FY 2018 Houston EMA/HSDA Ryan White Part A Service Definition **Medical Transportation (Van Based)** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Medical Transportation**
Local Service Category Title:	**a. Transportation targeted to Urban** **b. Transportation targeted to Rural**
Budget Type: **RWGA Only**	**Hybrid Fee for Service**
Budget Requirements or Restrictions: **RWGA Only**	• Units assigned to Urban Transportation must only be used to transport clients whose residence is in Harris County. • Units assigned to Rural Transportation may only be used to transport clients who reside in Houston EMA/HSDA counties other than Harris County. • Mileage reimbursed for transportation is based on the documented distance in miles from a client's Trip Origin to Trip Destination **as documented by a standard Internet-based mapping program (i.e. Google Maps, Map Quest, Yahoo Maps) approved by RWGA.** Agency must print out and file in the client record a trip plan from the appropriate Internet-based mapping program that clearly delineates the mileage between Point of Origin and Destination (and reverse for round trips). This requirement is subject to audit by the County. • Transportation to employment, employment training, school, or other activities not directly related to a client's treatment of HIV disease is not allowable. Clients may not be transported to entertainment or social events under this contract. • Taxi vouchers must be made available for documented emergency purposes and to transport a client to a disability hearing, emergency shelter or for a documented medical emergency. • Contractor must reserve 7% of the total budget for Taxi Vouchers. • Maximum monthly utilization of taxi vouchers cannot exceed 14% of the total amount of funding reserved for Taxi Vouchers. • Emergencies warranting the use of Taxi Vouchers include: van service is unavailable due to breakdown, scheduling conflicts or inclement weather or other unanticipated event. A spreadsheet listing client's 11-digit code, age, date of service, number of trips, and reason for emergency should be kept on-site and available for review during Site Visits. • **Contractor must provide RWGA a copy of the agreement between Contractor and a licensed taxi vendor by March 30, 2015.** • All taxi voucher receipts must have the taxi company's name, the driver's name and/or identification number, number of miles driven, destination (to and from), and exact cost of trip. The Contractor will add the client's 11-digit code to the receipt and include all receipts with the monthly Contractor Expense Report

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

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

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

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

FY 2019 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/14/18**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/07/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/15/18**
Recommendations:	Approved: Y: _____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMN Workgroup**	Date: **04/25/18**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

TRANSPORTATION

Transportation services provides transportation to persons living with HIV (PLWH) to locations where HIV-related care is received, including pharmacies, mental health services, and substance abuse services. The service can be provided in the form of public transportation vouchers (bus passes), gas vouchers (for rural clients), taxi vouchers (for emergency purposes), and van-based services as medically indicated.

(**Graph 1**) In the 2016 Houston HIV Care Services Needs Assessment, 47% of participants indicated a need for *transportation services* in the past 12 months. 40% reported the service was easy to access, and 7% reported difficulty. 10% stated they did not know the service was available. When analyzed by type transportation assistance sought, 84% of participants needed bus passes, 10% needed van services, and 6% needed both forms of assistance.

(**Table 1**) When barriers to *transportation services* were reported, the most common barrier type was transportation (28%). Transportation barriers reported include both lack of transportation and difficulty with special transportation providers.

