NON-EMERGENCY MEDICAL TRANSPORTATION

A Vital Lifeline for a Healthy Community

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1/7/2014

National Conference of State Legislatures

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Approximately 3.6 million Americans miss or delay medical care because they lack appropriate transportation to their appointments. Many low-income Americans lack the disposable income necessary to have access to a working automobile, and may lack public transit options to get to and from medical appointments. Medicaid provides a non-emergency medical transportation benefit that pays for the least costly and appropriate way of getting people to their appointments whether by taxi, van, public transit, or mileage reimbursement.

This brief provides an overview of the differing ways states are dealing with the increase in individuals who need transportation to medical services, due to age, chronic conditions or income. It is intended to provide guidance for state lawmakers to consider the vital role transportation plays in positive health outcomes for citizens.

The Increasing Need for Non-Emergency Medical Transportation Services

Medicaid funds are the single largest transfer of federal money to states, representing an average of 44 percent of all federal revenue received. The transportation component is about $3 billion of that yearly fund transfer, comprising less than 1 percent of total Medicaid expenditures. Though a small percentage of Medicaid overall, consistent transportation access to healthcare helps enhance the medical outcomes of Medicaid recipients and lead to cost-savings.

With more medical care provided on an outpatient basis, and an increasing number of people with chronic conditions, trips to medical appointments are the lifeblood of a sustainable healthcare system. Non-emergency medical transportation (NEMT) provides trips to and from scheduled medical appointments, return trips from hospital emergency rooms and transfers between hospitals for individuals without access to transportation. By providing consistent and efficient access to medical appointments, states can save money by helping these individuals avoid costly ambulance trips or emergency room visits.

Medicaid Expansion

Under the Affordable Care Act, the population of people eligible for Medicaid is expanding. Based on projections from the 25 states where coverage expansion is underway, it is estimated that 9 million individuals will be added to the Medicaid program; Medicaid and the Children’s Health Insurance Program (CHIP) have over 6 million new enrollees as of April 30, 2014. Because the expansion includes people who are 133 percent of the

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4 Ibid.
federal poverty rate, they are expected to have relatively fewer NEMT transportation needs. A study from the Transportation Research Board estimates that only 270,000 new enrollees will require NEMT, which nevertheless could potentially strain systems in some states.  

_Providing Health Care Access_

Non-emergency medical transportation is essential for disadvantaged Medicaid recipients, those who are older, or have disabilities or low incomes who have no transportation to access healthcare services.

Medicaid recipients who own a car or can provide their own transportation may receive travel service reimbursement for costs related to getting to their care, including gasoline, car maintenance or repair, cost of vehicle modifications for adaptive technologies and other financial stipends to support ongoing transportation needs. For those who are unable to provide their own transportation, whether due to income, age or disability, other methods of NEMT service delivery are necessary.

_Growth of Chronic Conditions_

Many individuals with chronic conditions which include arthritis, asthma, cancer, cardiovascular disease, chronic obstructive pulmonary disease and diabetes need medical services frequently. Treatment of chronic conditions, account for three-quarters of all U.S. healthcare spending. As of 2009, the Centers for Disease Control estimate that 78 percent of the adult population age 55 and older has at least one of these chronic conditions. Additionally, estimates predict that states will add over half a million adults who have serious behavioral health issues that impair their everyday functioning to the Medicaid population. These people will need NEMT to access life sustaining treatments and health care services.

For the nearly 20 million adults with chronic kidney disease who are undergoing dialysis three times a week, NEMT is a reliable way to get to appointments and avoid going to the emergency room if appointments are missed. Sixty-six percent of dialysis patients rely on others for transportation to their appointments, only 8 percent relied on public transportation or taxi services, and 25.3 percent drove or walked to the clinic themselves. A recent study examining Florida’s NEMT costs found that if one percent of total medical trips resulted in avoiding an emergency room visit, the state could save up to $11 for each dollar spent in non-emergency medical transportation.  

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**State Solutions to Increasing Need for Non-Emergency Medical Transportation**

*Coordinating Human Transportation Services can Reduce One-Purpose NEMT Trips*

One strategy for NEMT cost savings is to coordinate medical trips with other community transportation providers who are serving similar populations. However, few states have successfully coordinated their Medicaid trips with their entire transportation network. This may be due to differing service standards for ADA paratransit and NEMT, differing requirements for drivers of transit and NEMT, jurisdictional issues or restrictive interpretations of federal regulations.

