MOVING FORWARD TOGETHER:

Opportunities to Improve Program Integrity in Medicaid Non-Emergency Medical Transportation

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EXECUTIVE SUMMARY

This report reviews the non-emergency medical transportation (NEMT) benefit in Medicaid, with a focus on improving the program integrity of the NEMT benefit. The NEMT benefit enables Medicaid beneficiaries who lack reliable sources of transportation to use a benefit that will ensure they can access their primary care provider, dialysis appointment, child wellness check-up, addiction treatment, and other forms of non-emergent care. The benefit helps to remove transportation barriers to needed health services, improve health outcomes, and reduce utilization of more expensive emergency services.

States are required to provide the NEMT benefit to Medicaid beneficiaries due to longstanding regulation but have considerable discretion in what methods they may use to deliver the benefit. Currently, states use a range of methods including direct contracting with transportation providers on a fee-for-service (FFS) basis, statewide and regional brokers, managed care organizations (MCOs), and public transportation vouchers. Some states, like Iowa and Indiana, are experimenting with approaches that allow them to only offer the benefit to serve specific medically needy populations and not the Affordable Care Act (ACA) Medicaid expansion population. States are increasingly using models beyond FFS in order to better manage the benefit, provide beneficiaries with more options, and manage costs and program integrity concerns.

Leavitt Partners wrote this report based on insights from various stakeholders in Medicaid NEMT delivery, including current and former state Medicaid directors and staff, representatives from brokers and MCOs, representatives from a transportation network company, a state medical provider trade association, and individuals engaged in improving state standards for transportation provider accreditation and certification. The interviewees provided valuable first-hand experiences with NEMT that informed our understanding of the program integrity concerns and possible solutions outlined below.

Many states have faced challenges with program integrity in administering NEMT to beneficiaries. While only a very small fraction of Medicaid spending goes to NEMT, millions of beneficiaries receive rides each year. NEMT has been the subject of several of the Government Accountability Office (GAO) and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) reports due to its vulnerability to fraud, waste, and abuse. The GAO has recommended that updated guidance for state Medicaid programs would be useful given the risk for fraud and abuse in NEMT. The GAO noted that improper payments, ensuring appropriate use of program dollars, adequate Medicaid data, and access to quality care are among the oversight challenges faced in administering NEMT. The HHS OIG has also examined Medicaid NEMT, finding challenges with inadequate documentation, fraudulent billing of rides never provided, rides provided to beneficiaries who never received a Medicaid-covered service, drivers without required qualifications, vehicles that do not meet safety requirements, and inappropriate use of higher-cost vehicle types for transportation.

One way states manage program integrity concerns is with the increasing use of broker models. These models allow for better tracking of rides, patient data, and patient responsiveness, and place the responsibility for monitoring and addressing fraud and abuse at the MCO plans and brokers through capitated payments. Many states use brokers to administer the NEMT benefit or have MCOs administer the benefit while also utilizing brokers. The Medicaid program staff we spoke with noted that the shift to broker models in their state was often an effort to curb fraud, waste and abuse, as well as provide a more robust network of transportation providers and improve access to beneficiary services.

Another key aspect to improving program integrity is ensuring access to qualified transportation providers. The HHS OIG has found that properly screening transportation providers is a concrete step in enhancing program integrity in Medicaid NEMT. Specifically, requirements for individual drivers, individual vehicles, and financial requirements are areas with opportunities for improvement. States must ensure basic background checks and appropriate training for drivers while carefully balancing these requirements with the need for robust networks of providers to serve beneficiaries. Standard requirements for vehicle safety and usability are required, but more importantly, states must ensure that these requirements are actually enforced through regular inspections. States also have requirements for liability insurance. States must be cautious of any requirements that are overly burdensome and too costly, thereby limiting the number of otherwise eligible transportation providers.

Harnessing technology is an important avenue for ensuring program integrity. Global Positioning Satellite (GPS) technology is a useful tool for tracking rides and utilization, as are approaches that improve the complaint process for beneficiaries and help brokers and states to address missed rides. States have also found the ability to compile complaint data and provide transparency into concerns raised by beneficiaries a useful tool. Technology has enabled brokers to effectively confirm

beneficiary eligibility for NEMT more easily, reducing the number of denied claims and inappropriate trips. Lastly, technology has reduced Health Insurance Portability and Accountability Act (HIPAA) concerns raised by transportation providers using paper forms containing personal health information (PHI) from beneficiaries.

The use of Transportation Network Companies (TNCs), also known as ride sharing platforms, is also an opportunity to monitor potential program integrity concerns and offer improved service to beneficiaries. TNCs, like Uber and Lyft, have changed consumer expectations about reasonable pick-up times and have forced transportation providers and brokers to be more responsive to consumer expectations. One of the limitations we heard is that TNCs currently have limited access to vehicles for beneficiaries that require special accommodations. While states differ on their use of TNCs in Medicaid NEMT, brokers have embraced TNCs in many cases, especially in "emergency" situations, to ensure the patient is not stranded at a doctor's office or missing a needed ride to a medical service. TNCs, if used in specific situations while meeting appropriate standards, may further augment the NEMT benefit.

States can make headway in reducing program integrity problems and public concerns by looking to further improve NEMT broker and MCO models through the use of qualified transportation providers, useful technologies, and ride-sharing platforms. The following is a list of recommendations at the federal and state level to implement the opportunities for improvement in program integrity outlined above:

Federal Recommendations:

1. Update NEMT program integrity review.
2. Facilitate collaboration on leading practices.
3. Provide technical assistance to states.
4. Implement the GAO's open recommendation (GAO-16-238).
5. Require basic program integrity.
6. Analyze Transformed Medicaid Statistical Information System (T-MSIS) data for insights.

State Recommendations:

1. Require public transparency of key Medicaid NEMT data.
2. Leverage existing data to continually improve program integrity.
3. Position state systems to detect and prevent known fraud schemes.
4. Use prior approval strategically.
5. Ensure robust complaint and Medicaid appeals processes for beneficiaries.
6. Use contracting arrangements to incentivize program integrity and quality.
7. Transition to/between transportation brokers with careful planning.
8. Consider the role of TNCs and use them strategically.

REPORT METHODOLOGY

In preparing this report, Leavitt Partners utilized a wide range of data and sources to inform its thinking. In general, written public sources are cited throughout the paper as they are referred to in the analysis. The report draws from several sources of data, a review of existing literature, and an examination of published reports. Examples of such sources utilized include:

1. Federal guidance from the Centers for Medicare & Medicaid Services
2. Reports from the Government Accountability Office and the Office of the Inspector General at the U.S. Department of Health and Human Services
3. State audit reports and guidance
4. Industry reports and publications
5. White papers and academic research
6. National and local media coverage
7. Other publicly available sources

To qualitatively augment its analysis, Leavitt Partners also conducted informal, informational interviews with a wide range of experts on Medicaid NEMT. Specifically, Leavitt Partners spoke with six former Medicaid program[1] staff, six representatives of Medicaid MCOs, two representatives of a transportation network company, five representatives of NEMT transportation brokers, one state medical provider trade association, one independent organization focused on NEMT accreditation, certification, and transportation provider standards, as well as other Medicaid stakeholders. These informational interviews included conversations with current and former Medicaid program staff with varied geographies, regional dynamics[2], population needs, service delivery models, reimbursement structures, and other dynamics. The insights and information from these conversations informed our general understanding of the nuances of operational and policy concerns regarding providing NEMT to Medicaid beneficiaries.

To quantitatively augment its analysis, Leavitt Partners also requested information from a transportation broker, LogistiCare. LogistiCare is a large provider of Medicaid NEMT services, active in many state Medicaid programs. As LogistiCare notes, the company manages "over 230 client NEMT programs in 43 states and the District of Columbia" including "more than 65 million trips annually for approximately 24 million members" and they "respond to more than 26 million calls a year."[3] The company participates in state Medicaid programs spanning a range of geographies, delivery models, and population types. Where LogistiCare data is relied on for insights or information, their company information is cited in the paper.

The research in this report was supported by the Medical Transportation Access Coalition (www.mtaccoalition.org), a multi-stakeholder coalition devoted to educating policymakers and other stakeholders about the benefits of medical transportation and the need for policies that support continued access to these services.

Special thanks to Shannon Rohn of Leavitt Partners for her assistance in researching and writing this report.

[1]Unless otherwise noted, "state Medicaid program" refers to the Medicaid program in a state, Washington, D.C., or one of the territories.

[2]This includes at least one conversation a Medicaid program staff who had worked in a state which had waived NEMT services under a Medicaid Section 1115 demonstration waiver.

[3]LogistiCare, About, accessed Jun 10, 2019, Available from: https://www.logisticare.com/about.

MEDICAID NON-EMERGENCY MEDICAL TRANSPORTATION

The Importance of Transportation for Medical Care

One of the barriers many patients face in accessing health care services is transportation to and from doctor appointments and other forms of treatment. One study found that more than 3 million Americans do not obtain medical care in a year due to transportation issues.[4] Unfortunately, these Americans may be disproportionately female, poorer, and older—as well as more likely to have less education and be a member of a minority group.[5] Patients who are low-income, who have multiple chronic conditions, or who face challenges related to the social determinants of health[6] are too often challenged in accessing reliable transportation to and from health care providers. As noted in *Health Affairs*, in 2013, a systematic literature search of peer-reviewed studies on transportation barriers to health care access concluded that these barriers are common and greater for low-income and chronically ill patients.[7] In fact, the Center for Disease Control (CDC)'s Healthy People 2020 initiative identifies barriers to accessing transportation as a social determinant of health impacting vulnerable populations.[8]

Because of these barriers, Medicaid managed care plans are working to improve access to transportation through use of the NEMT benefit and through their own initiatives as well.[9] State leadership is key to delivering this benefit as well. A 2016 review by the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that the vast majority of Medicaid FFS spending on NEMT is for individuals with intellectual or developmental disabilities, or for individuals who are elderly.[10]

Patients who do not have reliable access to transportation may miss critical appointments. Two studies have reported that one in four patients have reported missing an appointment of some kind, and more than two dozen studies found that somewhere between one in ten and one in two patients identified transportation as a barrier to accessing health care.[11] In many cases, missed appointments can not only result in increased hassle for patients or providers, but also lead to poorer health outcomes and increased emergency department (ED) utilization. A 2012 study of Medicaid beneficiaries noted that 60 percent of those that utilized the ED on one or more occasions had trouble accessing transportation.[12] As noted in *Health Affairs*, one study in 2013 that examined the cost of ambulance transportation for patients needing dialysis suggested that, for those patients, greater use of NEMT might save as much as one-third of the cost of care.[13] Another study associated improved transportation access with cost-savings for patients accessing certain types of care such as prenatal care, care for asthma, congestive heart failure (CHF), and diabetes.[14] Research has also shown that Medicaid beneficiaries using NEMT in rural areas more frequently receive check-ups for their CHF, hypertension, and asthma than those who do not use NEMT services.[15]

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[4]Hughes-Cromwick et. al., Access to Health Care and Nonemergency Medical Transportation: Two Missing Links, Transportation Research Record Journal of the Transportation Research Board, 1924(1), January 2005, Available from: https://www.researchgate.net/publication/39967547_Access_to_Health_Care_and_Nonemergency_Medical_Transportation_Two_Missing_Links.

