁵ U.S. Department of Transportation, Federal Transit Administration. (n.d.). *Fact Sheet: Formula Grants for Rural Areas*. Retrieved October 21, 2020, from:

<https://www.transit.dot.gov/sites/fta.dot.gov/files/docs/funding/grants/40621/5311-rural-program-fact-sheet-fast.pdf>

¹⁶ Social Security Act, 42 U.S.C. §1902(a)(70)(B)(iv). Retrieved October 21, 2020, from:

https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

¹⁷ 42 CFR §440.170(a)(4)(ii). Retrieved October 21, 2020, from: <https://www.law.cornell.edu/cfr/text/42/440.170#>

¹⁸ 12 states (AZ, CT, FL, GA, ID, MI, MO, RI, TN, TX, VA, WI) currently authorize the use of TNCs; CA uses TNCs in their NMT program; MA and IN are in the process of enrolling TNCs.

¹⁹ Lyft reports that AZ, CA, DC, FL, GA, IN, MI, MO, NH, NY, OH, SC, TN, VA have incorporated and launched TNCs into their NEMT programs. In addition, TX recently passed a bill authorizing the use of TNCs, and IL currently allows TNCs under a waiver in response to the COVID-19 pandemic.

²⁰ TNCs may be operating directly for brokers without official Medicaid authorization.

²¹ Arizona Health Care Cost Containment System (AHCCCS). (2019). Notice of Public Information - Public Notice. Retrieved October 21, 2020, from:

<https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/TNCPublicNotice050119revised.pdf>

²² 86th Legislature. (2019). TX H.B. 1576. Retrieved October 21, 2020, from:

<https://legiscan.com/TX/text/HB1576/id/2027756>

²³ Nonemergency Transportation Services Under Medical Transportation Program. Texas Government Code, Sec. 531.02414. Retrieved October 21, 2020, from:

https://texas.public.law/statutes/tex.gov/t_code_section_531.02414

²⁴ Connecticut Department of Social Services. (2017). Non-Emergency Medical Transportation (NEMT) Frequently Asked Questions and Answers. Retrieved October 21, 2020, from: <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Non-Emergency-Medical-Transportation/FAQ-for-NEMT-Documents-Final-for-Posting-12-4-17.pdf?la=en>

²⁵ Lyft. (2020). *Modernizing Medical Transportation with Rideshare* (Rep.). Retrieved October 21, 2020, from:

<https://pages.questexnetwork.com/rs/294-MQF->

[056/images/Lyft%20fiercehealthcare%20white%20paper%20August%202020_01.pdf](https://pages.questexnetwork.com/rs/294-MQF-056/images/Lyft%20fiercehealthcare%20white%20paper%20August%202020_01.pdf)

²⁶ Ibid.

²⁷ Ibid.

²⁸ Connecticut Department of Social Services. (2017). Non-Emergency Medical Transportation (NEMT) Frequently Asked Questions and Answers. Retrieved October 21, 2020, from: <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Non-Emergency-Medical-Transportation/FAQ-for-NEMT-Documents-Final-for-Posting-12-4-17.pdf?la=en>

²⁹ United States Department of Transportation. (2020). Coordinating Council on Access and Mobility (CCAM).

Retrieved October 21, 2020, from: <https://www.transit.dot.gov/coordinating-council-access-and-mobility>

³⁰ Section 3006(c) of the Fixing America's Surface Transportation (FAST) Act (Pub. L. 114-94) requires the CCAM to improve Federal coordination of transportation services for people with disabilities, older adults, and individuals of low income and also requires CCAM to publish a strategic plan that includes recommendations for statutory or regulatory changes to eliminate barriers to coordination.

³¹ Coordinating Council on Access and Mobility (CCAM). (2020). *Coordinating Council on Access and Mobility Report to the President* (Rep.). Retrieved October 21, 2020, from:

<https://www.transit.dot.gov/sites/fta.dot.gov/files/2020-09/CCAM-Report-to-the-President.pdf>

³² Massachusetts Human Service Transportation Office. (n.d.). Human Service Transportation. Retrieved October 21, 2020, from

<https://www.mass.gov/human-service-transportation>

³³ Commonwealth of Massachusetts Executive Office of Health and Human Services, Human Transportation Office, Request for Responses for Non-Emergency Human Transportation Broker Services, November 25, 2019; Retrieved November 30, 2020 from:

<https://www.commbuys.com/bsa/external/bidDetail.sdo;jsessionid=04B5F6A54308CC4D545BC71CACED66B6.wor ker1?bidId=BD-20-1039-EHS01-EHS01-46229&parentUrl=activeBids>.

