FY 2015 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Transportation (Van Based)** (Revision Date: 06/03/14)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report (CER).

	• A copy of the taxi company's statement (on company letterhead) must be included with the monthly CER. Supporting documentation of disbursement payments may be requested with the CER.
HRSA Service Category Definition: **RWGA Only**	**Medical transportation services** include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.
Local Service Category Definition:	a. Urban Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Harris County. Clients residing outside of Harris County are ineligible for Urban transportation services. Exceptions to this requirement require <u>prior</u> written approval from RWGA. b. Rural Transportation: Contractor will develop and implement a medical transportation program that provides essential transportation services to **HRSA-defined Core Services** through the use of individual employee or contract drivers with vehicles/vans to Ryan White Program-eligible individuals residing in Houston EMA/HSDA counties other than Harris County. Clients residing in Harris County are ineligible for this transportation program. Exceptions to this requirement require <u>prior</u> written approval from RWGA. Essential transportation is defined as transportation to public and private outpatient medical care and physician services, substance abuse and mental health services, pharmacies and other services where eligible clients receive Ryan White-defined Core Services and/or medical and health-related care services, including clinical trials, essential to their well-being. The Contractor shall ensure that the transportation program provides taxi vouchers to eligible clients only in the following cases: • To access emergency shelter vouchers or to attend social security disability hearings; • Van service is unavailable due to breakdown or inclement weather; • Client's medical need requires immediate transport; • Scheduling Conflicts. **Contractor must provide clear and specific justification (reason) for the use of taxi vouchers and include the documentation in the client's file for <u>each</u> incident. RWGA must approve supporting documentation for taxi voucher reimbursements.** For clients living in the METRO service area, written certification from the client's principal medical provider (e.g. medical case manager or physician) is required to access van-based transportation,

	to be renewed every 180 days. **Medical Certifications should be maintained on-site by the provider in a single file (listed alphabetically by 11-digit code) and will be monitored at least annually during a Site Visit.** It is the Contractor's responsibility to determine whether a client resides within the METRO service area. Clients who live outside the METRO service area but within Harris County (e.g. Baytown) are not required to provide a written medical certification to access van-based transportation. All clients living in the Metro service area may receive a maximum of 4 non-certified round trips per year (including taxi vouchers). Non-certified trips will be reviewed during the annual Site Visit. Provider must maintain an up-to-date spreadsheet documenting such trips. The Contractor must implement the general transportation program in accordance with the Transportation Standards of Care that include entering all transportation services into the Centralized Patient Care Data Management System (CPCDMS) and providing eligible children with transportation services to Core Services appointments. Only actual mileage (documented per the selected Internet mapping program) transporting eligible clients from Origin to Destination will be reimbursed under this contract. The Contractor must make reasonable effort to ensure that routes are designed in the most efficient manner possible to minimize actual client time in vehicles.
Target Population (age, gender, geographic, race, ethnicity, etc.):	a. Urban Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Harris County. b. Rural Transportation: HIV/AIDS-infected and Ryan White Part A/B eligible affected individuals residing in Fort Bend, Waller, Walker, Montgomery, Austin, Colorado, Liberty, Chambers and Wharton Counties.
Services to be Provided:	To provide Medical Transportation services to access Ryan White Program defined **Core Services** for eligible individuals. Transportation will include round trips to single destinations and round trips to multiple destinations. Taxi vouchers will be provided to eligible clients only for identified emergency situations. Caregiver must be allowed to accompany the HIV-infected rider. **Eligibility for Transportation Services is determined by the client's County of residence as documented in the CPCDMS**.
Service Unit Definition(s): **RWGA Only**	One (1) unit of service = one (1) mile driven with an eligible client as passenger. Client cancellations and/or no-shows are <u>not</u> reimbursable.
Financial Eligibility:	Refer to the RWPC's approved *FY 2015 Financial Eligibility for Houston EMA Services*.
Client Eligibility:	a. Urban Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing inside Harris County will be eligible for services. b. Rural Transportation: Only individuals diagnosed with HIV/AIDS and Ryan White Program eligible HIV-affected individuals residing in

	Houston EMA/HSDA Counties other than Harris County are eligible for Rural Transportation services. Documentation of the client's eligibility in accordance with approved Transportation Standards of Care must be obtained by the Contractor prior to providing services. The Contractor must ensure that eligible clients have a signed consent for transportation services, client rights and responsibilities prior to the commencement of services. Affected significant others may accompany an HIV-infected person as medically necessary (minor children may accompany their caregiver as necessary). Ryan White Part A/B eligible affected individuals may utilize the services under this contract for travel to Core Services when the aforementioned criteria are met and the use of the service is directly related to a person with HIV infection. An example of an eligible transportation encounter by an affected individual is transportation to a Professional Counseling appointment.
Agency Requirements	Proposer must be a Certified Medicaid Transportation Provider. Contractor must furnish such documentation to Harris County upon request from Ryan White Grant Administration prior to March 1st annually. Contractor must maintain such certification throughout the term of the contract. Failure to maintain certification as a Medicaid Transportation provider may result in termination of contract. Contractor must provide each client with a written explanation of contractor's scheduling procedures upon initiation of their first transportation service, and annually thereafter. Contractor must provide RWGA with a copy of their scheduling procedures by March 30, 2014, and thereafter within 5 business days of any revisions. **Contractor must also have the following equipment dedicated to the general transportation program:** • A separate phone line from their main number so that clients can access transportation services during the hours of 7:00 a.m. to 10:00 p.m. directly at no cost to the clients. **The telephone line must be managed by a live person between the hours of 8:00 a.m. – 5:00 p.m.** Telephone calls to an answering machine utilized after 5:00 p.m. must be returned by 9:00 a.m. the following business day. • A fax machine with a dedicated line. • All equipment identified in the Transportation Standards of Care necessary to transport children in vehicles. • Contractor must assure clients eligible for Medicaid transportation are billed to Medicaid. This is subject to audit by the County. The Contractor is responsible for maintaining documentation to evidence that drivers providing services have a valid Texas Driver's License and have completed a State approved "Safe Driving" course. Contractor must maintain documentation of the automobile liability insurance of