In what has developed as a complex and often fragmented system, transportation services can be difficult to understand, access and navigate for users. Public and private agencies that administer or refer clients to human service transportation programs may have different goals and serve different populations. These agencies also receive funds from different sources, each of which comes with its own rules and restrictions. Eligibility and accountability standards, vehicle needs, operating procedures, routes and other factors also may vary greatly across organizations. At the local level, programs can differ across city or county boundaries. The large number, diversity and dispersion of coordinated transportation programs can lead to underutilization of resources, inconsistent safety standards, customer inconvenience and inadequate transportation service.

Services can overlap in some areas and be entirely absent in others. Funding shortfalls, policy and implementation failures and lack of coordination can leave many who need transportation with few or no options. The result is that many who need transportation to access essential services and to participate in community activities may be left unserved or underserved. Fortunately, technology developments related to coordination and mobility management have helped maximize resources by successfully managing eligibility standards and shared rides with multiple funding sources.

Yet, in many states, one of the largest human services transportation providers does not have a seat at the coordination table. State Medicaid agencies provide a substantial proportion of NEMT rides to populations that would benefit from coordinated transportation, however, with Medicaid regulations against self-referrals, barriers to effective coordination exist. The Medicaid rules on governmental brokerages provide that if, after winning the competitive bid, a governmental entity provides a brokerage service, the brokerage must be a distinct governmental unit, and it could not be paid for costs other than those unique to the brokerage function.

Additionally, the administrative burden for governmental brokerages is high. For every ride provided through another governmental entity, the broker must provide assurances that sending someone on a state or local transportation service was the most appropriate, effective and lowest cost. In addition, for each individual transportation service, the broker must document that the Medicaid program is not paying more than the rate

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charged to the general public. The rules were proposed so that state and local bodies would play on an equal playing field as private entities; however, they may be preventing effective coordination with other agencies because of administrative hurdles.

Because of the complexity of Medicaid NEMT regulations for eligibility and prohibitions on self-referrals, many Medicaid agencies prefer to put the obligation of complying with regulations on a private broker instead of risking losing their funding because of non-compliance.

Some states are finding ways to coordinate their Medicaid transportation with other agencies. Eighteen states coordinate with the Medicaid agency at some level by having them on the state coordinating council. In three states—Kentucky, Massachusetts and Vermont—non-emergency transportation is fully embedded in their coordinated transportation approach. In Vermont, rides are coordinated through the Vermont Public Transportation Association (VPTA), which is composed of non-profits, municipalities, para-transit providers and members of the general public. VPTA has a contract with the Agency of Human Services, and facilitates coordinated transportation services between nine public transportation providers using fixed route, demand response, taxis and volunteer driver services. VPTA also has recently partnered with a technology provider to increase its transit agencies’ scheduling and dispatching efficiencies and reporting capabilities.

Twenty-eight states do not coordinate transportation with their Medicaid agency at all, because they do not have a state coordinating council. This means that several agencies which are facilitating rides in one neighborhood may be sending a separate vehicle to a disabled veteran, a Medicaid patient, and someone who needs ADA paratransit, who all live a block from one another.

To combat these problems, governmental bodies, human service organizations and transportation planners have advocated improved coordination among human service agencies, providers of public transit and specialized transportation services and other stakeholders. This process, called human services transportation coordination, generally means better resource management, shared power and responsibility among agencies and shared management and funding. When key entities work together to jointly accomplish their objectives, they can achieve more effective, efficient and accessible transportation options for those who need it most: effective, in that they get people where they're going; efficient, in that they use public dollars economically; and accessible, in that services are easy for travelers to navigate and use.

Although coordination of transportation services can benefit more than just the NEMT population, many Medicaid agencies contract out their transportation services. The contract typically does not include a requirement to coordinate with other state transportation agencies, creating a barrier for efficient use of state transportation funding and effective service for underserved populations. Opportunities exist for states to coordinate services with Medicaid agencies to maximize efficient transportation funding.

