



# Medicaid Transportation Benefits: Changes Negatively Impact Recipients

## Key Takeaways

1. Non-Emergency Medical Transportation (NEMT) is a Medicaid benefit that provides critical access to health-care appointments for Medicaid recipients with no other means of transportation.
  2. Federal and state Medicaid policy changes have negatively impacted NEMT users, including reducing NEMT efficiency, availability, and quality of service, while increasing the local tax burden or trip costs in some communities.
  3. APTA opposes any effort to eliminate NEMT. We support legislation that a) mandates NEMT as a benefit in the Medicaid statute; and b) prohibits funding to implement proposals making NEMT for Medicaid recipients optional for states.
- 

## Introduction: The Benefits of NEMT and Current Risks to the Program

NEMT is a Medicaid benefit<sup>1</sup> that provides vital access to health-care appointments for Medicaid recipients, particularly in rural areas. NEMT trips are frequently made to mental health, substance abuse, chemotherapy, dialysis, and other critical chronic and preventive care appointments. Without NEMT, millions of Americans would not be able to access these important medical services and pick up necessary prescriptions from pharmacies. According to a National Academies of Sciences report (2005), an estimated 3.6 million Americans miss or delay essential, non-emergency medical care because of transportation-related difficulties. NEMT plays a crucial role in transporting this disadvantaged population who have a higher prevalence of chronic diseases. In addition, effective NEMT saves costs, as the service reduces expensive emergency vehicle trips and care. In the same National Academies of Sciences report, NEMT was found to be cost-effective for all 12 medical conditions analyzed (and cost saving for 4 of the 12), equating to a valuable return on investment.

NEMT is provided by a variety of organizations, from public transit agencies, to private and non-profit taxi or van services. To control Medicaid costs, some states have changed how NEMT is managed. For example, states such as Iowa and Pennsylvania have privatized (or have passed legislation to privatize) the service and transitioned to a brokerage or managed care model.<sup>2</sup> Federal policy, through the Center for Medicare and Medicaid Services (CMS), encourages this trend by providing an increased matching funds percentage to states using the brokerage model.<sup>3</sup> Transitioning to a brokerage or a managed-care model can result in inefficiencies due to a decrease in coordinated service, thus negatively affecting the

---

<sup>1</sup> See 42 C.F.R. § 431.53.

<sup>2</sup> Under these models, states contract with private companies to manage NEMT services (qualify and authorize beneficiaries and contract with transportation providers), as opposed to state Medicaid agencies. Brokers may be regional or statewide, as well as for-profit or not-for-profit. In managed-care models, states contract with Managed Care Organizations to administer NEMT and other services to Medicaid beneficiaries at specified rates.

<sup>3</sup> The Deficit Reduction Act of 2005 provided states the option of establishing an NEMT brokerage without a waiver (*see note 4, infra.*)

---

trips of NEMT customers. It may also result in increased costs for public transit agencies, as NEMT trips are shifted to paratransit services.

CMS also allows the use of waivers<sup>4</sup> to exempt states from providing NEMT services to different populations. In late 2018, CMS indicated that it would propose a rule that would allow states to eliminate Medicaid NEMT.<sup>5</sup> Eliminating NEMT would make it even more difficult for low-income enrollees, particularly participants without access to personal vehicles, to get to medical appointments.

## The Impact of Medicaid NEMT Changes on Customers

Changes in Medicaid policies relating to NEMT affect Medicaid customers and their experience with the service. Some NEMT users in states with Managed Care Organizations (MCO) providers have complained about improper vehicles, the amount of advance notice required, and lack of coverage. Because brokers have an incentive to pick the cheapest provider, ride quality may be compromised. For example, after Texas transitioned from a fee-for service model to a brokerage model, a report by the Texas Legislative Budget Board Staff found that the number of complaints regarding the quality of service increased.<sup>6</sup> In addition, the report found that the percentage of Medicaid clients using NEMT services decreased after the state's transition to a brokerage model, indicating that customers now have less access to services.<sup>7</sup>