GRAPH 1-Transportation Services, 2016

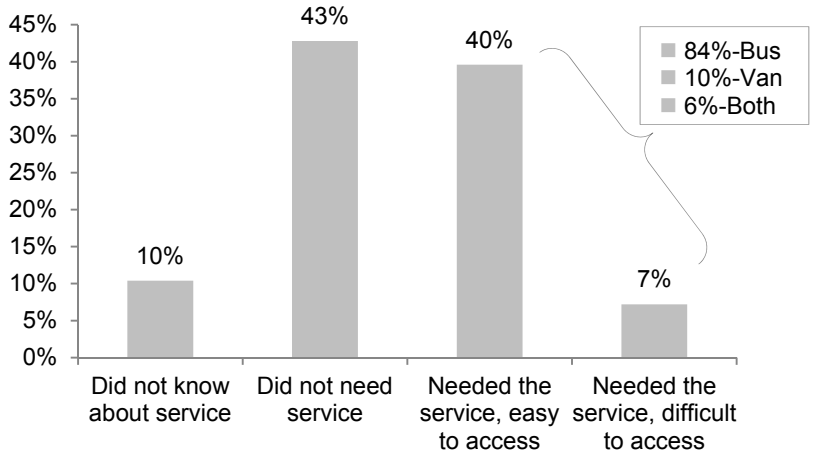

TABLE 1-Top 5 Reported Barrier Types for Transportation Services, 2016

	No.	%
1. Transportation (T)	9	28%
2. Education and Awareness (EA)	6	19%
3. Eligibility (EL)	4	13%
4. Accessibility (AC)	3	9%
5. Resource Availability (R)	3	9%

(**Table 2 and Table 3**) Need and access to services can be analyzed for needs assessment participants according to demographic and other characteristics, revealing the presence of any potential disparities in access to services. For *transportation services,* this analysis shows the following:

- More females than males found the service accessible..
- More African American/black PLWH found the service accessible than other race/ethnicities.
- More PLWH age 50+ found the service accessible than other age groups.
- In addition, more transgender, recently released, unstably housed, and MSM PLWH found the service difficult to access when compared to all participants.

TABLE 2-Transportation Services, by Demographic Categories, 2016

	Sex		Race/ethnicity				Age		
Experience with the Service	Male	Female	White	Black	Hispanic	Other	18-24	25-49	50+
Did not know about service	11%	8%	7%	9%	15%	13%	22%	10%	9%
Did not need service	47%	31%	55%	36%	41%	87%	43%	44%	40%
Needed, easy to access	35%	55%	27%	48%	38%	0%	30%	38%	44%
Needed, difficult to access	8%	6%	10%	8%	5%	0%	4%	8%	7%

TABLE 3-Transportation Services, by Selected Special Populations, 2016

Experience with the Service	Unstably Housed[a]	MSM[b]	Out of Care[c]	Recently Released[d]	Rural[e]	Transgender[f]
Did not know about service	17%	13%	50%	8%	6%	14%
Did not need service	27%	49%	50%	22%	72%	18%
Needed, easy to access	46%	31%	0%	59%	16%	50%
Needed, difficult to access	10%	8%	0%	11%	6%	18%

[a]Persons reporting housing instability [b]Men who have sex with men [c]Persons with no evidence of HIV care for 12 mo.
[d]Persons released from incarceration in the past 12 mo. [e]Non-Houston/Harris County residents [f]Persons with discordant sex assigned at birth and current gender

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FY 2016 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

Ryan White Part A
HIV Performance Measures
FY 2016 Report

Transportation

Van-Based Transportation	FY 2015	FY 2016	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Van Transportation services	464 (68.8%)	493 (69.1%)	**0.3%**
35% of clients will utilize Parts A/B LPAP services after accessing Van Transportation services	345 (51.2%)	386 (54.1%)	**2.9%**

Bus Pass Transportation	FY 2015	FY 2016	Change
A minimum of 50% of clients will utilize Parts A/B/C/D primary care services after accessing Bus Pass services	898 (34.3%)	914 (37.3%)	**3.0%**
A minimum of 20% of clients will utilize Parts A/B LPAP services after accessing Bus Pass services	440 (16.8%)	535 (21.8%)	**5.0%**
A minimum of 65% of clients will utilize any RW Part A/B/C/D or State Services service after accessing Bus Pass services	1,993 (76.2%)	1,955 (79.7%)	**3.5%**

National Public Radio (NPR) - March 1, 2018 9:00 AM ET
Producer: Emily Sullivan

Uber Launches Service To Get People To The Doctor's Office

Uber wants to get you from your home to your doctor's office – and you won't even need to open the Uber app. The company announced Thursday that it's teaming up with health care organizations to provide transportation for patients going to and from medical appointments.

The rides can be scheduled for patients through doctor's offices, by receptionists or other staffers. And they can be booked for immediate pickup or up to 30 days in advance. That means patients without a smartphone — who wouldn't be able to use Uber otherwise — can become Uber customers.

Instead of operating through an app, Uber Health will send its passengers' ride information through an SMS text message. The company also plans to introduce the option for passengers to receive a call with trip details to their landline instead. Drivers will still use the Uber smartphone app to pick up these passengers.

