

Medicaid Non-Emergency Medical Transportation

An Overlooked Lifeline for Older Adults

October 2016



JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults

ISSUE BRIEF • OCTOBER 2016

Written by

Fay Gordon

Staff Attorney, Justice in Aging

Acknowledgments

Justice in Aging would like to acknowledge the [Center for Consumer Engagement in Health Innovation](#) at Community Catalyst for their significant contributions to this issue brief as well state advocates for sharing the real experiences of consumers facing transportation barriers. The author would also like to acknowledge Justice in Aging colleagues Georgia Burke and Amber Christ for their edits and Carol Lee, a former Justice in Aging summer law clerk, for her research contributions to this paper.

Introduction

“When I first booked transportation for my kidney dialysis, they would not let me book more than one month out at a time. What did they think was going to happen, I would stop needing dialysis?”—Diana, on trying to access Medicaid’s non-emergency medical transportation (NEMT) benefit. Diana explained her frustration coordinating her NEMT: “I dread calling them because I know it will be another hour of my life just to book an appointment.”

Diana is one of 20 million adults who receive kidney dialysis three times per week,¹ and one of the 7.1 million individuals across the country² who rely on transportation services to access medical appointments. Medicaid plays a critical role in funding medical transportation,³ which the Centers for Medicare and Medicaid Services (CMS) define as transportation to and from appointments and services for eligible beneficiaries who have a medical need for those services.⁴ When these services work, they help people get to their doctors and other needed health services so they can continue to live at home and in the community. When they do not work, Medicaid beneficiaries like Diana are left stranded, frustrated, and without access to needed medical care and services.

As the country’s population ages and as health programs better support people’s desire to live independently rather than in institutions like nursing homes, demand for transportation services will continue to increase. Along with increased demand, policy factors—like changes in Medicaid funding and the shift to delivery of Medicaid

1 Centers for Disease Control, *National Chronic Kidney Disease Fact Sheet*, (2014), available at: http://www.cdc.gov/diabetes/pubs/pdf/kidney_factsheet.pdf.

2 Katherine Barrett and Richard Green, *States Struggle to Manage Medical Transportation*, *Governing Magazine*, (May 2016), available at: <http://www.governing.com/columns/smart-mgmt/gov-medical-transportation.html>.

3 42 CFR 431.53.

4 MaryBeth Musumeci and Robin Rudowitz, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*, (February 2016), available at: <http://kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers>.

services through managed care—have created additional challenges that make it difficult to adequately meet the growing NEMT need. An estimated 3.6 million Americans miss or delay medical care because of challenges accessing NEMT each year.⁵

This issue brief provides background on this increasingly important component of health care for low-income older adults and people with disabilities; explores challenges to accessing the benefit; and shares examples of state strategies to overcome those challenges.

⁵ P. Hughes-Cromwick and R. Wallace, *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transportation Research Board (October 2005), available at: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

Table of Contents

Acknowledgments	1
Introduction	1
Part 1: NEMT is a Lifeline for Low-Income Seniors.....	3
Part 2: Understanding Medicaid’s Role in NEMT	3
Medicaid’s Responsibility to Provide NEMT	3
NEMT’s Impact on State and Federal Budgets	4
Use of Brokerage Services	4
Part 3: NEMT Challenges and Policy Recommendations	5
Problem 1: Beneficiaries Struggle to Access Timely, Competent, and Appropriate NEMT Services.....	5
Solution 1: Negotiate Stronger MCO/State Contracts with Transportation Brokers and Include Benchmarks and Penalties for Poor Performance	6
Problem 2: Lack of Data and Information on Transportation Broker Performance and Quality.....	9
Solution 2: Improve Data Collection and Transparency with a Dedicated NEMT Consumer Complaint Reporting System	9
Problem 3: Infrequent and Unclear State and Federal Oversight Over the Transportation Benefit	10
Solution 3: Improve Oversight Mechanisms and Stakeholder Engagement	10
Problem 4: Beneficiaries in Rural Areas Have Difficulty Accessing Transportation	11
Solution 4: Manage Transportation Contracts at the State Level.....	11
Conclusion	11

