TCRP

PROJECT NO. B-44

Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination

Interim Report

Revised Post Panel Comment

Prepared for:
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CHAPTER 1. INTRODUCTION

Assurance of access to health care is a basic feature of the Medicaid program that serves the nation's poorest and most vulnerable populations. As a requirement to provide non-emergency medical transportation (NEMT), states recognize transportation as a fundamental aspect of healthcare (Medicaid's Medical Transportation Assurance, 2009). NEMT is the federal government's largest program for human services transportation.

States administer the Medicaid program and each state has its own rules and regulations. For this reason, coordination of NEMT with public transit and human services transportation is highly dependent on each state Medicaid agency's policies and procedures. Over the past decade, many states have encouraged coordinating NEMT with other federally funded transportation services. In recent years, however, numerous state Medicaid agencies have separated NEMT services from local or regionally coordinated transportation systems in order to create a statewide or regional brokerage for all NEMT trips. Public transit agencies, particularly in rural areas, mobility managers, and proponents of transportation coordination have expressed concerns about this trend.

RESEARCH OBJECTIVES

The objectives of the research are to present options for providing Medicaid-funded NEMT services and to compare and contrast the effects of the different options on:

1. Access to Medicaid services;
2. Human services transportation; and
3. Public transit services.

The research will assist state-level policymakers, program administrators and other stakeholders to gauge the effect of different NEMT service-delivery options on transportation coordination, customer service, and cost-effective community transportation services.

THE KEY PRODUCT: A HANDBOOK

The Handbook, the key product of this project, will be useful at all levels and for all key stakeholders. The Handbook will address the most significant problems now evidenced in current NEMT practices. The Handbook will provide:

- A comprehensive explanation and analysis of the wide variety of NEMT options in operation currently or potentially available;
- The costs, benefits, and other impacts of the various NEMT options;
- How decisions about NEMT options can be accomplished in a coordinated or inclusive manner for all key stakeholders that can result in optimal results for all interested parties; and,
- Possible outcomes based on a variety of approaches that can result in greater certainty.

State-level policy makers, program administrators, other stakeholders can use the Handbook to evaluate NEMT brokerage options to make informed decisions in the specific context regarding NEMT provision of service. Specifically, stakeholders will be able to use the handbook to:

- Understand the key features of NEMT transportation including
  - The variety of administrative options for providing NEMT services, including those with and without brokerage options.
  - The relative costs to key NEMT stakeholders associated with each of these options.
  - Impacts other than costs for each of the key stakeholders.
- Use decision-making options outlined in the Handbook as a reference, finding options comparable to their own state's circumstances.
- Apply lessons learned to implement NEMT solutions that are broadly beneficial to all relevant state and local stakeholders in their communities of interest.

CHALLENGE: MULTIPLE STAKEHOLDER PERSPECTIVES

A multiplicity of stakeholders is involved in NEMT. These stakeholders include:

- The customers of Medicaid NEMT services and customer advocates.
- The state agencies that administer and provide Medicaid services to individuals.
- Transportation providers—public transportation agencies, health and human service agencies, and private transportation companies.
- Organizations that assist state Medicaid agencies in administering NEMT services, including those agencies that officially function as brokers and are responsible for functions.

The ability to understand the complexities of multiple stakeholder perspectives and their interactions is vital to providing healthier outcomes for individuals.

PROJECT STATUS

To achieve the project objectives, the project includes two phases. The TCRP B-44 Team has completed Phase I of the project—completing Tasks 1 through 4. Phase II of the project—Tasks 5 through 8—will begin upon panel approval.

- Phase I included much of the information and data gathering needed to provide a historical perspective of NEMT, document the current status of each state's NEMT service delivery option and document Medicaid and NEMT trends.
- Phase II of the project includes in-depth case study research and research regarding the effects of separate NEMT brokerages on transportation coordination.

There are eight project tasks as follows:

Phase I.

- Task 0. Project Kick-Off/Amplified Research Plan.
- Task 1: Review and Summarize Relevant Literature.
- Task 2: Review How NEMT Services Are Currently Provided.
- Task 3: Identify Candidate Case Study States.
- Task 4: Prepare an Interim Report.

Phase II.

- Task 5: Conduct Approved State Case Studies.
- Task 6: Report Key Conclusions from Case Study Experiences.
- Task 7: Conduct Additional Research Regarding the Effects of Separate NEMT Brokerages on Transportation Coordination.
- Task 8: Prepare Executive Summary, Handbook and Final Research Report.

PHASE II DESIRED OUTCOME

The Team goal in Phase II is to conduct case study research and research regarding the effects of separate NEMT brokerages on transportation coordination with the desired outcomes to:

- Detail each of the options for providing NEMT services and option impact from multiple perspectives.
- Provide practical information to include in a decision-making option on applying the options to make decisions regarding NEMT services.
- Provide in-depth information on a state's option experience that stakeholders can compare to their own state's circumstances.
- Apply lessons learned to implement NEMT solutions that are broadly beneficial to all relevant state and local stakeholders in their communities of interest.

REPORT ORGANIZATION

This Interim Report has four chapters and three appendices.

- Chapter 1 is the introduction and the report organization.
- Chapter 2 provides information on what the Research Team has learned about NEMT and its components, and documents typical measures of program success and challenges, with a focus on how NEMT brokerages affect transportation services and their coordination.
- Chapter 3 provides a review of the research completed to date including the Team recommendation of the seven in-depth case study states for panel consideration.
- Chapter 4 describes the plan for Phase II of the research project.
- Appendix A is the final Literature Review & Emerging Trends summary report.
- Appendix B is the final State-By-State Profiles
- Appendix C is the Synopsis of the Mini-Case Study Research

CHAPTER 2. NEMT OVERVIEW

Medicaid non-emergency medical transportation (NEMT) services are vital to the Medicaid program and its consumers because the service provides access to necessary medical care. NEMT programs are administered by state Medicaid offices and can differ appreciably from state to state. Creating a national perspective on Medicaid NEMT programs involves an understanding of numerous possible complexities in program administration and operations; these complexities may increase when considering the sometimes differing perspectives of the multiple parties involved in NEMT services.

Chapter 2 provides basic information on Medicaid, NEMT, and its components. This chapter also documents typical measures of program success and challenges, with a focus on how NEMT brokerages affect transportation services and their coordination. More detailed information is provided in Appendices A and B.

KEY NEMT FEATURES

Table 1 shows the key features of Medicaid's NEMT program. (Additional details, including sources and supporting information, are found in Appendices A and B.) From the information presented in this table, the following can be readily seen:

- Medicaid is an extremely large program, serving large numbers of persons with extremely large program expenditures.
- A wide variety of practices and operating options are possible because states, operating within federal guidelines, are ultimately responsible for program operations.
- Funds for NEMT services constitute a very small part of Medicaid operations but can be a very large part of coordinated community transportation services.
- Recent changes to long-standing arrangements between some state Medicaid offices and community transportation services have led to concerns about the new NEMT services and their impacts on affected parties.
- This research project is needed to provide state-level policy makers, administrators, and stakeholders information on the impacts that NEMT options have on access to Medicaid services, human services transportation, and public transit services.

Table 1. Key Features of Medicaid's NEMT Program

- The federal Medicaid program is administered by the Centers for Medicare and Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. It is designed to provide health insurance coverage for families and individuals with low income and limited resources. Enrollment for Medicaid is expected to be 65.7 million persons in fiscal year (FY) 2014, or about 21 percent of the U.S. population. Medicaid is the largest source of funding for medical and health-related services for people with low income in the United States.
- The implementation of the Patient Protection and Affordable Care Act (ACA) is projected to further increase the number of individuals served in the Medicaid program.
- Medicaid is jointly funded by the state and federal governments and managed by the states. State programs must conform to federal guidelines for the state to receive matching funds and grants; states have broad leeway in determining how services are provided.
- Total federal appropriations for Medicaid grants to states were $284 billion in FY 2014; including state funds, total expenditures were $415 billion in 2013.
- Medicaid regulations stipulate that states must "assure access" to and from covered health care services. The ability to access health services is vital to the operations and success of the outpatient-based health care option now in practice.
- For more than a decade, states have typically used a bit less than 1 percent of their federal funding for their NEMT services. Based on research, combined state and federal NEMT expenditures in FY 2013 were estimated to be approximately $3 billion.
- While less than 1 percent of Medicaid program expenses, the $3 billion or so spent on Medicaid NEMT programs is substantially greater than the amounts spent by any other federally funded human services program on transportation services.
- NEMT program expenses have historically been a large portion of federal funds received by community-based transportation services.
- The Deficit Reduction Act of 2005 includes an amendment to the Medicaid statute to permit states to establish non-emergency transportation brokerage programs to help provide transportation services in an efficient, competitive, and supervised manner.
- State use of transportation brokers nearly doubled between 2003 and 2012. A recent source reported that in 2012, 78 percent (40 of 51) of the states and territories used a broker option. The CMS-supported trend for NEMT services to be administered by brokers instead of state Medicaid personnel has altered some long-standing arrangements in which Medicaid NEMT services are no longer provided by coordinated community transportation services, leading to concerns about the impacts of these changes on all parties, including consumers.
- An individual's access not only to health care but also to other quality-of-life factors such as healthy food, recreation, and social engagement can be strongly affected by how NEMT service delivery is designed and funded. The broader fiscal, coordination, and customer service effects of statewide Medicaid brokerages to deliver NEMT services have not yet been fully studied.