In Iowa, users have found navigating a constantly changing system to be burdensome. For example, as different MCOs enter and exit the Medicaid marketplace, customers must grapple with changing processes, procedures, timelines, and trip eligibilities. In Pennsylvania, the legislature blocked NEMT changes after it was demonstrated that a change in the system would lead to higher fare costs for seniors and persons with disabilities. In addition, customers in Pennsylvania would have been inconvenienced by having to complete additional paperwork and schedule trips through several different brokers and providers unfamiliar with their travel patterns. Unlike public transit agencies, brokers and other providers may not administer background checks, drug and alcohol tests, trainings<sup>8</sup> for drivers, or complete licensing and safety inspections for vehicles, leading to potentially lower quality standards for customers.

Many public transportation providers use Medicaid funding as a local match for federal transportation funds. Federal transportation funding serves as a foundation that allows public transit agencies to serve their constituents, providing access to more jobs, education, and opportunity. Smaller, more rural transit agencies are heavily reliant on federal funding to ensure access for its communities to essential services. Small and rural agencies may not be able to withstand a decrease in Medicaid funding and may be forced

---

<sup>4</sup> Under section 1115 of the Social Security Act (42 U.S.C. § 1315), waivers may be used to test new approaches to delivering and paying for Medicaid services. Two states, Iowa and Indiana, have received approvals to waive NEMT coverage for their Medicaid expansion populations (adults with incomes up to 138 percent of the federal poverty level).

<sup>5</sup> See Fall 2018 Unified Agenda of Regulatory and Deregulatory Actions relating to the Non-Emergency Medical Transportation in Medicaid (CMS-2481-P). Note that the Fall 2019 Unified Agenda revised this to a request for information on whether the Assurance of Transportation in the Medicaid program remains administratively necessary (CMS-2481-NC).

<sup>6</sup> The State of Texas, Legislative Budget Board Staff Reports, January 2017.

[https://www.lbb.state.tx.us/Documents/Publications/Staff\\_Report/3729\\_LBB\\_Staff\\_Reports.pdf](https://www.lbb.state.tx.us/Documents/Publications/Staff_Report/3729_LBB_Staff_Reports.pdf)

<sup>7</sup> Id.

<sup>8</sup> Including for passenger safety, disability awareness, and safety training.

to cease operations.<sup>9</sup> This result can lead to fewer outings and longer commute times for riders as other providers attempt to fill service gaps.

APTA opposes any effort to eliminate NEMT, and points to the following case studies to illustrate the harmful effects that changes to NEMT coordination methods can have on overall program efficacy and on public transportation agencies' efforts to serve this population. Moreover, APTA supports efforts to codify the NEMT benefits into law so that the service cannot be eliminated by states.

The case studies below demonstrate the impact or potential impact of changes to NEMT services on customers of two public transit agencies.

## **Case Study: Iowa — Des Moines Area Regional Transit Authority (DART)**

### **Background Information**

The Des Moines Area Regional Transit Authority (DART) operates three distinct paratransit program types, each with unique eligibility requirements and revenue structures:

- 1) Americans with Disabilities Act (ADA)<sup>10</sup> BusPlus—\$3.50 rider fare, subsidized through local tax levy;
- 2) Medicaid Services—No rider fare, reimbursed by Medicaid or MCOs at \$24.29/trip;<sup>11</sup> and
- 3) Polk County Services—No rider fare, reimbursed by Polk County at similar rates as Medicaid Services.

The average cost of providing DART paratransit is approximately \$24 per individual trip.

DART has been providing service to Medicaid recipients for more than 11 years as one of Iowa's NEMT providers. The state of Iowa privatized its Medicaid program in 2016, switching to a managed-care system, where private and non-profit health organizations are paid by the state to run Medicaid programs and administer benefits.

### **The New System**

In addition to moving to a managed-care system, Iowa also introduced a tiered-rate system<sup>12</sup> for benefit providers and bundled different services (housing, food, transportation, etc.) into one flat rate. The bundling system results in less money allocated to NEMT brokers because the funds are often shifted toward other necessities before transportation.