Part 1: NEMT is a Lifeline for Low-Income Seniors

Medicaid NEMT is transportation for Medicaid beneficiaries to and from appointments and services.⁶ Many Medicaid beneficiaries need this service, including people with disabilities and others, though in this brief we focus in particular on older adults. That's because access to reliable medical transportation services becomes increasingly important as individuals age. Vision or cognitive loss, as well as physical changes, such as reduced strength and arthritis, may compromise older adults' ability to drive or use public transportation. Without access to transit options, this loss causes isolation. On any given day, more than 50% of non-drivers 65 and older stay home.⁷ For older adults who need long-term services and supports, transportation to attend medical appointments can be the difference between aging at home and moving into an institution.

Medicaid transportation services are particularly important for low-income older women. While nearly 90% of women 50-64 drive, the number decreases dramatically with age.⁸ Among women older than 75, nearly 40% do not drive, causing increased risk of isolation and gaps in care. Non-driving older adults in rural communities are at a particular disadvantage as they tend to have fewer public transportation options.⁹

NEMT is critical for ensuring low-income individuals have access to behavioral health services, preventive health services, and care for chronic conditions.¹⁰ The most frequently cited reasons for using NEMT are accessing behavioral health services, dialysis, preventive services, specialist visits, physical therapy, and adult day health care services.¹¹ As low-income older adults do not have the resources to pay for transportation services out of pocket, Medicaid NEMT is a necessary lifeline to ensure low-income older adults can access medical services.

Part 2: Understanding Medicaid's Role in NEMT

Medicaid's Responsibility to Provide NEMT

Each state Medicaid program is responsible for providing NEMT to Medicaid beneficiaries. The Medicaid NEMT benefit¹² is authorized in federal statute¹³ and federal regulations require state programs to "assure" CMS that the state's Medicaid agency will ensure necessary transportation for beneficiaries to and from providers.¹⁴ CMS has interpreted this requirement to mean that state Medicaid agencies must, at a minimum, 1) ensure necessary transportation to and from providers, 2) use the most appropriate form of transportation, and 3) include coverage for transportation and related expenses necessary to secure medical

6 Centers for Medicare and Medicaid Services, *Non-Emergency Medical Transportation*, available at: <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf>.

7 AARP, *Enhancing Mobility Options for Older Americans* (2004), available at: http://www.apt.com/resources/reportsandpublications/Documents/enhancing_options.pdf.

8 Jana Lynott and Carlos Figueiredo, *How the Travel Patterns of Older Adults are Changing: Highlights from the 2009 National Transportation Survey*, AARP Public Policy Institute, (April 2011), available at: <http://assets.aarp.org/rgcenter/ppi/liv-com/fs218-transportation.pdf>.

9 Government Accountability Office, *Transportation Disadvantaged Populations: Nonemergency Medical Transportation Not Well Coordinated, and Additional Federal Leadership Needed*, (December 2014), available at: <http://gao.gov/assets/670/667362.pdf>.

10 MaryBeth Musemici and Robin Rudowitz, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*, Kaiser Family Foundation, (February 2016), available at: <http://kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicare-expansion-waivers>.

11 *Id.*

12 Centers for Medicare and Medicaid Services, *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, <https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf>.

13 *Id.* citing 42 U.S.C. § 1902(a)(7) and 44 CFR § 170.