"Transportation barriers are the greatest for vulnerable populations," says Chris Weber, the general manager of Uber Health. "This service will provide reliable, comfortable transportation for patients."

Cities With Uber Have Lower Rates Of Ambulance Usage

Transportation is, indeed, a barrier to good health care. Affordable access to a vehicle is consistently associated with increased access to medical care, according to a study. Around 3.6 million Americans miss doctor's appointments or delay medical care due to a lack of transportation every year, according to the National Conference of State Legislatures.

To meet the medical privacy standards outlined in the federal HIPAA law, drivers won't know which of their passengers are using Uber Health. Like a typical Uber ride, only a passenger's name, pickup and drop-off addresses will be given to the driver. So Uber drivers won't be able to opt into the health service the same way that they opt into Uber Eats, a food delivery service.

Peter Whorley, who drives a Honda Odyssey minivan for Uber in Fort Lauderdale, Fla., often picks up passengers who need the extra space, including patients traveling to and from doctor's offices.

No Car, No Care? Medicaid Transport Program Faces Cuts In Some States

"I just picked up someone with back surgery the other day," he says. "I like to help people, if they need extra assistance, I personally don't have that problem. But some people might be squeamish, and not want to."

Whorley, who has been driving for Uber for more than two years, is more skeptical about picking up people without smartphones. He thinks location tracking on smartphones is vital to the efficiency of the ride-hailing service. "When you're a good passenger, you should be able to have your phone out to communicate with your driver," he says.

Uber's Weber says that because health care providers will use their best discretion in scheduling the rides, they won't call Ubers for people in need of urgent medical attention. "It's not a replacement to ambulances," he says, but a reliable means of transportation to non-urgent medical services that he hopes will curb missed appointments.

One hundred health care organizations in the U.S., including hospitals, clinics, rehab centers, senior care facilities, home care centers, and physical therapy centers have already used Uber Health's test program. The service will be rolled out to health care organizations gradually.

States Struggle to Manage Medical Transportation

Millions of disabled, sick and elderly people rely on medical transportation that can leave them stranded for hours in times of need.

BY: Katherine Barrett & Richard Greene | May 2016

The dialogue around providing accessible health care includes such big issues as high-priced prescriptions, overuse of emergency rooms and a burgeoning need for long-term care. One topic that gets relatively little attention, but could have a big impact on accessibility, is transportation. It represents a tiny fraction of the total spent on health care, but it has been a big challenge for states to manage.

This piece of the health-care puzzle affects 7.1 million people, according to the nonprofit Altarum Institute, which provides health-care research and consulting. A chunk of this group are Medicaid patients. The federal government requires transportation reimbursement for all Medicaid recipients.

A report to the 2015 National Conference of State Legislatures described the extent of the overall problem. “Services can overlap in some areas and be entirely absent in others,” it said, noting that funding shortfalls, policy and implementation failures, and lack of coordination leave many who need transportation with few or no options.

Often the service shortfalls are as mundane as cars that show up late -- sometimes 15 minutes, sometimes hours. Or worse, they don’t arrive at all. This is more than an inconvenience. It can be devastating, particularly when the patients involved are frail or disabled and trying to get home from an appointment. Nathalie Molliet-Ribet, senior associate director of Virginia’s Joint Legislative Audit and Review Commission notes, for instance, how traumatic it would be for, say, an intellectually disabled child to be left alone for hours while waiting for a ride home.

Poor service isn’t the only issue states have to deal with. There have been a host of instances in which states wind up overpaying for transportation or paying for transportation that wasn’t necessary in the first place.

Massachusetts, for example, audited a company that had contracted to provide wheelchair van services based on a fee-for-service model. When Massachusetts examined the books, the state auditor’s office found that:

- More than $17 million in questionable payments were made to the provider for wheelchair van transportation.
- Hundreds of claims were made for members who were inpatients at hospitals at the time the alleged transportation was proffered.
- 16 percent of transportation services to methadone clinics occurred with members who were not receiving any medical services.

In a model of understatement, State Auditor Suzanne Bump says that “the administration of the program has not been its strong suit.” The provider’s failure to comply with the terms of the program was so blatant, she adds, “it blew the auditors and me away.”