	each vehicle utilized by the program as required by state law. All vehicles must have a current Texas State Inspection. The minimum acceptable limit of automobile liability insurance is $300,000.00 combined single limit. Agency must maintain detailed records of mileage driven and names of individuals provided with transportation, as well as origin and destination of trips. ***It is the Contractor's responsibility to verify the County in which clients reside in.***
Staff Requirements	A picture identification of each driver must be posted in the vehicle utilized to transport clients. Criminal background checks must be performed on all direct service transportation personnel prior to transporting any clients. Drivers must have annual proof of a safe driving record, which shall include history of tickets, DWI/DUI, or other traffic violations. Conviction on more than three (3) moving violations within the past year will disqualify the driver. Conviction of one (1) DWI/DUI within the past three (3) years will disqualify the driver.
Special Requirements: **RWGA Only**	Individuals who qualify for transportation services through Medicaid are not eligible for these transportation services. **Contractor must ensure the following criteria are met for all clients transported by Contractor's transportation program:** Transportation Provider must ensure that clients use transportation services for an appropriate purpose through one of the following three methods: 1. Follow-up hard copy verification between transportation provider and Destination Agency (DA) program confirming use of eligible service(s), or 2. Client provides receipt documenting use of eligible services at Destination Agency on the date of transportation, or 3. Scheduling of transportation services was made by receiving agency's case manager or transportation coordinator. The verification/receipt form must at a minimum include all elements listed below: • Be on Destination Agency letterhead • Date/Time • CPCDMS client code • Name and signature of Destination Agency staff member who attended to client (e.g. case manager, clinician, physician, nurse) • Destination Agency date stamp to ensure DA issued form.

FY 2016 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/11/2015**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/2015**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Assurance Committee**		Date: **05/21/2015**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup**	Date: **04/14/2015**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

NON-EMERGENCY MEDICAL TRANSPORTATION: A VITAL LIFELINE FOR A HEALTHY COMMUNITY

1/7/2015

Amelia Myers

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 nonemergency 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 different ways states are dealing with the increase in people who need transportation to medical services because of 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, making up 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 leads 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

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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 people 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 people will be added to the Medicaid program; Medicaid and the Children's Health Insurance Program (CHIP) have more than 6 million new enrollees as of April 30, 2014. Because the expansion includes people who are 133 percent of the 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, because of income, age or disability, other methods of NEMT service delivery are necessary.

Growth of Chronic Conditions

Many people 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 are that states will add more than a half 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 1 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.

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. Few states, however, have successfully coordinated their Medicaid trips with their entire transportation network. This may be because of 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 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. They may, however, 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 noncompliance.

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 nonprofits, 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 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

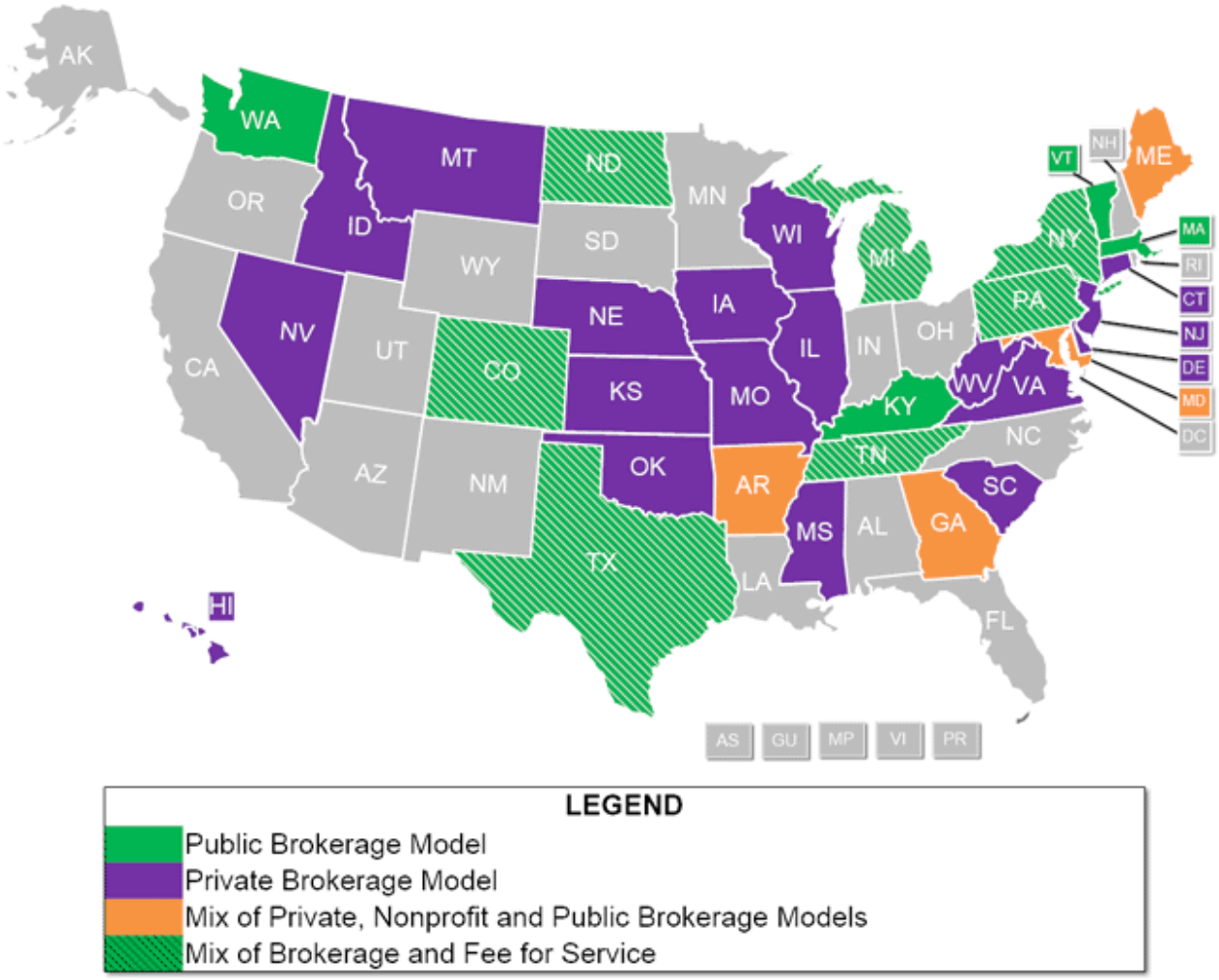
States can claim NEMT as either an administrative cost or a medical cost when submitting their state plans to the Centers for Medicare & Medicaid Services.

