
Members of the Taxicab, Limousine & Paratransit Association (TLPA) developed this paper, *Non Emergency Medicaid Transportation: How to Maximize Safety and Cost Effectiveness Through Better Use of Private For-Hire Vehicle Operators*. The paper serves two purposes: first, educating members of the TLPA on the issues involved with Non-Emergency Medicaid Transportation (NEMT); and second, as a tool to encourage public entities to develop better RFP processes for these types of services. The paper includes two Appendices, Appendix A is intended to illustrate how NEMT is essential because without transportation services, people who rely on Medicaid are placed at risk of missing routine or preventive care, the absence of which can lead to more costly care and hospitalization. Appendix B includes the summary of a rule on the use of brokers by states; *Medicaid Program: State Option To Establish Non-Emergency Medical Transportation Program* and the summary of a proposed rulemaking that would allow states to opt out of the obligation to provide NEMT if they offered Medicaid clients higher levels of insurance coverage.

**Introduction**

The Medicaid program provides health coverage and long-term care support services to 59 million individuals. The program provides this coverage and assistance to about 45 million people in low-income families and nearly 14 million elderly and disabled people, including nearly 9 million low-income Medicare beneficiaries for whom it fills gaps in Medicare coverage. Medicaid provides critical funding for a range of safety net providers. Medicaid plays a major role in our country’s health care delivery system, accounting for about one-sixth of all health care spending in the U.S. and nearly half of all nursing home care. States and the federal government jointly fund the Medicaid program. In 2006, total Medicaid expenditures exceeded $300 billion. The federal government guarantees matching funds to states for qualifying Medicaid expenditures, which include payments states make for covered Medicaid services provided by qualified providers to eligible Medicaid enrollees. The federal matching percentage (officially known as the Federal Medical Assistance Percentage, or FMAP) varies by state from a floor of 50 percent to a high of 76 percent. On average, across all states, the FMAP is now approximately 55 percent. Each state’s FMAP is calculated annually using a formula set forth in the Social Security Act.

As part of its services, Medicaid provides non-emergency medical transportation (NEMT) at an annual cost exceeding $2 billion. This transportation is essential to the Medicaid program carrying out its public service mandate. According to the Centers for Medicare & Medicaid Services (CMS) rule on Medicaid transportation a State plan must “specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers.” States have great flexibility in meeting the mandate of assuring medical transportation. To assure transportation, states look to contracting with transportation providers, using public transportation, helping clients obtain transportation by coordinating with other programs, or providing reimbursement directly to clients.

The Taxicab, Limousine & Paratransit Association (TLPA), formed in 1917, is the national organization that represents the owners and managers of taxicab, limousine, sedan, airport shuttle, paratransit, and non-emergency medical fleets. TLPA has over 1,000 member companies that operate over 100,000 passenger vehicles. TLPA member companies transport over 2 million passengers each day — more than 900 million passengers annually. Many TLPA operator members
participate in the Medicaid program through contractual arrangements. They understand and meet Medicaid client transportation needs in a safe and cost effective manner.

This paper was written by TLPA operators who provide Medicaid transportation services, in order to offer recommendations to government officials and others responsible for Medicaid transportation. TLPA wants to ensure that Medicaid clients receive a high level of service by qualified drivers working for qualified companies who are willing to meet high levels of scrutiny and maintain high performance standards by:

• Improving the quality and reliability of service and reducing costs by creating a competitive environment that provides for accountability;
• Reducing liability and claims by assuring safer and high quality transportation with drivers appropriately trained for Medicaid transportation service, vehicles that are safe and well maintained, and companies that are properly insured and licensed.

Quality, safe, reliable and cost effective Medicaid transportation benefits the Federal and State governments, Medicaid clientele, and taxpayers.

**Background**

There is a new public transportation paradigm in this country. No longer is the focus of public transportation providers limited to providing rides. More and more public transportation providers are evolving into mobility managers by coordinating human service transportation and utilizing existing public and private providers in order to meet the needs of consumers who must have access to health care, jobs or job training, education, social networks, and other quality of life services.

Human service transportation includes a broad range of transportation service options designed to meet the needs of transportation-disadvantaged populations including older adults, disabled persons and/or those with lower income. Individuals have different needs and may require a set of different services depending on their abilities, their environment, and the options available in their community. Examples may include dial-a-ride (responding to individual door-to-door transportation requests), the use of bus tokens and/or transit passes for fixed route scheduled services, accessing taxi vouchers and/or mileage reimbursement to volunteers or program participants. With the impetus provided by President Bush’s Executive Order on Human Service Transportation Coordination released on February 24, 2004, and the United We Ride program developed by the Federal Coordinating Council on Access and Mobility, coordination is a major initiative with every one of the 64 Federal programs that include funding for passenger transportation.