Previously, DART's NEMT procedures were straightforward: Medicaid would authorize the trips, DART provided the trips, and Medicaid would reimburse DART.<sup>13</sup> With managed care, transportation services

<sup>9</sup> As experienced in Tioga County, NY, after the state centralized its Medicaid ride-scheduling system. This system change drove most of the NEMT transportation to private taxi services and away from public transit, resulting in a dramatic loss of Medicaid reimbursement funds for the transit agency. <https://www.pressconnects.com/story/news/local/tioga-county/2014/09/18/tioga-county-suspends-public-transit/15829431/>

<sup>10</sup> ADA paratransit/demand-response trips must meet a variety of federal requirements. For example, there must be a minimum service area generally within a three-quarter mile radius of fixed-route service. The service must be available on the same hours and days as fixed-route service. Vehicles must be equipped with a lift or ramp for passengers in wheelchairs and drivers may assist door-to-door or curb-to-curb. There are no restrictions on the number of trips per eligible individual or restrictions on trip purpose. Source: <https://adata.org/factsheet/ADA-accessible-transportation>

<sup>11</sup> This rate is DART's cost to provide the trip as negotiated with Medicaid and others.

<sup>12</sup> A system that awards benefit providers based on the quality of their service.

<sup>13</sup> This is known as a fee-for-service NEMT model.

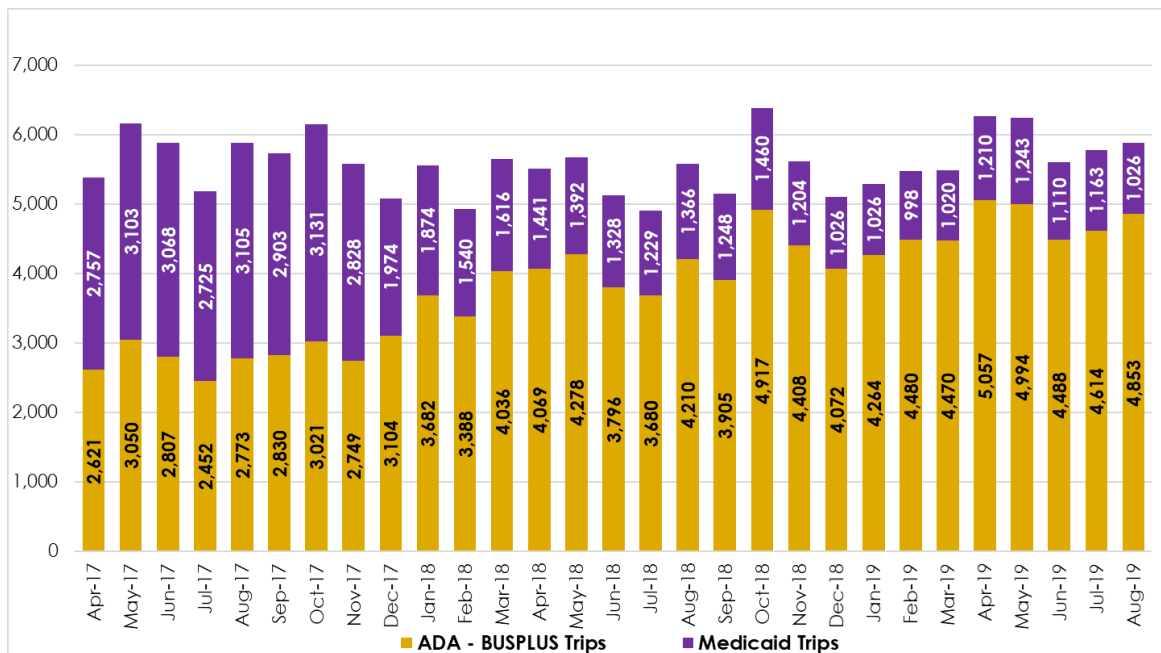
are now apportioned by three MCOs in addition to working directly with DART for some clients. The MCOs can also select brokers to oversee transportation services, further fragmenting the process and burdening customers with additional paperwork.

Today, NEMT trips are divided and not coordinated, resulting in fewer shared trips on DART and less efficiency. This system differs from the previous system where DART acted as a coordinator and could efficiently schedule shared trips.