**Mobility Management for NEMT Trips**

Some communities are utilizing Mobility Management in an attempt to better coordinate transportation options. Mobility Management is administered by transit agencies in some communities to improve network

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efficiencies, for example, through the utilization of a one-call one-click scheduling systems. Other communities utilize staff at human service organizations, such as Aging and Disability Resource Centers, as mobility managers to assist individuals to find the best transit options or provide instruction to people with disabilities on how to use public transit.

State Non-Emergency Transportation Delivery Options

After Congress passed the Deficit Reduction Act of 2005 (DRA), states had more options to deliver their non-emergency medical transportation. The DRA allowed states more flexibility in how they deliver NEMT, without requiring a burdensome administrative waiver process. All states are required to submit a plan to the Centers for Medicare & Medicaid Services (CMS) detailing how they will provide NEMT services and how it will be reimbursed—as either an administrative cost or a medical cost.

Requirements for NEMT under Medicaid regulations:

- Available in all political subdivisions of the state
- Provided with reasonable promptness to all eligible individuals
- Provided to all individuals in the same amount, duration, and scope
- Recipients must be allowed the “freedom of choice” of their transportation provider

Administrative Cost vs. Medical Cost

States can claim NEMT as either an administrative cost or a medical cost when submitting their state plans to the Centers for Medicare & Medicaid Services.  

When a state submits a request for administrative expenses, the amount of money reimbursed from federal medical assistance percentage (FMAP) is typically less, but the amount of cumbersome paperwork required for reimbursement is reduced as well.  

Submitting NEMT as an administrative cost also negates the requirement for a state to allow users “freedom of choice,” meaning that the state can direct NEMT users to specific providers, which could lower costs for service delivery. States providing NEMT as a medical service are eligible for a greater FMAP reimbursement, depending on the state’s per capita income and other factors. There are considerably more administrative costs to consider, and the freedom of choice of provider requirement requires states to be more flexible in the transportation providers they use, which might lead to increased costs.

Because of the administrative burden, many states submit NEMT as a line item in their overall administrative costs, creating barriers for CMS to analyze data on the prevalence of service delivery modes and their relative

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15 As of 2003, 25 states and the District of Columbia submitted their NEMT as a medical expense, 12 states submitted parts of NEMT as both an administrative expense and a medical expense, and 13 states submitted their NEMT costs as an administrative expense.
16 FMAP varies by state based on criteria such as per capita income. The regular average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82%). FMAPs are adjusted for each state on a three-year cycle to account for fluctuations in the economy.
effectiveness for health outcomes. These modes of delivery include brokerages, fee-for-service, public transit, managed care organization or a mixture of two or more of the above.\textsuperscript{17}

\textbf{MODES OF SERVICE DELIVERY}

\textit{Brokerages}

Following the DRA, many states chose to implement a brokerage system, where either a private company or a state agency connects riders with transportation providers in the most efficient and cost-effective way. Regulations for brokerages in states that submit their plan as a medical expense are contained in the other medical care regulations, 42 CFR 440.170. Requirements for brokerages include:

- Proof of cost-efficiency
- Competitive procurement process when selecting broker
- Procedures for auditing and overseeing brokerage for quality
- Brokerage will comply with the prohibition on self-referrals

Brokers confirm the Medicaid beneficiary’s medical eligibility, and then assure their trip is to an approved Medicaid destination and that they are receiving a medically necessary service. Brokers also confirm that the transportation provider has the proper licensing and safety inspections to confirm eligibility before contracting for services. Once the broker contracts with the eligible companies, they schedule eligible Medicaid beneficiaries’ transportation through one of the approved providers. Many brokers have leveraged industry technologies to facilitate trips with providers efficiently and effectively. States using a private broker can pass these responsibilities to the broker, and compensate them on a capitated, per-Medicaid beneficiary basis. Capitated payments are a common Medicaid payment where the rate of payment is based on the number of people served, not the amount of service that each individual receives.

Because of the restriction on self-referral, which creates administrative barriers for state agencies to broker transit services, a reduction in coordination of NEMT services with other community transportation options has arisen. This leads to inefficient use of transportation resources and poor service for users.

Many states use the broker model to keep costs consistent and predictable year-to-year, and to limit their liability and administrative costs when dealing with Medicaid regulations. In some states, a mixed model is used, oftentimes with brokerages in more populated areas and fee-for-service in less-populated areas. Colorado, Michigan, New York and Texas all have mixed models of NEMT service.