PROGRAM COMPONENTS AT THE LOCAL LEVEL

Many experts see promoting access to health care services as a strategy with significant consumer health and financial benefits, including improved health outcomes and quality of life, more use of preventive care services, less use of emergency services, and lower long-term program costs. Under the Medicaid program, states must "assure access" to health care services.

A key feature of Medicaid's NEMT program is that it is limited to low-income adults, their children, and people with certain disabilities. Each state has broad discretion to determine who is eligible for its implementation of the program. This means that a fundamental part of program operations—the first step—is confirming that an individual who requested Medicaid services is actually qualified and authorized to receive the services requested.

In most states, "qualified" has meant qualified to receive health care services through the Medicaid program and then qualified to received Medicaid's NEMT services. These considerations led to the concept of "medically necessary," which has been interpreted to mean the following:

- transportation provided is to and from a Medicaid-covered service;
- the least-expensive form of transportation available is used and is appropriate for the client;
- the Medicaid recipient has no other means of getting to and from the covered medical service;
- transportation is provided to the nearest qualified medical provider; and
- Medicaid is the "provider of last resort"—that is, no other transportation resource for this trip is available free of charge.

To provide such NEMT services as required, someone (or some organization) has to

- determine that the client requesting NEMT services is eligible for those services, meaning
  a. the person is eligible and
  b. the trip is for a valid medical purpose;
- assign the trip for those services to a transportation provider that is qualified to offer the appropriate level of service;
- manage invoicing and payment to the transportation provider(s);
- assure that all aspects of the transportation program are of appropriate quality and meet specified safety and other standards; and
- provide reports documenting each encounter and how these services are provided.

Regardless of which persons or organizations are providing NEMT services, these are the kinds of activities that must be undertaken at the local level to fulfill the goals and needs of the Medicaid program.

In recent years, states have increasingly turned to brokers of NEMT services to

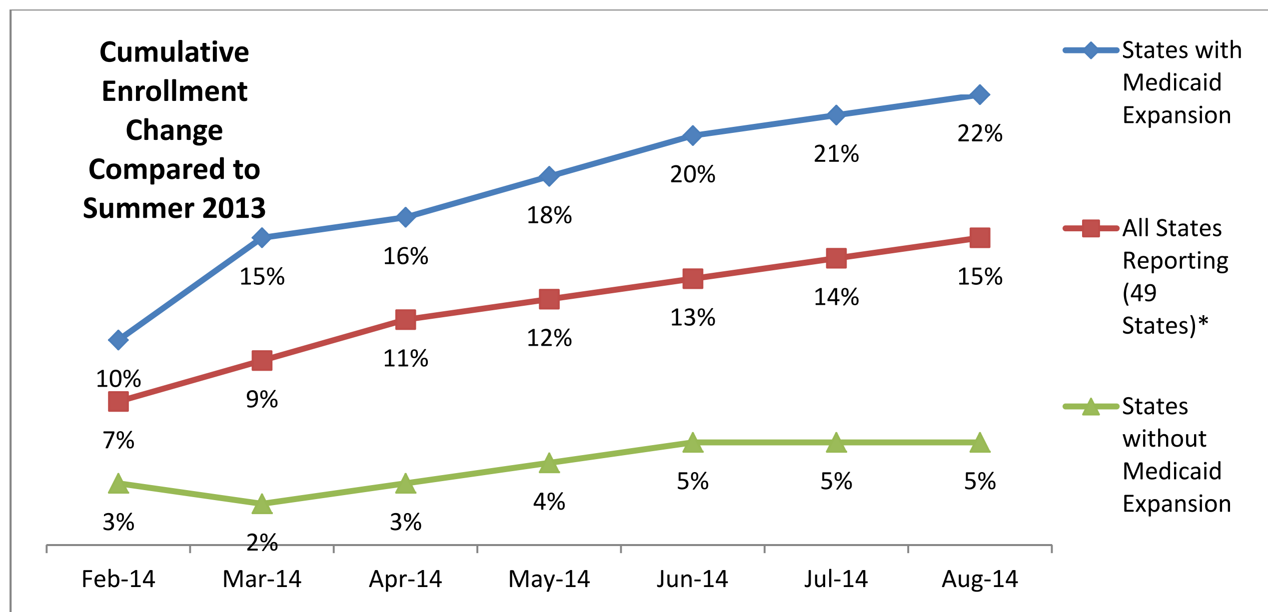
- help control or minimize costs,
- take over administrative responsibilities,
- improve the quality of services, and
- monitor fraud and inappropriate uses of services.

MEDICAID ENROLLMENT CHANGE AND THE ACA

Medicaid and CHIP enrollment grew by 15 percent between summer 2013 prior to open enrollment and August 2014.

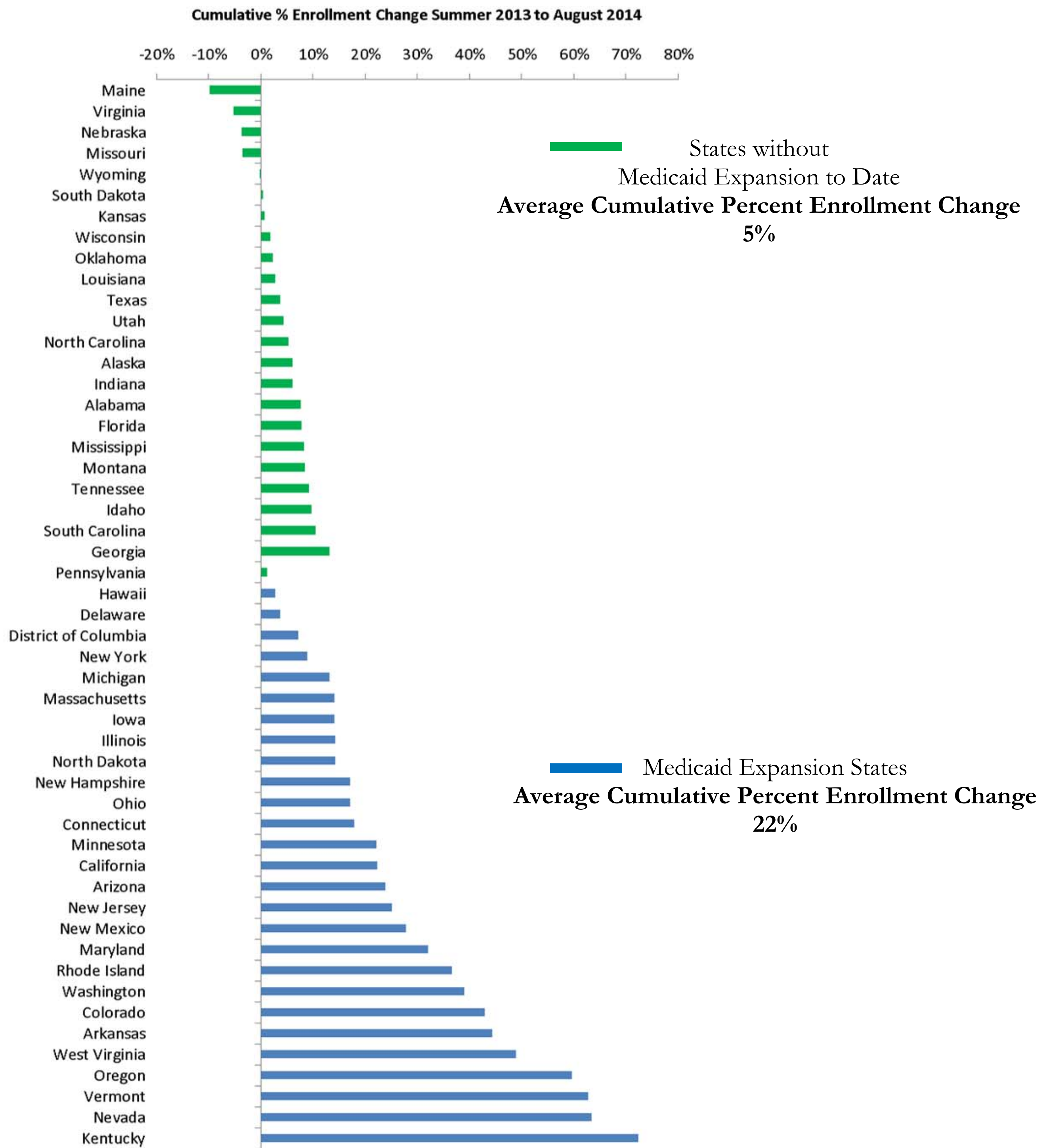
Medicaid enrollment has continued to increase and with the implementation of the ACA has further increased the number of individuals served by the Medicaid program. The ACA expands Medicaid eligibility to "nearly everyone under age 65 up to 133 percent of the federal poverty line" (RRD 383 2013). States that expanded Medicaid have experienced greater net Medicaid and Children's Health Insurance Program (CHIP) enrollment growth since prior to the beginning of open enrollment than states that have not expanded. Open marketplace enrollment began on October 1, 2013, and ended on March 31, 2014. CMS began reporting Medicaid and CHIP enrollment on a monthly basis in April 2014 and, in July, began reporting enrollment data for children. Nationally, total Medicaid and CHIP enrollment grew by 15 percent between summer 2013 (prior to open enrollment) and August 2014. Growth was 22 percent in states that implemented Medicaid expansion, as compared to 5 percent in states that did not expand Medicaid (see Figure 1).