### The Effects on Public Transit

With Iowa’s new system, many MCOs and brokers are transferring costs to other programs, such as DART’s ADA BusPlus paratransit, to reduce their expenses by avoiding the higher Medicaid transportation rate.<sup>14</sup> While DART provides approximately the same number of paratransit trips as it did before these changes, the makeup of the service types is drastically different. The number of Medicaid trips that DART provides is down, while the number of ADA trips is up. From April to November 2017, DART’s paratransit trip breakdown was 51 percent Medicaid and 49 percent ADA. From April to November 2018, that ratio shifted to 25 percent Medicaid and 75 percent ADA.

### DART Medicaid and ADA BusPlus Ridership, April 2017-August 2019



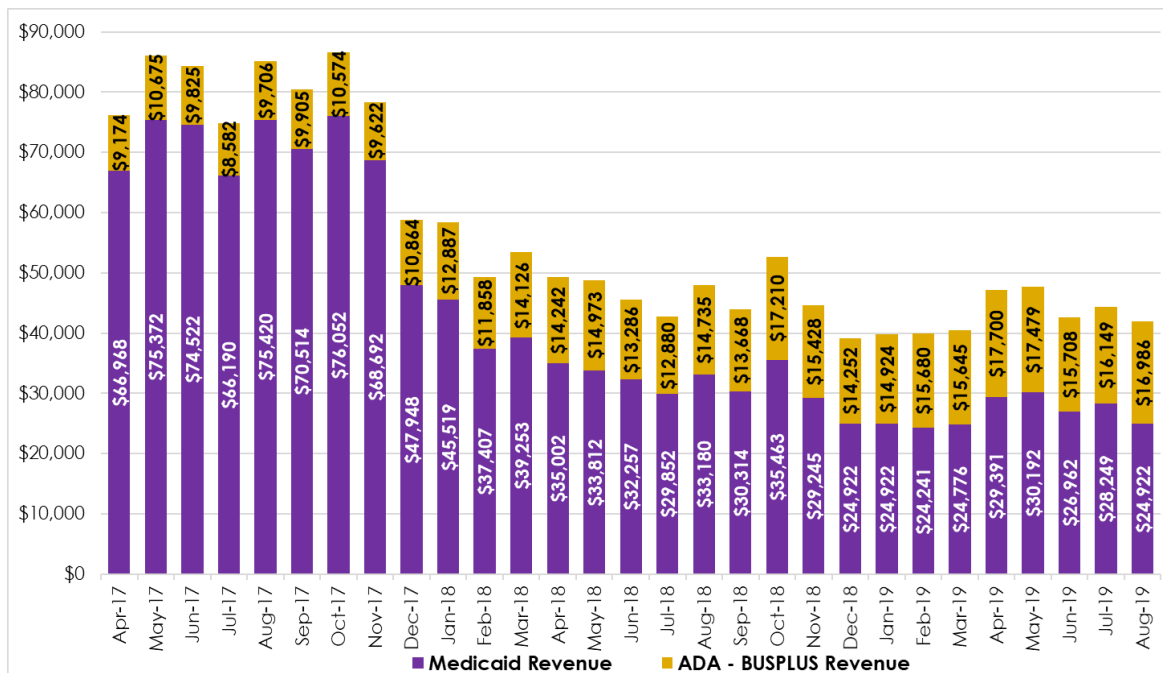
Source: Des Moines Area Regional Transit Authority

DART is federally mandated to provide ADA paratransit service and can charge riders no more than double the fixed-route base fare amount. This revenue is substantially lower than the actual cost of providing the trip for the individual (approximately \$24 on average). Transferring Medicaid NEMT trips to ADA trips has resulted in a substantial decrease in revenue for the transit agency because ADA trips only recoup \$3.50, as opposed to the \$24.29 Medicaid reimbursement (which aligns with the actual cost of providing the service).

<sup>14</sup> Many Medicaid recipients are also eligible for ADA services.

