



Current Issues in NEMT

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Introduction

By one estimate, nearly 3.6 million adults miss or delay needed care each year due to difficulties with transportation.¹ Lack of transportation poses a serious barrier to care, especially for individuals with lower incomes who on average have fewer transportation options and more significant health care needs. To better serve this population, state Medicaid programs must ensure that beneficiaries have access to non-emergency medical transportation (NEMT) to and from medical appointments.²

In addition, research indicates that increasing access to NEMT can improve health outcomes and even save money. Transportation barriers, such as limited access to private vehicles, can substantially reduce adherence to medications.³ Better adherence can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits. Thus, offering NEMT to individuals with common chronic conditions, like asthma, diabetes, and heart disease, can actually save more than the transportation benefit costs.⁴ Similarly, improving access to prenatal visits through NEMT saves an estimated \$367 per childbirth for pregnant women with limited transportation options, primarily by reducing premature births.⁵

¹ PAUL HUGHES-CROMWICK & RICHARD WALLACE, ALTARUM INST., COST BENEFIT ANALYSIS OF PROVIDING NON-EMERGENCY MEDICAL TRANSPORTATION 3 (2005), <http://www.trb.org/Main/Blurbs/156625.aspx>.

² 42 C.F.R. §§ 431.53, 440.170(a); HEW, MEDICAID ASSISTANCE MANUAL § 6-20-00, at 2 (1978) [hereinafter MAM]. The Medicaid Assistance Manual, though superseded in many instances by the State Medicaid Manual, contains important statements of early agency policy. Some courts continue to cite the Medical Assistance Manual with favor, while others have not accorded it great weight.

³ Timothy E. Welty *et al.*, *Effect of Limited Transportation on Medication Adherence in Patients with Epilepsy*, 50 J. AM. PHARM. ASSOC. 698 (2010); Ramzi G. Salloum *et al.*, *Factors Associated with Adherence to Chemotherapy Guidelines in Patients with Non-small Cell Lung Cancer*, 75 LUNG CANCER 255 (2012).

⁴ HUGHES-CROMWICK & WALLACE, *supra* note 1.

⁵ Richard Wallace *et al.*, *Cost-Effectiveness of Access to Nonemergency Medical Transportation*, 1956 TRANSPORTATION RESEARCH RECORD 86, 93 (2006); Talia McCray, *Delivering Healthy Babies: Transportation and Healthcare Access*, 15 PLANNING PRACTICE & RESEARCH 17 (2000).

Given the need for and value of NEMT services, particularly for low-income individuals, the NEMT benefit is a critical component of the Medicaid program.⁶ This brief reviews the NEMT requirement and details states' various implementation options. We then probe some of the potential threats to and the future direction of this benefit as: (1) health care delivery increasingly shifts toward capitated managed care; (2) the courts limit the ability to enforce portions of the Medicaid Act; (3) states experiment with eliminating this key benefit for certain adults through Medicaid demonstration waivers; and (4) CMS and states fail to adequately monitor entities that deliver NEMT services. Each of these distinct but related issues threatens enrollees' ability to access necessary Medicaid services.

Background

A. Coverage requirements and options

Under the Medicaid Act, all states must perform administrative functions necessary for the proper and efficient operation of their Medicaid programs.⁷ CMS has long interpreted this provision to require states to both ensure that enrollees have necessary transportation to and from Medicaid providers and to describe in their state plan how they will meet this requirement.⁸ Without this requirement, many enrollees would simply be unable to access health care services, thus undermining the entire purpose of the Medicaid program.⁹

States have the option to cover transportation as an administrative expense, as an optional medical service, or as both.¹⁰ When states cover transportation as an administrative expense, the freedom of choice provision, which requires states to allow beneficiaries to receive services from any willing

⁶ See, e.g., MAM at 2; *Smith v. Vowell*, 379 F. Supp. 139, 145 (W.D. Tex.), *aff'd*, 504 F.2d 759 (5th Cir. 1974) (citing amicus brief of CMS's predecessor agency: "[T]he basic [Medicaid] statute requires that medical assistance be available in all political subdivisions of the State, 42 U.S.C.A. § 1396(a)(1). In many circumstances, this provision could not be implemented in the absence of transportation services to enable the recipients to obtain needed treatment from specialized facilities and practitioners. The statute also mandates that medical assistance be furnished with reasonable promptness to all eligible individuals, *id.* at § 1396(a)(8), and be available to eligible recipients from qualified providers of their choice, *id.* at § 1396(a)(23). These statutory requirements would frequently be vitiated in the absence of a State provision for prompt transportation of eligible recipients to and from the qualified providers of their choice.").

⁷ 42 U.S.C. § 1396a(a)(4)(A).

⁸ 42 C.F.R. § 431.53. Note that several courts have found that the regulation is not enforceable under 42 U.S.C. § 1983. See, e.g., *Harris v. James*, 127 F.3d 993, 1112 (11th Cir. 1997); *Avila v. Smith*, No. 2:05-CV-309, 2006 WL 1519420, at *6 (D. Vt. May 26, 2006). It is also unclear whether the provision would be enforceable in federal court using the Supremacy Clause, given the Supreme Court's decision in *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S.Ct. 1378 (2015), described in more detail in section III.A. below.