Figure 2 provides the state-by-state Medicaid enrollment change—sorted by states without Medicaid expansion and states with Medicaid expansion. Of the 28 states to date participating in Medicaid expansion, all have had an increase in enrollment. The median enrollment increase of the expansion states is 22.3 percent—ranging from 1.2 percent to 72.4 percent. Of the remaining 23 states that have not participated in Medicaid expansion, the median increase is 4.8 percent—ranging from −9.8 percent to 13.2 percent enrollment change.



* Summer 2013 enrollment data based on monthly average for July–September 2013. Data not available for Connecticut and Maine. Data for North Dakota not available for February–June 2014. Source: (The Kaiser Commission on Medicaid and the Uninsured 2014).

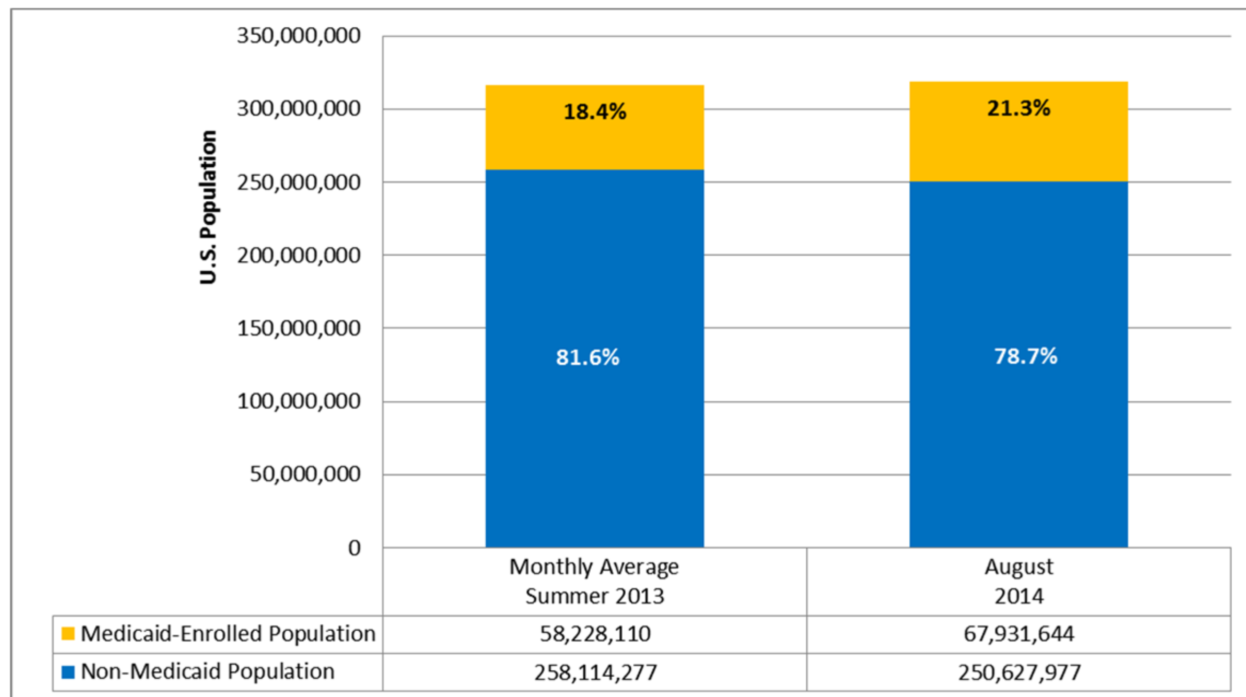
Figure 1. Change in Total Medicaid and CHIP Enrollment Compared to Summer 2013 (Prior to open enrollment that began October 1, 2013)



Note: Maine and Connecticut did not report 2013 data. Researchers calculated the estimate based on growth rates.
Source: Texas A&M Transportation Institute (TTI) using Centers for Medicare and Medicaid Services data (Kaiser Family Foundation 2014).

Figure 2. State Medicaid Percent Enrollment Change Post-ACA

A greater percent of the U.S. population is enrolled in Medicaid post-ACA. Figure 3 provides the Medicaid enrollment population compared to the total U.S. population. Prior to Medicaid open enrollment (summer 2013), 58.2 million Americans were enrolled in Medicaid programs—18.4 percent of the population. In August 2014, 67.9 million Americans were enrolled in Medicaid programs—21.3 percent of the population. An additional 9.7 million Americans were enrolled in Medicaid programs between ACA's inception and August 2014.



	Monthly Average Summer 2013	August 2014
Medicaid-Enrolled Population	58,228,110	67,931,644
Non-Medicaid Population	258,114,277	250,627,977

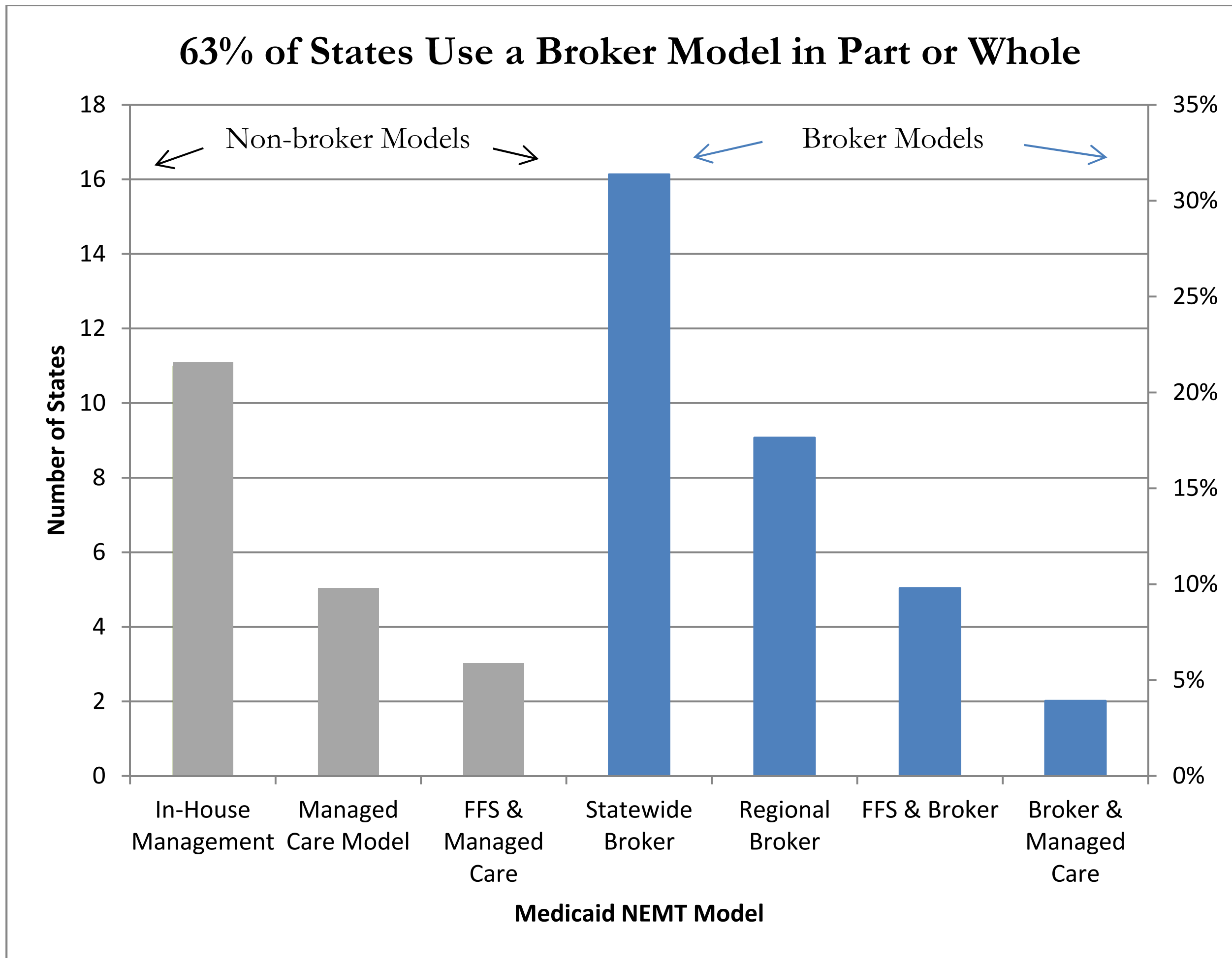
Source: TTI using Centers for Medicare and Medicaid Services data (Kaiser Family Foundation 2014).