[5]Ibid.

[6]The Centers for Disease Control and Prevention (CDC) defines "social determinants of health" (SDOH) as "conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes." For example, CDC notes that "poverty limits access to healthy foods and safe neighborhoods and that more education is a predictor of better health." Many current efforts to address the SDOH patients face focus on improving access to healthy food, safe and reliable transportation, and secure housing. CDC notes that "by applying what we know about SDOH, we can not only improve individual and population health but also advance health equity." Available from: https://www.cdc.gov/socialdeterminants/index.htm. Accessed June 10, 2019.

[7]Marsha Simon & Eliot Fishman, Budget Proposal Would Allow States to Drop Medicaid Transportation Benefits Across the Entire Program, Health Affairs, 2018, Available from: https://www.healthaffairs.org/do/10.1377/hblog20180608.971229/full/.

[8]Healthy People 2020, Access to Health Services, Available from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health.

[9]Beyond the Boundaries of Health Care: Addressing Social Issues, America's Health Insurance Plans, 2017. Available from: https://www.ahip.org/wp-content/uploads/2017/07/SocialDeterminants_IssueBrief_7.21.17.pdf

[10]K. Blom, Non-Emergency Medical Transportation (NEMT), December 15, 2016, Available from: https://www.macpac.gov/wp-content/uploads/2016/12/Non-Emergency-Medical-Transportation-NEMTMedical-Transportation-NEMT.pdf

[11]Supra footnote 7, Available from: https://www.healthaffairs.org/do/10.1377/hblog20180608.971229/full/.

[12]K.E. MacLeod et. al, Missed or Delayed Medical Care Appointments by Older Users of Nonemergency Medical Transportation Services, University of California Berkeley, Available from: https://escholarship.org/uc/item/1tm284cm.

[13]Michael Adelberg & Marsha Simon, Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?, Health Affairs, 2017, Available from: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.

[14]Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation, The National Academies Press, Available from: http://www.trb.org/Publications/Blurbs/156625.aspx.

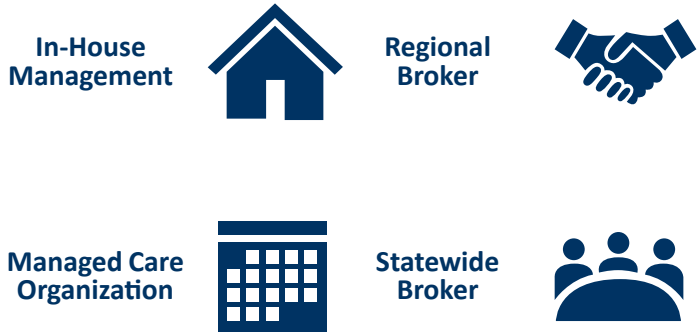
[15]Thomas and Wendel, Nonemergency medical transportation and health care visits among chronically ill urban and rural Medicaid beneficiaries, Journal of Social Work and Public Health, 2014, Available from: https://www.ncbi.nlm.nih.gov/pubmed/25144703.

To help ensure Medicaid patients have timely access to needed medical care, state Medicaid programs are required to provide for medically necessary transportation for non-emergency medical services, for beneficiaries unable to afford or access transportation to these services.[16] Today, Medicaid NEMT delivers more than 100 million trips total to a few million Medicaid beneficiaries.[17] With tens of millions of Americans enrolled in state Medicaid programs this year,[18] Medicaid's provision of non-emergency transportation to those who need it "represents one of the nation's largest publicly supported transportation undertakings."[19]

For many patients who lack reliable transportation, the value of the NEMT benefit is clear: increasing access to non-emergent appointments can help lead to better health outcomes over time and decrease health care costs associated with avoidable ED use. One study on the value of transportation in rural communities estimated that the cost of "foregone medical trips" on such communities ranged from about four to six dollars for every dollar spent on transportation.[20] Another study found NEMT spending had a return on investment more than ten times the original investment when considering the medical benefit.[21]

This paper will explore challenges associated with the Medicaid NEMT benefit. This paper will also propose solutions that state Medicaid programs, brokers, MCOs and Centers for Medicare & Medicaid Services (CMS) may utilize as they work toward the shared goal of improving the integrity of the NEMT benefit so that it best serves Medicaid beneficiaries who need transportation services.

How Medicaid NEMT Works



States are required to provide an "assurance of transportation" for Medicaid beneficiaries to and from providers.[22] While not included in its list of mandatory Medicaid benefits, long standing federal regulation[23] and the requirement that states provide for methods of administration necessary for the proper and efficient operation of Medicaid have kept NEMT in place.[24] Further, states are required to provide NEMT specifically to children up to age 21 with "necessary assistance with transportation" to and from providers as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.[25] State Medicaid programs may also provide an NEMT benefit beyond these requirements to enable Medicaid beneficiaries under Home and Community Based Service waivers to access non-medical community services or other services specified in the plan of care.[26]

States are free to determine the model with which they administer the NEMT benefit, provided that they describe the method to CMS.[27] Some states administer the benefit directly and reimburse transportation providers through a FFS reimbursement

[16]Requiring states to provide NEMT services is a long-standing requirement on state Medicaid programs. See CMS, Non-Emergency Medical Transportation, https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf. Accessed June 2019.

[17]Specific utilization data is hard to come by in a timely manner because of the lag in Medicaid data and state program data practices. However, on 2014 estimate calculated Medicaid paid for 103 million trips in 2013. Available from: http://groups.tti.tamu.edu/transit-mobility/files/2015/12/Interim-Report-Revised-Post-Panel-Comment.pdf. Based on MACPAC's MSIS analysis, there were 1.8 million NEMT users in CY 2012. See https://www.macpac.gov/wp-content/uploads/2016/12/Non-Emergency-Medical-Transportation-NEMTMedical-Transportation-NEMT.pdf. These numbers have only increased with more states expanding Medicaid under the ACA.

[18]Medicaid—CBO's May 2019 Baseline, Available from: https://www.cbo.gov/system/files/2019-05/51301 2019-05-medicaid.pdf.

[19]Rosenbaum et. al., Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform, Milken Institute of Public Health, The George Washington University, Available from: https://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/34/.

[20]Michael Adelberg & Marsha Simon, Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?, Health Affairs, 2017, Available from: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.

[21]Human Service Transportation Coordination State Profile: Florida, National Conference of State Legislatures, Available from: http://www.ncsl.org/documents/transportation/FL-HSTCprofile.pdf.

[22]42 C.F.R. § 431.53(a); 441.62.

[23]42 C.F.R. § 431.53(a).

[24]42 U.S.C. § 1396(a)(4)(A).

[25]42 C.F.R. § 441.62.

[26]K. Colello, Medicaid Coverage of Long-Term Services and Supports, Congressional Research Service, December 5, 2013, Available from: https://fas.org/sgp/crs/misc/R43328.pdf.

[27]42 C.F.R. § 431.53(b).

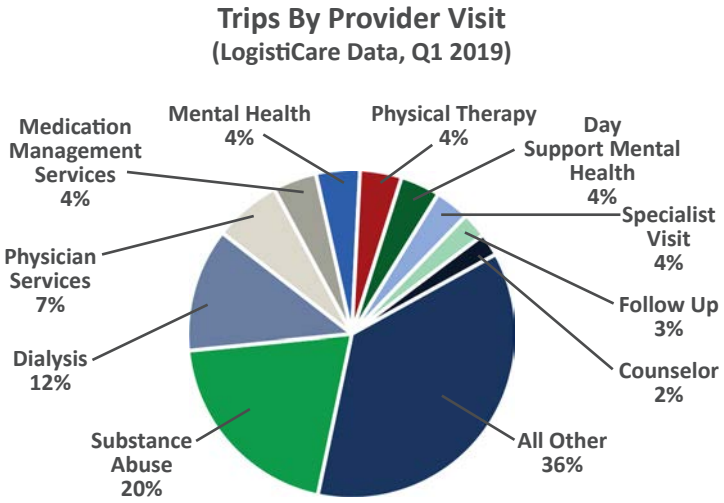
model. Today, the majority of states use a brokerage arrangement,[28] in which the state contracts with a third-party brokerage to administer the benefit in return for a capitated payment.[29] Brokers can be utilized regionally or statewide. (see the Appendix for a list of states and the delivery model they utilize)

The current brokerage model was created by Congress in 2006. The purpose of this option was to "…[p]ermit states to limit free choice of providers for NEMT as a medical assistance benefit (paid at the higher federal contribution rate) as a state plan option and without seeking special federal waiver approval under §1915 of the Social Security Act, which provides 'freedom of choice' demonstrations."[30] Under this model, a state "contracts with one or more transportation brokers to manage the NEMT services for beneficiaries who need transportation to or from medical providers." Typically, the transportation brokers provide an alternative to directly contracting with transportation providers on a FFS basis."[31] The brokers, in turn, "establish a network of NEMT providers" and often "manage the entire NEMT program from receiving the trip requests, to assigning trips to providers and scheduling the trips."[32]

Another method state Medicaid programs may utilize is to have the benefit carved into the states' MCOs, making those organizations responsible for administering NEMT to beneficiaries enrolled in their plan. In this case, the MCOs may, in turn, contract with brokers to administer the NEMT benefit.[33]

Finally, some states use multiple models to administer the benefit, utilizing some combination of FFS, brokers, MCOs, and public transportation vouchers.[34] While this approach adds notable complexity to the program's administration—and may present additional program integrity challenges—each state is able to design an approach that best meets the needs of the state program and Medicaid beneficiaries in that state.

The most common model, transportation brokers, are organizations that serve as intermediaries between beneficiaries, providers, transportation providers, and MCOs by taking transportation requests from beneficiaries, pre-authorizing services, and contracting rides using various forms of transportation.[35] Brokers can be privately owned or run publicly through the state. Currently, a majority of states use a private brokerage in Medicaid with the nation's largest private broker, LogistiCare, operating in 32 state Medicaid programs.



Brokers and states have many options for transportation providers based on type of patient and state requirements. The NEMT benefit can be delivered by taxi service, ambulance and specialty vehicles, broker-owned vehicles, public transportation, gas mileage reimbursement, as well as, in some specific circumstances, Transportation Network Companies (TNCs) like Uber and Lyft. NEMT also covers rides for a wide range of patient types and services. According to a review of LogistiCare Q1 2019 data, the most common types of rides include trips for dialysis, substance abuse, mental health,

[28]18 states use a statewide broker, and a total of 43 states and the District of Columbia use a broker in some capacity, whether a statewide broker, regional broker, or MCOs which utilize brokers in delivering the benefit. See Appendix.

[29]Kirsten J. Colello, Medicaid Coverage of Long-Term Services and Supports, Congressional Research Service, 2013. Available from: https://www.chcs.org/media/NEMT-Issue-Brief-022717.pdf.

[30]Rosenbaum et. al., Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform, Milken Institute of Public Health, The George Washington University, Available from: https://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/34/.

[31]Ibid.

[32]Ibid.