Coordinating individual human service transportation programs makes the most efficient use of limited transportation resources by avoiding duplication caused by overlapping individual program efforts and encouraging the use and sharing of existing community resources. In communities where coordination is made a priority, citizens benefit from more extensive service, lower costs and easier access to transportation. Coordination can improve overall mobility within a community, particularly when human service agencies are each providing transportation to their own clients. It works by eliminating the inefficiencies within disparate operations and service patterns that often result from a multiplicity of providers. Greater efficiency helps to stretch the limited (and often insufficient) funding and personnel resources of these agencies. When appropriately applied, coordination can lead to significant reductions of operating costs (per trip) for transportation
providers. People in need of transportation also profit from enhanced transportation and high quality services when operations are coordinated. Coordination offers numerous potential benefits to participating agencies, not the least of which is cost savings from economies of scale and sharing of resources. Whether it is a single agency or a number of coordinated agencies, contracting with existing private transportation providers brings many potential benefits to public and non-profit agencies including improved flexibility, expertise, innovation, balancing different demands, and fare and service options.

Executive Order 13330 established the Interagency Transportation Coordinating Council on Access and Mobility (CCAM). The purpose of the Council is to coordinate the different Federal programs that provide funding to be used in support of human services transportation, The Council is comprised of 11 Federal departments, including the Departments of Transportation, Health and Human Services, Labor, Education, Housing and Urban Affairs, Agriculture, Justice, Interior, the Veterans Administration, the Social Security Administration and the National Council on Disabilities. Specifically, the CCAM established the United We Ride initiative to support States and their localities in developing coordinated human service delivery systems. In addition to State coordination grants, United We Ride provides State and local agencies a transportation-coordination and planning self-assessment tool, help along the way, technical assistance, and other resources to help their communities succeed. In short, United We Ride is responsible for simplifying access to transportation, producing cost effective service within existing resources, and reducing duplication.

TLPA embraces transportation coordination and believes that its member transportation companies are a valuable existing resource that many agencies should use to the public’s benefit. Since coordination of human services transportation is being embraced across the country as good public policy, TLPA believes there will be increasing opportunities for private providers to participate in the provision of human services transportation such as Medicaid.

Models (Strategies) for Non-Emergency Medical Transportation

Currently, there are four prominent models or strategies that have emerged as a means to manage Medicaid transportation in an effort to increase control over costs, improve the quality of services and to reduce fraud and abuse: Administrative Managers, Managed Care Models, Transportation Brokerages, and Broker Operators (Transportation Brokers that are also transportation operators).

1. Administrative Manager Models utilize administrative managers who are state Medicaid agency staff members who assume the role of gatekeepers by monitoring transportation providers and client/recipient uses of services, or indirectly accomplish this function through contracts with county or regional agencies to handle administrative functions. This model can be a very effective model for managing Medicaid Non Emergency Transportation because it does not duplicate infrastructures already in place and does not place another layer of bureaucracy between the agency and the client, which is typically the case with the other Medicaid management strategies. However, this model is subject to the budgetary process and may have limited resources when there is a need to develop and maintain a Medicaid program encompassing the appropriate staffing levels, and Information Technology development and maintenance, required to take advantage of rapidly changing, cost effective technologies as they become available. The Alabama Medicaid Agency is typical of this Administrative Manager Model. Alabama uses ten
regional coordinators who familiarize themselves with their area, learning of all the various free and fee transportation services. These coordinators establish relationships with local transporters, local medical and human service agencies and are valuable in coordinating service for clients. Some clients prefer to select their own transporter and other clients ask for total assistance in finding, scheduling and obtaining transportation. A directory contains all the various transport source information and is constantly updated when coordinators find new sources of transportation. By having these 10 coordinators placed throughout the state, we believe we are able to find the least expensive appropriate transportation best suited to the needs of our beneficiaries without compromising quality of service.

2. Managed Care Models are evolving in states where responsibility for medical transportation has been assigned to managed care organizations (MCOs). Under the Medicaid Managed Care model, non-emergency transportation is included in benefit packages covering both acute and behavior health recipients. The projected costs of providing transportation assistance to Medicaid enrollees are included in the monthly payments to MCOs based on the number of covered individuals. The health plan assumes the risk that all medically necessary transportation can be provided to its Medicaid enrollees for a fixed monthly fee. Because the MCOs are directly concerned with the welfare of their clients, access to care may improve over the state managed model. The use of the managed care model for managing Medicaid transportation is growing. Currently, the states of California, Delaware, Illinois, Indiana, Iowa, Maine, Minnesota, New Jersey, New York, Oregon, Rhode Island, Texas, and Wisconsin use this model. In 2009, Florida, Michigan, New Mexico, North Carolina and West Virginia are introducing the managed care model for managing Medicaid transportation.