⁹ See note 2, *supra*.

¹⁰ CMS, STATE MEDICAID MANUAL § 2113.

provider, does not apply.¹¹ This means that states may restrict enrollees to particular transportation providers. Proper and efficient operation of the state plan requires states to try to use any available free services, as well as the least costly means of transportation.¹² When a state covers transportation as an administrative expense, CMS matches the expenditures at the fifty percent administrative services rate, which is lower than the match rate for medical services in most states.¹³

When states cover transportation as an optional medical service for adults, only providers to whom the state can make a direct vendor payment may participate.¹⁴ The freedom of choice provision applies and enrollees have the right to obtain transportation from any qualified Medicaid provider.¹⁵ As is the case when states provide transportation as an administrative cost, states must utilize all other available sources of transportation services before authorizing Medicaid payment, as Medicaid is generally the payer of last resort.¹⁶ Transportation costs claimed as an optional service are matched at the state's Federal Medical Assistance Percentage (FMAP).¹⁷ These include expenses for transportation and "other related travel expenses" necessary to secure medical examinations and treatment for a Medicaid enrollee, such as the cost of:

- transportation for the enrollee by ambulance, taxicab, common carrier, or other appropriate means;
- meals and lodging to and from medical care and while receiving care;
- an attendant to accompany the recipient; and
- the attendant's transportation, meals, and lodging, as well as the attendant's salary if he or she is not a family member.¹⁸

With respect to children under age 21, states must cover transportation under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit when necessary "to correct or ameliorate" a child's illness or condition.¹⁹ In addition, states must affirmatively offer transportation assistance to children and their families before the due date for each periodic screening.²⁰

¹¹ *Id.*

¹² MAM § 6-20-00 at 12.

¹³ See 42 U.S.C. §§ 1396b(a)(7), 1396d(b); Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 Through September 30, 2017, 80 Fed. Reg. 73,799 (Nov. 25, 2015).

¹⁴ 42 C.F.R. § 440.170(a)(2).

¹⁵ *Id.* § 440.170; cf. CMS, STATE MEDICAID MANUAL § 2113.

¹⁶ See 42 U.S.C. § 1396a(a)(25)(A); see also *Morgan v. Cohen*, 665 F. Supp. 1164, 1176 (E.D. Pa. 1987) (suggesting that state need only pay for transportation when volunteer drivers are unavailable, and then it "should make payment only 'for the least expensive means suitable to the recipient's medical needs'" (citing MAM § 6-20-20).

¹⁷ See 42 U.S.C. §§ 1396b(a)(1), 1396d(b).

¹⁸ *Id.* § 1396a(a)(70); 42 C.F.R. § 440.170(a)(3).

¹⁹ See 42 U.S.C. §§ 1396d(r)(5) (requiring states to cover "such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are

B. Delivering NEMT services

States have considerable flexibility regarding how to administer NEMT services. First, states may contract directly with transportation providers and pay them on a fee-for-service basis. The state Medicaid agency or a third party administrator may authorize and coordinate the services. Second, states may contract with managed care entities to cover transportation services for enrollees. Finally, under the Deficit Reduction Act of 2005, states that choose to cover transportation as an optional medical service may use a transportation broker to “more cost-effectively provide non-emergency transportation services” to enrollees who need access to services and have no other means of transportation.²¹

States electing the broker option may limit freedom of choice for transportation providers and may use the broker for only certain groups of enrollees and/or only in certain geographic areas.²² Transportation services furnished through a broker may include wheelchair vans, taxis, stretcher cars, transit passes and tickets, secured transportation, and other transportation methods covered under the state plan, including reimbursement for friends and family members who provide transportation in some cases.²³ States must select a broker through a competitive bidding process.²⁴ Currently, the majority of states use a broker for at least some Medicaid enrollees.²⁵

covered under the State plan.”), 1396d(a)(6) (listing “medical care, or any other type of remedial care recognized under State law. . .”); 42 C.F.R. § 440.170.

²⁰ 42 C.F.R. § 441.62(a); CMS, State Medicaid Manual § 5150.

²¹ 42 U.S.C. § 1396a(a)(70); 42 C.F.R. § 440.170(a)(4); CMS, Dear State Medicaid Director Letter (March 31, 2006).

²² 42 U.S.C. § 1396a(a)(70) (noting that state transportation brokerage systems need not follow paragraphs (1) (statewideness), (10)(B) (comparability), or (23) (freedom of choice)); 42 C.F.R. § 440.170(a)(4).

²³ 42 U.S.C. § 1396a(a)(70)(A); 42 C.F.R. § 440.170(a)(4).