³⁴ A state's NEMT methodology could build a capital component (e.g., vehicle depreciation) into the trip payment, but Medicaid cannot buy a vehicle outright.

- ³⁵ MTAC advocates for the benefits of NEMT to elected officials. The study found total ROI of NEMT for all three conditions and treatments per 30,000 members per month is more than \$40 million, and 58 percent of nearly 1,000 beneficiaries reported that they would not be able to go to their medical appointment without NEMT.
- ³⁶ Medical Transportation Access Coalition (MTAC). (n.d.). *The Value of Medicaid's Transportation Benefit: Results of a Return on Investment Study*. Retrieved October 21, 2020, from Medical Transportation Access Coalition website: <https://mtacoalition.org/wp-content/uploads/2018/08/MTAC-NEMT-ROI-Slide-Deck-.pdf>
- ³⁷ Indiana's and Iowa's evaluations of the impact of excluding NEMT for the Expansion populations under Section 1115 waivers found that members without NEMT coverage were not more likely to miss appointments than members with NEMT benefit; unmet need for transportation is associated with reduced use of certain types of care including well visits; individuals with lower incomes may be more likely to experience transportation-related barriers to access regardless of whether or not they have an NEMT benefit; and awareness and use of the NEMT benefit is low, even among individuals who have the benefit.
- ³⁸ Buderer, K. (2017). Preliminary Findings from Evaluations of Medicaid Expansion Under Section 1115 Waivers. In *Medicaid and CHIP Payment and Access Commission*. Retrieved November 4, 2020, from: <https://www.macpac.gov/wp-content/uploads/2017/04/Preliminary-Findings-from-Evaluations-of-Medicaid-Expansions-Under-Section-1115-Waivers.pdf>
- ³⁹ The Center for Health Law and Policy Innovation of Harvard Law School, & Lung Cancer Alliance. (2019). *Non-Emergency Medical Transportation: Past, Present, and Future of a Critical Service* (Issue brief). Retrieved November 4, 2020, from: https://www.chlpi.org/wp-content/uploads/2013/12/Non-EMT-Transportation_Issue-Brief-3_April-2019.pdf
- ⁴⁰ The Lewin Group. (2016). *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver* (Rep.). Retrieved November 4, 2020, from: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-eval-rpt-11022016.pdf>
- ⁴¹ AIAN beneficiaries cannot be mandatorily enrolled in managed care but can choose to enroll on a voluntary basis.
- ⁴² CMS. (2019). Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.). Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>
- ⁴³ Arizona Health Care Cost Containment System (AHCCCS). (n.d.). AHCCCS Medical Policy Manual (AMPM). Retrieved October 21, 2020, from: <https://www.azahcccs.gov/shared/MedicalPolicyManual/>
- ⁴⁴ HMA Information Services. (n.d.). AZ AHCCCS Contract Amendments, 2020. Retrieved November 04, 2020, from: <https://hmais.healthmanagement.com/arizona/az-ahcccs-contract-amendments-2020/>
- ⁴⁵ CMS. (2019). Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.). Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>
- ⁴⁶ Connecticut. (n.d.). *Connecticut Purchase of Service Contract with Total Transit, Contract Number: 17DSS1203HC*. Retrieved October 21, 2020, from: <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Contracts/MED--Medicaid/17DSS1203HC-Total-Transit-Executed-Contract.pdf?la=en>
- ⁴⁷ IDPs are required to meet or exceed all applicable requirements under state and federal law and any CMS requirements, complete training specific to the transportation needs of Medicaid members (including ADA Sensitivity, Cultural Competency, CPR/First Aid, HIPAA, Blood-borne Pathogens and Defensive Driving), and undergo multistate background checks. (Connecticut Department of Social Services. (2017). Non-emergency Medical Transportation (NEMT) Frequently Asked Questions and Answers. Retrieved from: <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Non-Emergency-Medical-Transportation/FAQ-for-NEMT-Documents-Final-for-Posting-12-4-17.pdf?la=en>)
- ⁴⁸ Geragosian JC and Kane RJ. Auditors of Public Accounts. (2019). Performance Audit: Connecticut Department of Social Services and Veyo Non-Emergency Medical Transportation. Retrieved October 21, 2020, from: <https://wp.cga.ct.gov/apa/wp->