How did the provider respond to the publication of these problems? They said that they were acting under the direction of MassHealth, the state’s Medicaid and children’s health insurance program. MassHealth denies that was the case. The provider has been suspended, and the attorney general’s office is investigating. Meanwhile, Medicaid recipients, with the help of MassHealth, have been scrambling to find other ways to get to their medical appointments.

The problems with nonemergency medical transportation in Virginia have been somewhat different. As many states do, Virginia uses a single broker to match transportation providers with Medicaid recipients. Under the contract, the broker is paid a fixed rate per enrollee. But the broker has claimed to be unable to cover its costs, arguing that the service rate set in its contract is too low. There is no demonstrated cause and effect between the reimbursement rate and the quality of service, but there would appear to be a link. The state has experienced an increased rate of complaints from patients about unfulfilled trips.

One of the challenges in fixing the problem was a lack of data. “Medicaid didn’t have any information on whether the broker was losing money, and why,” says Molliet-Ribet. A year ago, the state did a study and found enough justification to provide an increase in reimbursement.

But the broker continues to claim not to have enough money, and the state doesn’t appear willing to raise its rates again since “the broker has been unwilling or unable to provide [necessary] information,” says Molliet-Ribet. In the meantime, the auditor’s office has been pushing for greater transparency in order to deal fairly with its broker and optimize quality of service.

It’s not all failure out there. One state that has run a particularly efficient nonemergency medical transportation program is Vermont. The state is largely rural, and a lot of citizens live far away from medical facilities. As a result, many Medicaid recipients do not have easy access to health care. What’s more, the number of transportation-needy Medicaid recipients has been growing as a result of Medicaid expansion and an increase in the number of patients with addiction-related problems.

Vermont has taken a multiprovider approach to managing the transportation challenge. It gives 12 separate providers wide latitude to provide rides. “It’s their responsibility to develop their own transportation plans,” says Suellen Bottiggi, who heads up Medicaid provider relations. But that’s only the first part of their approach. The second is to practice oversight -- each of the 12 is audited once or even twice a year. “Ongoing monitoring is so important,” says Bottiggi.

Regardless of the public-sector service, we can’t repeat that sentiment often enough. There’s nothing like a focused look at the books to keep providers on their toes.

Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?

Michael Adelberg Marsha Simon, September 20, 2017

Medicaid delivers care to 74.5 million individuals for less money than any other large-scale health financing mechanism. A 2016 Henry J. Kaiser Family Foundation study noted that "spending per enrollee is lower for Medicaid compared to private insurance after controlling for differences in sociodemographic and health characteristics between the two groups." One reason might be that Medicaid covers certain inexpensive, non-medical services that, when delivered early in the progression of chronic diseases, can check or slow the diseases, thereby improving beneficiaries' health and saving money. One non-medical service—transportation to medical appointments—has been part of Medicaid since its inception in 1966 and addresses one of the socioeconomic disadvantages that prevent Medicaid beneficiaries from accessing health services. It is suggested that 3.6 million Medicaid beneficiaries "miss or delay care" annually due to transportation problems. Although non-emergency medical transportation (NEMT) is a mandatory Medicaid benefit, states can limit its availability through federal waivers. As Medicaid enters a period of unprecedented experimentation and, potentially, reduced federal resources, NEMT remains a critical feature of the program.

Since its inception, Medicaid has provided beneficiaries with transportation to medically necessary health care services. NEMT is found as early as 1966 in the "Handbook of Public Assistance" (Supplement D), the program's earliest comprehensive federal interpretive guidance. Additionally, as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, states are required to offer children (from birth to age 21) and their families "necessary assistance with transportation" to and from providers. In practice, NEMT provides Medicaid beneficiaries who lack the means to travel to and from medical appointments with the most appropriate and least costly form of transportation, which may involve the use of livery vehicles, vans, or public transit.