3. Transportation Brokerages coordinate transportation services for Medicaid recipients including screening of recipient, determination of eligibility, and arrangement and payment for actual transportation. As with each of these models, brokers serve as gatekeepers to control costs and the utilization of services, and to assure consistent quality of transportation services and access to care. In Arkansas, the state Medicaid agency establishes a capitated monthly rate for each Medicaid recipient, out of which the broker covers both its administrative and direct service costs. In Washington State, brokers accept a flat per trip reimbursement rate, which includes an administrative fee equal to roughly 13% of actual trip costs. In Oregon, the state caps total payments to its broker during a funding period at a fixed amount including 18% for program administration. The Washington State and Oregon methods for paying brokers appear to be better for client service than the capitated model used in Arkansas because when brokers are being paid a flat fee, they tend to hire the least expensive mode or type of transportation. To be fair, this tends to be the goal of the contracting agencies to begin with. Medicaid policy and program managers mandate using the least expensive transportation option based on the mode of service the client needs. To ensure transportation quality, credentialing of providers raises the bar and sets a level playing field for any interested and qualified Medicaid contractor. Increased requirements for providers in regards to vehicle standards, insurance, pre-employment screening, training, and billing verification will ensure that clients are receiving a high level of service by
safe drivers working for qualified companies who are willing to meet high levels of scrutiny and maintain high performance standards.

4. The Broker Operator model, i.e., transportation brokers that are also transportation operators, is another means of managing Medicaid transportation. Some transportation contract management firms have diversified into brokerage management. In a number of cases, this model has led to brokers contracting for trips with their own in-house operations reducing opportunities for other private operators and raising the issue of conflict of interest. Using an example from a paratransit operation, in the Washington, DC metropolitan area, between 1999 and 2006, the monthly trip volume grew from 40,000 to 150,000 trips per month. The broker contracted out for every one of those trips using over 25 small and medium-sized companies. Since 2006, under the management of a Broker Operator, seventy percent of the trips are being directly operated, and there are fewer contracts with small and medium size companies. The result has been less-reliable service with more complaints and higher costs per trip. The Broker Operator model, i.e., transportation brokers that are also transportation operators, is another means of managing Medicaid transportation. Some transportation contract management firms have diversified into brokerage management. In a number of cases, this model has led to brokers contracting for trips with their own in-house operations reducing opportunities for other private operators and raising the issue of conflict of interest. For example, in the Washington, DC metropolitan area, between 1999 and 2006, the monthly trip volume grew from 40,000 to 150,000 trips per month. The broker contracted out for every one of those trips using over 25 small and medium-sized companies. Since 2006, under the management of a Broker Operator, seventy percent of the trips are being directly operated, and there are fewer contracts with small and medium size companies. The result has been less-reliable service with more complaints and higher costs per trip.

**Recommendations to Maximize Safety and Cost Effectiveness of Non-Emergency Medical Transportation (NEMT)**

There are advantages and disadvantages for each of the above models, but TLPA suggests that regardless of which model is used, the following recommendations be utilized to ensure that Medicaid clients receive a high level of service by safe drivers working for qualified companies that are willing to meet high levels of scrutiny and maintain high performance standards.

**Vehicle, Driver and Operations Standards**

The TLPA Contracting & Paratransit Division Steering Committee has developed Paratransit Driver Screening and Training Standards (see http://www.tlpa.org/para_driver_training_standards.pdf). The TLPA Taxicab Steering Committee has developed Taxicab Driver Standards Recommended for Metropolitan Areas Of Greater Than One Million Population (see http://www.tlpa.org/news/taxidriverstandards_834bc.pdf). The following vehicle, driver and operator standards are taken from the recommendations in these papers. A State, county, or local agency, preferably an agency with transportation expertise, should establish vehicle standards, driver qualifications, and operations standards of the non-emergency medical transportation providers. Insurance levels or requirements should be set at the state-required levels for each type of transportation and should not be increased to levels that exclude any licensed providers. The agency
should maintain an annual inspection schedule for oversight, which may include unannounced on-site inspection visits. In fact, it is suggested that each state employ field investigators to ensure that transportation providers (and brokers if applicable) are meeting all the standards listed below. The standards should include:

- Financial stability – agencies need continuity in their Medicaid transportation programs, which requires the provider to have reasonable financial resources.
- Vehicles – every company qualified to provide Medicaid transportation must pass a rigorous vehicle inspection and have adequate vehicles in reserve.
- Insurance levels – insurance levels should be the same as state or local insurance requirements for commercial carriers, with each provider submitting proof of adequate insurance before being qualified to provide Medicaid transportation.
- Driver standards – companies eligible to provide Medicaid transportation services should be required to have a written comprehensive driver-training program of at least 16 hours.
- Licensing requirements – transportation companies chosen to provide Medicaid transportation services must meet all applicable federal, state, and local-licensing requirements for companies, drivers and vehicles.
- Company experience – agencies need to pay a responsible rate to attract qualified, licensed and experienced transportation providers.

The bottom line is that quality of service (including experience, safety and proper training) comes at a price. When a Medicaid agency chooses to pay a substandard price to non-licensed and unqualified providers, it increases the agency’s liability and exposure. Service levels are not going to improve and standards of compliance will not be met unless the reimbursement rates are at a high enough level that professional transportation providers will participate in the program. Raising the bar includes establishing responsible entry requirements, quality standards and paying appropriate reimbursement levels.

Client Eligibility Guidelines
It is common practice for the state health agency, the broker, or the MCO (or county/local agency that administers the Medicaid program) to handle the client functions such as:

- Confirming client eligibility
- Registration information for eligible individuals including records of allowed services;
- Determining prior approval of appropriate level of transportation service for the beneficiary;
- Contracting with pre-qualified private providers to provide transportation services;
- Collecting and keeping operational and cost data;
- Handling complaints from clients for substandard services;
- Coordinating and monitoring transportation providers; and
- Providing timely reimbursement to providers at a responsible fee schedule.

We believe that these responsibilities should remain with program administrators and not be contracted to a transportation provider. This division of responsibilities will maintain program efficiency and effectiveness and reduce the risk of fraud.
Transportation Operator Functions
The transportation provider should handle all transportation services-related functions such as:

- Curb-to-curb transportation of the eligible Medicaid beneficiary;
- Scheduling;
- Dispatching;
- Driver training
- Vehicle provision
- Vehicle Maintenance; and
- Insurance

TLPA’s private operator members understand how to meet Medicaid client transportation needs in a safe and cost effective manner.

Guidelines for the Strategies Used to Manage Medicaid Transportation
In addition to the recommendations presented above, TLPA urges the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) and or individual states to adopt the following guidelines for all of the Medicaid transportation management models.

- **Cost Savings** - Estimates of cost savings that might accrue from brokerage operations should take into consideration the real cost of a trip provided by a safe and reliable transportation service. Cost savings should not lessen the quality of service nor increase the risk of exposure. The risk exposure applies to the client, the agency, and the service provider. If the state or local Medicaid management allows the broker to contract with low-bid, unqualified transportation providers, then this short-term savings should be separated from any estimated savings from having a middleman (broker, managed care organization, or other entity) winning a contract and being allowed to award transportation operator contracts based on cost alone and not considering licensing or service issues. By adopting this provision, the state will better understand and account for how and where any savings are being accomplished.

- **Contract Payment Provisions** - Transportation provider contract provisions should be included to ensure providers are paid by the managing entity in a timely fashion for all services rendered. Medicaid managing entities should be prohibited from imposing punitive liquidated damages and/or penalties and fines that are not related to actual out of pocket costs. There also should be a provision to compensate providers for client “no-shows” and late cancels. Currently, Medicaid regulations require payment only for services or trips completed. Therefore, private operators have to calculate the cost of no-shows and cancellations into the cost of a completed trip. Acceptance of these provisions will serve to encourage quality transportation providers to participate in the Medicaid program at a reasonable fee.

- **Local Business Participation** – Medicaid transportation management entities should be encouraged to utilize local private transportation providers and meet local disadvantaged business participation program recommendations as a matter of good government practice.
Licensed Transportation Providers - Medicaid transportation management entities should be required to utilize experienced, licensed and properly insured transportation providers. They should be held accountable and penalized heavily if they use unlicensed or uninsured transportation providers. These provisions will help to ensure that Medicaid clients receive safe and reliable transportation service.

Reporting - Medicaid transportation management entities should be required to collect and fully report data associated with their management of the program, to include an accounting of transportation and administrative expenses and transportation operation information and statistics. This information should be made available to all stakeholders to enhance the competitive environment, which will ultimately result in lower program expense and higher quality service.