[33]M.B. Musumeci and R. Rudowitz, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, Kaiser Family Foundation, February 2016, Available from: https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/.

[34]S. Edrington, et. al., Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination (2018), National Academies Press, National Academies of Sciences, Engineering, and Medicine, Available from: https://www.nap.edu/download/25184#.

[35]Non-emergency medical transportation, MACPAC, Available from: https://www.macpac.gov/subtopic/non-emergency-medical-transportation/; A. Ganuza and R. Davis, Disruptive Innovation in Medicaid Non-Emergency Transportation, Center for Health Care Strategies, Inc., https://www.chcs.org/media/NEMT-Issue-Brief-022717.pdf.

day support for patients with intellectual and developmental disabilities, physician services, physical therapy, specialist visits, and follow-up visits.[36]

States also have two options for reimbursement: administrative expense or medical service expense. States that opt to be reimbursed for NEMT as an administrative expense receive a flat 50 percent matching rate. States choosing to be reimbursed for NEMT as a medical service receive the state's annually determined Federal Medical Assistance Percentage (FMAP), which ranges based on per capita income from a minimum of 50 percent to 76.39 percent for 2019.[37]

Medicaid's Evolving Landscape Impacts NEMT Services

State Medicaid programs have faced evolving challenges in the last decade in managing the NEMT benefit. The ACA expanded Medicaid, at a state's option,[38] to adults up to 138 percent of the federal poverty line (FPL).[39] As a result, a majority of states and the D.C.[40] have expanded Medicaid, which includes offering the NEMT benefit to the new group of non-elderly, non-disabled, childless adults.

At the same time, some states applied for Section 1115 demonstrations to expand Medicaid and the NEMT benefit in a way that differed from existing federal law. Other states looked to waive NEMT as part of their Medicaid expansion demonstrations. For example, Indiana and Iowa both received 1115 waivers which allowed them to model their expansion programs after commercial insurance, and therefore not include the NEMT benefit. Both state waivers excluded medically frail individuals from this waiver, and the states were required to provide those individuals with NEMT services.[41]

The growth of managed care and of the NEMT broker model has presented new opportunities for states in assessing which benefit delivery approach best meets the needs of the state and patients. This means states are facing new dynamics in ensuring an adequate network of transportation providers and meeting patient needs.

New technology platforms are presenting new opportunities and raising new questions. The rapid rise in the adoption of ride-sharing platforms is reshaping many Medicaid patients' expectations about what they can expect in transportation services. Balancing all of these dynamics and more, states continue to be generally accountable for ensuring the integrity of the Medicaid NEMT benefit: both in ensuring the program operates efficiently with adequate controls and safeguards, and in ensuring the program is effective in serving some of the most vulnerable patients. Recent years have seen a growing awareness of the needs of Medicaid beneficiaries who suffer from substance abuse or who have behavioral health needs. Many experts we talked with noted the important but challenging role NEMT services play in ensuring that these patients access the care they need.

[36]Data provided by LogistiCare, Spring 2019.

[37]Generally, claiming NEMT as an administrative expense allows states more flexibility in designing the program, enabling state programs to pursue issues like alternative payment models and limiting provider options made available. That is because, while federal matching for medical services is often higher, there more requirements with respect to program design because a state must provide free choice of providers and be subject to other guidelines. The exception to this is the Deficit Reduction Act of 2005's policy provision which allows states to use NEMT brokerage programs (and limit free choice of providers), but still allow the state to claim NEMT as a medical expense. See M.B. Musumeci and R. Rudowitz, Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers, Kaiser Family Foundation, February 2016, Available from: https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/.

[38]National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), Available from: https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[39]See 43 C.F.R. § 440.390.

[40]As of June 1, 2019. See Medicaid and CHIP Enrollment Data, CMS, Available from: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[41]S. Edrington, et. al., Handbook for Examining the Effects of Non-Emergency Medical Transportation Brokerages on Transportation Coordination (2018), National Academies Press, National Academies of Sciences, Engineering, and Medicine, Available from: https://www.nap.edu/download/25184#.

Finally, Medicaid NEMT services have grown more important in the last decade or so amid broader health care trends which have increasingly pushed more and more services from the inpatient setting to the outpatient setting. This macro-trend in health care is expected to continue for the next decade, thus further underscoring the need for strong program integrity controls in Medicaid NEMT.

OPPORTUNITIES TO IMPROVE MEDICAID NEMT PROGRAM INTEGRITY

A primary goal of this paper is to identify program integrity challenges with Medicaid NEMT and identify leading practices that can help improve program integrity. Because "program integrity" can have different connotations for different audiences, it is important to define the use of the term. The federal Chief Financial Officers Council notes that program integrity work "encompasses the concept that programs should be organizationally and structurally sound and capable of achieving their mission without compromise. It is the umbrella under which payment integrity, internal controls, fraud risk management, and improper payments prevention fall."[42] This definition is useful for the purpose of this analysis and we will use the term to refer in the specific sense to preventing improper payments, as well as in the more general sense to refer to ensuring the integrity and efficiency of the program more broadly.

Because Medicaid is a joint federal and state financed program that is operated by states under broad federal rules, state Medicaid program staff play the primary role in overseeing the integrity of the Medicaid NEMT program. At the same time, the CMS also play an important role in helping oversee the use of federal tax monies and ensure state programs are operating within policy requirements. CMS also conducts some limited oversight activities, including overseeing states' program integrity activities and periodically issuing guidance to states. As the GAO noted "recent guidance is targeted for patients and providers rather than state Medicaid programs,"[43] but state Medicaid programs "also benefit from updated guidance on strategies to ensure compliance with federal requirements while incorporating current practices to meet beneficiaries' needs."[44] The GAO concluded that "guidance for state Medicaid programs is particularly important because NEMT is at high risk for fraud and abuse; some selected states and stakeholders GAO interviewed reported that updated guidance could be helpful."[45]

Thus, both state and federal Medicaid program staff have an opportunity to improve program integrity.

Program Integrity Landscape

Medicaid NEMT benefit expenditures may constitute a fraction of the national Medicaid program,[46] but because the Medicaid NEMT benefit provides millions of rides each year to Medicaid patients across the states, D.C., and territories, it is important to ensure the integrity of the program. Strong program integrity measures can help improve enrollees' access to quality care, curb improper payments, and maintain public support for Medicaid NEMT. Yet the inverse is also true: weak internal controls that allow improper payments can undermine the quality of care for Medicaid beneficiaries, create reputational damage for entities involved in delivering the NEMT benefit, and erode public support for Medicaid services.

In one sense, it is entirely understandable that the provision of NEMT services across the 50 states, D.C., and the territories faces program integrity challenges—especially considering the large number of trips, the number of transportation providers, the various payment models, and other factors. However, in another sense, despite the fact that states, brokers, and Medicaid

[42]See Interactive Treasury Playbook, Chief Financial Officers Council, October 2018, https://cfo.gov/wp-content/uploads/2018/10/Interactive-Treasury-Playbook.pdf. To help advance the goal of safeguarding public resources, the Chief Financial Officers Council (CFOC) and the U.S. Department of the Treasury, Bureau of the Fiscal Service (Fiscal Service) have developed the Program Integrity: The Antifraud Playbook for use by the entire financial management community, including federal, state, and local agencies. The playbook and accompanying appendices are designed to provide practical guidance, leading practices, and helpful resources for agencies to establish or enhance their antifraud programs and meet the requirements of the Fraud Reduction and Data Analytics Act of 2015 and OMB Circular A-123. Furthermore, the playbook clarifies actions needed to streamline program integrity initiatives and will help agencies reduce the amount of money lost through improper payment.

[43]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.

[44]Ibid.

[45]Ibid.

[46]NEMT expenditures totaled $1.5 billion in CY2013, while national Medicaid expenditures totaled more than $445 billion that year. See Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, https://www.gao.gov/assets/680/674934.pdf; National Health Expenditure Data, CMS NHE, Available from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

health plans have many good program integrity efforts underway,[47] a review of current audits and media accounts in recent years that shows more needs to be done to improve program integrity.

For example, in 2018, a joint state and federal task force investigating Medicaid fraud led to the arrest of thirteen people in connection with NEMT fraud.[48] According to a press release by the U.S. Attorney's Office, one of the defendants was paid over "$2.45 million for Medicaid-funded transportation between 2014 and 2018."[49] Later in 2018, the U.S. Attorney's Office announced that two fraudulent billing schemes related to Medicaid NEMT were shut down in Indiana; each indictment claims losses were in excess of $100,000.[50] The Indiana arrests were part of a nationwide health care fraud take down, in which arrests were made for Medicaid NEMT fraud in New York[51] as well as Georgia.[52] As a 2017 article in *Health Affairs* summarized bluntly: "program integrity lapses have damaged NEMT's reputation."[53]

Arrests and prosecutions highlight successful program integrity enforcement actions. However, the continual presence of enforcement actions demonstrates the ongoing need for vigilance through strong program management and risk management strategies to protect the program from those who would exploit or defraud the program and could cause harm to Medicaid beneficiaries. In an effort to help state programs think about specific vulnerabilities, CMS' Medicaid NEMT provider booklet, last updated in 2016, also provides specific examples of the types of fraud against which Medicaid NEMT program leaders must be vigilant.[54]

Reviews of multiple state programs by the HHS OIG have found repeated challenges. These included a 2015 report on California,[55] a 2016 report on North Carolina,[56] reports in 2017 on Oklahoma[57] and Minnesota,[58] and a 2018 report on Michigan.[59] The prevalence of findings in the HHS OIG reviews across varying models, geographies, and delivery systems suggest all programs face common and ongoing challenges to achieving robust program integrity. The challenges that were identified include:

1. Transportation documents were not provided and/or services were not adequately documented
2. Trips were billed but not provided
3. Beneficiaries did not receive a Medicaid-covered service on the date of transportation
4. Transportation providers did not always maintain documentation for drivers and vehicles

[47]State Medicaid expenditures are subject to a number of federal and state program integrity reviews. For example, CMS operates the Payment Error Rate Measurement (PERM) program that measures improper payments in Medicaid and CHIP and produces error rates for each program. CMS also contracts with Unified Program Integrity Contractors (UPICs) that perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicaid claims. CMS also oversees state's use of Recovery Audit Contractors (RACs). Detailing the function and scope of each current effort is beyond the scope of this paper.

[48]Investigation Targets Medicaid Transportation Fraud in the North Country, Press Release, Department of Justice, May 23, 2018, Available from: https://www.justice.gov/usao-ndny/pr/investigation-targets-medicaid-transportation-fraud-north-country.

[49]Ibid.

[50]National Healthcare Fraud Takedown Results In Charges Against 601 Individuals Responsible For $2 Billion In Fraud Losses, Press Release, Department of Justice, June 29, 2018, Available from: https://www.justice.gov/usao-ndin/pr/national-healthcare-fraud-takedown-results-charges-against-601-individuals-responsible.

[51]Five Doctors and Eight Healthcare Professionals Charged as Part of National Healthcare Fraud Takedown, Press Release, Department of Justice, June 28, 2018, Available from: https://www.justice.gov/usao-edny/pr/five-doctors-and-eight-healthcare-professionals-charged-part-national-healthcare-fraud.