\textit{Public Brokerage}

Some states broker rides for individuals through a state agency. This presents a unique issue, because one of the requirements for brokers is that they comply with requirements related to prohibitions on referrals and conflict of interest. If a public agency is brokering rides using a public transportation provider, there are hurdles to providing the service.

State agencies that want to run a brokerage service must insulate the broker service from the rest of the agency budget. For example, a transit agency may be well positioned to provide a broker service because their employees are the most knowledgeable about the public transit system and the connections that a rider could make in order to get to their appointment. This employee would need to be separated from the transit agency and placed into a new brokerage with a separate salary that could not share any funds from the public transit agency’s budget. Once the employee is a separate brokerage employee, documenting the transit agency’s cost and cost-effectiveness for competitive bidding becomes more complex, as overhead numbers need to be parsed from other operating expenses. This creates a barrier for effective, efficient coordination between state agencies and non-emergency medical transportation being provided through existing state, regional and local transportation resources.

However, in rural areas, waivers are available for places where procuring a private broker is not feasible.

**Private Brokerage**

Since 2001, the number of states that are using some sort of brokerage has increased from 29 to 40. It is one of the most popular ways that states provide their Non-Emergency Medical Transportation.

States that deliver NEMT through a private brokerage use a competitive bidding process to procure a private for-profit company to work as an intermediary between transportation providers and eligible riders. States usually pay capitated payments to the broker for each eligible rider. This is the most common form of brokerage because it provides financial certainty that the state will only pay a set amount to a broker each year, instead of facing variable costs from using their own brokerage. A capitated rate provides an incentive for the provider to streamline its operations—for example, by providing automated call-out reminders of upcoming rides and automating the billing import and export process to lower operating costs.

States using this method should be aware of certain contract provisions that may not benefit the Medicaid agency or the users in the long run. For example, in Milwaukee, Wisc., the broker and state entered into a contract with a stop-loss clause, where if the broker provided more assistance than they were getting paid to do under the contract, the broker could cancel the contract. With the expanded Medicaid population, the broker was negotiating more rides than the contract called for and canceled the contract, leaving Milwaukee NEMT users stranded until another provider could be procured.

**Mix of Brokerage and Fee for Service**

In some states where there are concentrated urban areas and sparsely populated rural regions, a mixture of brokered services and fee for service models are used. Other states that have more dispersed populations use regional brokers to provide rides, and people outside those regions use fee-for-service modes. Under this model, the regional Medicaid agency contracts with a broker with a capitated contract, keeping costs stable for the regions that may have larger populations. By apportioning resources to the populated regions, the state agency can focus the rest of their resources on providing trips on a fee-for-service basis.

**Fee for Service**
Under this model, local and regional state-run Medicaid agencies handle all eligibility, trip authorization and trip arrangements. States have a centralized intake for trip requests and then assign trips to registered providers at either a regional or local level.

Transportation providers submit reimbursement requests to the agency, which pays for the service used. This model leaves the cost for transportation variable year-to-year, which may be difficult to budget for yearly.

**Public Transit**

In some states, public transportation is readily available to Medicaid recipients. In these states, Medicaid agencies almost exclusively rely on public transportation to provide NEMT and the agency reimburses the user for their trip. Some communities are utilizing mobility management administered by transit agencies to improve network efficiencies, through things like one-call one-click scheduling systems. If public transportation is not available, the agency focuses on personal transportation options.

**Managed Care**

One of the newest delivery models is a managed care model, where transportation delivery is part of the responsibility of the managed care provider or insurance firm that offers the covered Medicaid services. Typically, the state offers a capitated payment per enrolled individual over a period of time. This model aligns the incentive to care for patients in the most cost-effective way with the financial incentive for better outcomes by having the insurance company pay for the consequences of missed appointments and decreased health outcomes. This method is aligning incentives for better care with the entity that would be paying the price for inadequate service.

**Innovations through Managed Care Organizations**

In 2014, Oregon and Florida both modified the way they provide NEMT. Oregon recently put regulations in place that require the Coordinated Care Organizations (CCOs) to provide non-emergency medical transportation. The regulations state that when the healthcare authority “provides a CCO with a global budget that includes funds to provide NEMT services for its members, the CCO shall provide NEMT services to its members,” and that “all transportation services must be coordinated through the member’s CCO or the CCO’s designated transportation provider.” Because the healthcare authority will be paying a global fee for each patient, “reimbursement is a matter between the CCO and its transportation providers.”