Operator Contracts - Medicaid transportation management entities are fulfilling a state obligation and should be required to utilize contracts with transportation providers that mirror the contracts the operators would receive if they were contracting directly with the state. The state agency must approve the standard contract and all of its provisions in advance, including penalties and sanctions. The agency must be notified and approve any amendments to the standard contract agreement to assure reasonable contracts that are in compliance with public contract requirements. Also, each state should have a procedure for transportation operators to file a grievance when they have evidence that the transportation management entities are not meeting contractual obligations.

Service Standards - Medicaid transportation management entities should be held to specified quality of service standards themselves, particularly relating to factors in their control such as ride times, deadheading, telephone responsiveness and the routing and scheduling functions when provided by the broker. It is simply good management practice to hold those who are responsible for a service accountable for the level of service they are providing.

Procurement Process – The Request for Proposal (RFP) process is superior to the Request for Bid (RFB) process. The RFP process is better because the product that results is a licensed trained and qualified transportation provider who may not necessarily be the lowest bidder. This helps ensure that the liability exposure to the agency is minimized and provides for safe and reliable service for the clients. The state agency responsible for Medicaid should realize that it is in their best interest to limit the agencies exposure by ensuring that the Medicaid transportation management entities are using qualified, licensed transportation providers.

TLPA believes that these guidelines should be adopted by CMS to be implemented by state Medicaid agencies to ensure that quality, safe and reliable transportation is provided to their clients. Alternatively, individual state Medicaid offices should adopt these guidelines.

Conclusion
The provision of Medicaid transportation services is a necessary component of the larger Medicaid program. It has been proven time and again if a person cannot get to a doctor, then a doctor can do them no good. The current budgetary constraints have necessitated a process that has reduced costs, but at the same time increased liability and risk. The use of unlicensed, under insured transportation providers has created an environment that could have serious long-term effects. TLPA believes that
it is in everyone’s best interest for Medicaid to improve their accountability and use only licensed, insured, quality transportation providers. This will reduce liability and improve service quality.

This paper recommends steps for state Medicaid agencies to employ a limit on the liability for all parties and to ensure that safe, reliable, qualified, trained and licensed transportation providers are utilized to meet Medicaid’s transportation needs. These provisions will help to assure that Medicaid transportation management entities contracted with by the state, are accountable, responsive, and meet the needs of the Medicaid clients.

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APPENDIX A – Studies and Proposed Rules and Legislation

Florida Return on Investment Study

The Florida Commission for the Transportation Disadvantaged commissioned The Marketing Institute at the Florida State University College of Business to calculate the return on investment generated by funds invested by the State of Florida on transportation disadvantaged programs. The study report lists the five most common transportation disadvantaged services as: medical, employment, nutrition, education, and life sustaining (shopping/social). The report states that one of the primary purposes of transportation disadvantaged funding efforts is to support preventative medical care. Preventative medical care trips assist in keeping low income, elderly, and disabled Florida residents out of the hospital and nursing homes. Given that a nursing home costs approximately $5,000 per month, daily hospital stays cost approximately $7,900 and adult day care costs from $25 to $100 per day, the benefits that result from providing transportation disadvantaged Florida residents access to preventive medical care are substantial based on the state’s ability to avoid nursing home, hospital and/or adult day care costs. The report uses an extremely conservative estimate that if 1 out of every 100 trips prevents a one-day stay in the hospital, the resulting benefit would be a payback of $11.08 for every dollar invested by the state of Florida. A 1108% return on investment for NEMT makes it one of, if not the single most, cost effective programs that Medicaid or any other federal or state program offers.

The report found the benefits realized from funding the other four transportation disadvantaged services funded by the State of Florida as follows: Transportation programs that facilitate access to the labor market yield substantial direct and indirect benefits to society through reduced reliance on other assistance programs and by increasing the return on taxable expenditures. The report estimated quite conservatively that each workforce trip allowed an individual to work an average of 6 hours per day at a wage of $6.79. The return on investment for workforce trips was calculated to be 571 percent, i.e., $5.71 on each transportation dollar expended.