[content/cgacustom/reports/performance/PERFORMANCE_Department%20of%20Social%20Services%20and%20Voy%20Non-Emergency%20Medical%20Transportation_20200219.pdf](#)

⁴⁹ Connecticut. (n.d.). *Connecticut Purchase of Service Contract with Total Transit, Contract Number: 17DSS1203HC*. Retrieved October 21, 2020, from: <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Contracts/MED--Medicaid/17DSS1203HC-Total-Transit-Executed-Contract.pdf?la=en>

⁵⁰ The Americans with Disabilities Act (ADA) requires public transit agencies that provide fixed-route service to provide “complementary paratransit” service to people with disabilities who cannot use the fixed-route bus or rail service because of a disability. (The National Aging and Disability Transportation Center (NADTC)).

⁵¹ Interviewees noted that managed care organizations provide some transportation to their members as ‘value-added’ services, but DCH does not plan to carve NEMT into managed care at this time.

⁵² CMS. (2019). *Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.)*. Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>

⁵³ [Policies and Procedures for Non-Emergency Medical Transportation \(NEMT\)](#) Section 100.1

⁵⁴ [Policies and Procedures for Non-Emergency Medical Transportation \(NEMT\)](#) Sections 400.11 and 100.2

⁵⁵ [Policies and Procedures for Non-Emergency Medical Transportation \(NEMT\)](#) (Section 100.1)

⁵⁶ Burns & Associates, Inc. (2019). *Independent Assessment of Indiana's Non-Emergency Medical Transportation Benefit in the Medicaid Fee-For-Service Program (Rep.)*. Retrieved October 22, 2020, from:

https://www.in.gov/fssa/ompp/files/Independent_Assessment_of_Delivery_of_NEMT.pdf

⁵⁷ Previously, the member was responsible for calling and scheduling a trip with the NEMT provider. Under the broker arrangement, the member calls the broker, who is responsible for scheduling and managing the trip for the member.

⁵⁸ CMS. (2019). *Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.)*. Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>

⁵⁹ IN Hoosier Healthwise MCO Contracts, CY 2019. (n.d.). Retrieved October 21, 2020, from:

<https://hmais.healthmanagement.com/indiana/in-hoosier-healthwise-mco-contracts-cy-2019/>

⁶⁰ IN Hoosier Healthwise MCO Contracts, CY 2019. (n.d.). Retrieved October 21, 2020, from:

<https://hmais.healthmanagement.com/indiana/in-hoosier-healthwise-mco-contracts-cy-2019/>

⁶¹ Indiana Medicaid. (n.d.). *Indiana Health Coverage Programs (IHCP) Provider Enrollment, 26-Transportation Provider*. Retrieved October 21, 2020, from: <https://www.in.gov/medicaid/providers/564.htm>

⁶² Burns & Associates, Inc. (2019). *Independent Assessment of Indiana's Non-Emergency Medical Transportation Benefit in the Medicaid Fee-For-Service Program (Rep.)*. Retrieved October 22, 2020, from:

https://www.in.gov/fssa/ompp/files/Independent_Assessment_of_Delivery_of_NEMT.pdf

⁶³ HMA Information Services. (n.d.). *IN Hoosier Care Connect Managed Care RFP, Proposals, Awards, and Related Documents, 2019-20*. Retrieved November 04, 2020, from: <https://hmais.healthmanagement.com/indiana/in-hoosier-care-connect-managed-care-rfp-oct-19/>

⁶⁴ HMA Information Services. (n.d.). *IN Hoosier Healthwise MCO Contracts, CY 2019*. Retrieved November 04, 2020, from: <https://hmais.healthmanagement.com/indiana/in-hoosier-healthwise-mco-contracts-cy-2019/>