Figure 3. Percent Medicaid Enrollment to U.S. Population

MEDICAID NEMT OPTIONS

Facing Medicaid enrollment increases, almost all states are implementing or planning cost-containment strategies for NEMT. Researchers conducted a 2014 National NEMT Survey of Medicaid Agencies and found that 63 percent of the 50 states and District of Columbia now use a broker to provide Medicaid NEMT services in part or whole (see Figure 4 and Table 2). Of the 29 Medicaid agency survey participants that responded to the question regarding a recent (within the last 5-year period) change to the state Medicaid NEMT option, 12 responded that the state has made or is considering a change to a broker option, and seven responded that the state has made a change or is considering a change to a managed care option. The NEMT management strategies now in place are:

- In-House management
- Managed Care Option
- Statewide Broker
- Regional Broker
- Fee-for-Service (FFS) and Managed Care
- FFS and Broker
- Broker and Managed Care



Source: 2014 National NEMT Survey of Medicaid Agencies.

Figure 4. State Medicaid NEMT Option

Table 2. State Medicaid NEMT Option (2014)

Location	In-House Manage-ment	Managed Care Option	Statewide Broker	Regional Broker	Mixed: FFS & Managed Care	Mixed: FFS & Broker	Mixed: Broker & Managed Care
Alabama	X						
Alaska	X						
Arizona		X					
Arkansas				X			
California					X		
Colorado						X	
Connecticut			X				
Delaware			X				
District of Columbia							X
Florida							X
Georgia				X			
Hawaii		X					
Idaho			X				
Illinois			X				
Indiana	X						
Iowa			X				
Kansas		X					
Kentucky				X			
Louisiana							X
Maine				X			
Maryland	X						
Massachusetts				X			
Michigan						X	
Minnesota	X						
Mississippi			X				
Missouri			X				
Montana	X						
Nebraska			X				
Nevada			X				
New Hampshire					X		
New Jersey			X				
New Mexico		X					
New York					X		
North Carolina	X						
North Dakota	X						
Ohio	X						
Oklahoma			X				
Oregon							X
Pennsylvania						X	
Rhode Island			X				

Table 2. State Medicaid NEMT Option (2014) (Cont.)

Location	In-House Manage-ment	Managed Care Option	Statewide Broker	Regional Broker	Mixed: FFS & Managed Care	Mixed: FFS & Broker	Mixed: Broker & Managed Care
South Carolina				X			
South Dakota	X						
Tennessee		X					
Texas				X			
Utah			X				
Vermont				X			
Virginia			X				
Washington				X			
West Virginia			X				
Wisconsin			X				
Wyoming	X						
Nationwide	11	5	16	9	3	3	4

NEMT COST AND TRIP VOLUMES

States have looked to brokers to provide cost efficiencies through competitive bidding, scheduling trips to the least-cost provider, maximizing utilization of advanced technology, helping to combat fraud, and leveraging coordination of transportation services—with the ultimate objective of providing greater access to medical services. Participants in the 2014 National NEMT Survey of Medicaid Agencies responded that the most important reason for using a transportation broker option and/or including NEMT services in a managed care organization's capitated payment is to

- achieve cost certainty or savings (37 percent),
- improve access to primary care (30 percent),
- reduce fraud and abuse (19 percent),
- other (10 percent), and
- reduce emergency room use (4 percent).

Transportation costs and utilization are impacted not only by the NEMT management option chosen by the state, but also the state demographics, built/natural environment, and economic environment. The variation in the NEMT expenses and trips are influenced also by what mode of transportation is provided and what type of medical trips are eligible. No two states are alike, and regions within each state vary. Where medical services are located affects the distances traveled and the ability to coordinate service—and therefore the cost. There are considerable variations in how NEMT is provided in each state and region within a state. Each variation affects eligible recipient access to Medicaid services and affects human services and public transit providers.

Researchers collected NEMT cost and trip volumes in the 2014 National NEMT Survey of Medicaid Agencies. Of the 50 states and the District of Columbia, 38 reported annual NEMT expenses, and 33 reported annual NEMT trips. Of the 33 states that reported both NEMT

expenses and trips, the average NEMT expense per trip was an estimated $45.78 including three outliers—Alaska, Iowa and Utah and $28.22 excluding the state outliers (see Table 3). Researchers estimate $2.9 billion was expended on NEMT to provide 103.6 million NEMT trips in FY2013.

Table 3. State-by-State 2013 NEMT Expenses and Trip Volume
(33 States that Reported Expenses and Trips to 2014 NEMT Survey of Medicaid Directors)

State	NEMT Expenses Adjusted to 2013	NEMT Trips Adjusted to 2013 Based on Enrollment Change	NEMT Expense Per Trip 2013
Alabama	$18,758,359	1,530,000	$12.26
Alaska	$35,000,000	100,000	$350.00
Arkansas	$33,900,000	1,088,117	$31.15
Colorado	$9,262,410	642,804	$14.41
District of Columbia	$25,100,000	1,262,533	$19.88
Florida	$61,051,033	2,815,811	$21.68
Georgia	$83,000,000	3,911,483	$21.22
Idaho	$20,000,000	1,195,000	$16.74
Iowa	$10,769,030	100,434	$107.22
Kansas	$9,887,646	458,030	$21.59
Kentucky	$65,000,000	3,264,495	$19.91
Massachusetts	$78,787,934	3,896,684	$20.22
Minnesota	$38,000,000	1,615,880	$23.52
Mississippi	$35,000,000	1,440,000	$24.31
Missouri	$41,455,931	1,227,356	$33.78
Nebraska	$18,911,160	400,000	$47.28
Nevada	$11,700,000	600,639	$19.48
New Jersey	$140,000,000	4,500,000	$31.11
New York	$646,923,540	10,701,315	$60.45
Oklahoma	$28,969,000	837,000	$34.61
Oregon	$40,468,834	1,557,228	$25.99
Pennsylvania	$148,579,847	11,468,394	$12.96
South Carolina	$62,008,732	1,850,000	$33.52
South Dakota	$2,498,345	57,858	$43.18
Tennessee	$68,000,000	1,467,000	$46.35
Texas	$260,679,919	9,290,567	$28.06
Utah	$2,483,242	13,115	$189.34
Vermont	$10,961,213	390,000	$28.11
Virginia	$80,602,002	4,380,000	$18.40
Washington	$70,429,520	2,818,910	$24.98
Wisconsin	$63,171,133	2,450,224	$25.78
Wyoming	$516,693	9,000	$57.41
Total 33 States	$2,221,875,523	77,339,877	$45.78 Average
Without Alaska, Iowa and Utah			$28.22

MEDICAID NON-EMERGENCY TRANSPORTATION HISTORY

The Social Security Amendments of 1965 added Title XIX, the Medicaid program, to the Social Security program. The assurance of transportation for Medicaid recipients has been an integral part of the Medicaid program from its inception. As Medicaid enrollment and medical care costs have grown, there has been continued concern regarding NEMT costs, quality-related issues, and program fraud and abuse.

In the 1970s and 1980s, a shift in medical practice to deinstitutionalized/outpatient care further demonstrated the inability of transportation disadvantaged individuals to access health care without assured transportation. Court cases solidified the assurance of transportation for Medicaid clients (see Working Paper #1, Review and Summary of Relevant Literature, p.6). The cost of medical services continued to grow in the 1980s, bringing a surge of ambulatory care centers and managed care/health maintenance organizations. With the availability of Medicaid waivers, states began moving more and more to a brokerage option in the delivery of NEMT in the 1990s as one means of controlling costs and managing abuse.

The Deficit Reduction Act (DRA) of 2005 provided greater incentive to employ brokers for NEMT delivery by no longer requiring a waiver to operate a brokerage system while allowing states to still receive reimbursement at a possibly higher federal medical assistance percentage (FMAP). The DRA Final Rule on the implementation of the broker program provides important clarification about CMS's view of the roles of states, brokers, and transportation providers, as well as the requirements that impact the delivery of NEMT, coordination, and the provision of transportation. As the ACA phases in, the expansion of eligibility for medical services is expected to significantly increase the number of Medicaid recipients, and this could also be expected to increase NEMT ridership.