²⁴ 42 U.S.C. § 1396a(a)(70)(B)(i); 42 C.F.R. § 440.170(a)(4)(i)(A)

²⁵ AMELIA MYERS, NATIONAL COUNCIL OF STATE LEGISLATURES, NON-EMERGENCY MEDICAL TRANSPORTATION: A VITAL LIFELINE FOR A HEALTHY COMMUNITY (2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx#mix>.

Current issues

A. Increased need for transportation due to inadequate provider networks

1. MMC plans with narrow networks

The increasing volume of Medicaid beneficiaries, including seniors and individuals with disabilities, enrolled in Medicaid managed care plans has exacerbated the need for transportation, as plans typically contract with fewer providers than traditional fee-for-service Medicaid. Currently, approximately three quarters of Medicaid beneficiaries receive services through some type of managed care arrangement.²⁶ Most Medicaid managed care enrollees receive their services through capitated plans, meaning that the plans receive a set payment per Medicaid enrollee in exchange for providing services.²⁷ Moreover, MCOs contract with the state on a “comprehensive risk” basis, such that the plan loses money if the cost of services exceeds the capitated payments. This can create a powerful financial incentive to discourage access to care.²⁸ In order to manage costs, plans that contract with Medicaid programs often contract with a limited number of providers to serve their enrollees.²⁹ As a result, Medicaid enrollees in these “narrow network” plans are frequently required to travel significant distances to see providers—especially specialists—and require transportation assistance to use their medical benefits.

For example, since the expansion of Medicaid managed care to several rural counties in the far northern part of California in 2013, many enrollees are sent to see specialists many hours away, but are not offered any assistance with the substantial travel costs they incur. Enrollees report that local specialists whom they were previously able to see while enrolled in fee-for-service Medicaid do not contract with their managed care plans, forcing them to see specialists further away. In other instances, there are one or two local providers who accept the Medicaid managed care plans, but appointment waiting times are very long. Enrollees are presented with the impossible choice of delaying care to see a nearby provider or traveling to see a provider hundreds of miles away. Access to providers is also a problem in major urban centers, where low-income Medicaid enrollees lack access to reliable transportation and may have to spend three hours taking four buses to get to a specialist across town. California recently took steps to ameliorate this problem by enacting a new law clarifying that Medicaid Managed Care plans in

²⁶ CENTERS FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT AND PROGRAM CHARACTERISTICS 2014 at 17 (2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>. Medicaid managed care entities can deliver care through managed care organizations (MCOs), primary care case managers (PCCMs) or Prepaid Health Plans (PHPs). 42 U.S.C. §§ 1396u-2(a)(1)(B), 1396b(m)(1)(A) (regarding managed care organizations), 1396d(a)(25), 1396d(t) (regarding primary care case managers). For more on how these arrangements work, see Sarah Somers, Nat’l Health Law Prog., *Medicaid Managed Care*, 5 HEALTH ADVOCATE 1 (Sept. 2012), www.healthlaw.org/images/stories/2012_09_Vol_5_Health_Advocate.pdf.

²⁷ KAISER COMM’N ON MEDICAID AND THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 30 (2011), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8220.pdf>.

²⁸ See 42 C.F.R. § 438.2 (defining “comprehensive risk contract” and “capitation payment”).

²⁹ U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE (2014), <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

California are responsible for providing transportation assistance for covered benefits; the law will take effect in July 2017.³⁰

In addition, federal Medicaid law requires each Medicaid managed care plan to ensure that all services covered under the State plan are available and accessible to managed care enrollees.³¹ In addition, federal regulations require Medicaid managed care plans to maintain a provider network sufficient in number, type and geographic distribution.³² Under new federal rules, by 2018 states will be required to develop time and distance standards for many Medicaid services, ensuring that enrollees have access to care within their geographic area.³³ Hopefully, the new rule will help to resolve the common problem of plans offering certain services some distance away from where beneficiaries live and work. For the time being, enrollees are frequently required to travel significant distances to see providers and likely depend more on transportation assistance to use their medical benefits.

2. Provider rates and participation after *Armstrong v. Exceptional Child*

Low provider payment rates have long bedeviled state Medicaid programs. When the payment rate for services is too low, states may not attract an adequate number of providers to make services accessible to all beneficiaries who need them. But too often, states set provider rates for transportation and other services based on how much they want to spend on the Medicaid program rather than what services actually cost. Such a stance can impact access to NEMT in two ways. First, having fewer overall participating providers may increase demand for NEMT if the only available provider is further away. Second, low rates (and fewer transportation providers) could decrease the availability of NEMT.

The Medicaid Act requires states to set Medicaid payments at a level “sufficient to enlist enough providers so that care and service are available under the [Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area.”³⁴ Previously, providers and beneficiaries had relied on the civil rights act, 42 U.S.C. § 1983, and, in later years, the Constitution’s Supremacy Clause to enjoin state policies that conflicted with the federal Medicaid requirement that provider rates be sufficient to ensure that services are available.³⁵ Unfortunately, the U.S. Supreme Court’s recent decision in *Armstrong v. Exceptional Child Care Center* has constrained Medicaid providers’ ability to enforce this requirement in federal court.³⁶ And while *Armstrong*

³⁰ Cal. Assem. Bill 2394 (enacting Cal. Welf. & Inst. Code § 14132(ad)).