In November 2017, DART reported close to \$80,000 in paratransit revenue from Medicaid and ADA trips. In November 2018, its paratransit revenue dropped to approximately \$45,000. DART lost approximately \$530,000 in fiscal year (FY) 2019 and will see a loss of approximately \$700,000 in FY 2020 because of the shift in trip types. Across the state, Sioux City saw a similar decrease in revenue (approximately \$500,000) as ADA trips increased from 17,000 to 40,000. Prior to the new system, 50 percent of its paratransit revenue had been coming from Medicaid.

### DART Medicaid and ADA BusPlus Revenues, April 2017-August 2019



Source: Des Moines Area Regional Transit Authority

With this shift, the financial burden of Medicaid transportation is transferred to local taxpayers and their public transportation agencies. To fill its revenue hole, DART had to increase property taxes.<sup>15</sup> The local taxpayer is now not only paying state taxes for Medicaid, but additional local property taxes to support the same number of paratransit trips as previously provided. In addition, the trips provided by transit agencies are often the most challenging and expensive to serve. Rural transit agencies have also been impacted, though it varies because non-fixed route systems are not required to provide ADA services.

Finally, DART has incurred additional administrative costs associated with a change to an MCO system. Some of the MCO billing systems are contracted individually, resulting in differing rates and information needed for each MCO or sub-broker. This transition has resulted in transit agencies needing to pay into the proprietary systems to have invoices reimbursed. The instability of the transition is also worth noting—MCOs have continued to exit the market and be replaced on short notice. Recouping outstanding invoices from the exiting MCOs has proved challenging. For DART, these changes have caused a significant increase in the agency’s administrative work (i.e., contracting, administration, billing, collections) and expenses.

<sup>15</sup> DART has limited authority to raise property taxes up to a cap of 95 cents per \$1,000 of taxable valuation.

## Case Study: Pennsylvania — South Central Transit Authority (SCTA)

### Background Information

The Commonwealth of Pennsylvania has provided NEMT through its coordinated Medical Assistance Transportation Program (MATP) with public transportation agencies since 1980. This coordinated system is very efficient, providing more NEMT trips than other states of comparable size, at the third lowest cost nationally. This efficiency is due, in large part, to public transportation agencies that have handled eligibility and scheduling for all programs and trip types, including MATP trips.

The South Central Transit Authority (SCTA) operates shared-ride NEMT services and coordinates approximately 20 additional services in Berks and Lancaster counties. SCTA's shared-ride budget is \$13 million, \$6 million of which is generated from MATP. Pennsylvania is unique in that the state lottery provides free rides for seniors over the age of 65 on the fixed-route system and covers 85 percent of the cost of the paratransit fare on the shared-ride system. In addition, the state funds a Persons with Disabilities (PWD) Program for individuals with disabilities in rural areas where ADA service is not available.

In 2018, the state legislature proposed to move the coordinated MATP system to a brokerage model. SCTA, together with the Pennsylvania Public Transportation Association (PPTA), argued against these changes. They argued that these changes would result in reduced available services to seniors and persons with disabilities, increased costs to the state of approximately \$31.5 million, and loss of service productivity. On December 13, 2019, the Commonwealth of Pennsylvania informed the state legislature that it had completed a required legislative analysis on the potential impact of MATP being administered through a regional or statewide brokerage model and concluded that it would not be the best solution at that time.<sup>16</sup> It proposed to work with interested parties to explore improvements to the MATP system. While it is working through these improvements, no statewide brokerage contract will be awarded.

### The Proposed System

In June 2018, despite having a coordinated NEMT system considered one of the most efficient systems in the country, a provision was added to the state budget requiring a shift to a brokerage model. Proponents of the shift note that in doing so, Pennsylvania would be able to obtain additional federal Medicaid funds by classifying MATP service as a medical expense, rather than an administrative expense. Under current policy, federal funds can reimburse 50 percent of NEMT expenses under the administrative services option, compared to up to 83 percent of expenses under the medical services option.<sup>17</sup> However, under the brokerage model outlined by the Request for Application<sup>18</sup> issued by the state, public transit agencies would no longer coordinate or provide NEMT service and would not be eligible to be brokers. Transit agencies would not be eligible to be brokers because they cannot enter contracts that do not guarantee payment or break-even margins, and the new model is based on "full-risk" brokers.