[52]National Health Care Fraud Takedown Results In Charges Across The Country And In Southern District Of Georgia, Press Release, Department of Justice, June 28, 2018, Available from: https://www.justice.gov/usao-sdga/pr/national-health-care-fraud-takedown-results-charges-across-country-and-southern.

[53]Michael Adelberg & Marsha Simon, Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?, Health Affairs, 2017, Available from: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.

[54]CMS, Non-Emergency Medical Transportation, Available from: https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf.

[55]California Claimed Medicaid Reimbursement for Some Nonemergency Medical Transportation Services That Did Not Comply with Federal and State Requirements, Report, HHS OIG, January 2015, Available from: https://oig.hhs.gov/oas/reports/region9/91302033.pdf.

[56]North Carolina Improperly Claimed Federal Reimbursement for Some Medicaid Nonemergency Transportation Services, HHS OIG, November 2016, Available from: https://oig.hhs.gov/oas/reports/region4/41504037.asp.

[57]Oklahoma Did Not Adequately Oversee Its Medicaid Nonemergency Medical Transportation Program, HHS OIG, August 2017, Available from: https://oig.hhs.gov/oas/reports/region6/61600007.asp.

[58]Minnesota Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program, HHS OIG, September 2017, Available from: https://oig.hhs.gov/oas/reports/region5/51500026.asp.

[59]Michigan Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Brokerage Program, HHS OIG, June 2018, Available from: https://oig.hhs.gov/oas/reports/region5/51600021.asp.

5. Driver qualifications were not met.
6. State vehicle requirements for vehicles used to transport Medicaid beneficiaries (regarding vehicle inspection, safety, and insurance requirements) were not met.
7. Services paid were not the lowest cost type of medical transportation adequate for beneficiaries' medical needs.

Individuals familiar with health care delivery generally, and Medicaid in particular, will not be surprised that challenges exist regarding documentation of services, correctly enrolling the right providers, and ensuring accurate reimbursement for services rendered. In fact, many of the opportunities to improve program integrity within the Medicaid NEMT benefit may not be specific to NEMT per se, as much as they are reflective of challenges facing Medicaid more generally. As the GAO has noted, Medicaid is a "large, growing, and complex program" and "covered about 75 million people in fiscal year 2018, at an estimated cost of $629 billion."[60] The GAO extensively documented numerous challenges in this critical safety net program that states operate under broad federal rules. Overall, the GAO has found that "CMS faces oversight challenges [for Medicaid generally] in four areas: improper payments, appropriate use of program dollars, Medicaid data, and access to quality care"[61]—and the GAO has made a number of recommendations for improving the integrity and operation of the Medicaid program. These recommendations are applicable to improving oversight in NEMT as well.

At the same time, the NEMT benefit provides some unique challenges for state Medicaid programs, given notable differences in the background, training, and expertise of transportation providers when compared to medical providers. The provision of transportation services also notably differs from the provision of medical services. As the GAO noted in its 2016 report "Medicaid claim reviews revealed that NEMT providers overbilled and documented trips poorly and that overpayments tended to occur more frequently in states that delegate NEMT responsibility to counties where officials may not be familiar with documentation requirements."

Positively, experts we talked with noted much work has occurred in recent years that is improving the program integrity of Medicaid NEMT services—and more efforts are underway to improve NEMT program integrity. For example, many of the experts we spoke with explained that a state program's move from a FFS model to a transportation broker model was driven by a significant desire to reduce NEMT fraud. They explained that improper payments and fraud in the utilization of bus passes and taxi services was a common denominator in several cases in pushing states to adopt the broker model. As one researcher noted, "the brokerage model is designed to address and mitigate these problems through capitated arrangements that [somewhat] insulate Medicaid budgets from fraud losses and encourage brokers to root out abuses."[62]

Several experts underscored that the transportation broker model, where states contracted with an entity regionally or statewide to subcontract with transportation providers and administer the benefit, greatly improved states' oversight of Medicaid NEMT. They observed the state received greatest benefit from the broker's experience, utilization management tools, and staffing resources, compared to a state-run, FFS model. In particular, states that transitioned to the broker model benefited from utilization management tools that included the ability of broker staff to identify the eligibility of a Medicaid beneficiary for a specific medical service before the service was received. These states also benefitted from a transportation broker's staffing resources, as a call center (for services and for complaints) could be available for beneficiaries virtually around the clock, compared with gaps during nights, weekends, and holidays with state run, county-run, or non-profit run call centers.

One former Medicaid staff individual underscored how brokers played a critically important role in reviewing and credentialing providers in a specific state. He explained brokers also importantly helped provide a standardized way for linking qualified providers with beneficiaries in need of transportation. In his view, the broker model offered his state a way to improve the quality of the network and provide a more organized scheduling system, while also enhancing the ability of the state to conduct oversight of the NEMT services provided. Additionally, the capitated payment system used by states in contracting with brokers allowed the state to be more insulated from fraud, waste, and abuse, attributed to transportation providers.

[60]Medicaid—High Risk Issue, GAO, Available from: https://www.gao.gov/key_issues/medicaid_financing_access_integrity/issue_summary.
[61]Ibid.
[62]Michael Adelberg & Marsha Simon, Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?, Health Affairs, 2017, Available from: https://www.healthaffairs.org/do/10.1377/hblog20170920.062063/full/.

ENSURING ACCESS TO QUALIFIED TRANSPORTATION PROVIDERS

One of the important roles state programs and transportation brokers play is to screen and credential transportation providers in accordance with the relevant Medicaid guidelines. A 2009 review by the HHS OIG found that screening providers is one of the key ways states enhance program integrity in Medicaid NEMT.[63] Since state Medicaid programs provide the NEMT benefit under broad federal rules, most requirements for provider credentialing are created and overseen at the state level. Accordingly, there can be significant variation between the types of processes transportation providers are required to undergo before they can provide their first ride for Medicaid beneficiaries. The types of requirements for transportation providers generally fall into one of three categories: (1) requirements for individual drivers, (2) requirements for vehicles, or (3) financial requirements.

Requirements for Individual Drivers

All experts we talked with stressed the importance of thoroughly screening the background of individuals who own or work for transportation providers. However, they also noted that states vary in specific requirements they require of drivers. For example, most states require drivers providing NEMT services to hold a valid driver's license, successfully pass a criminal background check, not be listed on the HHS OIG exclusion list, successfully pass a drug screen, and have a driving record free from major incidents. Some states also require fingerprinting as well as training in defensive driving, CPR, and first aid. Other states require, or are considering requiring, training specific to drivers, such as training through the Community Transportation Association of America,[64] or the Non-Emergency Medical Transportation Accreditation Commission (NEMTAC).[65]

Certainly, basic training is a fundamental requirement for strong program integrity and should not be ignored. As the GAO noted in its report, during its review, at least one state reportedly "did not require and collect key information needed for effective oversight, such as criminal conviction information from NEMT providers, making the state vulnerable to enrolling problem providers in its NEMT program."[66] The GAO also noted that "officials from six states cited challenges obtaining certain information on NEMT providers that could reduce program risks," such as being able to access information on criminal convictions in other states.[67] To improve program integrity, it is important that CMS ensure all states are implementing basic requirements.

Experts we talked with underscored that at the field level, the desire for high standards and robust training for individual transportation providers must also be combined with the operational need for a sufficient network of transportation providers to ensure beneficiaries have timely access to NEMT services. For example, one Medicaid program expert from a rural state noted that it was challenging to locate high quality transportation providers that had strong program integrity practices. While he felt oversight from CMS was somewhat thin, he noted the primary responsibility of the state is to ensure that beneficiaries are served by high integrity providers, since the state has the responsibility for network oversight.

Many experts noted that while increasing the number and complexity of training requirements can improve the expertise of individual drivers, these same requirements can add time and cost to credentialing providers and discourage some drivers from serving NEMT beneficiaries. However, perspectives were rather divergent with respect to whether certain types

[63]Memorandum Report: "Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services", OEI-06-07-00320, May 28, 2009, Available from: https://oig.hhs.gov/oei/reports/oei-06-07-00320.pdf.

[64]The Passenger Assistance Safety and Sensitivity (PASS) Trainer and Driver Certification, CTAA, Available from: https://ctaa.org/pass/.

[65]NEMTAC Accreditation, Non Emergency Medical Transportation Accreditation Commission, Available from: https://www.nemtac.org/accredit.

[66]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.

[67]Ibid.

of training (including first aid, CPR, and other more modular training requirements) should be required of all drivers in all geographies in all cases. Several experts we talked with explained that building a network of transportation providers was challenging in specific geographies—such as in rural areas—and adding additional requirements, no matter how well intended, could inadvertently create barriers for more drivers serving more beneficiaries. The GAO noted a similar divergence of views in their report, explaining that "state officials and stakeholders reported challenges ensuring access to NEMT when the demand for trips exceeded the supply of NEMT providers," and this includes "factors that affected the supply of NEMT providers," as well as provider requirements.[68] Given the wide variety of state geographies, patient populations, service delivery models, and program priorities, debate about what levels of individual requirements should be standard across all states will continue.

Requirements for Vehicles

State Medicaid programs generally have in place a range of requirements to ensure that vehicles used to transport Medicaid beneficiaries are safe and reliable. These include basic rules to ensure the vehicles are in safe working condition, such as requiring that vehicles have passed state-mandated safety and emissions tests within a certain period and that vehicles have functioning safety belts, doors, windows, air conditioning, and heat. Many states also require that vehicles be equipped with first aid kits, two-way communication capability (which may include a cell phone) and a functioning GPS (which may include a cell phone). Finally, it is useful to note that while the majority of beneficiaries receiving NEMT services may be ambulatory, because some NEMT occurs in wheelchair-accessible vans or buses, or in an ambulance for patients who require constant medical monitoring during a trip, state level requirements may vary by type of vehicle. For example, many states require that vehicles used to transport passengers using a wheelchair must meet ADA requirements.[69]

While having robust requirements in place is fundamental, as previously noted, enforcing them is critically important. One expert we talked with explained that he saw a transportation broker in his state make a significant improvement to the quality of NEMT services, simply by reviewing vehicle inspection documentation and conducting its own reviews. These broker-led inspections identified numerous vehicles or providers that did not meet existing standards, and stronger enforcement of the background and vehicle requirements improved patient safety.

Financial Requirements

State programs generally place certain financial requirements on transportation providers, including requirements to maintain general liability insurance and auto liability insurance. A review of state requirements reveals that most states have requirements for general liability insurance policies for coverage ranging from $500,000 to $1,000,000, and requirements for auto liability coverage ranging from $500,000 to $1,000,000. Virtually all experts we talked with agreed such requirements are important in principle. However, one transportation broker we talked with noted that while maintaining insurance coverage is important, requiring this level of coverage may be a requirement that adds additional system costs and creates a barrier to entry for some transportation providers participating in serving Medicaid beneficiaries. Barriers to transportation provider participation in NEMT service networks are especially important to consider when working to ensure access to specialty providers.