14 42 CFR §431.53. The regulations detail the state Medicaid agency's requirement in a state plan.

examination and treatment.¹⁵

In 2005, the Deficit Reduction Act (DRA)¹⁶ amended the Medicaid statute¹⁷ to create state flexibility that made it more attractive for states to establish NEMT brokerage programs.¹⁸ The DRA amendments, clarified in 2008 regulations, permit states to establish an NEMT brokerage program without regard to statutory requirements for “comparability, state-wideness and freedom of choice.”¹⁹ With this flexibility, states can designate certain allowable modes of transportation or determine transportation on a contract basis with transit providers, thus limiting the beneficiaries’ choice of provider.²⁰ Over time, states have become increasingly reliant on transportation brokers to deliver the NEMT benefit.²¹

NEMT’s Impact on State and Federal Budgets

Medicaid federal and state spending on NEMT is a small part of the total Medicaid program, but spending on the benefit is not trivial. In 2013, Medicaid spending on NEMT was approximately \$1.5 billion,²² a \$500 million increase in spending since 2010.²³ That \$1.5 billion represents less than 1% of total state and federal Medicaid expenditures.²⁴ Studies demonstrate that NEMT offers a positive return on investment for states; one Florida study estimated that 1% of all medical transportation trips prevent a one-day stay in a hospital, resulting in a return on investment of 11: 1.²⁵

Use of Brokerage Services

Many states took advantage of the DRA changes and shifted NEMT management to brokerage services, and brokerage firms now dominate the Medicaid NEMT market.²⁶ At least 39 states use transportation brokers.²⁷

Brokerage firms operate in the transportation space like a managed care organization (MCO) operates in health care. The state or MCO contracts with the brokerage firm, and the broker assumes the responsibility to coordinate transportation benefits in a particular geographic area for a capitated fee. The broker does not actually transport consumers, rather, the broker coordinates with local transportation providers to provide

15 CMS, *Medicaid Non-emergency Medical Transportation Booklet for Providers* at 4.

16 Pub. L. 109-171.

17 Sara Rosenbaum, *Medicaid’s Medical Transportation Assurance, Origins, Evolution, Current Trends and Implications for Health Reform*, (2009), available at: http://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/34.

18 *Id.* citing: 73 FR 77519 (December 19, 2008) adding §1902(a)(70) to Social Security Act; 42 C.F.R. 440.170(a)(4), effective January 20, 2009.

19 *Id.* citing 73 FR 77520 (December 19, 2008).

20 Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community*, National Conference of State Legislatures, (January 2015), available at: <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.

21 Pub. L. 109-171.

22 Government Accountability Office, *Nonemergency Medical Transportation*, GAO-16-238 (February 2, 2016), available at: <http://www.gao.gov/assets/680/674934.pdf>.

23 *Id.*

24 Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community*, National Conference of State Legislatures, (January 2015), available at: <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.

25 The Stephen Group, *Arkansas Health Reform Task Force: Health Care Reform/Medicaid Consulting Services*, (October 2015), available at: <http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20II%20Recommendations.pdf>, citing: Joseph Cronin, Jr., *Florida Transportation Disadvantaged Programs return on Investment Study*, (March 2008), available at: http://s3-ap-southeast-2.amazonaws.com/resources.farm1.mycms.me/transportconnect-org-au/Resources/PDF/ROI_Florida.pdf.

26 Sara Rosenbaum, *Medicaid’s Medical Transportation Assurance, Origins, Evolution, Current Trends and Implications for Health Reform*, (2009), available at: http://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/34.

27 *Id.*

the beneficiary with transportation services. The beneficiary must go through the transportation broker to book and schedule all rides and services. Thus, in most instances, the broker acts as an administrative gatekeeper, call center, and transportation case coordinator.

The largest broker of non-emergency transportation programs in the United States is LogistiCare, LLC.²⁸ LogistiCare pioneered the transportation broker model, and according to its operations map (which was removed from their website in 2016), the company currently operates in 39 states and the District of Columbia.²⁹ LogistiCare's broker services include customer and trip authorization, utilization management, data collection, billing, and claims. The majority of LogistiCare's revenue is generated under capitated contracts with states, regions/districts and counties, or contracts with MCOs.³⁰ These contracts range in size by state. For example, in 2012, Wisconsin paid LogistiCare \$37.5 million for brokerage services,³¹ while New Jersey contracted with LogistiCare for \$165 million annually.³²

Part 3: NEMT Challenges and Policy Recommendations

In the decade after the DRA, older adults have increased both in number and in transportation need. There are over 7 million more older adults today than a decade ago.³³ Furthermore, in the last ten years many states shifted their programming and payment models for both transportation and health care³⁴ from a fee-for-service model to a capitated, contract model.