Older Adult Health Care Issues

Prior to the passage of Medicaid, health care services for persons that could not afford health care were provided primarily through state and local government programs, charities, and community hospitals. The poverty rate of those 65 years and older was 35 percent in 1960, more than twice that of the non-elderly. In 1965, Congress adopted a combination of approaches to improve access to health care for the elderly. The Social Security Amendments of 1965 created a hospital insurance program to cover nearly all of the elderly (Medicare Part A), a voluntary supplementary medical insurance program (Medicare Part B), and an expansion of the Kerr-Mills program to help elderly individuals with out-of-pocket expenses such as premiums, deductibles, and co-payments. The Kerr-Mills program—now the Medicaid program—was extended to cover other populations including persons with disabilities, the poorest families with children, and persons who are blind.

Health Care Cost Issues

The option for health care delivery in the 1960s was a system where patients relied on autonomous physicians; patients received complex care from independent, non-profit hospitals; and insurers did not intervene in medical decisions, reimbursing on a fee-for-service basis. Rapid expansion of nursing homes occurred in the 1960s—functioning as miniaturized acute-care hospitals. From 1950

to 1967, U.S. medical care expenditures rose an average of 8.4 percent annually—nearly 35 percent of all health expenditures went to purchase hospital care in 1967. To control costs, private health care plans increasingly used an experience rating to set health premiums, creating financial hardships for some retirees and persons with serious or expensive health conditions.

NEMT PROGRAM SUCCESS MEASURES

Successful Medicaid NEMT services are those that achieve the Medicaid program's goals and requirements. The literature review (see Appendix A) suggests a broad consensus that successful programs will

- serve the needs of the clients, including providing timely access to medical services for the purpose of maintaining or improving their health status;
- serve those needs efficiently and effectively;
- provide services that are eligible, appropriate, and authorized; and
- be able to document what services were provided and that they were authorized and appropriate.

If Medicaid programs are successful, they will show positive changes over time in services, cost control, service quality, and satisfaction levels of all parties involved, but it is important to note that neither CMS nor most states measure any of these factors. It is also important to note that the weighting of these factors may change depending on the perspectives of the party involved.

NEMT PROGRAM CHALLENGES

NEMT programs face the challenge of satisfying multiple stakeholder perspectives and meeting multiple Medicaid NEMT regulations.

The Complexity of Various Perspectives

Many kinds of individuals and agencies are involved in the operations of state non-emergency Medicaid transportation programs. A short list includes the following:

- Medicaid clients seeking medical care and family members or advocates for those clients;
- state Medicaid agencies;
- if applicable, organizations administering or brokering NEMT services on behalf of state Medicaid agencies;
- health care providers who depend on patients arriving on time for scheduled appointments and leaving the facility when their treatment is finished;
- other state agencies, such as state departments of transportation, also engaged in supervising or providing transportation services in the state; and
- transportation providers, be they public, private for-profit, or non-profit organizations.

In addition, there may be local governmental representatives in various portions of the state, state legislators, regional or local transportation officials, or regulators of transportation operators who

might also have key interests in how NEMT services are provided and consumed. Ensuring that NEMT operations meet the needs and expectations of this wide variety of interests can be a definite challenge.

Medicaid Regulations Regarding NEMT

Understanding all of the regulations involved in Medicaid's non-emergency transportation services can be a challenge for persons not directly in the health care field. A full understanding involves knowledge of a variety of laws and regulations that influence payments, client eligibility, and numerous other factors.

Payment as Optional Medical Service/Administrative Service

In 1978, the U.S. Department of Health, Education, and Welfare (HEW) issued further interpretive guidance clarifying transportation as an assurance. The interpretive guidance also clarifies that the state has a choice of claiming *federal financial participation* as an optional medical service, an administrative activity, or both.

If the *optional medical service* classification is chosen, uniformity of service, consumer freedom of choice of provider, and direct payment of vendors are all required. Under an optional medical service, NEMT expenses are matched by the federal government at the state's FMAP rate, between 50 percent and 83 percent. For most states, the optional medical service provides a higher reimbursement rate than the administrative option. However, additional requirements come with claiming transportation as a medical service: states must assure that service is available throughout the state at comparable quality, a system is in place to pay the service provider directly, and Medicaid clients are provided freedom of choice in selecting a service provider.

Under the *administrative services* option, the federal government matches expenses at 50 percent instead of the higher FMAP rate. The administrative option has historically allowed more flexibility because the freedom-of-choice requirement does not apply, application of certain medical assistance payment standards do not apply, and enrolling vendors as providers is not necessary. However, because the transportation assurance is paid at a 50 percent federal financial participation rate, states may be financially better off paying for transportation as a medical assistance service if their FMAP rates are higher than 50 percent.

Waivers

The Secretary of Health and Human Services (previously HEW) is permitted to grant waivers of several provisions of the law under the Social Security Act:

- Section 1115 Demonstration Waivers permit a state to implement broad changes in the traditional Medicaid program if the state can demonstrate that it will further the intent and purposes of Medicaid law. The Secretary of Health and Human Services has broad authority under Section 1115 to waive state plan requirements and certain other statutory requirements and to implement regulations that permit states to pursue research and demonstration activities that promote the Social Security Act's objectives.

- Section 1915(b) waivers, known as Freedom of Choice Waivers, allow states that furnish transportation as a medical assistance service the flexibility to establish prepaid medical plans, Medicaid transportation brokerages, or other arrangements that may restrict the choice of providers.
- Section 1915(c) waivers, called Home and Community-Based Services Waivers, allow states flexibility in implementing creative alternatives to institutionalized care, including non-medical transportation, if the services prevent premature institutionalization.

Medicaid as the Payer of Last Resort

For NEMT services, Medicaid considers itself to be a payer of last resort, meaning that if an individual or an individual trip is eligible to be paid by another source, payment must be received from that other source and not from Medicaid. This dual eligibility situation can apply to other governmental or human service programs, and has sometimes been applied to payments for Americans with Disabilities Act (ADA) paratransit services.

The Deficit Reduction Act of 2005

The Final Rules and Regulations for the Deficit Reduction Act of 2005, issued in the *Federal Register* on December 19, 2008, were effective January 20, 2009. These regulations include, among other items, a provision to give states the flexibility to establish a certain type of NEMT brokerage program. These broker rules provide important clarification about CMS's view of the roles of the states, brokers, and transportation providers; plus clarification of the rule requirements that affect the delivery of NEMT, coordination, and the provision of transportation.

Patient Protection and Affordable Care Act of 2010

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). When fully phased in, the ACA will mandate that Americans purchase health insurance, will significantly broaden the eligibility requirements for Medicaid, and will provide subsidies for the purchase of health insurance. The ACA provisions that affect NEMT are provisions that are intended to reduce fraud, increase the number of Medicaid-eligible persons, and result in higher FMAP rates for the newly eligible. The ACA provisions include additional compliance and reporting requirements for NEMT as a means to reduce fraud. The ACA expands Medicaid eligibility to nearly everyone under age 65 and up to 133 percent of the federal poverty line.

Under the ACA, all states will initially receive an FMAP of 100 percent for the newly eligible Medicaid population. The 100 percent match will be in effect for 3 years and will then fall to 95 percent in 2017 and 90 percent in 2020. An increase in the additional compliance and reporting requirements and the expected increase in Medicaid-eligible recipients will likely mean more work for the current NEMT infrastructure. The higher FMAP rates for the newly eligible population could further influence how states choose to claim NEMT reimbursement.

Coordination of Transportation Services

Individuals concerned with the coordination of transportation services may encounter other challenges when trying to coordinate with Medicaid's NEMT program. CMS regulations clearly state that CMS's other concerns are more important than concerns about coordination:

- "For programs such as Medicaid, the policies of the CCAM [Interagency Coordinating Council on Access and Mobility] are appropriate ***as long as they do not conflict with the policies and rules of the Medicaid program*** [emphasis added]."
- "Medicaid program's responsibility is limited to ensuring cost-effective transportation for beneficiaries to and from Medicaid providers."
- "Federal Medicaid funding must be matched by non-federal funding."
- "It should be noted that Medicaid funds may only be used for Medicaid services provided to eligible beneficiaries."
- "States must comply with all applicable Medicaid policies and rules regardless of whether the Medicaid rules interfere with their ability to coordinate their transportation efforts."

Public Transit Rates

The regulations state that Medicaid should pay the same amounts as other riders for fixed-route services— for paratransit services, Medicaid clients may pay more than general public riders but no more than clients of other human service agencies:

- "In the case of publicly-provided transportation on fixed routes, while there are other third-party payers that often cover and reimburse these trips for their clients, we have been informed that such third-parties or agencies generally pay the same amount as the public is charged for these rides. Therefore, we are prohibited from paying more than the public is charged for public transportation on a fixed-route trip."
- "In the case of publicly-provided paratransit services and rides…we believe that it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride… Therefore, in this final rule we have modified the regulations text to require the governmental broker to document that Medicaid is paying for public fixed-route transportation at a rate that is no more than the rate charged to the general public, and no more than the rate charged to other State human service agencies for public paratransit services." (see Working Paper #1, Review and Summary of Relevant Literature, p.10).