Despite federal funding and regulations, Medicaid is best understood as a set of diverse state-directed programs. This diversity carries into NEMT, as states deploy several models to manage and finance the benefit:

1. Dominant model: brokers and managed care organizations (MCOs). The majority of states have evolved to deliver NEMT through NEMT-focused brokers or MCOs (which typically subcontract with NEMT brokers). In most of these states, the broker or MCO receives a capitated payment to manage the NEMT benefit.
2. Other models:
    - State entities: A few states rely on government entities such as Departments of Transportation to provide the service and directly fund those entities through an annual contract to reimburse ride providers on a per-ride (fee-for-service) basis.
    - Local service providers: Other states deliver NEMT through county or municipal ride services that may, in turn, fund independent taxi companies—and pay these transportation providers on a fee-for-service basis.

For several reasons, states have increasingly chosen NEMT brokers and MCOs over the other models. As in fee-for-service in medical care, there is worry that fee-for-service transportation incentivizes overuse, and it has been linked to program integrity problems in a few states. In contrast, most NEMT brokers receive a capped amount of money and therefore need to manage limited funds by, for example, assuring the assignment of the least expensive appropriate form of transportation necessary and monitoring trip information to identify the most efficient, highest-quality ride providers.

Due to lags and gaps in national Medicaid data, it is challenging to compile a contemporary snapshot of NEMT usage, although transportation researchers at Texas A&M estimated $2.9 billion was expended on NEMT to provide 103.6 million NEMT trips in fiscal year 2013. The Kaiser Commission on Medicaid and the Uninsured noted in 2016 that NEMT was used most frequently to access behavior health services (including mental health and substance abuse treatment), dialysis, preventive services (including doctor visits), specialist visits, physical therapy/rehabilitation, and adult day health care services.

Beyond Medicaid, NEMT is increasingly used in other government programs and health insurance markets. The Centers for Disease Control and Prevention includes transportation options as a social determinant of

health in its Healthy People 2020 initiative, and the Association of Health Insurance Plans recently published a report on this topic. Government and private-sector payers increasingly recognize that providing transportation to routine health care improves health outcomes and limits unnecessary expenses, such as hospitalization costs. Below, we briefly survey the use of NEMT in these other programs and markets.

Medicare

NEMT has become a popular supplemental benefit in the Medicare Advantage program. According to a 2016 *Health Affairs* blog, NEMT is available to roughly one-fourth of that program's 19 million enrollees. The benefit is most commonly available in $0 premium plans that focus on lower-income beneficiaries. This occurs despite the fact that traditional Medicare provides NEMT via ambulance only and only when other means of transportation, such as a taxi or wheelchair van, would jeopardize the health of the beneficiary. Ken Thorpe, a nationally recognized proponent of value-based insurance design and Medicare Advantage, has called NEMT "cost-effective for a wide range of medical conditions."

Department Of Veterans Affairs

The Department of Veterans Affairs (VA) offers mileage reimbursement and NEMT services for travel to health care and rehabilitation appointments for disabled veterans that meet one of eight qualifying criteria. The VA also provides transportation for family caregivers of veterans when certain criteria are met.

Employer-Sponsored Insurance

As of today, NEMT is uncommon in employer-sponsored insurance. This is likely because most people with employer-sponsored insurance are able to make it to and from their medical appointments without assistance. There is no easy way to know how many employers offer NEMT and whether the benefit is limited to specific care management contexts. But there are signs that commercial insurers are considering NEMT as they increasingly deploy customized interventions to address social determinants of health and value-based benefits. We offer two examples: A 2016 "innovation model" manual from the State of Connecticut to self-insured plan employers surveys value-based insurance benefits and notes NEMT as a supplemental benefit worthy of consideration. The Blue Cross Blue Shield Association recently announced a national partnership with Lyft "to ensure Americans are not missing vital health care appointments simply because they lack reliable transportation."

Accountable Care Organizations (Episode Model)

A Robert Wood Foundation report by Linda Wilson about accountable care organizations (ACOs) notes that these new provider-led care systems "are developing strategies to address social needs that have an impact on health." These strategies include providing beneficiaries with NEMT. Several Medicare ACOs recognize the need for "transportation assistance" in the description of their services. A recent study by Taressa Fraze and colleagues published in *Health Affairs*, concluded that several ACO leaders "view transportation as a barrier for patients to receive timely, high-quality care." As a result, many ACOs assist patients with transportation to medical appointments by providing transportation subsidies, hiring brokers, or managing NEMT for patients.