Increased need has led to increased demand for spending on NEMT. Yet, despite increased spending and efforts to better manage the delivery of NEMT, anecdotal reports and documented complaints demonstrate persistent challenges with the NEMT benefit. Problems include accessing services, monitoring delivery of services, oversight of brokers and providers, and access to transportation in rural areas. The next section of this brief describes these challenges in detail and recommends policy solutions to improve the NEMT benefit.

Problem 1: Beneficiaries Struggle to Access Timely, Competent, and Appropriate NEMT Services

Across states, Medicaid beneficiaries report challenges accessing quality NEMT services. Advocates in New Jersey note that Medicaid beneficiaries “regularly struggle to make appointments, are treated with disrespect by drivers and customer service staff, are abandoned at medical offices, (and are) picked up several hours late for appointments.”³⁵ Similarly, in 2016, advocates from the Center for Children's Advocacy in Connecticut filed a federal complaint against LogistiCare after the broker failed to transport

28 LogistiCare, <https://www.logisticare.com/>.

29 LogistiCare Operations Map, previously available at <http://www.LogistiCare.com/operations-map.php> (webpage removed in 2016).

30 Texas A & M Transportation Institute, *Examining Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination*, (December 2015) available at: <http://tti.tamu.edu/group/transit-mobility/files/2015/12/TCRP-B-44-Review-and-Summary-of-Relevant-Literature-FinalR.pdf>.

31 *Id.*

32 Susan Livio, *Medicaid ride service is called unreliable in patient survey*, NJ.Com, (May 20, 2016), http://www.nj.com/healthfit/index.ssf/2016/05/medicaid_ride_service_called_unreliable_and_unsafe.html.

33 Compare 43.1 million adults 65 and over in 2012 (<https://www.census.gov/prod/2014pubs/p25-1140.pdf>) to 35.9 million in 2005 (<https://www.census.gov/prod/2006pubs/p23-209.pdf>).

34 Paul Saucier, et. al., *The Growth of Managed Long-Term Services and Supports Programs: A 2012 Update*, (July 2012), available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf (Finding the number of states with MLTSS programs doubled from 8 to 16 between 2004 and 2012).

35 Letter from Faith in New Jersey to Division of Medical Assistance and Health Services, (August 2014), available at: <http://www.faithinnewjersey.org/resources/body/PICO-CCOP-Medicaid-Transportation-RFP-comments-8-7-14.pdf>.

children to their chemotherapy treatments.³⁶

Solution 1: Negotiate Stronger MCO/State Contracts with Transportation Brokers and Include Benchmarks and Penalties for Poor Performance

With the majority of states contracting with private transportation brokers, contracts are a natural place to build accountability. In the health care space, consumer advocates have sought managed care contract provisions that include measurable goals and penalties to improve performance. A similar approach should be applied to transportation. There are several options for states seeking to strengthen their contracts with transportation brokers to improve performance:

Implement strict benchmarks and performance requirements in the contract

While performance benchmarks and quality metrics are standard in health care organization contracts, states are just beginning to utilize benchmarks to evaluate NEMT. In New Jersey, after advocates persuaded the state Medicaid director to conduct on-site visits in communities where Medicaid beneficiaries were struggling to access NEMT services,³⁷ the state agreed to amend its contract with LogistiCare, incorporating many advocate recommendations. Building on the work of the New Jersey advocates, we recommend the following changes:

- **Improved complaint collection:** Advocates have reported that many contracted brokers have their own complaint process that is unknown to advocates and separate from the state or MCO's complaint process. There is concern that not all complaints are being tracked properly and adequately addressed. Accordingly, the contractor should log all complaints and submit reports of all complaints to the state/MCO on a monthly basis. The state/MCO should have some method of independently verifying the data submitted by the contractor, and the data should be shared with stakeholders at least quarterly.
- **Electronic tracking to pinpoint driver location:** The contractor should be required to use real-time GPS monitoring to ensure timeliness in pick-ups, as well as data quality.
- **Driver training:** The contractor must ensure that all of its transportation vendors adequately train their drivers on the type of transportation service being provided (e.g. door-to-door versus curbside) and how to appropriately serve their passengers in a culturally competent manner.
- **Additional customer service training:** The contractor must train all customer service representatives in a standard model to document, resolve, and log all complaints.
- **Shortened wait times for scheduled trips:** All pick-ups and drop-offs should be delivered with a wait time that does not exceed 20 minutes for 90% of beneficiaries.
- **Shortened wait times for unscheduled will-call trips:** Will-call trips should have a wait time of 45 minutes or less.³⁸

Link performance benchmarks with progressive penalties

To incentivize performance, the benchmarks should be tied to progressive enforcement penalties. For

36 Josh Kovner, *Civil Rights Complaint Made Against Company that Provides Patient with Rides*, Hartford Courant, (March 18, 2016), available at <http://www.courant.com/news/connecticut/hc-children-logisticare--medicaid-0319-20160318-story.html>.

37 Kim Mulford, *Why NJ overhauled a Medicaid transportation contract*, Courier Post, (January 2016), available at: <http://www.courierpostonline.com/story/news/health/2016/01/21/camden-beat-goliath-LogistiCare-medical-transport/79068508>.

38 Letter from Faith in New Jersey to Division of Medical Assistance and Health Services, (August 2014), available at: <http://www.faihinnewjersey.org/resources/body/PICO-CCOP-Medicaid-Transportation-RFP-comments-8-7-14.pdf>.

example, in New Jersey, advocates recommended linking wait times and no-shows to penalties, such that if the contractor only reaches 80% of on-time pickups, the penalty is \$20,000. If the contractor improves, and hits a benchmark of 85% of on-time pickups, the penalty for the 15% of delays is capped at \$15,000. Similarly, Texas has created a quality performance matrix with progressive liquidated damages to track and enforce quality in the transportation benefit.

EXAMPLE: Texas NEMT Performance Metrics and Liquidated Damages:³⁹

RFP Section	Performance Standard	Performance Standard	Liquidated Damage Value
2.3.10.11	<p>The monthly average maximum wait (before answered by a live person) will not exceed 900 seconds.</p> <p>This measure is calculated as follows: 1. The contractor must track the length of the call that had the longest wait prior to speaking to a live person, each day. 2. The wait time includes all time spent in the customer service line as well as the time waiting in queue. 3. The length of each daily call with the longest wait, prior to speaking to a live person for the month will be combined and divided by the total number of business days in the month, 4. The resulting number must not exceed 300 seconds.</p>	Monthly average maximum wait of 900 seconds, or less.	\$2,500 for the first month in which the average maximum wait times fail to meet the monthly standard specified related to the client toll free line for transportation services. Liquidated damages will continually increase by \$1,250 for each subsequent, consecutive month that noncompliance continues.
2.11.1	Customer Service Surveys The contractor must maintain a 95% client satisfaction survey result as determined by the survey conducted by the independent research organization. Corrective action plans must be submitted to HHSC if less than 95% client satisfaction	95% of all client surveys will indicate satisfaction with transportation services provided or arranged by MTO or its Performing Providers.	\$2,500 for each quarter that client surveys did not meet the 95% threshold.

³⁹ Texas Health and Human Services Commission, Nonemergency Medical Transportation Organizations Key Performance Requirements, released via RFP contract number 529-15-0002 on November 25, 2013 (no longer available online).