³¹ 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(a) (requiring states to ensure that services are available to enrollees in Medicaid managed care organizations (“MCOs”), Prepaid Inpatient Health Plans (“PIHPs”) and Prepaid Ambulatory Health Plans (“PAHPs”)); *id.* § 438.207(b) (requiring state to ensure adequate network adequacy in Medicaid managed care plan contracts).

³² 42 C.F.R. § 438.207(b)(2).

³³ *Id.* § 438.68.

³⁴ 42 U.S.C. § 1396a(a)(30)(A).

³⁵ See, e.g., *Detgen ex rel. Detgen v. Janek*, 752 F.3d 627, 630 (5th Cir. 2014); *Lewis v. Alexander*, 685 F.3d 325, 345, 346 & n.20 (3d Cir. 2012), *cert. denied*, 133 S. Ct. 933 (2013); *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006).

³⁶ 135 S.Ct. 1378 (2015). For a more detailed analysis of the *Armstrong* decision, see JANE PERKINS, NAT’L HEALTH LAW PROG., *ARMSTRONG V. EXCEPTIONAL CHILD CARE CENTER: HEALTH CARE PROVIDERS’ ACCESS TO COURT IS BLOCKED* (2015), <http://www.healthlaw.org/about/staff/jane-perkins/all-publications/armstrong-v-exceptional-child-care-center>.

specifically concerned only health care providers' ability to enforce the Medicaid payment provision, lower courts have applied its reasoning to hold that Medicaid beneficiaries also cannot enforce the Medicaid payment provision.³⁷

With providers unable to enforce the Medicaid payment provision in federal court, some states will likely continue to keep down payment rates, further depressing provider participation and forcing enrollees to travel further to access needed care. Some states may compound this problem by setting inadequate payment rates for transportation providers as well. If payment rates decrease, providers are more likely to stop participating in Medicaid. With fewer transportation providers, enrollees may find it more difficult to obtain reliable transportation services at the same time they are required to travel further to get to their appointments.³⁸ While CMS released regulations in November 2015 that will require states to more regularly report on how they ensure access in their fee-for-service Medicaid programs, the impact of these regulations on beneficiary access remains to be seen.³⁹ What is clear is that the federal government must begin to take seriously its oversight responsibility to ensure adequate payment rates so that Medicaid-covered services, including transportation services, are available to Medicaid beneficiaries at least to the extent they are available to the paying population in the geographic area.

B. Waivers of NEMT and Medicaid expansion

1. Section 1115 demonstrations

Despite clear evidence that many low-income individuals have trouble getting to providers when they need care, a number of states have pushed to eliminate NEMT for certain Medicaid groups as part of a § 1115 demonstration. Section 1115 of the Social Security Act authorizes HHS to waive certain provisions of the Medicaid Act to allow states to test innovations using pilot demonstrations, provided that:

1. The demonstration only waives provisions in 42 U.S.C. § 1396a, and only to the extent necessary to run the demonstration;
2. The demonstration is likely to promote the Medicaid program's objectives; and
3. The state identifies a clear and testable demonstration or experimental purpose for the waiver.⁴⁰

In the late 1990s and early 2000s, HHS approved a wave of demonstrations that offered limited Medicaid benefit packages, often with premiums or higher cost sharing, to adults not traditionally

³⁷ See, e.g. *O.B. v. Norwood*, No. 16-2049, 2016 WL 5335494, at *4 (7th Cir. Sept. 23, 2016); *Providence Pediatric Med. DayCare, Inc. v. Alaigh*, 112 F. Supp. 3d 234, 251 (D.N.J. 2015).

³⁸ See, e.g., Jeffrey Clemens & Joshua D. Gottlieb, *Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?*, 104 AM. ECON. REV. 1320 (2014) (finding that, in Medicare, changes to reimbursement rates corresponded to changes in patient access), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144420/>.

³⁹ See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67,575 (Nov. 15, 2015) (to be codified at 42 CFR Part 447).

⁴⁰ 42 U.S.C. § 1315(a).

covered by the Medicaid program.⁴¹ A number of these demonstrations did not cover NEMT, including the Oregon Health Plan, Michigan’s Adult Benefit Waiver, Utah’s Primary Health Care Network, and the Healthy Indiana Program.⁴² None of the states receiving these waivers adequately justified how the elimination of this benefit would promote Medicaid objectives, but they generally couched their demonstrations in terms of expanding coverage to groups not typically covered by traditional Medicaid. Multiple court decisions have found that CMS did not undertake adequate review as required by § 1115 in approving these “expansion” waivers.⁴³

With the 2010 enactment of the ACA, low-income adults became a mandatory state plan eligibility group.⁴⁴ Because this group is now described in the Medicaid statute, the previous justification for providing limited benefit coverage without NEMT to “expansion” groups has become moot. Nearly all the limited benefit expansions have expired or been subsumed under ACA-related adult Medicaid expansions.