Despite the expansion of NEMT services generally, and of brokerage as the preferred model for delivering NEMT, the benefit has drawn increased scrutiny within Medicaid. The most prominent concerns are discussed below.

Fraud and Abuse

Program integrity lapses have damaged NEMT's reputation. Like other parts of the Medicaid program, NEMT is not free from fraud and abuse. Over the past few years, investigators have uncovered bad conduct by some NEMT drivers and vendors. In Massachusetts, a ride vendor billed rides for deceased beneficiaries, and in Connecticut, an ambulance provider billed rides for dialysis transport when an ambulance was not required. Incidents of billing for false trips or up charging on vehicle type have resulted in out-of-court settlements as high as $300,000. These examples explain why states looked to the brokerage model in the first place. The brokerage model is designed to address and mitigate these problems through capitated arrangements that insulate Medicaid budgets from fraud losses and encourage brokers to root out abuses.

Administration

Recent audits by the Department of Health and Human Services (HHS) Office of Inspector General suggest that the Medicaid programs of New Jersey and North Carolina both had gaps in their oversight of the NEMT benefit. A 2016 Government Accountability Office (GAO) study noted gaps in NEMT guidance at the state and federal levels and suggested a review by regulators because "NEMT is at high risk for fraud and abuse." A few months after the publication of the GAO report, the Centers for Medicare and Medicaid Services (CMS) issued a NEMT Toolkit designed to give states and NEMT providers a primer on providing NEMT.

Necessity

Concerns over the necessity of the NEMT benefit may be fueling a desire to re-examine its use in the Medicaid program, at least for particular populations. Currently, two states—Indiana and Iowa—have waived NEMT for their Medicaid expansion populations. In a 2016 *Health Affairs* blog, Seema Verma and Brian Neale, now the CMS administrator and head of Medicaid, respectively, made the case for not providing NEMT in the Indiana Medicaid expansion program, HIP 2.0 (Healthy Indiana Plan 2.0): "Consistent with commercial market benefit packages, HIP does not require health plans to cover non-emergency transportation (NEMT) services. Transportation availability has not proven to be a significant issue for HIP members during its eight-year history."

NEMT skepticism is not universal, even in Republican-led states. At least four states led by Republican governors—Michigan, Nevada, New Jersey, and Ohio—have shown a commitment to continue providing NEMT as they implement the Medicaid expansion.

Two other states with Republican governors—Arkansas and Massachusetts—have sought to limit NEMT, while continuing the benefit for select populations. Arkansas, which contemplated the limitation of NEMT for its expansion program, nonetheless contracted for a favorable report on the benefit in its traditional Medicaid program. A state taskforce convened in 2015 concluded that it has a "very effective brokerage model for non-emergency medical transportation (NEMT) with a capitated benefit structure that manages the program in a cost effective manner." A recent 1115 waiver amendment request from Massachusetts proposes to waive the "assurance" of NEMT for its Medicaid expansion population but retains NEMT for opioid addiction recovery. Thus, Massachusetts acknowledges the importance of NEMT for adherence in medication-assisted treatments and recognizes that the scarcity of Medicaid enrolled practitioners that provide medication-assisted treatments often requires long-distance travel to and from services.

Several studies note that missing routine, preventive care can lead to unnecessary costs and hospitalization. Although it is difficult to isolate the impact of transportation on health outcomes, a study conducted by Florida State University concluded that if only 1 percent of the medical trips funded resulted in the avoidance of an emergency department hospital visit, the payback to the State would be 1108 percent, or about $11.08 for each dollar the State invested in its medical transportation program. According to the study, "Overall, the State of Florida invested $372,264,302 in these transportation disadvantaged programs in 2007. These funds generated benefits of $3,172,813,246.31, which is a payback of 835%, or $8.35 per each dollar invested in these programs."

Other studies offer less dramatic, but still affirming, findings on the value of NEMT. A 2014 study by Leela V. Thomas and Kenneth R. Wedel concluded that Medicaid beneficiaries with asthma, heart disease, or hypertension who required monitoring to keep their chronic conditions stable were significantly more likely to attend medical appointments if they used NEMT (see Exhibit 1).