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 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.

Modes of Service Delivery



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 make sure 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.

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.

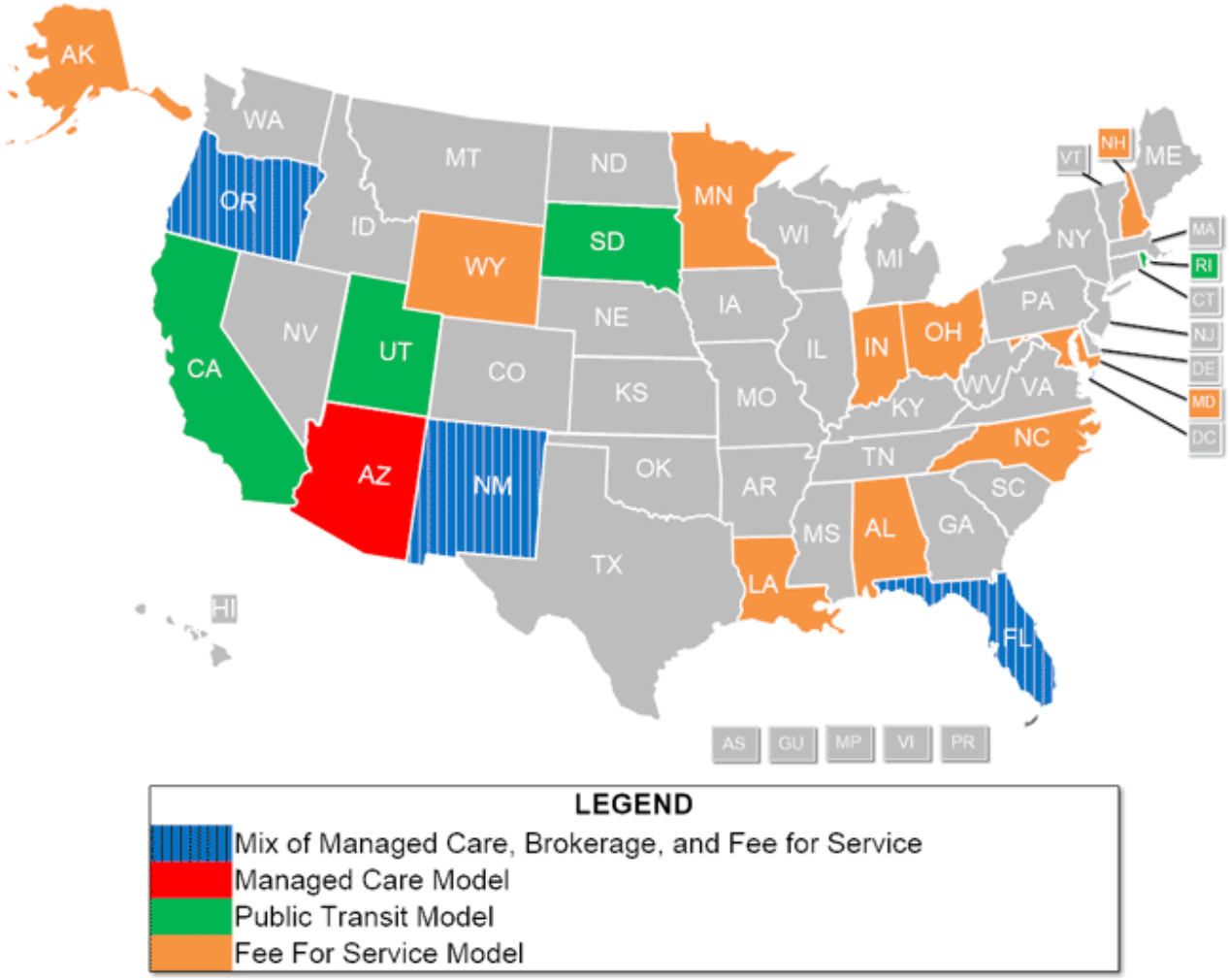
States that deliver NEMT through a private brokerage use a competitive bidding process to procure a private for-profit company to work as an intermediary between transportation providers and eligible riders. States usually pay capitated payments to the broker for each eligible rider. This is the most 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, 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 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." 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. 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. 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. 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.

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 nonprofit organizations working together to help citizens learn how to handle their chronic conditions. However, many nonprofit 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.

In Brief

Expanding Specialized Transportation: New Opportunities under the Affordable Care Act

Wendy Fox-Grage and Jana Lynott
AARP Public Policy Institute

The Affordable Care Act (ACA) provides new but limited opportunities to promote or fund specialized transportation services—such as door-to-door paratransit or escorts into doctors' offices—for older people and adults with disabilities. However, relatively few states are currently taking advantage of these opportunities for low-income people with mobility limitations. Even among the states with transportation benefits, the ACA programs are small and specialized, and transportation services are restricted.

Transportation is vital to helping people live as independently as possible. Many older people and adults with physical disabilities need specialized transportation that can be provided upon request by van, small bus, or taxi. Specialized transportation is especially critical for high-risk, low-income populations who do not drive and have difficulty taking public transportation because of disability, age-related conditions, or income constraints.

Specialized transportation can help states and communities achieve the ACA's goals. Transportation is an important element for states balancing their Medicaid programs toward home- and community-based services (HCBS). Transportation enables people to access preventative care, improves health outcomes, and avoids unnecessary hospital readmissions. The following ACA initiatives offer incentives to states to expand specialized transportation.