The Supreme Court’s decision in 2012 to remove HHS’s power to enforce the Medicaid expansion dramatically shifted the politics of expansion. A number of states have since pushed to “customize” their Medicaid expansions through the 1115 demonstration process. Several have been allowed to eliminate NEMT for adults in the expansion group. Again, the states provided no valid demonstration purpose for this “experiment.” For example, Iowa’s NEMT waiver extension proposal described the exclusion of NEMT as part of a “compromise” to make Medicaid expansion coverage look more like commercial health insurance.⁴⁵ But Medicaid is not commercial insurance. Congress designed Medicaid to serve the unique needs of low-income beneficiaries, and transportation to providers is one of those needs. Section 1115 authority is intended for experiments likely to promote Medicaid objectives, not for “compromises” that actually undermine Medicaid coverage. Nevertheless, in the last three years HHS has approved new short-term NEMT waivers in Iowa, Pennsylvania, and Indiana.⁴⁶

⁴¹ HENRY J. KAISER FAM. FOUND., FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS 5 (2011), <http://kff.org/health-reform/issue-brief/five-key-questions-and-answers-about-section/>.

⁴² In addition to using § 1115 demonstration authority, states were briefly permitted to use Alternative Benefit Plans (ABPs, previously known as Medicaid benchmark coverage) to offer benefit packages that excluded NEMT to certain Medicaid populations. ABPs were established by the Deficit Reduction Act in 2005, and the regulation permitting NEMT exclusion was finalized in December 2008. The option to limit coverage of NEMT in ABPs was eliminated after a statutory change enacted through the CHIP Reauthorization Act of 2009. The ABP regulations were revised to prohibit exclusion of NEMT in benchmark coverage in 2010. See 75 Fed. Reg. 23068, 23069 (Apr. 30, 2010.) See also 42 C.F.R. § 440.390. Separately, HHS has also waived NEMT in a number of family planning demonstrations.

⁴³ Specifically, courts have found that CMS was not evaluating a waiver request to determine whether it served a valid demonstration or experimental purpose. *Newton-Nations v. Betlach*, 660 F.3d 370 (9th Cir. 2011); *Wood v. Betlach*, 922 F.Supp.2d 836 (D. Ariz. 2013); see also *Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994).

⁴⁴ 42 U.S.C. §1396a(a)(10)(A)(VIII). The ACA also created an optional group covering adults with incomes above 133% FPL. *Id.* § 1396a(a)(10)(B)(XX).

⁴⁵ IOWA DEPT. OF HUMAN SERVS. IOWA HEALTH AND WELLNESS PLAN: NEMT WAIVER AMENDMENT PROPOSAL 1 (Sept. 2014).

⁴⁶ The Pennsylvania demonstration was abandoned before full implementation. See MEDICAID & CHIP PAYMENT AND ACCESS COMM’N, PENNSYLVANIA MEDICAID EXPANSION WAIVER FACT SHEET 1 (2015), <https://www.macpac.gov/wp-content/uploads/2016/02/Pennsylvania-Medicaid-Expansion-Waiver.pdf>.

2. Evaluation of NEMT Waivers

Until recently, HHS has not consistently demanded rigorous evaluation of approved demonstrations. Few if any states that implemented pre-ACA demonstrations with no NEMT benefit meaningfully evaluated the impacts. For example, the original Healthy Indiana Plan demonstration began in 2008, but none of the readily available evaluation documents included any analysis of the effect of waiving NEMT on beneficiary access to care.⁴⁷ The state claims that its 2012 beneficiary survey included one question on transportation as an access barrier and showed minimal impact.⁴⁸ This data has not been available for public review and is hardly adequate to justify extending a waiver of this important benefit.

In the latest iteration of NEMT waivers under § 1115, HHS has at least required direct evaluation to test the unlikely hypothesis that the “waiver of non-emergency transportation to the non-pregnant and non-medically frail population does not pose a barrier to accessing care.”⁴⁹ Both Iowa and Indiana have now produced several beneficiary surveys evaluating principal mode of transport, unmet care needs, and financial burden for Medicaid expansion adults compared against a group of Medicaid beneficiaries in different eligibility categories who retain the NEMT benefit.

We draw two key insights from these surveys. First, a relatively small but substantial proportion (6-15%) of all Medicaid respondents reported ongoing unmet care needs due to lack of transportation. As income decreases, that proportion goes up. Iowa’s surveys found that adults without NEMT relied more on friends and family for transportation, which has been demonstrated to increase the odds of missing or delaying care.⁵⁰ In short, while most people can get to their doctor most of the time, others experience problems. The purpose of NEMT is to ensure that *all* beneficiaries have the opportunity to get the care they need when they need it. Although the percentage of enrollees facing transportation barriers may appear relatively small, it amounts to tens of thousands of beneficiaries in each state who stand to benefit from effective NEMT.