HARNESSING TECHNOLOGY TO IMPROVE PROGRAM INTEGRITY

A 2009 report by the HHS OIG examining fraud and abuse safeguards for state Medicaid NEMT found that "most states and their brokers concentrate their safeguard activities on three areas: screening providers, requiring prior approval for services, and implementing methods to prevent and detect improper billing."[70] As the report noted, "depending upon the State, responsibility for conducting these activities lies with the State Medicaid agency itself, other State agencies, brokers, or some combination of these entities."[71]

As noted previously, program integrity includes "payment integrity, internal controls, fraud risk management, and improper payments prevention." Also essential is the concept that a "program should be organizationally and structurally sound and

[68]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.

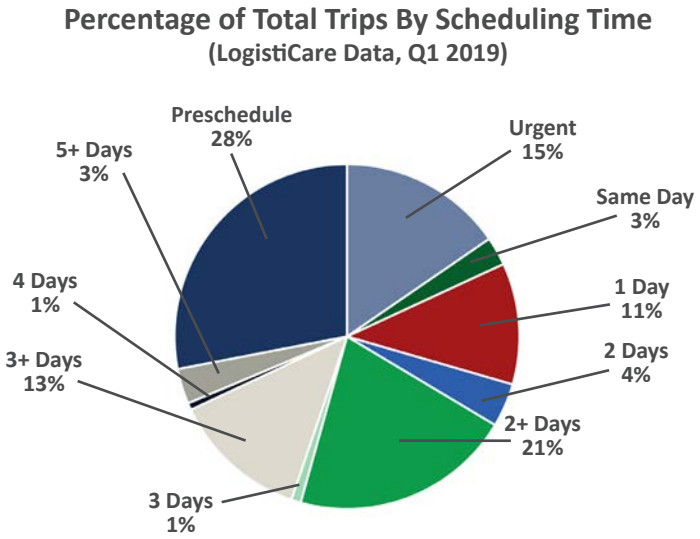
[69]"ADA" refers to "Americans with Disabilities Act." Pub. L. No. 101-336, 104 Stat. 328 (1990).

[70]Memorandum Report: "Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services", OEI-06-07-00320, May 28, 2009, Available from: https://oig.hhs.gov/oei/reports/oei-06-07-00320.pdf.

[71]Ibid.

capable of achieving their mission." In this case, the mission of Medicaid NEMT transportation providers is to ensure Medicaid beneficiaries travel safely to and from care. Thus, a program integrity focus from Medicaid leaders must not only include preemptive efforts to curb waste, fraud, and abuse, but should also proactively inform the broader view of the integrity of the Medicaid NEMT benefit that helps ensure beneficiaries receive needed care.

Thankfully, there's much good work underway in the provision of NEMT services. The proliferation of personal cell phones with GPS technology in the last decade has improved the technological ability of NEMT brokers, transportation vendors, Medicaid beneficiaries, and others to connect with each other. The Pew Research Center found that 95 percent of Americans "now own a cellphone of some kind" and "the share of Americans that own smartphones is now 77 percent, up from just 35 percent in Pew Research Center's first survey of smartphone ownership conducted in 2011."[72] This means that it's much easier for riders and transportation providers to connect. While not all Medicaid beneficiaries have, or could successfully use, a smart phone, the sheer availability of this technology also has dramatically improved the ability to track and audit the location of drivers and riders for program integrity purposes. For example, the GAO noted that a review of one state's Medicaid NEMT program showed that the agency "did not require brokers to maintain consistent trip data and that the agency lacked written policies and procedures to ensure clear management and consistent processes. As a result, the state's six brokers reported inconsistent practices, which could lead to overbilling for trips."[73] While state leadership actions were required to remedy the lack of written requirements and consistent guidance, GPS can potentially be part of a state's requirements for brokers to maintain consistent trip data.



Some researchers have noted that one area in particular where brokers face challenges is in responding to requests for rides that need to occur urgently.[74] Certainly, it is more challenging to arrange a transportation provider and take certain steps to ensure robust program integrity, such as checking eligibility of the Medicaid beneficiary and verifying the medical necessity of the patient's visit, when there is simply less time in which to take those steps. A nearby chart shows data from Q1 2019 for LogistiCare's percentage of total trips, broken out by scheduling time. While many trips are scheduled days in advance, a significant number are requested for urgent action.

A key area for continued improvement of Medicaid's NEMT program integrity is in the area of reducing missed rides—whether providers who do not show up to transport a beneficiary, or beneficiaries who request a trip but are not present when the provider arrives. Due to the nature of the NEMT service, as well as the scope and scale of state Medicaid programs, NEMT complaints may be ever present. However, that does not mean complaints should be tolerated. While zero complaints may be impossible, improving the integrity of the Medicaid NEMT benefit also includes taking reasonable steps to ensure beneficiaries receive needed care. This means that complaint data is a critical part of understanding the patient experience with NEMT. A nearby chart shows a breakout of LogistiCare Q1 2019 data, noting the reasons for cancelations of rides. While more than half the rides are cancelled because beneficiaries were not at the pick-up location at the appointed time, there are a multitude of factors that may also be contributing to the bulk of other cases.

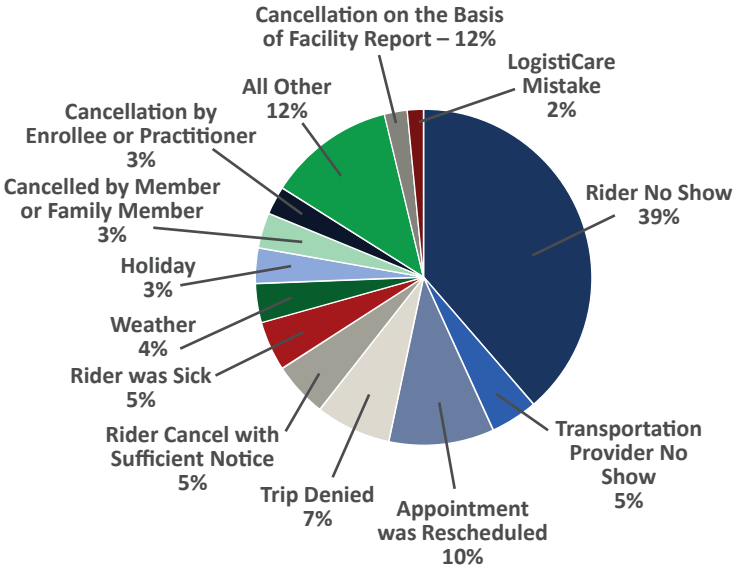
[72]Mobile Fact Sheet, Internet and Technology, Pew Research Center, Available from: https://www.pewinternet.org/fact-sheet/mobile/.

[73]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.

[74]A. Ganuza and R. Davis, Disruptive Innovation in Medicaid Non-Emergency Transportation, Center for Health Care Strategies, Inc., Available from: https://www.chcs.org/media/NEMT-Issue-Brief-022717.pdf.

A former Medicaid director we spoke with suggested that more work can be done to use GPS data to better understand missed and late rides. Medicaid NEMT program administrators have a lot of data regarding on-time drop offs and pick-ups. Examining the data could help reexamine beneficiary expectations and behaviors. For example, if a broker says a driver has to be ready for pickup between noon and 1:00pm for a 2:00pm appointment, GPS data could potentially help assess if the driver was at the designated pick-up spot during that time, and also assess whether the provider underestimated the time for traffic, weather, distance, or other factors.

Cancellations, by Cancellation Reason
(LogistiCare Data, Q1 2019)

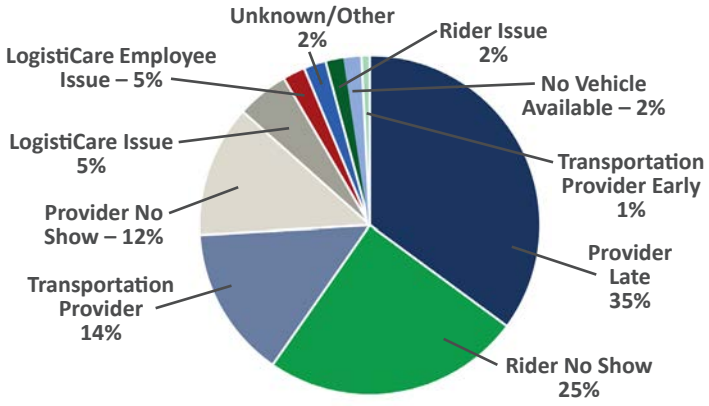


While estimates for the potential savings for Medicaid programs or providers from reducing no-shows are inherently speculative, there are potential financial benefits for state Medicaid programs and providers in reducing no-shows—for states through avoidable ER utilization, and for providers in reimbursed patient visits. One estimate suggested that appointment no-shows more broadly can cost the overall health system roughly $150 billion each year.[75] Using data from the Agency for Health Research and Quality, one estimate suggests that between one in ten and one in four emergency department visits could be referred to a cheaper site of care and save the health care industry nearly $50 billion over a decade.[76]

There are other ways to use GPS data as well. Mining the GPS data routinely, based on certain factors and considerations, could help further weed out remaining fraud in the program in many cases. And in some cases, regulations need to be updated to reflect the presence of GPS technologies. For example, some state regulations still require drivers to record the odometer at the start and end of the ride. Most drivers have analogous GPS tracking but it may not meet the language of the regulation. Other researchers have noted how GPS capability, coupled with smart analytical tools, can improve a transportation provider's service delivery, leading to improvements in quality and program integrity.[77]

More can be done to harness available technology and integrate it into the NEMT service benefit delivery to improve program integrity, but not all technological improvements are high-tech. We received reports from at least two Medicaid experts that noted some single operator transportation providers were tracking NEMT rides on paper, including the beneficiary's name, location, condition, and type of medical visit. While single operator providers can play an important role in delivering Medicaid NEMT services, especially in rural areas, state programs and brokers that rely on them need to take steps to ensure such providers are aware of existing HIPAA requirements to protect personally identifiable health information.

Complaints, Top Ten Types
(LogistiCare Data, Q1 2019)



One Medicaid expert explained that, in his view, the best way to help put concerns about missed rides and late rides in the appropriate context was through making

[75]Assembling the Elements of NEMT's Future, CTAA, Available from: https://ctaa.org/wp-content/uploads/2018/12/NEMT_DigitalCT_18.pdf.

[76]Sara Heath, How Community Care Coordination Drove Down Avoidable ED Visits, Patient Care Access News, Patient Engagement HIT, September 24, 2018, Available from: https://patientengagementhit.com/news/how-community-care-coordination-drove-down-avoidable-ed-visits.