Money Follows the Person (MFP)

- MFP is a grant program for states to shift Medicaid funds toward HCBS and to identify and transition Medicaid beneficiaries who are living in an institution and want to return to the community.
- Forty-four states plus the District of Columbia receive an enhanced federal match for the services provided to Medicaid participants for the first 12 months after the beneficiary's transition back into the community.
- More than 40,000 people have moved from institutions to the community.
- MFP participants from 16 states—out of 25 that provided service expenditure data—utilized transportation during 2012.

Community First Choice

- This new optional Medicaid benefit allows consumers to direct much of their own care.
- Four states receive an enhanced federal match of 6 percentage points for "participant-directed" services.
- Montana and Oregon specifically provide Community Transportation as a permissible service under this option.

Balancing Incentive Program

- This grant encourages states to balance their Medicaid spending toward HCBS.
- Twenty-one states are using this grant to make structural changes and to spend more on HCBS by October 2015.
- Connecticut is using the grant for strategic planning that includes transportation.

Section 1915(i) State Option

- This option allows states to provide Medicaid HCBS to individuals who do not meet the more stringent institutional level of care requirements to qualify for HCBS without waivers.
- Services must be offered statewide, and enrollment cannot be capped.
- Twelve states have this option, but mostly for people with mental illness.
- Connecticut specifies community transportation for older people or adults with physical disabilities.

Duals Demonstrations

- These demo projects seek to improve care for people who are "dually eligible" for both Medicare and Medicaid, who are typically sicker, use more health care, and have higher costs.
- Twelve states have signed memoranda of understanding to participate in the demos.
- Most demos are testing risk-based, capitated, managed care models.
- States do not have to expand transportation in these demos beyond what is currently covered in the Medicaid program, but California and Massachusetts are doing so.
- Care coordinators who help dual eligibles in the demos can also ensure access to transportation by scheduling trips for treatment and follow-up.

Care Transition Programs

- Several ACA initiatives seek to improve care transitions when patients move between one care setting or provider to another.
- Better care transitions can prevent costly hospital admissions and readmissions, particularly for people who are at high risk and who often have multiple chronic conditions.
- Many sites (102) are participating in the Community-based Care Transitions Program (CCTP) to reduce 30-day hospital readmissions.
- Atlanta is providing supplemental transportation through its CCTP.

Conclusion

This paper highlights opportunities to expand transportation and tap new funds within the ACA. Although new funding for transportation in the ACA is restricted and often targeted to specific low-income populations with mobility needs, states can expand transportation benefits through these ACA initiatives.

For a more complete description and to read the case studies that describe how the Atlanta region and the state of Connecticut are using the ACA options to expand specialized transportation, see the AARP Public Policy Institute's *Insight on the Issues* #99.

In Brief IB 220, January 2015

A synopsis of the AARP Public Policy Institute *Insight on the Issues* 99, of the same title.

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In Brief

Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) To Coordinated Care for Chronically Ill Patients

by MJS & Company
with a forward from the
Community Transportation Association of America

March 2014

Forward by Dale J. Marsico, CCTM
Community Transportation Association of America, Executive Director

This year marks the 40th anniversary of *Smith vs. Vowell*, a federal court case dealing with transportation for those receiving health care benefits under Title XIX of the Social Security Act — what we know today as Medicaid. Many people believe this case created the non-emergency medical transportation program (NEMT) that provides access to health care for millions across America, in communities of all shapes and sizes. In making its decision about the merits of transportation in health care for Medicaid patients in the 1970s, the court grasped fundamental health care concepts that few understood at the time of its ruling but that dominate medical transportation issues today.

Patients who brought this litigation had the need for multiple trips to-and-from outpatient services, often weekly or monthly. At the time of their lawsuit, the state of Texas only provided ambulance transportation for Medicaid recipients to the "nearest emergency facility." Yet, these patients needed services to non-emergency treatment facilities, like physical and occupational therapy, gastroenterology clinics and urology treatments by specialists. The court found that these patients' complex medical needs were, "of such a magnitude that no single doctor or clinic" was capable of meeting their needs, and that the absence of this service in the state Medicaid plan was "preposterous." When the state raised costs as a concern the court responded by ruling, "the deprivation of medically necessary transportation is disadvantageous to the state" and "a kind of false economy that only results, in the end, in higher medical costs."

Today's medical environment has only increased the complexity observed by the court 40 years ago, and the failure to take appropriate steps to maintain outpatient connections costs considerably more. That's why NEMT was a good idea then and today.

The paper prepared by MJS & Co., recognizes the complexity of today's medical environment by highlighting the important role that behavioral health and other complex medical conditions play in transportation to today's medical services. These new challenges in patient management include the scheduling of transportation services. The court addressed this, as well, when it stated that the patent cannot be expected "to assume the administrative as well as the fiscal burden of arranging" their own transportation. To ask the patient to do that, especially those with complex health issues, according to the Court was "neither therapeutic, practical, nor legal." The need for skilled intermediaries in the transportation process was viewed as important for 40 years, not for financial reasons, but as an essential element in a plan of care.

The expanding Medicaid population, especially those with chronic care and special health care needs, needs the same transportation benefit. If the federal government permits states to drop the NEMT benefit, it will not take many patients to repeat the mistakes found by the judge writing in *Smith vs. Vowell*, who found that limitations on transportation are a "false sense of economy." That is why past experience is key and this paper by MJS & Co., so relevant.

Community Transportation ASSOCIATION

Medicaid Expansion and Premium Assistance:
The Importance of Non-Emergency Medical Transportation (NEMT)
To Coordinated Care for Chronically Ill Patients

February 2014

New data shows that, last year, millions of chronically ill Americans relied on the Medicaid program for transportation to life sustaining medical care such as kidney dialysis and treatment for severe mental illnesses, such as schizophrenia. Lack of health insurance is often equated with lack of access to health services. However, the experience of millions of low-income Medicaid beneficiaries makes clear that health insurance coverage alone does not guarantee access to healthcare services. A previous analysis[1] of National Health Interview Survey data (1999 to 2009) found that 7% of Medicaid beneficiaries reported transportation as a barrier to accessing timely primary care treatment and even 0.6% of those with private coverage reported struggles with similar transportation barriers. As many states propose to scale back the Medicaid transportation benefit, it is important to note that no other barrier varied so greatly in prevalence between individuals with commercial insurance and those with Medicaid.