Exhibit 1: Non-Emergency Medical Transportation And Health Care Visits Among Chronically Ill Urban And Rural Medicaid Beneficiaries

Condition	Recommended number of annual visits	Used NEMT and had a recommended visit	Did not use NEMT but had a recommended visit
Asthma	2--12 per year	73.97%	53.89%
Heart disease	10 per year (2 with specialist)	64.81%	27.60%
Hypertension	4 visits per year	50.97%	27.20%

Source: Thomas LV, Wedel KR. Nonemergency medical transportation and health care visits among chronically ill urban and rural Medicaid beneficiaries. Social Work in Public Health. 2014;29(6):629-39. Notes: Sample size = 10,824. NEMT population within sample = 697.

A 2013 study in the *Journal of Health Economics and Outcomes Research* examined the high costs of ambulance transportation for people in need of dialysis (roughly $3 billion annually) and suggested that greater use of public and NEMT transportation might save as much as one-third of these costs. A broader study of the value of transportation services in rural areas also affirmed NEMT's return on investment. The cost to rural communities of "foregone medical trips" was estimated at between $4.16 and $6.65 for every dollar spent on transportation.

Final assessments of the waiver programs in Iowa and Indiana will help us understand the impact of not providing NEMT to Medicaid expansion beneficiaries. A state-sponsored interim assessment by the Lewin Group suggested that NEMT was not important to expansion beneficiaries. However, this interim assessment focused narrowly on missed appointments, not medical appointments never made because of lack of NEMT or the potential default to emergency care. While we await final assessments, it is worth noting that two Medicaid MCOs—United Healthcare in Iowa and Anthem in Indiana—continue to provide NEMT even without the state requirement.

NEMT is one of many parts of the Medicaid program that will likely be subject to experimentation in the coming years. A March letter from HHS secretary Tom Price and CMS administrator Seema Verma promises to "empower" states seeking flexibility in any of seven listed areas, one of which is NEMT. Beyond Indiana and Iowa, two other states—Kentucky and Massachusetts—have waiver applications that would curtail NEMT to some expansion population beneficiaries.

Meanwhile, the NEMT industry is changing rapidly: The dramatic growth of rideshare services such as Uber and Lyft may create new flexibilities for the delivery of NEMT. Policy makers are watching: A 2015 NEMT brief by the National Council of State Legislatures foreshadows greater integration of rideshare and NEMT providers (even while affirming the value of the benefit as "a vital lifeline"). A Medicaid and CHIP Payment and Access Commission presentation concurs: "Services such as Lyft and Uber could improve beneficiary experience with shorter wait times and faster service." In addition, an article authored by Brian Powers and colleagues published in the *Journal of the American Medical Association* suggested that new medical transportation technology offered by Uber and Lyft could reduce wait times and produce cost savings of more than 30 percent. NEMT brokers, for their part, are not resisting the use of rideshare services. Brokers and local service providers use rideshare services—particularly Lyft—although rider limitations (physical and cognitive) and state credentialing requirements limit the number of NEMT rides that can be delivered by typical rideshare drivers.

To address program integrity concerns, Congress could require states to manage the NEMT benefit by contracting with brokers, incentivize states to choose the broker option, or require states that do not use brokers to use utilization management tools commonly used by brokers, such as prior authorization. Several years ago, the HHS Office of the Inspector General identified NEMT brokerage (the report refers to brokers as prime vendor contracts) as a "proactive safeguard." An NEMT broker with a capitated, risk-based contract is the best way to ensure that the service is provided in a timely fashion only to eligible Medicaid beneficiaries (at the appropriate level of transportation for the beneficiary's needs) by screened, credentialed drivers and safe vehicles.

In the coming months, states will no doubt use waiver authority to experiment with Medicaid in new ways—by implementing work requirements, increasing member cost sharing, adding healthy behavior incentives and disincentives, providing value-based benefits, and, potentially, limiting NEMT. Research shows that transportation is one of the most common barriers faced by low-income populations in accessing timely and necessary medical care, and NEMT fills this access gap by providing the appropriate and least costly method of transportation. Given the high needs of the Medicaid population and the trend across health insurance toward greater use of non-medical benefits, including NEMT, to improve the efficiency of medical care, we expect that NEMT will continue to be an important part of Medicaid.