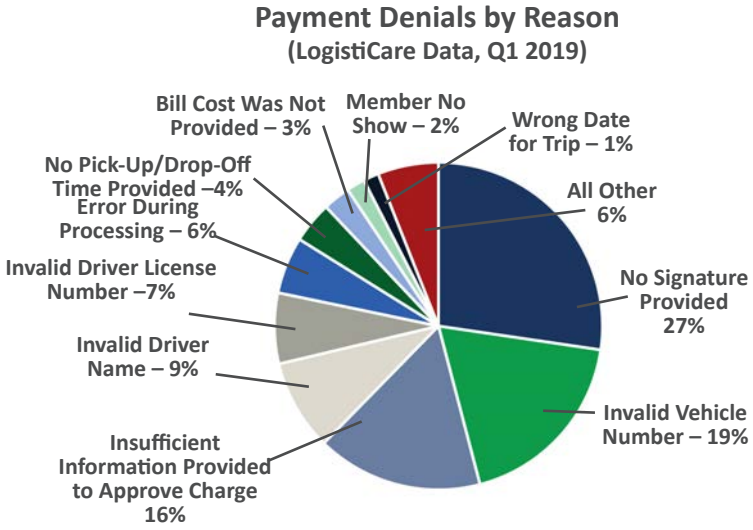
[77]A. Ganuza and R. Davis, Disruptive Innovation in Medicaid Non-Emergency Transportation, Center for Health Care Strategies, Inc., Available from: https://www.chcs.org/media/NEMT-Issue-Brief-022717.pdf.

key Medicaid NEMT data elements public. After increased scrutiny from the public and media regarding NEMT service provision in one state, the state elected to make data elements publicly available.[78] This included basic information about substantiated complaints. At a practical level, this put some specific concerns in context of the number of rides provided. At another level, it helped state and local leaders to understand the number of NEMT rides and Medicaid beneficiaries served in their local area. While merely releasing the data did not remedy some issues, it went a long way to ensuring all parties had the facts of the program's benefit. It also freed up Medicaid resources to more proactively address other program integrity challenges, like ensuring that the state was only paying for medically necessary rides.

Finally, Medicaid experts we talked with noted the importance of the transportation provider verifying the eligibility of the beneficiary, caseworker, or family member who scheduled the ride, especially if a ride is scheduled in advance. Several of the brokers we spoke with explained that they will utilize an eligibility file from a state or Medicaid managed care plan and then call a provider in advance of a medical visit to ensure the eligibility of the patient.

The GAO noted that determining beneficiary eligibility is a challenge in some cases. For example, the GAO found that key Medicaid stakeholders "reported challenges verifying Medicaid enrollment because the state updates its Medicaid enrollment database daily; thus, beneficiaries who were enrolled in Medicaid when trips were requested may not be enrolled on the days trips were provided."[79] In another case, "officials from another state reported that it had challenges verifying that the beneficiary did not have other means of transportation."[80]

In several conversations we had with Medicaid experts, they noted challenges verifying some NEMT trips that took the beneficiary to medically warranted locations. For example, in some cases, NEMT rides take beneficiaries to pick up pharmacies, but these pharmacies may also be located in larger commercial retail stores that sell non-medical products, such as food and clothing. In this case, experts noted it can be challenging to assess medical necessity, and reviewers may often need to review other data. A nearby chart details Q1 2019 data from LogistiCare showing the reasons for payment denials to transportation providers.



Not all brokers establish eligibility for all beneficiaries before the medical services are delivered. In some limited cases, beneficiary verification may be logistically impractical. However, in general, in situations in which verifying eligibility is not routinely occurring on wide scale, it is reasonable to expect improper payments to increase.

[78]Monthly Non-Emergency Medical Transportation Data, Wisconsin Department of Health Services, Available from: https://www.dhs.wisconsin.gov/nemt/data.htm.
[79]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.
[80]Ibid.

RIDE-SHARING PLATFORMS

Currently, ride-sharing represents only a small fraction of the total vehicle miles in the U.S. each year, and only a modest fraction of the percentage of overall rides in most NEMT programs. For example, a report by McKinsey & Company found that in 2016, only one percent of vehicle miles traveled in the U.S. came from ride-sharing.

However, the potential of ride-sharing platforms to impact future transportation trends is notably more significant. Consider how fast ride-sharing has been adopted. Apple's iPhones, which helped make consumer use of smartphones with GPS technology a norm, were first launched just over a decade ago—in 2007. Uber was only founded in 2009 and Lyft was founded in 2014. Given their relatively recent emergence as a consumer technology, it is significant how widespread the use of ride-sharing platforms through smartphones has become. According to a Pew Research Center survey conducted last fall, more than one in three adults reported having used a ride-sharing app like Uber or Lyft.[81]

Today, the growing use of ride-sharing may contribute to evolving expectations of Medicaid NEMT services. As Pew noted, in 2015, "just 15 percent of Americans said they had used these services" and "one-third had never heard of ride-hailing before."[82] Today, 36 percent of adults have used such a service. McKinsey & Company reported in their research findings that "83 percent of U.S. rideshare consumers report convenience, not price, to be the primary reason for choosing a provider such as Lyft or Uber over traditional taxi options."[83] McKinsey's report found that "ridesharing's appeal lies in large measure in the consumer's positive sense of experience" and "half of surveyed passengers enjoy ride shares for social outings."[84] They also found that "elderly users enjoyed a new sense of freedom, reporting that they have come to use ridesharing for doctor appointments, errands, and visits to friends without having to rely on family or caregivers for transportation."[85]

One NEMT transportation broker we talked with noted that as more Medicaid beneficiaries have utilized and grown accustomed to ride-sharing services, offering beneficiaries a 30-minute to one-hour window for arriving to pick them up is no longer seen as acceptable. In this case, this broker's quality scores and reimbursement from the state was being reduced because drivers were not meeting the five to ten-minute window that beneficiaries expected. While tying a portion of broker reimbursement to patient satisfaction is entirely reasonable, this dynamic of lower transportation broker quality scores and reimbursement based on consumer ride-sharing expectations will likely only grow over time as the use of ride-sharing platforms spreads.

Ride-sharing platforms, formally referred to as TNCs, are in some ways a cousin to many taxi-based NEMT providers. However, despite some similarities, the relationship between TNCs and Medicaid state programs, brokers, or transportation providers has some natural tension. This tension, and the breath of

[81] Jinjing Jiang, More Americans are using ride-hailing apps, Fact Tank, Pew Research Center, January 4, 2019, Available from: https://www.pewresearch.org/fact-tank/2019/01/04/more-americans-are-using-ride-hailing-apps/.

[82] Ibid.

[83] Russell Hensley et. al., Cracks in the ridesharing market—and how to fill them, McKinsey Quarterly, July 2017, Available from: https://www.mckinsey.com/industries/automotive-and-assembly/our-insights/cracks-in-the-ridesharing-market-and-how-to-fill-them.

[84] Ibid.

[85] Ibid.

service delivery models, geographies, beneficiary needs and other dynamics has resulted in a wide array of opinions on the relationship between TNCs and Medicaid NEMT providers.

In general, TNCs do not have to meet as rigorous of state standards as NEMT transportation providers do, nor do they typically have as stringent background and training requirements for traditional Medicaid NEMT providers. Several of the Medicaid directors and managed care plan leaders we talked with noted that the proliferation of TNCs has reduced the capacity of the legacy taxi system and also prevented some other drivers who would have become Medicaid NEMT transportation provider drivers from serving Medicaid beneficiaries. Some experts we talked with who tended to be more skeptical of the role of TNCs in Medicaid NEMT noted that TNC drivers do not have sensitivity training for how to handle certain Medicaid subpopulations, most notably beneficiaries with mental health challenges or who have intellectual disabilities. Additionally, TNCs do not have specialized vehicles for transporting beneficiaries with disabilities. These same individuals noted that the TNC model would not work at all for some beneficiary types, including the most medically frail. One Medicaid expert we talked with relayed they had audited call center calls and found that the TNCs' call center staff were unprepared to handle questions about Medicaid benefits in general.

At the same time, the arrival of TNCs has introduced many positive developments. Several Medicaid state programs and Medicaid MCOs we talked with utilize TNCs in "rescue" or "recovery" situations—situations which a beneficiary has missed a pickup and may be either at risk of missing a forthcoming medical appointment or is stuck at a medical provider's office after receiving care. At least one Medicaid managed care plan we spoke with noted they provide a limited number of rides through one popular TNC outside of Medicaid NEMT, with the goal of ensuring that Medicaid beneficiaries can access grocery stores and other needed stops with ease. Some health plans see additional benefit to expanding rides for individuals, commercial, and Medicare Advantage plans.

One MCO we spoke with suggested that delegating NEMT needs to TNCs is difficult as they are not equipped to handle the regulatory requirements under Medicaid. Another MCO noted that there is a natural tension between more program flexibility and potentially lower standards, or less flexibility with higher standards. Some research has noted one practical challenge with TNCs is that the platform often results in different drivers for the same patient if they have multiple trips. This lack of patient continuity, coupled with some TNC systems that asks riders to rate drivers, can create challenging dynamics in some cases.[86]

TNCs generally have emphasized that their business model is deeply popular with consumers and stressed that they are focused on the necessary requirements for success—not bureaucratic hurdles. A TNC we spoke with noted that they see Medicaid as an important service line, but because NEMT regulations are not standardized across states, it has been a difficult road to working with states. Some states have pursued legislation to allow NEMT to be provided by ride-sharing companies.[87] This same TNC noted that they have an in-house vehicle requirement, and while it's not precisely the same as most state NEMT vehicle requirements, it is sufficient in their experience.

One large national transportation broker we talked with uses TNCs in markets for clients that allow it, because they found that otherwise there is an inadequate network capacity which makes it hard to deliver the benefit consistently. They also noted that in the past, it was hard to regulate taxi drivers, because they had other business interests, and it was difficult to track mileage. They noted that when allowed, they use TNCs for rescue situations. However, the broker expert was quick to note that TNCs augmented, not replaced, traditional Medicaid NEMT providers. The expert said, for example, that they would never use rideshare for behavioral health patients or for children under 16.

While the evolution of TNCs promises to continue, this is an area where Medicaid NEMT transportation providers will continue to see some complementary and some competing actions. Most experts we talked with generally concluded that TNCs have an important, but not unlimited, role to play in providing Medicaid NEMT.

[86] A. Ganuza and R. Davis, Disruptive Innovation in Medicaid Non-Emergency Transportation, Center for Health Care Strategies, Inc., Available from: https://www.chcs.org/media/NEMT-Issue-Brief-022717.pdf.

[87] See e.g. Uber, Lyft may be used to transport Florida Medicaid patient in nonemergency cases, Mackenzie Garrity, Becker's Hospital Review, April 10, 2019, Available from: https://www.beckershospitalreview.com/healthcare-information-technology/uber-lyft-may-be-used-to-transport-florida-medicaid-patients-in-nonemergency-cases.html.

CONCLUSION

One of the barriers many patients face in accessing health care services is transportation to and from doctor appointments and other forms of treatment. Patients who are low-income, who have multiple chronic conditions, or who face challenges related to the social determinants of health are too often challenged in accessing reliable transportation to and from health care providers. Patients who do not have reliable access to transportation miss critical appointments, which could complicate or worsen their condition. Medicaid beneficiaries—particularly patients with intellectual or developmental disabilities, patients suffering from mental health and behavioral health needs, elderly patients, and patients with dialysis needs—face transportation challenges and may benefit the most from Medicaid NEMT services. NEMT is a valuable tool, increasingly deployed to improve care management and address social determinants of health. Today's Medicaid NEMT benefit is an important part of the Medicaid safety net, helping provide access to care for millions of Medicaid beneficiaries.