---

<sup>16</sup> The Commonwealth of Pennsylvania, Letter on Medical Assistance Transportation Program, December 13, 2019.

<sup>17</sup> As part of the increased reimbursement rates come additional requirements, most notably, giving Medicaid clients freedom of choice in selecting a service provider.

<sup>18</sup> A Request for Application to become a broker was issued in December of 2018, with proposals received in April of 2019 and currently under review.

Under a full-risk model, brokers assume the financial risk for their responsibilities. Thus, if service needs exceed the capitation payments,<sup>19</sup> the broker will lose money. Conversely, if the service needs are less than the capitation payments, the broker will make a profit.<sup>20</sup> Opponents claim that, under this model, brokers are incentivized to provide less service to make profits.<sup>21</sup> Private brokers also have the option of contracting with transportation providers that are not required to meet the insurance, training, or safety standards required of public transit agencies.

### The Effects on Public Transit

At SCTA, losing its position as an NEMT coordinator would have resulted in reduced service for customers as well as lost jobs. The loss of MATP funding would have also severely reduced SCTA's shared-ride budget. As depicted below, such a revenue loss may have led to higher fares for riders, risking the possibility of isolating residents from critical services. Like DART's experience in Iowa, an increase of ADA trips and a reduction in Medicaid trips were anticipated under this new brokerage model. The shared-ride programs being funded directly by the state would have suffered the most, likely leading to reduced services for seniors and individuals with disabilities.

Other Pennsylvania public transit agencies might have also lost revenue depending on their size and exposure. For example, the transit agencies serving the surrounding Philadelphia counties<sup>22</sup> might have encountered significant revenue losses with the projected increase in ADA trips and loss of MATP funds. The PPTA estimated that a change to a full-risk brokerage would have the potential to "increase annual costs borne by the state for human services transportation programs by \$17.3 million, reduce annual Federal Transit Administration (FTA) apportionments to Pennsylvania's transit agencies by \$5.0 million, and increase annual state Medicaid costs by \$31.3 million through degraded health outcomes."<sup>23</sup> In total, this change would cost Pennsylvania an estimated \$53.6 million annually. In addition, PPTA estimated the costs to the state and transit agencies would total \$38.4 million annually.<sup>24</sup> The study also noted the impact on customers, including having to arrange for MATP and other transportation needs through multiple reservation systems, and a potential degradation of service as brokers are incentivized to minimize the cost of service without an incentive to increase ridership.<sup>25</sup>

Pennsylvania's decision to forgo a transition to a brokerage model at this time was welcome news to PPTA and its member agencies.

---

<sup>19</sup> Capitation payments are the fixed-rate payments that the broker receives based off the number of Medicaid enrollees, as opposed to the amount of service provided.

<sup>20</sup> Pennsylvania Department of Transportation policy allows for public transit agencies to set fare rates that only cover costs, making profits unobtainable as compared to a for-profit broker.

<sup>21</sup> Concerns about the brokerage model were heightened when a New Jersey State Legislature audit on New Jersey's Department of Human Services, Division of Medical Assistance and Health Services, Transportation Broker Service Contract, Capitation Rates found that the state paid over \$20 million more than the actual cost of NEMT service from FY 14-16. Source: <https://www.njleg.state.nj.us/legislativepub/Auditor/545916.pdf>