The third type of mobility funded by the State of Florida for its transportation-disadvantaged citizens is to provide access to educational and training programs. This investment provides access to programs that enhance the employability of participants contributing to the long-term economic health of Florida by reducing unemployment benefits, as well as savings that accrue as working outside the home improves the mental and physical health of those participating. To assess the annual benefit of the investment made in this type of program, it was assumed that each day trip would be balanced by a minimum of one day of work by the individual taking the trip. Thus, if the education or training program requires 30 days, the benefits accruing to the state were estimated on the basis that the rider would work at least 30 days at the minimum wage of $6.79 for 6 hours. Realistically, this most likely underestimates the program benefits since those receiving job training are more likely to work far more days than the number of days they participated in training. The study estimates that the wages earned by individuals gaining employment through these job training/vocational trips result in a Return on Investment of 585 percent, or a payback of $5.86.

A fourth purpose of transportation-disadvantaged funding is to enable transportation disadvantaged citizens to satisfy their nutritional needs thus reducing the cost associated with future health care costs. The report uses a conservative estimate that if 1 out of every 100 nutritional trips enabled a program participant from a one-day stay in the hospital, the resulting benefit would be a payback of $12.52 for every dollar invested by the State of Florida.
A fifth purpose of transportation-disadvantaged funding is to enable transportation-disadvantaged citizens to make life sustaining and other essential trips. Such trips are made to pay bills and to secure every day shopping needs such as purchasing clothing, medications, personal services and other essential goods and services that enable transportation disadvantaged Florida residents to live day-to-day. The state benefits from sales taxes collected as a result of these shopping trips. The report estimates that the economic activity generated because Florida transportation funds are invested in this program produced a Return on Investment of 462%, or a payback of $4.62 for each dollar invested. In 2007, the State of Florida invested more than $372 million in its five types of transportation-disadvantaged programs. These funds generated benefits in excess of $3.1 billion, equating to an overall Return on Investment of 835%.

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APPENDIX B – Regulations, Proposed Rules and Proposed Legislation

Medicaid Program: State Option To Establish Non-Emergency Medical Transportation Program

This final rule that went into effect on January 20, 2009, implements section 6083 of the Deficit Reduction Act of 2005, which provides States with additional State Medicaid plan flexibility to establish a non-emergency medical transportation (NEMT) brokerage program, and to receive the Federal medical assistance percentage matching rate. This authority supplements the current authority that States have to provide NEMT to Medicaid beneficiaries who need access to medical care, but have no other means of transportation.

When Medicaid was created under the Social Security Act of 1965, it required states to ensure the necessary transportation of Medicaid beneficiaries to and from their medical providers. The state can then claim these transportation related costs as either administrative costs (reimbursed at a flat 50% rate), or can elect to include them as medical assistance (reimbursed at the state's federal rate, which is anywhere from 50% to 76%). When transportation is treated as a medical service, states usually receive a higher reimbursement rate, but have less control over how services are provided. States have more flexibility in how they provide administrative services, but also must accept a lower federal reimbursement rate. Before the enactment of this new rule, if a state wanted to provide medical assistance transportation it could not restrict a beneficiary's choice by contracting with a broker, nor could it provide services differently in different areas of the state without receiving a waiver under section 1915(b) of the Act. These waivers allow states to selectively contract with brokers and to operate their programs differently in different areas of the state. This final rule:

- Allow brokers to provide for transportation services that include wheelchair vans, taxis, stretcher cars, bus passes and tickets.
- Allows the Secretary to allow for the use of other forms of transportation, such as air transportation in states with significant rural populations.
- Creates a competitive bidding process for selecting the broker. The state has to evaluate the broker's experience, performance, references, resources, qualifications, and cost, and that the contract with the broker include oversight procedures to monitor beneficiary access and complaints, and ensure that transport personnel are licensed, qualified, competent, and courteous. Also, state and local bodies that wish to serve as brokers have to compete on the same terms as non-governmental entities.
- Declares the contract between the broker and the state must include oversight procedures so that the state can monitor beneficiary access, complaints, and to ensure that the broker's personnel are licensed, qualified, competent and courteous.
- Requires the broker must be an independent entity, in that the broker cannot provide transportation under the contract with the state. The broker also cannot also refer or subcontract to another transportation provider with which it has a financial relationship. A financial relationship includes any direct or indirect ownership or investment interest in the entity that furnishes designated transportation services and any compensation arrangement between such an entity and the broker or an immediate family member of the broker.
- The rule does provide an exception for a non-governmental broker that provides transportation in a rural area where there is no other qualified provider available; when the necessary transportation provided by the non-governmental broker is so specialized that no
other qualified provider is available; or when the availability of qualified providers other than
the non-governmental broker is insufficient to meet the existing need.