The delivery of Medicaid NEMT services has evolved in the last decade or so, as external forces have created new opportunities and placed new expectations on the program. Some of these forces include Medicaid expansion, the growth of managed care, the growth of brokers, new technological tools, the emergence of ride-sharing platforms, the move to deliver more care in an outpatient setting, a growing awareness of the role of social determinants of health, including transportation, and the need to provide care to the most vulnerable patients.

Abundant research and program audits show the need for additional federal and state actions to improve the program integrity of Medicaid NEMT services. There are numerous, existing, actionable steps that be taken to identify and adopt leading practices and improve the integrity and quality of the program.

Moving forward, it is essential that Medicaid leaders across Medicaid state programs, brokers, managed care plans and delivery systems work collaboratively to improve the integrity of the program for the benefit of patients and the program itself. The presence of strong program integrity measures can help improve enrollee access to quality care, curb improper payments, and maintain public support for Medicaid NEMT. By focusing on improving program integrity, Medicaid leaders can help improve quality of care for Medicaid beneficiaries and improve support for NEMT from policymakers.

RECOMMENDATIONS TO IMPROVE PROGRAM INTEGRITY

Federal Recommendations

1. **Update NEMT Program Integrity Review.** CMS should request that the HHS OIG conduct a new review of Medicaid NEMT efforts, based on its 2009 report, "Fraud and Abuse Safeguards for Medicaid Nonemergency Medical Transportation" (OEI-06-07-0003200). This report should examine all 50 States and D.C., to identify their safeguards to prevent and detect NEMT fraud and abuse. The report should also identify the numbers, types, and outcomes of NEMT fraud and abuse cases that State Medicaid Fraud Control Units (MFCUs) investigated in recent years. Data on commonalities or trends in program integrity could inform CMS and states' risk management strategies.[88]

2. **Facilitate Collaboration on Leading Practices.** CMS should convene a collaborative opportunity with key stakeholders to facilitate discussion and shared learning about the leading practices for improving Medicaid program integrity. This collaboration could be centered around key ongoing challenges to program integrity, as well as leading practices to address them. Stakeholders could include individuals from state Medicaid programs, NEMT brokers, TNCs, Medicaid patient advocates, and others. As the GAO noted in their report, CMS already has some information to build on leading practices since "CMS reported that it collects information on state approaches for administering NEMT through state Medicaid plans and state plan amendments" and since "CMS collects information on Medicaid programs and noteworthy program integrity practices, including those related to NEMT, as part of its program integrity reviews."[89] These focused collaborative sessions can also address specific challenges raised by Medicaid NEMT stakeholders,

[88]The underlying data may also be useful to the CMS Office of the Actuary, Congressional Budget Office, and others, for evaluating possible future legislation or administrative actions further strengthening Medicaid NEMT's program integrity.

[89]Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States, United States Government Accountability Office, February 2016, Available from: https://www.gao.gov/assets/680/674934.pdf.

including unique considerations for certain groups of Medicaid beneficiaries meriting particular attention, such as American Indians and tribal land issues or accommodations for individuals with disabilities.

3. **Provide Technical Assistance to States.** CMS has a range of authorities and avenues to provide technical assistance to states about the federal requirements and leading practices for improving Medicaid NEMT program integrity. While Medicaid is state administered, CMS has a fiduciary and practical responsibility to take reasonable actions to help ensure state successes in improving the program's core integrity. Moreover, the provision of technical assistance may not be an actionable policy change that would constitute a scorable change by Congressional budget scorekeepers, but implementing specific, targeted improvements in processes and policies can save states and the federal budget real monies. CMS should consider updates to the State Medicaid Manual regarding NEMT as be warranted or appropriate.[90]

4. **Implement the GAO's Open Recommendation.** CMS should implement GAO's open recommendations (GAO-16-238) on Medicaid NEMT. GAO recommends CMS review and update Medicaid NEMT guidance to ensure states have appropriate and current guidance.

5. **Require Basic Program Integrity.** Whether through current Medicaid program authority or new authority granted by Congress, as appropriate, CMS should require state Medicaid programs to:
   - **a)** Ensure all Medicaid NEMT transportation providers:
     - **i)** Are checked for exclusion from federal health care programs and are not listed on the HHS OIG exclusion list.
     - **ii)** Disclose all prior criminal convictions.
     - **iii)** Hold a valid driver's license.
     - **iv)** Pass a drug screen.
     - **v)** Disclose their driving history, including traffic violations.
   - **b)** Conduct onsite audits or "secret shopping" of transportation providers periodically within reason.

6. **Analyze T-MSIS Data for Insights.** Later this year, CMS will release a full nation-wide data set under the Transformed Medicaid Statistical Information System (T-MSIS). This data system is a new approach to the traditional Medicaid Statistical Information System, which was used to "collect utilization and claims data as well as other key Medicaid and CHIP program information, to keep pace with the data needed to improve beneficiary quality of care, assess beneficiary to care and enrollment, improve program integrity, and support our states, the private market, and stakeholders with key information."[91] This new T-MSIS data set contains (a) enhanced information about beneficiary eligibility; (b) beneficiary and provider enrollment; (c) service utilization; (d) claims and managed care data; and (e) expenditure data for Medicaid and CHIP.[92] CMS has already released an issue brief regarding how states should report NEMT expenditures in certain T-MSIS files.[93] As the T-MSIS becomes public and is used for research, analysis, and program insight, CMS may have an opportunity to improve the quality of the underlying data and to leverage it for better analysis regarding NEMT and other related dynamics.

State Recommendations

1. **Require Public Transparency of Key Medicaid NEMT Data.** State Medicaid programs should make certain Medicaid NEMT data is publicly available online. This information may help build trust with state lawmakers, media, and Medicaid stakeholders by providing transparency that helps put any identified program integrity challenges in perspective, in respect to the overall delivery of Medicaid NEMT services. For example, the Wisconsin Department of Health Services provides a monthly report that details NEMT performance and quality data and makes the report publicly available.[94] At a minimum, public reporting should include data on:

[90]The State Medicaid Manual, CMS, Available from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html.
[91]Transformed Medicaid Statistical Information System (T-MSIS), CMS, Available from: https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html.
[92]Ibid.
[93]Reporting Non-Emergency Medical Transportation (NEMT) Prepaid Ambulatory Health Plans (PAHPs) in the T-MSIS Managed Care File (Managed Care), CMS, Available from: https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/?entry=47540.
[94]Monthly Non-Emergency Medical Transportation Data, Wisconsin Department of Health Services, Available from: https://www.dhs.wisconsin.gov/nemt/data.htm.

a) The number of NEMT trips during a specific period (monthly or quarterly) in a specific geography, such as counties or other subdivisions of the state.[95]

b) The types of Medicaid services most frequently accessed by NEMT, such as dialysis, adult day care, mental health care, behavioral health care, substance abuse treatment, and maternal or pediatric care.

c) The number of complaints received and basic information on how complaints are resolved.

2. **Leverage Existing Data to Continually Improve Program Integrity.** Virtually every single Medicaid expert we talked with noted the critical importance of using data –which already exists inside a Medicaid program, Medicaid health plan, and/or NEMT broker—to inform program integrity efforts.

   a) Standardize Data Reporting for Routine Visibility. State Medicaid programs should, depending on their NEMT delivery model, require Medicaid health plans and transportation providers to provide the state with robust data on an ongoing, regular basis regarding Medicaid NEMT utilization and trends. While frontline responsibility for program integrity may, depending on the model, lie with Medicaid health plans and transportation providers, ultimately, state Medicaid programs should have strategies in place for using this data to inform oversight and enforcement actions on a timely basis. For example, due to the direct impact on Medicaid enrollee experience and potential implications for enrollee's health care, state Medicaid programs should have routine data feeding back to them via a dashboard or other intuitive mechanism regarding:

      i) Missed trips and no-shows.

      ii) The duration of service windows.

      iii) Late trips.

      iv) Trip utilization.

      v) The number and nature of complaints from beneficiaries.

      vi) Trends in complaints coming in through a call center or online.

      vii) Other program integrity activities such as physician improper billing for patient no-shows.

   b) Use Automated System Edits to Flag Specific Activities or Circumstances. Several of the Medicaid experts we talked with about the importance of automated system edits or routinized system checks that look for outliers in utilization (frequency of trips or length of trips) and using such processes to trigger additional reviews. For example, one broker we talked with uses mile limits on NEMT service trips as a kind of soft edit to trigger additional review. In most cases, this is effectively a gatekeeping trigger to ensure that if a beneficiary is frequently using trips, or taking long trips, such utilization is medically warranted. It was rather surprising to us that the 2009 report by the HHS OIG report revealed that only 36 states were conducting claims reviews and only 35 states were conducting data analysis and monitoring.[96] Every state should be taking advantage of existing technologies to improve the integrity of the Medicaid NEMT benefit.

   c) Pay Special Attention to Eligibility and Medical Necessity Data Needs. Given what is known about Medicaid NEMT fraud, it is especially critical that Medicaid state program leaders work with Medicaid MCOs, NEMT brokers, and transportation providers to ensure timely access for program integrity purposes to eligibility files and medical necessity data. While hammering out the operational and security components of data agreements is not glamorous, it is essential to ensure that Medicaid does not inappropriately pay for a beneficiary or service that is not eligible. One former Medicaid director highlighted the importance of MCO dashboard broker coordination because he noted that about five percent of the Medicaid rider population each month was not eligible. He noted the fragmentation of the delivery of transportation through MCOs has increased the administrative burden for brokers in some way but noted it can be addressed with data agreements and routinized processes.

3. **Position State Systems to Detect and Prevent Known Fraud Schemes.** CMS's Medicaid NEMT provider booklet, last updated in 2016, provides specific examples of the types of fraud against which Medicaid NEMT program leaders must

[95]Such reporting needs to be done in such a way that gives proper consideration to HIPAA concerns, reporting by the county or zip code level in very rural areas may inadvertently allow the public to deuce the beneficiary's identify.

[96]See page 6, Memorandum Report: "Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services", OEI-06-07-00320, May 28, 2009, Available from: https://oig.hhs.gov/oei/reports/oei-06-07-00320.pdf.

be vigilant.[97] Given these known vulnerabilities, Medicaid program leaders should design simple, routinized strategies for assessing the presence of such fraud schemes. Proactively reviewing the specific types of fraud schemes that have been active in the past can help build specific strategies to prevent their perpetuation and continuance. Some types of fraud schemes noted by CMS include:[98]

a) Independent contractor-parent: "some States reimburse parents, considered independent contractors, for the cost of medically necessary trips." Fraud occurs when parents bill for trips that did not occur.

b) Beneficiary fraud: beneficiaries who transport themselves have committed fraud by conspiring with NEMT providers to allow the provider to bill Medicaid for transportation to medical appointments.

c) Company ownership: "providers should only bill for services rendered. If a beneficiary fails to show for a transportation appointment, a provider cannot bill Medicaid for the no-show. Nor should providers misuse beneficiary information to claim services they never provided … Providers must use the most cost-effective mode of transportation when transporting Medicaid beneficiaries. They normally use ambulettes for transporting beneficiaries with a disability or for those who are convalescing and need additional care … it is cost prohibitive to use ambulettes for those who do not need them."

d) Company-qualified drivers: "drivers must qualify to transport Medicaid beneficiaries. Otherwise, the services are ineligible for reimbursement."

e) Company owner-authorized vehicles: "vehicles must be qualified when transporting Medicaid beneficiaries."

f) Taxi driver: "beneficiaries who qualify for transportation services may only use the services for medically necessary appointments, providers may not be reimbursed for services, even if they are furnished, if the services do not meet Medicaid rules (for example, dropping beneficiaries off at the grocery store or at a friend's home)."