RFP Section	Performance Standard	Performance Standard	Liquidated Damage Value
2.11.1	The contractor must contract with an independent research organization to conduct quarterly client and medical service provider satisfaction surveys.	100% of all client surveys will be performed by an independent contractor.	\$8,000 for each quarter that client surveys are not conducted by an independent organization.

Suspend or terminate providers with consistent performance problems

The Government Accountability Office (GAO) recently found that states do not adequately discipline poorly performing transportation providers.⁴⁰ When complaints and data identify consistent poor performers, contract suspension and/or termination may be necessary. The GAO has recommended states strengthen discipline for poor performers using probation periods or suspension to address patterns of provider no shows.⁴¹

Re-open the transportation broker contract

Following the transportation problems in Connecticut, consumer advocates and medical providers joined forces and convinced the state legislature to take action. In 2016, the legislature approved a bill that would have required the state Department of Social Services to solicit competitive bids, via formal requests for proposals, before entering new contracts for NEMT.⁴² LogistiCare is the current state contractor, with a contract for \$25 million over four years.⁴³ In June 2016, the governor vetoed the bill on grounds of legislative overreach. Despite the veto, the administration decided on its own to proceed with a new RFP process to improve the broker contracting process.⁴⁴

Some states are pursuing contracts with brokers that use new and highly technology-dependent approaches to providing the transportation benefit. In Idaho, the state initiated a contract with a completely new transportation broker following an open RFP process. When the state’s contract with American Medical Response (AMR) expired in early 2016, the state opened up the bidding process and initiated a contract with Veyo, a new app-based Independent Driver Program.⁴⁵ Veyo spun off from a traditional NEMT transportation provider, Total Transit,⁴⁶ and as of July 2016, the company became responsible for administering, coordinating, and managing all NEMT for Idaho Medicaid participants.⁴⁷ The company uses GPS, cloud-based, mobile systems and data analytics to track and monitor drivers and trips in real time.⁴⁸ The transition to a single, technology-based provider has faced resistance from the previous Idaho

40 GAO at 25. <http://www.gao.gov/products/GAO-16-238>.

41 GAO at 25. <http://www.gao.gov/products/GAO-16-238>.

42 John Lender, *Malloy Vetoes Bill Requiring Competitive Bids for \$25M Contract*, Hartford Courant, (June 3, 2016), available at: <http://www.courant.com/politics/hc-malloy-transit-bill-20160603-story.html>.

43 *Id.*

44 *Id.*

45 Audrey Dutton, *Can Uber-style rides work for Medicaid Patients in Idaho?*, Idaho Statesman, (July 13, 2016), available at: <http://www.idahostatesman.com/news/local/watchdog/article89518017.html>.

46 Veyo, *5 Reasons to Say Goodbye to the traditional Provider Fleet and Hello to the Veyo Virtual Fleet*, (April 6, 2016), <http://news.veyo.com/5-reasons-to-say-goodbye-to-the-traditional-provider-fleet-and-hello-to-the-veyo-virtual-fleet>.

47 Idaho Department of Health and Welfare, *Medical Transportation*, <http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/MedicalTransportation/tabid/704/Default.aspx>.

48 Audrey Dutton, *Can Uber-style rides work for Medicaid Patients in Idaho?*, Idaho Statesman, (July 13, 2016), available at: <http://www.idahostatesman.com/news/local/watchdog/article89518017.html>.

NEMT provider network⁴⁹ and some user frustration.⁵⁰ The company claims that their on-time delivery rates are 99.5% and grievance rates are 0.1%.⁵¹ At this time, it is too early in the transition to independently evaluate or to recommend this tech-based model versus traditional brokers. However, we do recommend close monitoring of the experiment in Idaho to determine if that state's new approach to providing the transportation benefit results in improved services for consumers.