- Provides that if a governmental entity is awarded the brokerage contract it can subcontract
  with a government-owned or controlled transportation provider if the broker:
  - Is a distinct governmental unit, and the contract could not include payment of costs other
    than those unique to the distinct brokerage function; and,
  - The broker would have to document, after considering the specific transportation needs
    of the individual, that the government provider is the most appropriate, effective, and
    lowest cost alternative for each individual transportation service; document that for each
    trip, and the Medicaid program is paying no more than what the general public is
    charged.
  - Gives the Secretary the authority to add any other medical care, which can be covered, by
    the state.

The complete text of this final rule can be viewed by accessing the following link:
http://regulations.justia.com/view/129493/

**Centers for Medicare and Medicaid Services Proposed Rule on State Flexibility for Medicaid Benefits Packages**

In February 2008, the Centers for Medicare and Medicaid Services published a Proposed Rule on
*State Flexibility for Medicaid Benefits Packages*. The proposed rule came about from Section 6044
amended the Act by adding a new section 1937 that allows States to amend their Medicaid State
plans to provide for the use of benefit packages other than the standard benefit package, namely
benchmark benefit packages or benchmark-equivalent packages, for certain populations. Under
section 1937 of the DRA, a State may require that medical assistance to individuals, within one or
more groups of individuals specified by the State, be provided through enrollment in a benchmark or
benchmark-equivalent benefit coverage package. A State has the option to amend its State plan to
provide benchmark or benchmark-equivalent coverage without regard to comparability,
statewideness, freedom of choice, the assurance of transportation to medically necessary services
and other requirements in order to tailor and provide the coverage to the individuals. The purpose of
this section, as indicated in the title of section 6044 of the DRA, was to provide States with increased
flexibility. In order to maximize that flexibility, the Centers for Medicare and Medicaid Services
(CMS) are proposing

“To interpret the statutory clause “notwithstanding any other provision of this title” to
relieve States of the responsibility to assure transportation to and from providers,
which is the regulatory requirement at 42 C.F.R. 431.53 that is based on sections
1902(a)(4) and 1902(a)(19) of the Act. The statute provides benchmark options
available to States that are equivalent to those found in the private health insurance
market. Generally, private health insurance plans do not offer non-emergency medical
transportation as a benefit to enrollees. It would be a strong disincentive for States to
offer benchmark coverage through private health insurance plans if States had to
supplement benchmark benefit plans with additional transportation benefits. We are
therefore proposing to exempt States that elect benchmark coverage from the
transportation assurance requirement. This provides maximum flexibility to states and
is consistent with the stated purpose of section 6044.”
TLPA Opposed This Proposed Rule As Being Too Costly
A summary of the testimony filed by TLPA in response to this proposed rule follows. “The great fallacy with the proposal is that it fails to take into account that people with private health care plans do not live at the poverty level and have many transportation options to get them to medical appointments. However, there are millions of Americans that are transportation disadvantaged because they cannot provide or purchase their own transportation. Often, these transportation-disadvantaged citizens have special needs that qualify them to participate in the Medicaid program as they are elderly, poor, mobility impaired, disabled, or some combination of these conditions. Also since their transportation options are extremely limited, it is virtually a certainty that the majority of transportation disadvantaged Medicaid clients will not receive regular non-emergency medical treatment (NEMT) if states are allowed to set up a set of Medicaid benefits that do not include payment for NEMT. The result of removing NEMT assistance to these special needs persons is that overall Medicaid costs will increase as medical visits become less frequent resulting in much more serious medical problems once the delayed treatment is obtained. The old adage that an ounce of prevention is worth a pound of cure is truly applicable to this situation and the pound of cure is dramatically higher medical treatment costs for persons who no longer have ready access (transportation) to medical facilities. Transportation to treatment facilities is needed to keep overall program costs down. If transportation costs are cut, then medical costs will increase well beyond the short-term transportation cost savings, resulting in higher overall costs for Medicaid. There are at least three studies, one local, one statewide and one national that illustrate the value and necessity of NEMT. The finest medical services are of little value to individuals who cannot access them. A 2001 report by the Cabarrus Health Alliance, Kannapolis, NC, stated that transportation is a key component in the health care equation. Lack of access to medical services results in:

- Decreased usage of preventive care services and health improvement programs, in other words, delayed medical attention, leading in turn to more serious illnesses, reduced quality of life, and an overall increased cost of care.
- The unnecessary use of emergency room facilities and staff, which increases costs and prevents those persons requiring immediate assistance from receiving necessary care.
- An increased dependence on expensive ambulance services for non-urgent care, resulting in increased cost and less ambulance availability for true emergencies.