Data Collection Issues

Managed care service delivery options are expected to see increasing use in the future. In these options, a state relies on the services of a managed care provider that offers the entire range of covered Medicaid services, including NEMT. Reimbursement is typically based on a capitated payment rate per enrolled individual per period of time (the carved-in option under which NEMT expenses are not specifically identified or reported). The lack of reporting can be a detriment to

understanding how services and costs have changed over time. States may not require managed care providers to use existing NEMT delivery networks.

Summary of Recent Medicaid NEMT Legislative Changes

The DRA Final Rule demonstrates that Medicaid and CMS view the state as the final decision maker on program design and mix. The CMS focus for NEMT is on the best price at the highest quality for the Medicaid recipient to access Medicaid services, and on preventing conflict of interest, abuse, and fraud. The Final Rule recognizes that public fixed-route transportation should be considered as a first choice, that bus passes are acceptable if they are the least-cost alternative, and that an allowance for Medicaid to pay for paratransit at a higher rate than the fare box rate charged to the general public may be appropriate. The Final Rule recognizes coordination as a worthwhile goal but not at the expense of Medicaid policies and rules for NEMT, and does not allow shared costs to be charged to Medicaid. Expectations are provided for operations standards and broker oversight, with timeliness of transportation a focus to ensure medical appointments are met. The Final Rule recognizes that service needs may differ across the state and may require customization of programs by region. (see Working Paper #1, Review and Summary of Relevant Literature, p.10).

Research Results Digest 109 estimates that, when taking into account Medicaid expansion and non-participating or potentially non-participating states, the potential number of new Medicaid enrollees resulting from implementation of the ACA is about 6.16 million persons. Based on experience from demonstration waiver states, the newly eligible population is not as transit dependent, and thus it is projected that about 185,000 to 616,000 individuals will require NEMT.

SUMMARY OF KEY POINTS AND EMERGING THEMES

Researchers have summarized key points and emerging themes in the literature; Appendix A discusses these points in depth. The following subsections provide highlights of key points and themes that have particular relevance to the objectives of this research. The objectives of this research are to present options for providing Medicaid-funded NEMT services and to evaluate the effects of these different options on:

- access to Medicaid services;
- human services transportation, particularly coordinated transportation services; and
- public transit services, including ADA complementary paratransit services.

Key Points

The following highlights key points from the literature:

- **Transportation assurance.** Transportation services were assured to Medicaid clients from the program's inception.
- **Transportation key to outpatient health care.** The shift in the 1970s and 1980s to a deinstitutionalized/outpatient health care option has had important impacts on NEMT services and costs. Individuals without access to transportation have limited or no ability to access health care in an outpatient care option.

- **Legislative initiatives.** Legislative initiatives have encouraged the use of brokers as a means to controls costs, eliminate conflict of interest, monitor fraud and abuse, and reduce state administrative burden.
- **Deficit Reduction Act:**
  - The DRA in 2005 included an amendment to the Medicaid statute to "permit states to establish non-emergency transportation brokerage programs." The majority of states have adopted a broker option for providing NEMT service.
  - The Final Rule effective 2009 for the DRA broker program reflects the following:
    - Medicaid and CMS view the state as the decision maker on program design/mix.
    - CMS's focus for NEMT is on the best price at the highest quality for the Medicaid recipient to access Medicaid services, and on preventing conflict of interest, abuse, and fraud.
    - Public fixed-route transportation should be considered as a first choice. Bus passes are acceptable if they are the least cost. Allowing Medicaid to pay for paratransit at a higher rate than the rate charged to the disabled passenger may be appropriate.
    - CMS views coordination as a worthwhile goal but not at the expense of Medicaid policies and rules for NEMT, and does not allow shared costs to be charged to Medicaid. A focus is on ensuring medical appointments are met.
    - CMS recognizes service needs may differ across the state and may require customization of programs by region.
- **Affordable Care Act.** NEMT usage is expected to significantly increase with the change in the ACA thresholds for Medicaid enrollment.
- **Coordination:**
  - Coordination is a recognized benefit and means to enhance access, minimize duplication of transportation service, and facilitate the most appropriate, cost-effective transportation service.
  - Broker options can promote coordination of services with public transit providers and health and human service agencies, or can work against coordination.
  - Accurate cost reporting and cost-sharing agreements are the founding elements of coordination necessary to ensure an equitable and accurate distribution of costs among all participating agencies. The Government Accountability Office (GAO) recommends federal guidance on cost sharing for better coordination.
- **Broker impacts:**
  - Brokers, acting as gatekeepers, can deter fraud and abuse; they may also have expertise in and access to software and technology that can realize cost efficiencies. A capitated payment may create an incentive for denial of service and lowered performance standards, and may exclude smaller brokers.
  - Broker options excluding public transit providers and health and human service transportation operators may inadvertently decrease the amount of transportation available to a community because of the reduction in Medicaid revenue available for federal transportation matching funds from the Federal Transit Administration and Health and Human Service–sponsored funding programs.

- **NEMT health care impacts.** NEMT net health care benefits to the client have been shown to exceed the additional costs of transportation, which supports the argument that transportation should be an assurance of the Medicaid program.

Themes and Identified Research Needs

The following key themes that impact this research project emerged from the literature:

- The literature points to the need to evaluate the impact of Medicaid NEMT service delivery options on a community-wide basis and to include impacts on public transit and health and human service transportation.
- The literature review demonstrates that much of the previous research conducted on NEMT focused on the Medicaid program and its efforts to deter fraud and abuse, eliminate conflicts of interest, and reduce per-trip costs.
- Both the transportation and NEMT industries lack adequate research on the impacts of:
  - separating transportation services from coordinated transportation systems and the overall cost of service duplication,
  - loss of local revenue for transportation providers,
  - trip shifting, and
  - transportation challenges for Medicaid beneficiaries regarding access community services other than medical services.
- A gap in research exists in identifying how NEMT service delivery options influence the quantity, quality, and sustainability of transportation available to the community as a whole.
- Research is needed to understand how NEMT options affect not only access to medical services for Medicaid beneficiaries, but also access to other important quality-of-life services/activities, such as access to fresh food, recreation, social activities, day care, education, and jobs. Access to destinations other than medical services can significantly improve an individual's overall physical and mental health.

CHAPTER 3. RESEARCH TO DATE

Phase I of the TCRP B-44 project included Tasks 1 through 4:

- Task 1: Literature Review and Emerging Trends
- Task 2: Review How NEMT Services Are Currently Provided.
- Task 3: Identify Candidate Case Study States [mini case study results].
- Task 4: Prepare an Interim Report [in-depth case study recommendation].

TASK 1. LITERATURE REVIEW AND EMERGING TRENDS

The first step in the research process was to conduct a comprehensive literature search. The Literature Review and Emerging Trends report in Appendix A first presents a historical timeline of legislation/policy and drivers of policy change. Second, literature concerning coordination policy and the impact of brokers on coordination is discussed. Lastly, an overview of findings from the literature on the impact of NEMT brokers on costs, public transit, and clients is provided.

Researchers added the recently published, RRD109, *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies* to the literature review final report. The final Literature Review and Emerging Trends document that incorporates panel comments and RRD109 is provided in Appendix A.

TASK 2. REVIEW HOW NEMT SERVICES ARE CURRENTLY PROVIDED

Appendix B provides an update to address panel comments of the State Profiles. The State Profiles in Appendix B include two state profiles—both a descriptive and statistical profile by state are documented. The following provides the State Profile organization and documents the data source for each statistical state profile.

The state profiles provide a descriptive and statistical profile for each state: 1) a description of the option that each state has adopted to manage its NEMT program and recent or pending changes in state management, and 2) a statistical profile providing the state population, matching rates, expenditures, and NEMT utilization.

Descriptive Profiles

The source of information for each state descriptive profile comes from responses that state Medicaid agencies provided as part of TCRP B-44 Task 2 2014 National NEMT Survey of Medicaid Programs. Where necessary, these data have been supplemented by published reports, program evaluations, and related materials. The supplemental information source is documented as a footnote to the state descriptive profile. The descriptive profiles provide information in the following sequence:

- NEMT Option
- Operating Authority
- Description
- Unique Features
- Recent or Future Changes

NEMT Option is the classification used by the researchers to classify each state into one of seven options:

- In-House Management
- Managed Care
- Statewide Broker
- Regional Broker
- Mixed—FFS and Managed Care
- Mixed—FFS and Broker
- Mixed—Broker and Managed Care

Operating Authority is the authority provided by the federal government to the state for providing Medicaid NEMT service. Operating authority can be classified into the following categories (see Glossary):

- NEMT assurance under the State Medicaid Plan
- Authority to operate NEMT brokerage under State Plan Amendment (Sec. 1902(a)(70))
- Federal Sec. 1115 Demonstration Waiver
- Federal Sec. 1915(b) Freedom-of-Choice Waiver

Description gives a brief history of the state's NEMT program and current status.