In 2011, the Florida Legislature established the Managed Medical Assistance program. As part of the program, it required Managed Care Organizations (MCO) to provide covered services, including NEMT, except for those who are “excluded from participating in managed care, authorized to voluntarily opt out of managed care, or have not yet enrolled in managed care.” Those who are not participating in managed care will continue to receive

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NEMT through Florida’s Commission for the Transportation Disadvantaged (CTD). This dual strategy minimizes the number of rides provided by the CTD and puts more emphasis on the MCOs to provide transportation.

**Other Strategies to Mitigate NEMT Rides: Technology and Disease Management Education**

States can minimize the number of patients who need NEMT by utilizing new telehealth technology, sending community health workers to people’s homes to deliver healthcare and providing training for those with chronic diseases so they can better manage their conditions.

**Telehealth**

*Telehealth* is defined as “the use of technology to deliver health care, health information or health education at a distance.” 20 The two types of telehealth applications are real-time communication and store-and-forward. Real-time communication allows patients to connect with providers via video conference, telephone or a home health monitoring device, while store-and-forward refers to transmission of data, images, sound or video from one care site to another for evaluation. New telehealth technology can reduce the number of people who need rides to routine medical appointments by allowing people to have their checkups at home.

For example, in Colorado, where most of the population and health care providers are located along the Fort Collins/Denver/Colorado Springs corridor, those who live in other areas of the state face long drives to access healthcare. 21 By using telehealth, nearly 200 hospitals, clinics and behavioral health centers in rural areas of Colorado and nearby western states have connected through high-speed broadband into the Colorado Telehealth Network since 2008.

**Community Health Workers**

*Community healthcare workers*, who can travel to many patients’ homes daily, may also reduce the need for in-person medical care at a doctor’s office. 22 Their trips may be optimized through the use of a computer program to help them get to as many patients as possible in one day for maximum efficiency.

Community health workers are especially useful in rural areas where accessing a doctor requires a day or more of travel. In Alaska, remote villages and small populations do not support having a year-round physician, so local health workers were trained in primary care. 23 The local community health workers work remotely with a physician who may only visit the village once or twice a year. This helps people who otherwise would have little to no healthcare access receive check-ups and care without traveling by boat or airplane to a physician’s office.

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DISEASE MANAGEMENT EDUCATION

A third strategy to help people more effectively manage their health and reduce the need for NEMT is to teach them how to self-manage their chronic conditions. Chronic Disease Self-Management Education (CDSME) programs teach adults with chronic conditions how to better manage their chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS, chronic pain, and depression. These programs are supported by the U.S. Administration on Aging (AoA) and are active in 22 states, with 11 more currently rolling out pilot programs. The AoA supports CDSME programs through grants to states since 2003. States can use these funds to develop an infrastructure to deliver these disease management education programs in their communities. Five programs are available online, removing the need for transportation to attend the in-person classes held over six weeks.

Currently, there are thousands of non-profit organizations working together to help citizens learn how to handle their chronic conditions. However, many non-profit organizations have not added medical transportation as a curriculum component. Opportunities exist for states to incentivize these groups to add mobility as part of their chronic disease management education.

Vermont uses its NEMT funding to serve dual purposes for chronic care management. The state holds its chronic care management classes next to the physician’s office, where patients can go to their regularly scheduled appointment and then go to chronic care management class. By combining patients’ appointments into one trip, Vermont cost-effectively allocates scarce funding to provide two services in one trip.

By utilizing new technology for telehealth, sending community health workers to people’s homes to deliver healthcare services and providing training on how best to manage their diseases, states can reduce the number of people who need to physically show up for their appointments. This will help minimize overall NEMT spending and allow states to focus on people who have the highest need for service: those with behavioral health issues, those on dialysis and chemotherapy patients.

Conclusion

States will continue to make adjustments to their Medicaid programs in response to changes from the Affordable Care Act. Opportunities for cost savings through NEMT programs and other new technologies must be included in the conversation on how states can cost-effectively provide transportation services to achieve better health outcomes.