Transportation is a major barrier for a number of vulnerable individuals --whom a new data set shows are chronically ill Medicaid beneficiaries that need recurring access to live-saving health services. The Medicaid non-emergency medical transportation (NEMT) benefit removes this barrier by providing the least costly, but appropriate, method of transportation service, including taxis, vans and public transit for Medicaid beneficiaries unable to get to and from their medically necessary appointments. The data presented below shows the vital importance that transportation plays in the lives of those patients with chronic health conditions who require recurring visits to dialysis centers or behavioral health services. Millions of beneficiaries with chronic conditions will enter the Medicaid program through the Affordable Care Act. For instance, "in the District of Columbia and the 25 states where the expansion is under way, nearly 1.2 million uninsured adults newly eligible for coverage will have substance abuse problems, according to federal estimates, and more than 1.2 million are projected to have some sort of mental illness. An estimated 550,000 of those will have serious mental disorders that impair their everyday functioning."[2,3] They will need NEMT to access life sustaining health care services and treatments.

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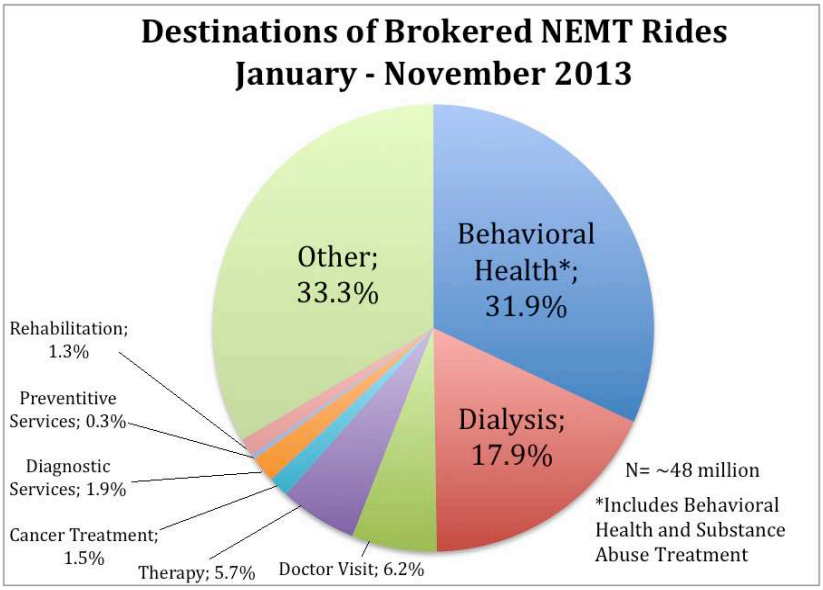
[1] Cheung PT, Wiler JL, Lowe RA, Ginde AA. "National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries." Annals of Emergency Medicine. 2012 Jul;60(1):4-10.e2.
[2] Pugh, Tony. "Medicaid expansion is expected to strain mental health services." McClatchy Washington Bureau. 2/13/2014. www.sacbee.com/2014/02/13/6151677/medicaid-expansion-is-expected.html. Article estimates are compiled from Substance Abuse and Mental Health Services Administration data in "National and State Estimates of the Prevalence of Behavioral Health Conditions Among the Uninsured." July 2013. http://store.samhsa.gov/product/National-and-State-Estimates-of-the-Prevalence-of-Behavioral-Health-Conditions-Among-the-Uninsured/PEP13-BHPREV-ACA

Medicaid Non-Emergency Medical Transportation

Since the Medicaid program's inception, the federal government has required states to assure access to medically necessary health services. Accordingly, Medicaid state plans are required to "Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers." (Federal Code of Regulations, 42 C.F.R. §431.53). Although many state Medicaid agencies have tried to eliminate the NEMT benefit, federal agency guidance and numerous court cases have affirmed the requirement for transportation. In *Smith v. Vowell*[4], the first case to test the enforceability of the transportation assurance, a federal district court found the Medicaid NEMT regulations "unequivocal" and that transportation was essential to the proper administration of Medicaid as an entitlement to critical health services.[5]

Many states contract with transportation brokers[6] to administer NEMT services and typically compensate these managers on a capitated, per-Medicaid beneficiary basis. This intermediary confirms the beneficiary's Medical eligibility, assures the destination is for a Medicaid-approved covered, medically necessary service, contracts with transportation providers, verifies transportation providers' licensing and safety inspections, and coordinates and schedules beneficiary transportation.



The chart to the right uses national data from the nation's largest intermediary, managing an estimated 48 million rides in 2013 in 39 states.[7] (Note: the chart

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[4] SMITH v. VOWELL. Civ. A. No. SA-72-CA-285. 379 F.Supp. 139 (1974). Benjamin Edward SMITH et al. v. Raymond W. VOWELL et al. United States District Court, W. D. Texas, San Antonio Division. June 27, 1974.

[5] Sara Rosenbaum, Nancy Lopez, Marsha Simon, Melanie Morris. "Medicaid's Medical Transportation Assurance." George Washington University Department of Health Policy. July 2009.

[6] Note: The Medicaid and CHIP Payment and Access Commission (MACPAC) defines these arrangements as prepaid ambulatory health plans (PAHP) wherein an entity that does not have a comprehensive risk contract is paid on the basis of prepaid capitation payments or another payment arrangement that does not use state plan rates. The brokerage option was created in Section 6083 of the Deficit Reduction Act (Public Law 109-171), subsection (iv). T

The option allows states to work with a broker who "complies with such requirements related to prohibitions on referrals and conflict of interest " These entities have been called "brokers," "managers," "intermediaries" or "prime vendors". This paper will use the term "intermediaries" to illustrate their role as independent liaisons between the transportation providers and the Medicaid beneficiaries.