Unique Features highlights features that may be of particular interest to the research effort.

Recent or Future Changes provides a description of NEMT changes that have recently occurred or are planned to occur in the near future.

Statistical Profile

The statistical profile includes 20 data elements. Table 4 provides the primary source information for each data element in the state statistical profile. Supplemental data are provided where datasets are incomplete and the supplemental data is documented as a footnote below each statistical profile.

Table 3. State Statistical Profile Data Sources

Statistical Profile Data Element	Source
1) State Population Census 2010	Population Distribution and Change: 2000 to 2010—www.census.gov/prod/cen2010/briefs/c2010br-01.pdf (U.S. Census)
2) Medicaid Enrollment 1,000s (a/o Dec. 2012)	Compiled by Health Management Associates (HMA) from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured (KCMU). These data are part of a long-standing report series that collects monthly Medicaid enrollment data for December and June going back to 2000. The report series is an important source of historical trend data that provides the necessary context to understand these new sources of Medicaid enrollment data. While not directly comparable to the enrollment data released by CMS (see methodology in the [report] (http://kff.org/medicaid/issue-brief/medicaid-enrollment-data-snapshot-december-2013)for more details) - these data provide helpful context, additional detail and historical trend information not available in the CMS data.
3) Managed Care % (a/o July 2011)	Managed Care Enrollees as a Percent of State Medicaid Enrollees as of July 2011—http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/ (Kaiser Family Foundation)
4) Medicaid Expense (a/o Dec. 2012)	Total Medicaid Spending, FY 2012—www.kff.org/medicaid/state-indicator/total-medicaid-spending/ (Kaiser Family Foundation)
5) Federal Medical Assistance Percentage (FMAP) FY15	FMAP and Enhanced Federal Match (CHIP), FY 2015—www.gpo.gov/fdsys/pkg/FR-2014-01-21/pdf/2014-00931.pdf (Federal Register, 1/21/2014)
6) Medicaid Expansion	Status of Medicaid Expansion under ACA, as of November 19, 2014—kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/ (Kaiser Commission on Medicaid and the Uninsured)
7) Medicaid Expense per Medicaid Enrollment	Calculation: Medicaid Expense divided by State Medicaid Enrollment
8) % Medicaid Population to Total State Population	Calculation: Medicaid Enrollment Population divided by State Population
9) NEMT Expenses	2014 National NEMT Survey of Medicaid Agency
10) Number of Trips	2014 National NEMT Survey of Medicaid Agency
11) Cost per Trip	Calculation: NEMT Expenses divided by NEMT Number of Trips
12) NEMT Percent	Calculation: NEMT expenses divided by Medicaid Budget
13) Cost Category	2014 National NEMT Survey of Medicaid Agency
14) Users	2014 National NEMT Survey of Medicaid Agency
15) Utilization Rate	Calculation: Users divided by Medicaid Population

Table 4. State Statistical Profile Data Sources (Cont.)

Statistical Profile Data Element	Source
16) Modes	2014 National NEMT Survey of Medicaid Agency Transportation modes: • Public transit, • Demand response • Volunteer • Private occupancy vehicle (POV) • Other
17) NEMT Authority	2014 National NEMT Survey of Medicaid Agency • Standard • 1915(b) • 1115 • State Plan Amendment (SPA)
18) NEMT Option	2014 National NEMT Survey of Medicaid Agency • MCO Carve-In (Statewide, Metro, Regional • In-House FFS • Broker (Statewide, Regional, County) Contract Admin (Statewide, Regional) • Other
19) NEMT Procurement	2014 National NEMT Survey of Medicaid Agency • Competitive • Negotiated • Inclusive
20) Payment Type	2014 National NEMT Survey of Medicaid Agency • Cost Reimbursement • Cost Plus Fee • Capitation • Global Budget

TASK 3: IDENTIFY CANDIDATE CASE STUDY STATES.

Researchers used a four-step screening process to identify seven candidate states for in-depth case studies as follows:

1. Develop criteria and populate the criteria in a matrix for each state.
2. Screen to select states for "mini" case studies.
3. Conduct "mini" case studies by calling candidate state representatives to verify that important questions about the effects of different NEMT brokerage options on transportation coordination can be answered.
4. Based on the results of steps 1- 3 above, identify seven (7) candidate case studies to present to the B-44 Project Panel in the Interim Report.

Mini-Case Study Selection

The mini-case study selection process strongly relied on NEMT change history as a key variable, and the variety of experiences in the NEMT change. The 15 mini-case study selection process was an iterative process to ensure that differing state and NEMT typologies were represented in the case studies. The goal was to include a variety of examples that will aid in developing a guidebook for policymakers, program administrators and stakeholders.

To determine the initial mini-case study states, researchers created a criteria matrix in an Excel spreadsheet using the data from each state gathered to include current NEMT option, NEMT option change history, NEMT expenditure data, Medicaid agency data (recipients, trips, users, % public transit utilization), demographics, region, and rural transit data. Using the criteria matrix information, the research team created a list of advantages and disadvantages for the inclusion of each of the state for consideration. Researchers scored the states reviewed on a scale from 1 Low to 5 High for inclusion as candidate mini-case study states. Researchers focused on coordination levels, use of public transit, availability of expense data, rural/ demographics of the state, creative or unique approaches to administering or operating NEMT, utilization of NEMT and recent change in NEMT option.

In the initial scoring, the Research Team scored 23 states as a 4 or a 5. The Research Team then individually evaluated each of the 23 states to first select 13 states and then revised to 15 states for mini-case study after panel review (see Table 5). The Research Team evaluated the states on a variety of factors including:

- Cross-section of regions
- States with a recent change to (or from) a NEMT broker option
- States with coordination success/ examples
- States that utilize transit NEMT service delivery
- Representation of a variety of NEMT options
- Representation of rural states

Table 5. Mini-Case Study Finalists

State	15 State Case-Study Selection Comments
Colorado	Mixed option offering contrast between metro brokerage and county-based FFS program in outlying rural area of the state. Reported examples of coordination within some county systems.
Florida	Long-time leader in coordination field. Recent transition to carve-in managed care option should offer some useful contrasts with former brokered system.
Iowa	State shifting to coordinated care option as a result of Affordable Care Act. Moving from statewide brokered system to carve-in managed care program. Also, first state in the nation to opt out of providing NEMT services to Medicaid expansion population.

Table 5. Mini-Case Study Finalists (Cont.)

State	15 State Case-Study Selection Comments
Kentucky	Effective example of cooperation between transit and Medicaid, at both the state and local levels. Option relies on indigenous regional brokers (some of whom also provide NEMT trips), and a conscious state effort to coordinate medical and other human services transportation.
Maine	State recently changed options – from regional community brokerage program relying on local public and community transportation brokers to competitive risk-based contract brokers. Long history of coordination. Current unsettled political situation and lack of comparable data may present problems.
Massachusetts	Option relies on public transit agencies as regional NEMT brokers. State program designed to coordinate both medical and other human service transportation.
New Jersey	Example of statewide full-risk contract broker. Innovative efforts underway to involve public transit agencies as NEMT providers, and test contracting strategies to address coordination issues.
North Carolina	Conventional, county-based fee-for-service NEMT option, but reportedly includes examples of effective local coordination of transportation resources.
Ohio	Also represents traditional, county-based FFS option with examples of local coordination and county-level brokered NEMT services.
Oregon	State NEMT program currently undergoing dramatic change, from network of community-based regional brokers to carve-in managed care option. Current unsettled situation in the state may be too unsettled to offer good contrasts or comparative information about new option.
Pennsylvania	Mixed NEMT option offering contrast between large private brokerage in Philadelphia metro area and county-based system in rural counties. Innovative features include county-designed brokerage in Pittsburgh area.
Rhode Island	Until recently, state relied on a unique statewide NEMT brokerage operated by the Rhode Island Public Transit Authority (RIPTA), which was an option for coordination of ADA paratransit, Medicaid and other human service transportation. Recently switched to risk-based private broker, which may provide useful contrast with former program.
Texas	Second largest NEMT program in the country. Recently adopted regional brokered NEMT program, providing contrast with former exclusive contract-provider option that relied heavily on local public and transportation providers.
Vermont	Example of indigenous, regional brokerage program involving public transit agencies operating under capitated, shared-risk contracts.
Washington	Oldest regional brokerage program in the country, relying on community based public and nonprofit brokers. Represents laboratory for studying NEMT coordination initiatives and efforts to serve dual eligible riders — meaning ADA paratransit and Medicaid.