Both Iowa and Indiana have pointed to findings that Medicaid beneficiaries *with* NEMT actually reported higher unmet transportation needs to conclude that waiving NEMT does not affect access to care for the expansion population. But the method used to reach this conclusion is fatally flawed. The evaluations

⁴⁷ CAROL IRVIN, MATHEMATICA POLICY RESEARCH, HEALTHY INDIANA PLAN: THE FIRST TWO YEARS (2010), http://www.mathematica-mpr.com/publications/pdfs/health/healthyIndiana_Irvin.pdf; TIMOTHY K. LAKE ET AL., MATHEMATICA POLICY RESEARCH, HEALTHY INDIANA PLAN: LESSONS FOR HEALTH REFORM (2011), http://www.mathematica-mpr.org/publications/PDFs/health/healthyindianaplan_ib1.pdf; IND. FAM. AND SOC. SERVS. ADM., HEALTHY INDIANA PLAN DEMONSTRATION: 2012 ANNUAL REPORT (2013), http://www.in.gov/fssa/hip/files/2012_HIP_Annual_Report.pdf; IND. OFF. MEDICAID POLICY & PLANNING, HEALTHY INDIANA PLAN 2013 ANNUAL REPORT (2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-HIP/in-healthy-indiana-plan-pa-2014-ext-app.pdf>. In a submitted draft evaluation plan for the Healthy Indiana Plan 2.0, the State claims that in the original program “surveys indicated that this was not a concern to the Healthy Indiana Plan population,” but provides no supporting data for this claim. IND. FAM. AND SOC. SERVS. ADM., HEALTHY INDIANA PLAN: DRAFT EVALUATION DESIGN, 25 (2015), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-draft-eval-design-10292015.pdf>.

⁴⁸ U.S. GOV’T ACCOUNT. OFF., EFFORTS TO EXCLUDE NONEMERGENCY TRANSPORTATION NOT WIDESPREAD, BUT RAISE ISSUES FOR EXPANDED COVERAGE 11 (2016), <http://www.gao.gov/assets/680/674674.pdf>.

⁴⁹ IND. FAM. AND SOC. SERVS. ADM., HEALTHY INDIANA PLAN: DRAFT EVALUATION DESIGN, *supra* note 47, at 27.

⁵⁰ Jeremy Mattson, *Transportation, Distance, and Health Care Utilization for Older Adults in Rural and Small Urban Areas*, 2265 TRANSPORTATION RESEARCH RECORD 192 (2011).

broadly compare the expansion population to a very dissimilar population receiving full state plan services (with NEMT). These populations differ markedly by age, gender, race/ethnicity, income, and health status – all factors that affect access to transportation. In a classic example of bureaucratic understatement, Indiana’s evaluator, the Lewin Group, acknowledges that “a direct comparison of their proportions is not advisable.”⁵¹ Moreover, even if the comparison groups were similar demographically, evidence that transportation problems persist even when NEMT is available hardly justifies waiving the benefit. The unmet transportation needs in the state plan group could be explained by an ineffective or poorly publicized NEMT program, which would hardly be a legitimate justification for waiving the benefit. In fact, prior research from Iowa suggests that lack of awareness of the NEMT benefit is a significant problem.⁵² Similarly, Indiana’s 2013 external quality review identified substantial issues with Indiana’s transportation vendors, including lack of rural availability, delays, difficulties scheduling trips, and failure to provide needed Spanish interpretation services.⁵³

The second key insight comes from Iowa’s most recent survey, which provides strong evidence that transportation barriers are more common among people of color, women, and people with significant health needs, even after controlling for income and other related factors. Regression analysis showed that people of color in Iowa’s Medicaid program are much more likely to report an unmet care need due to transportation (83% higher odds for Blacks, 31% for Hispanics). Women are 24% more likely to report an unmet transportation need.⁵⁴ Finally, people in relatively poorer health (58% higher odds), with multiple physical ailments (63%) or who have any functional deficit (245%) are all *much* more likely to report unmet transportation needs.⁵⁵ These findings suggest that waiving NEMT likely perpetuates or even exacerbates longstanding health care disparities for historically underserved populations. Health equity is a clear priority for CMS, which recently required all states with Medicaid managed care programs to develop a written plan to identify and reduce disparities.⁵⁶ Based on Iowa’s evidence, waiving NEMT contradicts these efforts.

We anticipate that a planned federal evaluation of Indiana’s expansion demonstration will move away from the flawed comparative approach and focus instead on key nuances about who needs NEMT and how it is delivered. We believe no NEMT waivers should be approved or re-approved unless a valid evaluation is conducted and that evaluation conclusively shows that access is not being impeded,

⁵¹ THE LEWIN GROUP, INDIANA HIP 2.0: EVALUATION OF NON- EMERGENCY MEDICAL TRANSPORTATION (NEMT) WAIVER 21 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-eval-nonemerg-med-transport-02262016.pdf>.