[7] AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, NE, NJ, NM, NV, NY, OH, OK, PA, RI, SC, TN, TX, UT, VA, WA, WI

includes data from states that have already expanded Medicaid to include individuals with incomes up to 138% of FPL, the population covered by ACA.) It shows that about half of Medicaid NEMT services were provided to facilities providing dialysis treatment or behavioral health services (including mental health services and substance abuse treatment)**.** That is, the most rides were for individuals with chronic illness for whom the lack of treatment would be life threatening or would result in institutionalization in the criminal justice system or psychiatric hospital.

There is, however, variation from state-to-state, which reflects states' differing benefits and covered populations. For instance, most Medicaid NEMT rides in Connecticut (49.3%) and Pennsylvania (56.8%) were behavioral health services for substance abuse. By comparison, rides for dialysis services were the most prevalent in Mississippi (46%) and Hawaii (42%) while rides to behavioral health services were highest in Florida (24.2%) and New Jersey (26.8%).

The "Other" category in the chart above represents destinations such as: adult day care, federally qualified health centers, outpatient surgery facilities, pharmacies, or smoking cessation services. It also includes transportation to specialists such as gastroenterologists, dermatologists, neurologists, obstetricians and gynecologists, orthopedists, pulmonologists, or urologists. In most cases, NEMT rides to these facilities and providers are provided in standard vehicles or through the use of public transportation.

However, as the chart above illustrates, the majority of current NEMT services are for regularly scheduled, non-emergency medical trips for individuals requiring additional assistance with transportation to coordinated care for behavioral health services, substance abuse treatment and dialysis services. Thus, the majority of NEMT rides are more than a transportation subsidy to low-income patients. Most Medicaid subsidized rides transport chronically ill beneficiaries requiring a more robust, specialized transportation benefit to more intensive and recurring treatments and services. **The dominance of the chronically ill as users of the NEMT benefit underscores the danger of eliminating the NEMT benefit.** More than 75% of health care costs are due to chronic conditions[8] and therefore account for a growing share of Medicaid costs. The NEMT benefit is a key element of a coordinated care plan and if eliminated, could prevent the implementation of new strategies to coordinate care for the highest cost beneficiaries. Because, as the judge writing the *Smith v. Vowell* decision noted, there are concerns that a patient's transportation difficulties could have "a direct and causally injurious effect upon the course of his medical treatment."

NEMT in Medicaid Expansion Using Premium Assistance

The Affordable Care Act (ACA) permits states, as they determine, to expand Medicaid to nearly all individuals with incomes up to 138 percent of the federal poverty level (FPL) ($15,856 for an individual; $26,962 for a family of three in 2014). Some states have proposed to adopt an insurance model based on premium assistance in lieu of expanding their traditional Medicaid programs. Under this long available model, states use Medicaid funds to purchase Qualified

[8] Centers for Disease Control and Prevention. "Chronic Diseases: The Power to Prevent, The Call to Control: At A Glance 2009." www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.

Health Plans (QHPs) in the Exchanges/Marketplaces for some or all newly eligible Medicaid beneficiaries under the ACA. In order to offer premium assistance, a state must first file either a state plan amendment or section 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) in order to be granted authority or approval by the federal government.

CMS has issued final regulations providing guidance to states on how to implement Medicaid expansion through premium assistance.[9] CMS explained: "Under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. Therefore, states must have mechanisms in place to "wrap-around" commercial [insurance] coverage to the extent that benefits are less than those in Medicaid."[10] These wrap-around benefits include NEMT that is rarely covered in commercial insurance health plans.

However, despite transportation's proven benefits, especially to the chronically ill, some states are proposing to waive the NEMT assurance requirement in premium assistance plans, arguing that the QHPs are commercial plans that do not traditionally offer NEMT services. In Iowa, CMS has agreed to temporarily "relieve the state from the responsibility to assure non-emergency transportation to and from providers" for its Medicaid expansion population. This waiver authority sunsets after one year during which the state is required to collect data in order to evaluate the impact of lack of access on care. Pennsylvania recently submitted a premium assistance proposal to CMS that requested to waive all wraparound services, including non-emergency transportation. Other states, including New Hampshire, are considering premium assistance options and may request to waive the assurance of NEMT services for this expansion population as well.

A small proportion of newly Medicaid eligible adults in states opting to use premium assistance may be considered "medically frail" (defined in 42 CFR 440 § 440.315) and given the choice whether to enroll in the Exchange, with, or perhaps without, a NEMT wrap-around benefit, or traditional Medicaid with an NEMT benefit. Each state defines medical frailty, but federal regulations require that the definition include at least include certain groups of children, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

The states that currently have CMS-approved premium assistance programs anticipate a small number of newly eligible Medicaid beneficiaries will be considered medically frail through self-attestation. The Arkansas waiver request projected, of the 225,000 newly eligible individuals, 10% (22,500) will be deemed medically frail. In Iowa, the state waiver request estimates that 15.8% of the 93,968 newly eligible individuals will default to the traditional Medicaid plan due

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[9] CMS. Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment. Federal Register, 78 FR 42159. July 15, 2013.
[10] CMS. "Medicaid and the Affordable Care Act: Premium Assistance." March 2013.

to medical frailty. It is unclear to what extend the self-attested medically frail will overlap with the chronically ill and if this will be sufficient to ensure transportation of the most medically needy.

NEMT is Essential to Medicaid Beneficiaries

Non-emergency medical transportation is a vital element of healthcare delivery to low-income patients. As presented in the intermediary data above, beneficiaries utilizing behavioral health and dialysis services rely heavily on transportation to access health care. The studies below demonstrate the importance of Medicaid-supported NEMT to health and healthcare outcomes, continuity of care and hospital avoidance.

Lack of Transportation is a Barrier to Care: Studies have identified transportation as a barrier for low-income individuals in accessing timely, necessary and continuing medical care. Many low-income patients do not have automobiles and cannot afford public transportation.[11] The assurance of such medical transportation ensures access to physicians' offices and outpatient facilities to receive routine and preventive care, as well as care for chronic conditions, such as dialysis and cancer treatment. Additionally, persons with disabilities may have special transportation needs and barriers that require specialized vehicles and additional safety measures.