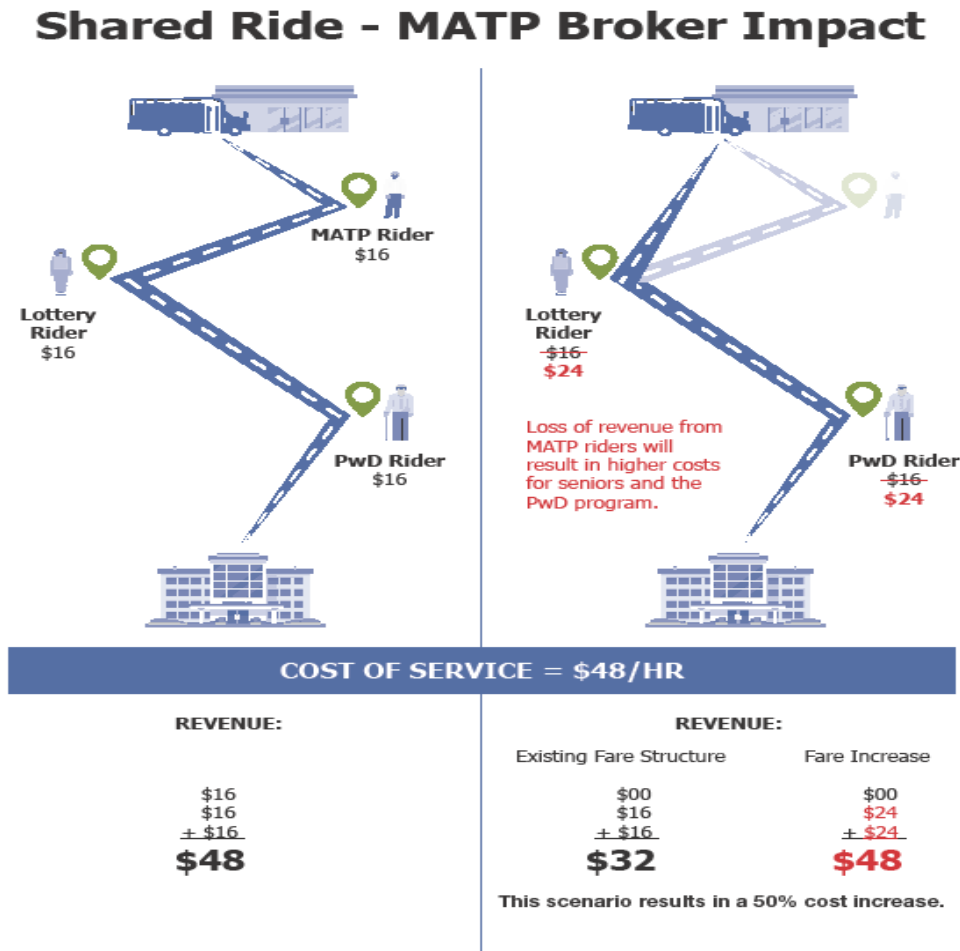
<sup>22</sup> Philadelphia County already uses a broker that places 70 percent of NEMT trips on public transit buses.

<sup>23</sup> See PPTA, *Pennsylvania's Medical Assistance Transportation Program (MATP): Full-Risk Brokerage Model Impact* (Econsult Solutions Inc. and Texas A&M Transportation Institute) (January 2020) at 3.

<sup>24</sup> *Id.* This amount includes the loss of the potential annual benefit of \$15.2 million in federal MTAP matching funds.

<sup>25</sup> *Id.* at 9, noting that service quality declines are associated with potential declines in ridership.

Example of Shared Ride – MATP Broker Impact in Pennsylvania



The graphic above depicts before (left) and after (right) scenarios of shared-ride public transportation services in Pennsylvania. Because of the decrease in coordination and loss of MATP riders, public transit shared-ride services lose riders and revenue. To make up for the cost of providing the service, the agency would need to increase fares for existing riders (seniors and persons with disabilities). Source: Pennsylvania Public Transportation Association.

### Conclusion

NEMT is essential for patients with chronic medical care needs, according to the Kaiser Family Foundation. Policies that reduce NEMT service and coordination are contrary to Medicaid’s mission to provide health-care access to those who need it the most. Furthermore, eliminating NEMT through waivers diminishes the opportunity for recipients to receive preventive care to avoid potentially more costly treatments later.



While reducing costs<sup>26</sup> is the stated goal of many recent NEMT policy changes, these changes have hurt Medicaid customers and had unintended impacts on transit agencies. Chief among these impacts is cost transference, either from the state to local communities or from private, for-profit brokerages to public transit agencies through increased use of agencies' ADA paratransit services. This cost transference places a significant financial strain on local taxpayers who fund some public transportation agencies, particularly small urban and rural systems.