⁵² We know of only one study that examined Iowa Medicaid beneficiaries’ understanding of the NEMT benefit. In that 2008 survey, roughly half of Medicaid respondents reported low or very low knowledge of the NEMT process. PAUL F. HANLEY *ET AL.*, IOWA PUBLIC POLICY CTR., IOWA MEDICAID NON-EMERGENCY MEDICAL TRANSPORTATION SYSTEM REVIEW AND OPTIONS FOR IMPROVEMENTS 40 (2008), <http://ppc.uiowa.edu/publications/iowa-medicaid-non-emergency-medical-transportation-system-review-and-options>. Results were even poorer for the population of younger adults without disabilities. *Id.* at 41

⁵³ MARK PODRAZIK *ET AL.*, BURNS & ASSOCIATES, INC., EXTERNAL QUALITY REVIEW OF INDIANA’S HOOSIER HEALTHWISE PROGRAM AND HEALTHY INDIANA PLAN FOR THE REVIEW YEAR CALENDAR 2012 at VI-18 (2014), http://www.burnshealthpolicy.com/wp-content/uploads/2011/07/External-Quality-Review-of-the-Hoosier-Healthwise-and-Healthy-Indiana-Plan_Review-Year-CY2009.pdf.

⁵⁴ SUZANNE BENTLER *ET AL.*, U. IOWA PUBLIC POLICY CTR., NON-EMERGENCY MEDICAL TRANSPORTATION AND THE IOWA HEALTH AND WELLNESS PLAN 22 (2016), http://ir.uiowa.edu/ppc_health/132.

⁵⁵ *Id.*

⁵⁶ 42 C.F.R. § 438.340(b)(6).

especially for historically underserved populations. To improve the evaluation process, we recommend that states and CMS:

- Ensure that survey questions explore the right metrics. Indiana’s evaluation focuses narrowly on missed appointments, which ignores individuals who have no access to transportation and make no appointments, or who may have trouble getting to urgent care or a pharmacy (where an appointment is not needed).
- Carefully consider response bias. Iowa respondents skewed older and more likely female than the sampled population. Indiana’s evaluation did not report on potential response bias.⁵⁷
- Design survey questions to evaluate how many enrollees with access to NEMT are aware of and know how to access that benefit. Also ask about reliability. Low awareness or poor service quality could mask the impact of NEMT as a means to reduce access barriers related to transportation.
- Examine the effectiveness of states’ screening process for medically frail individuals to ensure that individuals in poor health retain access to full state plan benefits, including NEMT.
- To the extent that NEMT is ever offered as a wraparound benefit, such as for 19- and 20-year-olds entitled to EPSDT, explore the systems for publicizing and accessing this benefit.

Unfortunately, CMS has already extended Iowa’s NEMT waiver three times (and Indiana’s once) pending more evaluation data.⁵⁸ In a recent sign that CMS is beginning to understand that NEMT waivers do not promote the objectives of Medicaid, Arizona’s proposal to implement a new NEMT waiver was not approved.

C. Lack of Monitoring and Oversight of NEMT entities

1. Transportation Brokers

Transportation brokers established under 42 U.S.C. § 1396a(a)(70) must follow certain requirements designed to ensure that enrollees have access to necessary NEMT services of sufficient quality. In particular, brokers must have in place “oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and that transport personnel are licensed, qualified, competent, and courteous.”⁵⁹ Brokers are also subject to regular state auditing and oversight to ensure the quality and timeliness of NEMT services and the adequacy of enrollee access to medical care.⁶⁰ In addition, federal regulations explicitly prohibit brokers from withholding necessary NEMT services or

⁵⁷ It is reasonable to hypothesize that many of the individuals who could most benefit from NEMT, such as people without a mailing address or individuals with substance use disorders, might also be less likely to receive or reply to such a survey. This could lead to a response bias that underestimates the actual need for transportation to providers for these subpopulations.

⁵⁸ In May 2016, CMS extended Iowa’s NEMT waiver through December 31, 2016, which is the end of the demonstration period. Letter to Mikki Stier, Iowa Medicaid Dir., from Eliot Fishman, Dir., Ctrs. Medicare & Medicaid Servs., State Demonstrations Group (May 31, 2016), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-ca.pdf>. Iowa applied for another extension into 2017 last June. Indiana’s NEMT waiver is set to expire November 30, 2016, and the state has requested an extension as well.

⁵⁹ 42 U.S.C. § 1396a(a)(70)(B)(ii); 42 C.F.R. § 440.170(a)(4)(i)(B).