In 2007, the Florida Commission for the Transportation Disadvantaged commissioned The Marketing Institute at the Florida State University College of Business to calculate the return on investment generated by funds invested by the State of Florida on transportation disadvantaged programs. The report defined transportation disadvantaged as those individuals who because of age, disability or income restraints do not have access to public transportation options. The soon to be published report notes that in 2006 Florida had 6.6 million persons who were transportation disadvantaged and it cites the 2000 U.S. Census as defining the potential national size of this transportation disadvantaged group as substantial given that 35.1 million people were reported over age 65, 44.5 million were over the age of 21 and disabled and 33.9 million had income below the poverty line. The report lists the five most common transportation disadvantaged services as: medical, employment, nutrition, education, and life sustaining (shopping/social). The report states that one of the primary purposes of transportation disadvantaged funding efforts is to support preventative medical care. Preventative medical care trips assist in keeping low income, elderly, and disabled Florida residents out of the hospital and nursing homes. Given that a nursing home cost
approximately $5,000 per month, daily hospital stays costs approximately $7,900 and adult day care costs from $25 to $100 per day, the benefits that result from providing transportation disadvantaged Florida residents access to preventive medical care are substantial based on the state’s ability to avoid nursing home, hospital and/or adult day care costs. The report uses an extremely conservative estimate that if 1 out of every 100 trips prevents a one-day stay in the hospital, the resulting benefit would be a payback of $11.08 for every dollar invested by the state of Florida. A 1108% return on investment for NEMT makes it one of, if not the single most, cost effective programs that Medicaid or any other federal or state program offers.

In response to the importance of examining the need for improved access to NEMT nationally, in 2006 the Transit Cooperative Research Program, which operates under the auspices of the Transportation Research Board of the National Academy of Sciences, published Project B-27, “Cost Benefit Analysis of Providing Non-Emergency Medical Transportation.” The goal of this study was to compare the costs and benefits, including potentially large net health benefits, of providing NEMT to those who lack access to it. The study researchers conducted an analysis of nationally representative healthcare datasets for the year 2004, which revealed that about 3.6 million Americans miss or delay non-emergency medical care each year because of transportation issues. (Note that about 36 million Americans covered under Medicaid depend on NEMT. This study concentrated on 10 percent of that total population.) This target population of 3.6 million persons was found to have a higher prevalence of chronic diseases and a higher rate of multiple chronic conditions. The researchers determined that the most appropriate method of evaluating the benefits of improved access to medical care is cost-effectiveness analysis. For all 12 medical conditions analyzed, the researchers found that providing additional NEMT is cost-effective; for four of these conditions, the researchers found that providing additional NEMT is actually cost saving — additional investment in transportation leads to a net decrease in total costs when both transportation and healthcare are examined. The study concludes that the net healthcare benefits of increased access to medical care for the transportation-disadvantaged exceed the additional costs of transportation for all of these conditions. These benefits include both actual decreases in healthcare costs for some conditions (e.g., emergency care replaced by routine care) and improved quality of life for those who receive access. For three of the chronic conditions (asthma, heart disease, and diabetes), results show net cost savings; for the other four (depression, hypertension, chronic obstructive pulmonary disease, and end-stage renal disease), improvements in life expectancy or quality of life were determined to be sufficient to justify the added expense. In today’s economy, NEMT is inexpensive compared to the high and rapidly growing cost of health care, therefore, while implementation of this proposed rule may result in a very brief period of short-term savings for state Medicaid programs, the long-term medical costs for the care of the 36 million or more America citizens that will be affected will certainly rise as their quality of life diminishes.”

**Olver Bill**

On September 26, 2008, Congressman John W. Olver of Massachusetts introduced legislation to protect transportation to and from medical appointments for Medicaid beneficiaries by preventing CMS from enacting this proposed rule. The Congressman stated, “This transportation benefit, know as Non-Emergency Medical Transportation (NEMT), is essential because without transportation services, people are placed at risk of missing routine or preventive care which can lead to more costly care and hospitalization. There are approximately 4 million rural and urban families and
children participating in the Medicaid program whose sole means of transportation to medical care is through NEMT. We cannot simply abandon these people. It is critical that they have access to preventive care so that they don’t end up in our emergency rooms for higher cost procedures that could have been prevented. The loss of the transportation benefit would be particularly harmful to people living in rural communities. This service is especially important for those living in rural areas where there may not be public transit options. As Chairman of the Transportation and Urban Development Appropriations Committee, one of my primary goals has been to bolster support for public transportation. However, I realize that public transit is not always an option in rural communities. For many low-income people in rural areas, there may be no affordable way to get to their doctor’s office. That’s what makes continuing to provide this service so very important.”

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