In addition, other public transit agencies, particularly rural agencies, rely on Medicaid transportation as a source for local matching funds for FTA grants to provide their network of services in their communities.<sup>27</sup> If NEMT is made optional or transit agencies are no longer used to provide the service, a vital source of revenue will be lost. Those transit agencies must make up this difference through other state and local funding or may need to cease operations altogether.

APTA opposes any effort to eliminate NEMT. It believes that efforts to allow states to eliminate NEMT service do not serve the needs of the public or the mission of Medicaid.<sup>28</sup> It supports legislation that both mandates NEMT as a benefit in the Medicaid statute, and prohibits funding proposals making NEMT for Medicaid recipients optional for states.

## References

Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), Non-Emergency Medical Transportation: Past, Present, and Future of a Critical Service Part 1, June 2018 Issue Brief.

Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), Non-Emergency Medical Transportation: Past, Present, and Future of a Critical Service Part 3, April 2019 Issue Brief.

Kaiser Family Foundation, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, February 2016. <https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>

National Academies of Sciences, Engineering, and Medicine. 2005. Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation. Washington, DC: The National Academies Press. <http://www.trb.org/Main/Public/Blurbs/156625.aspx>

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. <https://doi.org/10.17226/25184>.

Virgil Dickson, CMS is Developing a Rule that Could Curtail Medicaid Transportation Access, Modern Healthcare, November 7, 2018. <https://www.modernhealthcare.com/article/20181107/NEWS/181109932/cms-is-developing-a-rule-that-could-curtail-medicaid-transportation-access>

---

<sup>26</sup> Medicaid NEMT spending is less than \$3 billion annually, making it less than one percent of the entire \$565 billion Medicaid program.

<sup>27</sup> On October 29, 2019, the U.S. Department of Health & Human Services (HHS) reiterated the ability to use HHS funding for transportation as a match when applying to various FTA grant programs (Sections 5307, 5310, 5311) at the Department of Transportation's Access and Mobility for All Summit. See <https://www.transportation.gov/accessibility>.

<sup>28</sup> As stated in APTA's Recommendations on Surface Transportation Law, which can be found at: [https://www.apta.com/wp-content/uploads/APTA-RECOMMENDATIONS-Surface-Trans-Auth\\_10122019.pdf](https://www.apta.com/wp-content/uploads/APTA-RECOMMENDATIONS-Surface-Trans-Auth_10122019.pdf)

Sam Smink, Patients Losing Patience with Non-Emergency Medical Transportation Services, WPTV, September 26, 2018.

<https://www.wptv.com/news/local-news/investigations/patients-losing-patience-with-non-emergency-medical-transport-services>

### **Acknowledgements**

Elizabeth Presutti, Chief Executive Officer, Des Moines Area Regional Transit Authority

David W. Kilmer, Executive Director, South Central Transit Authority

Richard H. Farr, Executive Director, Central Pennsylvania Transportation Authority

### **The American Public Transportation Association (APTA)**

The American Public Transportation Association is a nonprofit international association of 1,500 public and private-sector organizations that represents a \$74 billion industry that directly employs 435,000 people and supports millions of private-sector jobs. APTA members are engaged in the areas of bus, paratransit, light rail, commuter rail, subways, waterborne services, and intercity and high-speed passenger rail. This includes transit systems; planning, design, construction, and finance firms; product and service providers; academic institutions; transit associations; and state departments of transportation. APTA is the only association in North America that represents all modes of public transportation. APTA members serve the public interest by providing safe, efficient, and economical transit services and products.

### **Authors**

MacPherson Hughes-Cromwick  
Former Policy Analyst  
American Public Transportation Association

Stacie Tiongson  
Senior Director, Government Affairs and  
Advocacy  
202.496.4810 | [stiongson@apta.com](mailto:stiongson@apta.com)

Darnell Grisby  
Director, Policy Development and Research  
202.496.4887 | [dgrisby@apta.com](mailto:dgrisby@apta.com)

---

### **APTA Purpose Statement**

APTA leads public transportation in a new mobility era, advocating to connect and build thriving communities.

---