⁶⁰ 42 U.S.C. § 1396a(a)(70)(B)(iii); 42 C.F.R. § 440.170(a)(4)(i)(C).

providing services that are not the “most appropriate and cost-effective means of transportation for that [enrollee] for the purpose of financial gain. . .”⁶¹

Despite these requirements, reports from enrollees and advocates across the country indicate that enrollees experience a number of difficulties when trying to use NEMT services provided by brokers. Such difficulties include: providers arriving late or not at all, causing enrollees to miss appointments and/or wait hours after appointments for a ride home; brokers refusing to provide the mode of transportation that is most appropriate for the enrollee; brokers refusing to transport a patient’s child or sibling, causing the patient to forgo care; and drivers who are disrespectful or do not help seniors or individuals with disabilities get into their appointments, instead dropping them at the curb. These reports, as well as recent audits of NEMT services in select states, reveal the need for CMS and state Medicaid agencies to engage in more robust monitoring and oversight of NEMT brokers.⁶² There has also been litigation to address the problem.⁶³

2. Prepaid Ambulatory Health Plans (PAHPs)

Similar access and quality concerns apply to managed care entities that provide NEMT services. A number of states require that managed care organizations (MCOs), which provide a comprehensive set of services to enrollees, cover NEMT services.⁶⁴ Other states contract with prepaid ambulatory health plans (PAHPs), which provide limited outpatient services, to deliver NEMT services to Medicaid enrollees. Some PAHPs provide only NEMT services. As of 2012, there were 22 NEMT PAHPs participating in the Medicaid program across the country.⁶⁵

In May 2016, HHS issued a final rule overhauling the regulations governing Medicaid managed care entities.⁶⁶ The rule contains a number of substantial changes, including expanding the universe of regulations that apply to PAHPs. For example, like MCOs and prepaid inpatient health plans (PIHPs), PAHPs must now maintain a grievance and appeal system and adhere to the enhanced quality

⁶¹ 42 C.F.R. § 440.170(a)(4)(ii)(D).

⁶² See DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, NEW JERSEY DID NOT ADEQUATELY OVERSEE ITS MEDICAID NONEMERGENCY MEDICAL TRANSPORTATION BROKERAGE PROGRAM A-02-14-01001 (2016), <https://oig.hhs.gov/oas/reports/region2/21401001.pdf>; WISC. LEG. AUDIT BUREAU, NON-EMERGENCY MEDICAL TRANSPORTATION 3 (2015) <http://legis.wisconsin.gov/lab/reports/15-4full.pdf> (additional oversight needed in Wisconsin to improve “dependability, quality, and cost of NEMT”).

⁶³ See, e.g., *Doe v. District of Columbia*, No. 08-1646 (D.D.C. Jan. 28, 2009) (Joint Notice of Settlement) (establishing process for recipients who expressed continued need for specialized transportation services (e.g. wheelchair lift van) to obtain them following District’s proposal to replace specialized services with metro/bus).

⁶⁴ See, e.g., TENN. DIV. OF HEALTH CARE FINANCE & ADMIN., TENNCARE, STATEWIDE CONTRACT WITH AMENDMENT 4 (2016), <https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>.

⁶⁵ Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules, 80 Fed. Reg. 31,098, 31,249 (June 1, 2015).

⁶⁶ Medicaid and Children’s Health Insurance Program (CHIP) Programs, Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27,498 (May 6, 2016).

measurement and improvement requirements.⁶⁷ In addition, under the final rule, states must adopt a monitoring system that addresses all aspects of the managed care program, including the performance of each PAHP in a number of areas.⁶⁸

Notably, however, the rule exempts NEMT PAHPs from many of the requirements that apply to PAHPs generally, including those listed above.⁶⁹ This is troubling, as NEMT PAHPs are no different from PAHPs that cover medical services, such as dental PAHPs. In fact, capitated NEMT PAHPs have the same financial incentives to limit enrollees' access to services. These incentives make the grievance and appeal system, the quality requirements, and the monitoring system equally important for NEMT PAHPs. To help ensure that enrollees have access to necessary NEMT services of sufficient quality, states should incorporate these requirements into their contracts with NEMT PAHPs and consistently monitor plans' compliance.

Conclusion

NEMT plays a critical role in Medicaid by ensuring that low-income beneficiaries have real access to covered health care services. Yet recent developments at the state and federal levels have weakened access to NEMT in Medicaid around the country. As a result, Medicaid beneficiaries experience more difficulty accessing the services they need. Advocates must work closely with their states to ensure that their state Medicaid program, including any waiver program, is designed to ensure appropriate access to NEMT. Advocates should also work closely with state and federal officials to ensure that Medicaid NEMT programs are routinely monitored, and any problems are promptly resolved.

⁶⁷ See 42 C.F.R. §§ 438.400-424 (grievance system), 438.310-370 (quality measurement and improvement and external quality review). Some of these provisions are currently in effect, while others go into effect for rating periods for Medicaid managed care contracts beginning on or after July 1, 2017. 81 Fed. Reg. at 27,499.

⁶⁸ 42 C.F.R. § 438.66.

⁶⁹ *Id.* § 438.9. In the preamble to the proposed rule, HHS failed to articulate the distinction between NEMT PAHPs and transportation brokers. See Proposed Rules, 80 Fed. Reg. at 31,149, 31,166. (June 1, 2015). Further guidance on this point could help ensure that states, brokers, and PAHPs understand their obligations and that enrollees understand their rights. See Letter from Elizabeth G. Taylor, Executive Dir., Nat'l Health Law Program, to Victoria Wachino, Dir. Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs. at 35 (July 27, 2015), <http://www.healthlaw.org/publications/comments-managed-care>.