Mini Case Study Results

In the mini-case studies, the researchers assessed the state's availability of data and the willingness of key sources to cooperate with the study to provide information most useful to the research outcomes. Researchers focused on identifying states that provide a cross-section of NEMT service delivery options for the purpose of documenting and measuring the option outcomes from multiple perspectives. Specifically, the mini-case study protocol was designed as a means to identify states that would meet the in-depth case study goal to:

- Detail each of the options and option impact from multiple perspectives.
- Provide practical information to include in a decision-making option on how to apply the options to make decisions regarding NEMT services.

- Provide in-depth information on a state's option experience that stakeholders can compare to their state's circumstances.
- Apply lessons learned to implement NEMT solutions that are broadly beneficial to all relevant state and local stakeholders in their communities of interest.

TASK 4. IN-DEPTH CASE STUDY RECOMMENDATION FOR PANEL CONSIDERATION [INTERIM REPORT]

In determining the states for in-depth case study, the Team kept in mind the research objectives—to present options for providing Medicaid-funded NEMT services and to compare and contrast the effects of the different options on:

1. Access to Medicaid services;
2. Human services transportation; and
3. Public transit services.

The Team selected seven states for in-depth case study based on the mini-case study responses. Appendix C provides the summaries of each of the 15 mini-case studies. The Team selected the seven states for in-depth case study based on the ability to: 1) gauge the effect of different NEMT service-delivery options on transportation coordination, customer service, and cost-effective community transportation services, 2) offer local, regional and state-level service delivery examples, and 3) provide perspectives from multiple stakeholders.

Table 6 provides a summary of the seven in-depth case study state selection including the advantages and disadvantages for the selection. The Team selected seven case study states with the intention of selecting at least one NEMT option type. The Team determined that the best candidates for case studies were those identified through mini-case study research as 1) having specific examples of coordination efforts and impacts, 2) having specific success stories the provide best practice policies, practices and procedures, and 3) having multiple perspectives represented including the customer or customer advocates.

Seven States Selected for Panel Consideration

Option	Seven State(s) Selected for In-Depth Case Study
• In-house Management:	(1) North Carolina
• Managed Care Organization:	(1) Florida
• Statewide Broker:	(1) New Jersey
• Regional Broker:	(2) Massachusetts and Texas
• Mixed:	(2) Pennsylvania (FFS & Broker) and Oregon (FFS Broker)

Table 6. In-Depth Case Study Selection for Consideration
(Alphabetical Order)

State	In-house Management	Managed Care	Statewide Broker	Regional Broker	Mixed	Selection Basis
Total	**1**	**1**	**1**	**2**	**2**	
Florida (In Transition to Managed Care)		x				Florida's advantage is in being a long-time leader in transportation coordination. The recent transition to a managed care model should offer some useful contrasts with the former brokered system relying on community transportation coordinators. Data and research references (previous studies) are available. A good variety of contacts is available for outreach that represent all stakeholders. A disadvantage is that the transition from a statewide NEMT broker to a carved-in managed care approach is very recent (May to August 2014).
Massachusetts				x		Massachusetts advantage is in providing a good example of a long and stable use of regional brokerages in a coordinated transportation system. The state Medicaid agency is cooperative and willing to share information and data. Massachusetts emphasizes cost effectiveness and service quality. NEMT per-trip costs have not increased significantly despite increases in trip volume. A disadvantage is the existing NEMT regional brokerage system has been in place for more than 10 years. No recent change in the NEMT service-delivery model.
New Jersey			x			New Jersey's advantage is in its unique approach to rate setting that benefits public transportation providers. The Medicaid agency and state DOT are cooperative and willing to share information and data. A disadvantage is the impacts on coordinated transportation resulting from loss of casino revenues may be difficult to separate from the impacts on coordinated transportation resulting from NEMT changes.
North Carolina	x					North Carolina's advantage is in the variety of good coordination examples across the state with the current NEMT county-based FFS model. Data are available from multiple sources and contacts from all stakeholder perspectives are identified. Previous studies provide good background. A disadvantage is there is no recent change in the NEMT service-delivery model and the large number of NEMT service delivery agreements across different counties.
Oregon (In Transition to Fee for Service Broker)					x	Oregon's advantage is in providing an example of transitioning from a regional community-brokerage model to a managed care model. Historical data is available by mode in the urban and rural areas. Differences within the state may provide good compare and contrast study of before-and-after data. Examples such as Lane Transit District may provide best practice examples of coordination to provide good health outcomes to Medicaid clients. Historical NEMT trip data is available because under the state's previous model, transportation providers were required to report detailed trip information with their invoice. The data included trip lengths, purposes, cost, trip counts, eligible users, frequencies, destinations/origins and distribution of trips across modes. Direct point of contact for consumer advocate groups were identified. A disadvantage is that the model change is very recent with full transition by July 2015.

Table 6. In-Depth Case Study Selection for Consideration (Cont.)
(Alphabetical Order)

State	In-house Management	Managed Care	Statewide Broker	Regional Broker	Mixed	Selection Basis
Pennsylvania					x	Pennsylvania's advantage is in providing a mixed NEMT model offering contrast between large private brokerage in Philadelphia metro area and county-based system in rural counties. Innovative features include county-designed brokerage in Pittsburgh area. A variety of contacts from all stakeholder perspectives are identified. Public transit is high use in providing NEMT. The Medicaid agency shares data and costs. A disadvantage is that there has not been a change in the NEMT model.
Texas				x		Texas' advantage is in its recent adoption of a regional brokered NEMT program, providing contrast with the former exclusive contract-provider model that relied heavily on local public and transportation providers. Comparison study of differing brokers including public transit, health and human service and private brokers can be conducted. There is a good level of cooperation from the Medicaid agency and state DOT and a good level of data available for all 68 rural and small urban transit districts and eight large urban transit providers in Texas. The major metropolitan transit agencies have expressed interest in participating in the study. The State DOT is funding a study to assess risk of reduction in Medicaid NEMT on rural and small urban transit providers. A disadvantage is that the model change is recent (2014) and the state is large and complex.

Table 7 provides a summary of the remaining eight states not selected for in-depth case study.

Eight States Not Selected

Option	**Remaining Eight State(s) Not Selected**
• In-house Management:	(1) Ohio
• Managed Care Organization:	No other mini-case study state in option category
• Statewide Broker:	(2) Iowa and Rhode Island
• Regional Broker:	(4) Kentucky, Maine, Vermont, Washington
• Mixed Options	(1) Colorado

Table 7. States in Mini-Case Study Not Selected for In-Depth Case Study
(Ranked in Order of Strength for In-Depth Case Study with 1 Strongest)

Rank	State	In-house Management	Managed Care	Statewide Broker	Regional Broker	Mixed	Rank Basis
Total		1	0	2	4	1	8
8	Kentucky				x		Kentucky's advantage is in providing two distinct periods for useful comparison to examine community-based regional NEMT brokers and their coordination with public and human service transportation—from 2006 to 2010 brokers schedules and managed services but did not provide transportation and beginning 2010 brokers became eligible to serve as a provider. However, a disadvantage is that Kentucky has had no recent change in the NEMT service-delivery model.
9	Vermont				x		Vermont's advantage is in providing good examples of indigenous, regional brokerages involving public transit agencies operating under a capitated, shared-risk contract and is a rural state. However, a disadvantage is that Vermont does not have a variety of transportation examples to offer.
10	Washington				x		Washington's advantage is in providing examples of mutually beneficial negotiated rates between public transit providers and regional brokers and of how public transit can be maximized in providing NEMT service. However, a disadvantage is that Washington has had no major changes in the state's NEMT model.
11	Colorado					x	Colorado's advantage is in providing coordination examples through the Denver region broker incentivizing the use of public transit. The 55 county-based service model means data collection would be complex and the recent change in the Denver broker may make data collection difficult.
12	Iowa			x			Iowa's advantage is in providing an example of a transition from a fee-for-service model to a state-wide brokerage model in 2010. Iowa is unique in that Iowa was approved to eliminate NEMT for the expanded Medicaid population under the ACA. Limited data under the FFS model is available prior to 2010 change.
13	Maine				x		Maine's advantage is in providing an example of moving from a local community transportation agency based program to a regional broker NEMT program. Maine Medicaid agency has not responded to information requests for the research. A report is expected in 2015 providing an evaluation of the broker program performance.
14	Ohio	x					Ohio's advantage is in providing an example of a transition from a county-based FFS model to a managed care plans. A disadvantage is that data is limited and the current model is complex with managed care plans both brokering NEMT and providing on a FFS basis.
15	Rhode Island			x			Rhode Island's advantage is in providing an example of a joint contract with the Rhode Island Transit Authority to serve as a statewide broker heavily relying on bus passes to Medicaid recipients. Responsibility for NEMT moved to a national private broker in May 2014. A disadvantage is that changes are very recent and researchers may not have the data to assess the change impacts.

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