Missing preventive care or prescribed medication can lead to more costly, resource intensive care and hospitalization.[12] A 2006 study found a delay or failure to fill a prescription was more common among those under age 65, African Americans, those with reported incomes of less than $25,000, or those who reported transportation issues.[13] The researchers found that even after adjusting for socio-demographic characteristics, those who reported transportation problems were more likely to report medication non-adherence.

Additionally, many studies have documented the impact of poor transportation on lower use of preventive and primary care and increased use of emergency department services. The provision of-- and access to-- transportation increases the likelihood of primary care physician visits in the pediatric population, HIV-positive adults, and frequent emergency room users.[14] A 2010 study of low-income adults found that nearly one-quarter reported having transportation problems that had caused them to miss or reschedule a clinic appointment in the past.[15]

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[11] Rosenbaum, et al.
[12] MedPAC. *Report to the Congress: Aligning Incentives in Medicare*. June 2010. page 133.
[13] Wroth, T, Pathman, D., "Primary Medication Adherence in a Rural Population: The Role of the Patient-Physician Relationship and Satisfaction with Care," *Journal of the American Board of Family Medicine,* September-October 2006; Volume 19**:** No. 5.
[14] Kim, J, Norton, E, Stearns, S, "Transportation Brokerage Services and Medicaid Beneficiaries'' Access to Care," Health Services Research, 44:1, February 2009.
[15] Silver, Diana, Jan Blustein, and Beth C. Weitzman. 2012. Transportation to clinic: Findings from a pilot clinic-based survey of low-income suburbanites. *Journal of Immigrant and Minority Health* 14, (2) (04): 350-5.

Under the premium assistance option, the newly eligible Medicaid beneficiaries will have health insurance but without NEMT, their access to medical services could be limited, leading to delayed care and/or increased, avoidable hospitalizations.

New Demand for Recurring Behavioral Health Services: Only about 5.5 percent of the currently uninsured who are eligible for Medicaid under expansion report having seen a mental health professional in the last year. However, according to the Kaiser Commission on Medicaid and the Uninsured,[16] over 60 percent of adults with a diagnosable behavioral health disorder and 70 percent of children in need of treatment do not receive mental health services, and nearly 90 percent of people over age 12 with a substance use or dependence disorder did not receive specialty treatment for their illness. Further, a large number of uninsured adults (46% of those with mental illness and 54% of those without) reported that they had not had a check-up in the past two years[17]. Therefore, it has been suggested, "that there is some amount of unmet demand" and as this population gains Medicaid coverage there might be an increase in the use of mental health and substance abuse treatments.[18]

Treatments for behavioral health issues help patients to be productive members of society, maintain employment and care for themselves. However, the new data above shows that transportation is integral to treatment of behavioral health issues. Lack of transportation is a particular problem for beneficiaries with mental illness, as they may be adverse to their medical care and unlikely to seek a means of transportation independently. As noted above, 31.9% of the intermediary's Medicaid NEMT rides were to behavioral health services including substance abuse treatments. To ensure the new Medicaid beneficiaries with unmet behavioral health needs receive such life sustaining treatment, states must offer NEMT to the expansion population.

Transportation Key to Dialysis Treatments: Because people on hemodialysis must receive treatment two to three times a week, reliable transportation is essential to ensure that hemodialysis patients have access to their treatment centers.[19]

According to the United States Renal Data System,[20] the majority of hemodialysis patients rely on others to transport them to and from the dialysis clinic, with 66.8% of patients being

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[16] Kaiser Commission on Medicaid and the Uninsured. "Mental Health Financing in the United States: A Primer." April 2011.
[17] Kaiser Commission on Medicaid and the Uninsured. "The Role of Medicaid for People with Behavioral Health Conditions." November, 2012.
[18] Truven Health Analytics. "Medicaid Expansion: Profiling the Future Medicaid-Eligible Population". January 2012.
[19] Note: Nearly 84% of people receiving dialysis (hemodialysis or peritoneal) have Medicare coverage (through Medicare fee-for-service, Medicare-Medicaid dual coverage, a Medicare HMO, or Medicare Secondary Payer coverage). Medicare does not have a non-emergency medical transportation benefit. Medicare-Medicaid dual eligibles and Medicaid beneficiaries in the three-month waiting period for ESRD Medicare coverage (for beneficiaries that will be participating in hemodialysis treatment in a dialysis facility) are eligible to use Medicaid's NEMT service. In 2011, 14.4% of patients receiving hemodialysis and 11.6% of beneficiaries receiving peritoneal dialysis were Medicare-Medicaid dual eligibles. Data Source*:* U.S. Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. 2013.

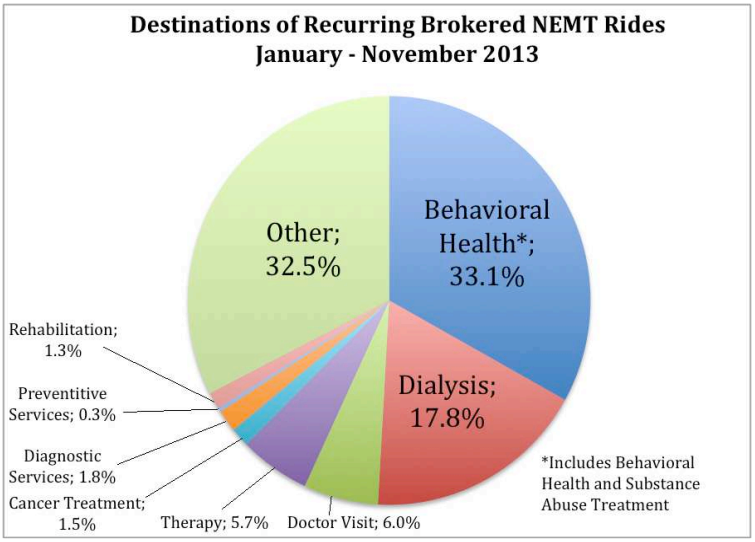
driven by others, including by ambulance. Nearly 8% relied on public transportation such as bus, subway, train or taxi while only 25.3% drove themselves or walked.