Problem 2: Lack of Data and Information on Transportation Broker Performance and Quality

To ensure that the solutions above work, states need to collect data on provider performance and share the data in a transparent manner with stakeholders. It is currently exceedingly difficult to access NEMT broker quality data or even to know whether such data exists. There are few standards about the kind of data that brokers are required by states or CMS to collect, and in many cases brokers claim that the data they do have is proprietary. This is an unacceptable standard of transparency for taxpayer dollars.

Solution 2: Improve Data Collection and Transparency with a Dedicated NEMT Consumer Complaint Reporting System

Develop a dedicated NEMT consumer complaint reporting system

States that provide Medicaid managed care will soon be required, under federal regulations, to develop a Beneficiary Support System (BSS).⁵² The BSS will provide an access point for complaints and concerns and will be required to review program data to offer states guidance on resolving systemic issues. The BSS complaint tracking system should track and monitor complaints about transportation brokers, which would provide the benefit of a neutral party tracking complaints instead of simply relying on the broker itself to log complaints accurately. This information should be shared regularly with the state Medicaid agency to help the state understand underlying systemic problems. In addition to the complaint tracking and monitoring, the BSS is tasked with helping Medicaid beneficiaries understand and navigate managed care. This should include assistance with transportation challenges and complaint reporting on missed appointments and customer service problems.

Share transportation reporting data in a transparent manner with stakeholders

States should include transportation in health care quality dashboards and transparently share information with stakeholders on at least a quarterly basis. In 2015, Connecticut proposed developing a Health Data Dashboard,⁵³ an online repository showcasing select metrics on individual Medicaid services. The core services the state planned to track were medical, behavioral, non-emergency transportation, dental, pharmacy, and LTSS (Long Term Services and Supports). Under NEMT, the state planned to report on covered services, outcomes, member experience, provider experience, spending, and utilization. While the state has not yet launched the dashboard, it will be one of the first in the country to track and share this transportation information in a transparent manner.

Another model for reporting transparency is the reporting dashboards used to track data in the

49 Idaho Providers, <http://www.idahoproviders.com>.

50 Audrey Dutton, *Can Uber-style rides work for Medicaid Patients in Idaho?*, Idaho Statesman, (July 13, 2016), available at: <http://www.idahostatesman.com/news/local/watchdog/article89518017.html>.

51 *Id.*

52 42 C.F.R. §§ 438.71, 438.819, 438.816.

53 Connecticut Medical Assistance Program Oversight Council, *HUSKY Health Data Dashboard Presentation*, (January 16, 2015), available at: <http://www.ct.gov/dss/lib/dss/husky/MAPOC11615HUSKYHealthDataDashboard.pdf>.

Medicare-Medicaid financial alignment demonstration projects currently underway in about a dozen states. In California, for example, the state prepared a monthly dashboard when it transitioned to capitated, managed care for dual eligible individuals. The state regularly shares data on plan enrollment, health risk assessment completion, service utilization, and appeals.⁵⁴ Applying this level of transparency to transportation services would help ensure that all stakeholders have access to the same information when contemplating programmatic improvements.

Problem 3: Infrequent and Unclear State and Federal Oversight Over the Transportation Benefit

The recommendations above require consistent and thorough oversight at the state and federal level. Currently, states are responsible for NEMT program oversight, with CMS utilizing the agency's regular oversight activities to monitor the state activity. According to a recent GAO report, this process needs updating.⁵⁵

Solution 3: Improve Oversight Mechanisms and Stakeholder Engagement

Both CMS and the states can contribute to improvements in oversight.