4. **Use Prior Approval Strategically.** Most states use brokers and require beneficiaries to obtain prior approval before using some or all NEMT services. As the HHS OIG notes, prior approval "typically involves verification of the beneficiary's Medicaid eligibility, the medical necessity of the trip, and the beneficiary's lack of alternative transportation options."[99] While the wide application of prior authorization requirements in Medicaid would not be cost-effective, experts we spoke with underscored prior authorization requirements are an important tool that should be deployed for individuals accessing costlier forms of transportation (such as ambulances).

5. **Ensure Robust Complaint and Medicaid Appeals Processes for Beneficiaries.** Virtually every Medicaid expert we talked with stressed the importance of having a transparent, predictable, and fair complaint process by which beneficiaries can express their concerns. In 2009, the HHS OIG found that only 40 states had a fraud or complaint hotline operative. Today, states should make available a hotline, as well as a web page, for submitting complaints. A robust complaint process is not only important to understand beneficiary concerns and address them, but such a complaint process can also help identify breakdowns in communication with beneficiaries, identify potential fraud schemes, or identify beneficiary access problems that could worsen relatively quickly. Medicaid state program leaders should also consider conducting a beneficiary satisfaction survey or conducting focus groups to better appreciate Medicaid beneficiaries functional understanding of the Medicaid NEMT benefit.

6. **Use Contracting Arrangements to Incentivize Program Integrity and Quality.** Most experts we talked with discussed the importance of states utilizing smart contracting processes to oversee NEMT vendors, regardless of their delivery model. Several state program staff noted contingency fees and fee-withholds were effective mechanisms for incentivizing NEMT vendor performance. At least two state program leaders noted that contract provisions requiring liquidated damages were helpful in situations in which their state experienced unexpected operational challenges.[100] Other contract

[97]CMS, Non-Emergency Medical Transportation, Available from: https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf.

[98]CMS, Non-Emergency Medical Transportation, Available from: https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf.

[99]Memorandum Report: "Fraud and Abuse Safeguards for State Medicaid Nonemergency Medical Transportation Services", OEI-06-07-00320, May 28, 2009, Available from: https://oig.hhs.gov/oei/reports/oei-06-07-00320.pdf.

[100]A liquidated damages contract clause generally details a specific amount of money that one party to a contract fails to perform as required under the contract. While the presence of (and potential payout of) such a clause is usually taken into account during contract negotiations and may be essentially accounted for in the per-member, per-month fee the transportation broker receives, states have found that including it may enable them to quickly secure additional staff or resources when there is a significant problem or crisis to address.

mechanisms we discussed with experts included:

- **a)** The use of risk corridors when brokers are under full-risk contracts.
- **b)** The use of remittances related to addressing the differences between allowable costs and targeted spending.
- **c)** Clarifying the responsibilities for start-up and implementation costs.
- **d)** Recoupment expectations related to claims suspected of, or verified as, fraudulent.
- **e)** Performance metrics (such as fee-withholds or performance bonuses) related to:
    - **i)** How quickly and in what manner complaints are addressed (specific hour or day requirements for specific responses).
    - **ii)** The number and nature of, and response to, serious incidents and accidents.
    - **iii)** How quickly calls are answered (second and minute requirements, as well as lost calls and voicemails, tracked as an average).
    - **iv)** Substantially late rides or no-show rides attributable to the transportation provider or broker (vs. beneficiary or external factors such as weather, natural disaster).
    - **v)** Safety inspections for vehicles' maintenance and records.
    - **vi)** Surprise inspections of transportation providers' staff, facilities, or vehicles.
    - **vii)** Drivers' compliance with certification, licensing, and training requirements.
    - **viii)** Scheduling rides within a reasonable time from the date/time of the request.
    - **ix)** The percentage/number of rides being completed on time.
    - **x)** Feedback from client satisfaction surveys.
    - **xi)** Acknowledgement of appeals within specific timeframes.
- **f)** The implementation of a Corrective Action Plan when necessary.
- **g)** The provision of driver education/training modules or services.
- **h)** The use of encounter data.
- **i)** Prompt pay requirements to ensure clean claims are paid to transportation providers in a timely manner.

7. **Transition To/Between Transportation Brokers with Careful Planning.** Several experts we talked with identified problems when states were transitioning from a FFS model to a brokered model, or from one NEMT broker to another. These experts felt that the operational and process problems that occurred during transition were generally due to insufficient planning or the lack of a phased approach to transitioning to a new model by populations or regional areas. While detailed planning before a transition or a phased transition approach creates more work for the state program and for brokers, it may help avoid needless interruptions to patient care and also avoid public outcry that creates reputational risks.

   In the worst cases we heard about, improperly managed transitions may have too heavily discounted providers' concerns and inadvertently jeopardized the continuity or quality of Medicaid beneficiary care because beneficiaries could not get timely access to care – including to dialysis appointments. In other cases, the infrastructure of the new model (call centers, automated service notifications, beneficiary eligibility verifications, etc.) were not tested and encountered problematic glitches during rollout. One stakeholder we talked with suggested the creation of a state advisory panel or ad hoc committee, composed of representatives from Medicaid beneficiary advocacy groups, the state legislature, and other key stakeholders. The creation of such an advisory entity could be a forum for sharing more granular data and for helping work through any challenges with a complaint process to ensure it is clear, objective, and transparent.

   Another Medicaid program leader we talked with relayed her experience of a significant public challenge regarding the timeliness and accessibility of Medicaid NEMT benefits during a transition to a broker. She noted that there were significant challenges with the readiness plan and the state underestimated some provider challenges. However, while the experience was difficult, she noted that previously developed rapid response plans with clear deliverables and

actionable tasks were a key to successfully and quickly addressing the program challenges in this case. She noted that the preparation time was invaluable to ensure the state program and relevant stakeholders could respond in a timely manner.

8. **Consider the Role of TNCs and Use Them Strategically.** As discussed, TNCs present both challenges and opportunities for Medicaid programs, as well as NEMT brokers and transportation providers. State Medicaid leaders need to carefully assess a range of specific factors within their state when evaluating what level of provider registration or background process may be appropriate. However, the reality is that TNCs are already playing a role in reshaping Medicaid NEMT – both because TNCs are partnering with plans, brokers, and states, and because they are reshaping Medicaid beneficiary expectations. One area of clear consensus between the experts we talked with is that TNCs are not appropriate for transporting certain kinds of patients, such as those patients who are not ambulatory, or who have severe mental health or behavioral health issues, or who are vulnerable youth. Yet, experts we talked with, especially those with operational experience from state Medicaid programs, brokers, and plans, noted that TNCs play an important role in the current delivery model for some populations, in certain geographies, and in specific circumstances. Therefore, we recommend that state Medicaid leaders work in an open and collaborative process with key stakeholders—including TNCs, Medicaid MCOs, NEMT brokers, transportation providers, and beneficiary advocates—to identify policies, processes, and procedures that both acknowledge the operational needs of a transportation network and uphold high standards for drivers and their vehicles.

APPENDIX

NEMT Model and Operating Authority by State

State	NEMT Model	Operating Authority
AL		NEMT Assurance under State Medicaid Plan
AK		1902(a)(70) State Plan Amendment, and Federal section 1915(b) Freedom-of-Choice Waiver
AZ		Federal Section 1115 Demonstration Waiver
AR		Federal section 1915(b) Freedom-of-Choice Waiver
CA		1902(a)(70) State Plan Amendment
CO		1902(a)(70) State Plan Amendment
CT		Federal Section 1115 Demonstration Waiver
DE		Federal section 1915(b) Freedom-of-Choice Waiver
DC		Federal Section 1115 Demonstration Waiver, and Federal Section 1915(b) Freedom-of-Choice Waiver
FL		Federal Section 1115 Demonstration Waiver
GA		Federal Section 1915(b) Freedom-of-Choice Waiver
HI		Federal section 1915(b) Freedom-of-Choice Waiver
ID		1902(a)(70) State Plan Amendment
IL		Federal Section 1115 Demonstration Waiver
IN		Federal Section 1115 Demonstration Waiver
IA		Federal Section 1115 Demonstration Waiver
KS		Federal Section 1115 Demonstration Waive
KY		Federal Section 1115 Demonstration Waiver, Federal section 1915(b) Freedom-of-Choice Waiver
LA		1902(a)(70) State Plan Amendment, and Federal Section 1115 Demonstration Waiver
ME		1902(a)(70) State Plan Amendment
MD		NEMT Assurance under the State Medicaid Plan
MA		Federal Section 1115 Demonstration Waiver
MI		NEMT Assurance under the State Medicaid Plan, and Federal section 1915(b) Freedom-of-Choice Waiver
MN		NEMT Assurance under the State Medicaid Plan
MS		1902(a)(70) State Plan Amendment
MO		1902(a)(70) State Plan Amendment
MT		Federal Section 1115 Demonstration Waiver, and Federal Section 1915(b) Freedom-of-Choice Waiver
NE		1902(a)(70) State Plan Amendment
NV		1902(a)(70) State Plan Amendment
NH		NEMT Assurance under State Medicaid Plan, and Federal Section 1115 Demonstration Waiver
NJ		1902(a)(70) State Plan Amendment
NM		Federal Section 1115 Demonstration Waiver
NY		NEMT Assurance under State Medicaid Plan, and Federal Section 1115 Demonstration Waiver
NC		NEMT Assurance under State Medicaid Plan
ND		NEMT Assurance under State Medicaid Plan
OH		NEMT Assurance under State Medicaid Plan
OK		1902(a)(70) State Plan Amendment
OR		Federal Section 1115 Demonstration Waiver
PA		NEMT Assurance under State Medicaid Plan, and 1902(a)(70) State Plan Amendment
RI		Federal Section 1115 Demonstration Waiver
SC		1902(a)(70) State Plan Amendment
SD		NEMT Assurance under State Medicaid Plan
TN		Federal Section 1115 Demonstration Waiver
TX		1902(a)(70) State Plan Amendment, and Federal section 1915(b) Freedom-of-Choice Waiver
UT		Federal section 1915(b) Freedom-of-Choice Waiver
VT		Federal Section 1115 Demonstration Waiver
VA		1902(a)(70) State Plan Amendment
WA		1902(a)(70) State Plan Amendment
WV		1902(a)(70) State Plan Amendment
WI		1902(a)(70) State Plan Amendment
WY		NEMT Assurance under the State Medicaid Plan

KEY

In-House Management	Regional Broker
Managed Care Organization	Statewide Broker

National Academies Press, National Academies of Sciences, Engineering, and Medicine, Available from: https://www.nap.edu/download/25184#.

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