⁶⁵ HMA Information Services. (n.d.). *IN Healthy Indiana Plan (HIP) MCO Contract Amendments, CY 2019*. Retrieved November 04, 2020, from: <https://hmais.healthmanagement.com/indiana/in-hip-mc-contract-amendments-apr-19/>

⁶⁶ Massachusetts Human Service Transportation Office. (n.d.). *Human Service Transportation*. Retrieved October 21, 2020, from: <https://www.mass.gov/human-service-transportation>

⁶⁷ Due to its daily volume and structured start and end times, program-based transportation to Day Habilitation and Early Intervention services are bid out per route (as opposed to a per trip basis). According to Massachusetts state officials, this allows for efficient route development, adherence to program start times, and in most cases allows for continuity in transportation vendor for the member. Payment of the Brokers’ average trip cost is made per every trip provided.

- ⁶⁸ CMS. (2019). Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.). Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>
- ⁶⁹ The National Academies of Sciences, Engineering, and Medicine. (2018). *State-by-State Profiles for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination* (Rep.). Retrieved October 21, 2020, from: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_202_companion.pdf
- ⁷⁰ Ibid.
- ⁷¹ CommBuys. (n.d.). Bid Solicitation: BD-20-1039-EHS01-EHS01-46229. Retrieved October 21, 2020, from: <https://www.commbuys.com/bsol/external/bidDetail.sdo;jsessionid=04B5F6A54308CC4D545BC71CATED66B6.wor ker1?bidId=BD-20-1039-EHS01-EHS01-46229&parentUrl=activeBids>
- ⁷² The National Academies of Sciences, Engineering, and Medicine. (2018). *State-by-State Profiles for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination* (Rep.). Retrieved October 21, 2020, from: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_202_companion.pdf
- ⁷³ CommBuys. (n.d.). Bid Solicitation: BD-20-1039-EHS01-EHS01-46229. Retrieved October 21, 2020, from: <https://www.commbuys.com/bsol/external/bidDetail.sdo;jsessionid=04B5F6A54308CC4D545BC71CATED66B6.wor ker1?bidId=BD-20-1039-EHS01-EHS01-46229&parentUrl=activeBids>
- ⁷⁴ Ibid.
- ⁷⁵ 86th Legislature. (2019). TX H.B. 1576. Retrieved October 21, 2020, from: <https://legiscan.com/TX/text/HB1576/id/2027756>
- ⁷⁶ CMS. (2019). Medicaid Managed Care Enrollment and Program Characteristics, 2017 (Rep.). Retrieved October 21, 2020, from: <https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf>
- ⁷⁷ Among demand-response trips, taxis/vans make up the majority (60-90%) depending on the region, with higher utilization in urban areas. Mileage reimbursement requests make up the remaining 10-30% of trips, with the highest utilizers in rural areas.
- ⁷⁸ According to state regulations, Advanced Plus Program funds are for clients through age 20 and Children with Special Health Care Needs services program clients age 21 and over who have been diagnosed with cystic fibrosis.
- ⁷⁹ Texans Care for Children, & United Ways of Texas. (n.d.). *Ensure More Texas Mothers and Babies are Healthy by Streamlining Medical Transportation Options for New Moms*. Retrieved October 21, 2020, from: <https://static1.squarespace.com/static/5728d34462cd94b84dc567ed/t/5cb0b5794785d340b6a07509/1555084665371/HB25-one-pager.pdf>
- ⁸⁰ Texas Constitution and Statutes. (n.d.). Government Code: Title 4. Executive Branch, Subtitle I. Health and Human Services, Chapter 531. Health and Human Services Commission, Subchapter A. General Provisions; Organization of Commission. Retrieved October 21, 2020, from: <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm>
- ⁸¹ Texas Public Law. (2020). Sec. 531.02414 Nonemergency Transportation Services Under Medical Transportation Program. Retrieved October 21, 2020, from: https://texas.public.law/statutes/tex.gov/t_code_section_531.02414
- ⁸² Gordon, F. (2016). *Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults. Justice in Aging*. Retrieved from: <https://www.justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf>
- ⁸³ Justia US Law. (n.d.). 2005 Texas Transportation Code CHAPTER 461. Statewide Coordination of Public Transportation. Retrieved October 21, 2020, from: <https://law.justia.com/codes/texas/2005/tn/006.00.000461.00.html>