Additionally, a 2005 survey[21] of rural North Carolina dialysis patients found that primary transportation barriers include: (1) prohibitive costs; (2) riders being ineligible for transport services; (3) insufficient transportation provider operating hours; (4) depleted transportation provider funding.

Waiving the requirement to provide NEMT to the expansion population enrolled in Medicaid through premium assistance will increase transportation barriers to dialysis services leading to poor health outcomes, increased hospitalizations, and increased transplantations or even deaths. Moreover, waiving NEMT may lead to increased use of more expensive ambulance transportation. Medicare only covers ambulance services for medical emergencies or if alternate forms of transportation could endanger the patient's health. Nonetheless, Medicare has seen an increase in the use of ambulance transportation to non-emergency medical services, particularly to essential dialysis services, as vulnerable patients have few transportation alternatives and Medicare does not include an NEMT benefit.[22]

Transportation to Treatments for Chronic Illness Are a Majority of NEMT Rides

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. Medical spending has grown rapidly in recent years and is placing a significant burden on state budgets. The data provided by the Medicaid NEMT intermediary to the right shows that the majority of rides provided are for recurring transportation, meaning they occur greater than twice per week.



As mentioned above, most Medicaid NEMT rides were to services for substance abuse, dialysis or behavioral health services. Reflecting the differences in benefits and populations, the destinations of recurring rides vary by state. According to the data provided by the transportation intermediary, the states with the highest percentage of recurring rides in

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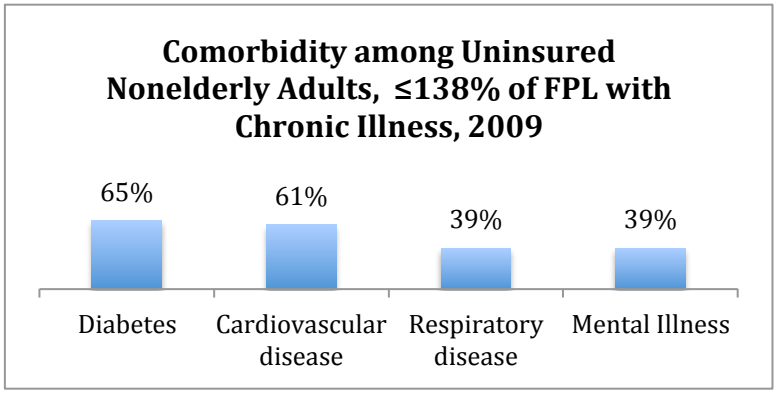
[20] CE Latham, Obstacles to achieving adequate dialysis dose: Compliance, education, transportation, and reimbursement, American Journal of Kidney Diseases, Volume 32, Issue 6, Supplement 4, December 1998, Pages S93-S95.
[21] Lind, M., Sulek, J. (2005). Assessing dialysis transportation needs in rural and small urban transit systems. Urban Transit Institute: North Carolina A & T State University.
[22] MedPAC. Report to the Congress; Medicare and the Health Care Delivery System. June 2013. Pages 167-193.

each category were:

Destination	State with Highest Recurring Rides	State with Second Highest Recurring Rides
Substance Abuse Treatment	Pennsylvania: 57%	Connecticut: 49.4%
Behavioral Health Services	Florida: 31.9%	New Jersey: 26.9%
Dialysis Services	Mississippi: 47.4%	Hawaii: 43.4%

Compounding the impact of the primary conditions on Medicaid beneficiaries, comorbidities are common among individuals with chronic conditions. The Kaiser Commission on Medicaid and the Uninsured found that many uninsured have physical and mental illness comorbidities as illustrated in the adjacent chart.[23]



In addition to expanding health insurance coverage, several provisions of the ACA expand access to health care services that help Medicaid beneficiaries prevent and manage chronic disease. Waiving the NEMT requirement for this population will exacerbate chronic disease, increase comorbidities and result in hospitalizations that would have been avoided if treated with timely and appropriate medical care.

Medicaid NEMT Ensures the Right Type of Transportation at Lowest Cost

Providing a NEMT benefit to Medicaid beneficiaries receiving coverage through premium assistance would reduce unnecessary visits to the emergency department and overutilization of ambulance services. When these new Medicaid beneficiaries need transportation to medical care, without an NEMT benefit they are likely to call an ambulance that is only permitted to transport them to the emergency department, where they will receive care at almost 15 times the cost of routine treatment. A study conducted by Florida State University concluded that if only one percent of the medical trips funded resulted in the avoidance of an emergency room hospital visit, the payback to the State would be 1108%, or about $11.08 for each dollar the State invested in its medical transportation program.[24] A NEMT benefit for this population would ensure these Members receive the preventive care needed to avoid unnecessary and more costly treatment.

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[23] Table adapted from Kaiser Commission. The Role of Medicaid for Adults with Chronic Illnesses. November 2012.

[24] Florida Transportation Disadvantaged Programs Return On Investment Study Prepared By The Marketing Institute / Florida State University's College of Business – Dr. J. Joseph Cronin, Jr.

Conclusion

Allowing states to waive the requirement to provide NEMT to the expansion population enrolled in Medicaid runs counter to the overall goal of the Affordable Care Act to increase access to health care services for all. Eliminating NEMT will increase transportation barriers to life sustaining services for chronic illness. Despite having health insurance, the newly eligible Medicaid beneficiaries will have poor health outcomes, increased hospitalization, or preventable deaths. Additionally, lack of an NEMT benefit will likely increase Medicaid spending through overuse of expensive ambulance services. As described in *Smith v. Vowell* forty years ago, "an untreated, minor medical problem becomes the major medical problem and…... the individual ….. becomes….. sick enough to qualify as an emergency case to be transported by ambulance and to be admitted as a hospital in-patient. It is the worst kind of false economy." The dominance of the chronically ill as users of the NEMT benefit underscores the danger of eliminating the NEMT benefit for any low-income patients, including the new Medicaid beneficiaries.