At the federal level, update guidance to states on NEMT

States need updated guidance to better manage the NEMT program. A recent GAO report pointed out the last time CMS issued state guidance on operating an NEMT program was 1998.⁵⁶ In response to the report, HHS has stated that the agency is examining current guidance and will update the guidance as necessary.⁵⁷

At the state level, fund and invest in a dedicated NEMT oversight entity

One promising state model, from Texas, is a centralized NEMT oversight office. Following legislation in 2014, Texas' Health and Human Services Commission (HHSC) designated a specific office, the Texas Medical Transportation Program (MTP) to arrange, administer, and conduct oversight of its \$183 million NEMT program.⁵⁸ The oversight is conducted by designated staff, known as Contract Specialists, who monitor NEMT contractors.⁵⁹ The office uses on-site and desk reviews as part of its oversight of driver compliance with training requirements and criminal history checks, vehicle standards, call metrics, and quality and timeliness of the delivery of transportation services. Corrective action plans and assessments of liquidated damages are available remedies for failure to comply with contract requirements.⁶⁰

Building on Texas' model, the oversight entity should also be responsible for regularly convening transportation advocates and beneficiaries who use NEMT to learn first-hand about problems faced by consumers and work collaboratively to develop systemic fixes.

Oversight of this scale requires investment. In Texas, the investment in oversight has helped ensure the

54 Department of Health Care Services, *Cal MediConnect Performance Dashboard*, (March 2016), available at: <http://www.calduals.org/wp-content/uploads/2016/03/CMC-Performance-Dashboard-March-2016-Release.pdf>.

55 Government Accountability Office, *Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States*, (March 2016), available at: <http://www.gao.gov/products/GAO-16-238>.

56 *Id.*

57 *Id.* at 33.

58 Texas Health and Human Services, *Self Evaluation Report*, (September 2013), available at <https://www.sunset.texas.gov/public/uploads/files/reports/Accessible%20HHSCSER2013Final.pdf>.

59 *Id.*

60 *Id.*

state is only contracting with providers that deliver quality services. The heightened oversight to date has resulted in issuance of one Corrective Action Plan against one transportation broker, termination of one contract, and two assessments of liquidated damages, one in 2015 for \$95,000 and the other in 2016 for \$200,000.⁶¹

Problem 4: Beneficiaries in Rural Areas Have Difficulty Accessing Transportation

In a 2016 report, GAO identified officials from seven states and nine stakeholders who reported a low supply of NEMT providers in rural areas, and officials from seven states and four stakeholders who reported a low supply of specialty vehicles, such as stretcher or wheelchair vans in rural areas.⁶²

Solution 4: Manage Transportation Contracts at the State Level

One rural state, Vermont, has recently taken a collaborative approach to managing its transportation provider challenge. The state does not use a transportation broker and instead offers 12 separate provider contracts for transportation services.⁶³ The Medicaid program oversees and monitors the providers but the providers themselves manage the delivery of services. Vermont's experiment should be monitored closely to see if it offers a promising path for improving services to rural consumers.

Beyond the approach being implemented by Vermont, we struggled to identify solutions for increasing transportation access in rural areas. Long distances, a shortage of providers, and isolated consumers all serve to make this a challenging problem to solve. We recommend that CMS convene a subgroup of rural consumers, providers, and state Medicaid directors to work together to identify solutions to this problem.

Conclusion

Consumer stories, news articles, and auditing agency findings all demonstrate a need to significantly improve NEMT oversight and reporting in order to address growing consumer access challenges. Without access to a functioning, quality transportation assistance program, many low-income older adults will continue to struggle to access medical services, thereby threatening their ability to age at home and in the community. As the number of older adults with transportation needs increases daily, states and CMS should prioritize NEMT improvements in their overall health care delivery system reform efforts.

61 E-mail with Dimitria Pope, Director, Texas HHSC Medical Transportation Program, dated July 14, 2016.

62 Government Accountability Office, *Nonemergency Medical Transportation: Updated Medicaid Guidance Could Help States*, (March 2016), available at: <http://www.gao.gov/products/GAO-16-238>.

63 Katherine Barrett and Richard Greene, *States Struggle to Manage Medical Transportation*, (May 2016), <http://www.governing.com/columns/smart-mgmt/gov-medical-transportation.html>.