

Managing Medicaid Transportation

*A Manual Examining Innovative Service Delivery
Models Under State Medicaid Managed Care Plans*

December 1997

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The Community Transportation Association of America (CTAA) is a national nonprofit organization that conducts policy-oriented research and assists states and localities to develop effective community transportation services. CTAA is a recognized national leader in the areas of coordinating human service transportation, developing rural public transit services, and designing medical transportation programs. This nationwide study of state Medicaid programs to identify emerging policies and strategies for assuring access to health care for Medicaid recipients was funded by the Center for Health Care Strategies and made possible by a major grant from the Robert Wood Johnson Foundation through its *Medicaid Managed Care Program*.

Introduction

Since its inception, CTAA has been concerned with the management of non-emergency Medicaid transportation. Medicaid is important to community transportation operators for both symbolic and practical reasons. First, it is the only federally-sponsored program that guarantees that citizens have an enforceable right to transportation access to medical or any other services. Secondly, its sheer size makes it important -- both to the 36 million recipients who are entitled to Medicaid transportation, and to the community transportation industry. And third, as conventional federal transit funding resources have decreased in recent years, reimbursement for transporting Medicaid recipients now makes up an increasingly important larger portion of many community transit agencies' budgets.

As a result, CTAA has been in the forefront of efforts to document the importance of non-emergency Medicaid transportation, and the struggle to assure that those services are continued, and that they are managed in an effective and cost-efficient manner. For more than a decade, CTAA has covered non-emergency Medicaid transportation issues in its monthly *Community Transportation magazine*. We have studied the operation of state Medicaid transportation programs around the country, and have published several reports analyzing innovative local delivery systems. In fact, most of the literature available today dealing with Medicaid transportation has been researched and published by CTAA.

In the last few years, there has been a radical change in the delivery of health care in America. The traditional fee-for-service practitioner of medicine is being replaced by pre-paid health care systems. These changes are having a profound impact on the Medicaid system generally and the provision of

medically-necessary transportation to Medicaid recipients. For instance, the rapid shift to state Medicaid managed-care plans is changing dramatically the way non-emergency medical transportation is organized and financed.

Assuring that poor people continue to have access to basic medical services under managed care poses complex, new challenges and some risk to community transportation providers and Medicaid recipients themselves. At the same time, however, the prospect of effectively "managing" Medicaid transportation and developing replicable models offers significant opportunities to states Medicaid administrators and others seeking to improve access to quality health care. That's why we were so pleased that the *Center for Health Care Strategies* in Princeton, New Jersey, agreed to support CTAA's study of new and emerging approaches to Medicaid transportation under managed care. Operating under a major grant from the Robert Wood Johnson Foundation, the Center has established its *Medicaid Managed Care Program*.

This analysis of state Medicaid transportation and *Best Practices* manual is the result of the Center's support. We are grateful for that support and hope that this report will be useful to a broad audience -- made up of state and federal Medicaid officials, local health plan administrators, community medical transportation providers and others. We are also hopeful that we can make a positive contribution to the on-going public debate about the importance of assuring access to basic health care facilities and services, and how best to coordinate those medical access services with other resources to enhance the overall mobility and livability of communities.

Summary of Major Findings

In the Spring of 1997, CTAA began a study of the non-emergency Medicaid transportation programs administered by all 50 states and the District of Columbia. This research effort was designed to gather basic financial, demographic and transportation services information from each state. It represents the first systematic and comprehensive collection of data about the Medicaid transportation program, and was designed to compare non-emergency medical transportation services and expenditures among the various states. The following is a summary of the findings of that study. A 50-state Profile of Medicaid programs is appended to this report.

VARIATIONS BETWEEN STATE PROGRAMS

Currently, all states and the District of Columbia participate in the Medicaid program. There are wide state differences in the number and percentage of people enrolled in Medicaid, and in the amounts that states spend per enrollee. For example, only 6% of the population in Kansas is eligible for Medicaid benefits, as compared with 21% in New York and 20% in Mississippi. In eight states, Medicaid recipients make up less than 8% of the population. By contrast, 10 states have enrollments of 15% or more.

Similarly, the per capita expenditures that states spend annually for Medicaid medical care vary significantly. The national average is \$5,685. However, 11 states spend less than \$4,500 per recipient, with Oklahoma being the lowest at \$2,750, although it enjoys one of the highest federal funds matching rate (71%). Per capita Medicaid expenditures are highest in New Hampshire (\$9,603), but they exceed \$8,000 in six states.

PENETRATION OF MANAGED CARE

In CTAA's survey, states reported that nearly one quarter of the total Medicaid population was enrolled in managed programs.¹ Again, the range is enormous, with enrollments in five states (Alaska, Montana, South Carolina, Vermont and Wyoming) cover 2% or less of the states' populations, while two states (Arizona and Tennessee) claim that more than 90% of their Medicaid recipients are covered under managed care contracts. The average for all 50 states was 40%.

As noted earlier, shifting responsibility for Medicaid transportation to HMOs is underway, but just barely. State Medicaid agencies in 23 states remain exclusively responsible for all non-emergency medical transportation. In about half the states, some capitation agreements require health plans to provide and pay for medically-necessary trips for their Medicaid customers. However, such "carved in" agreements still represent a small portion of states' overall Medicaid population. The exceptions are Arizona, Rhode Island and Tennessee, where virtually all Medicaid transportation is contracted through managed care organizations.

CAPITATION RATES

Accurate and comparable data about capitation rates, particularly sub-rates that have been established to cover the costs of providing Medicaid transportation, is scattered and

¹ This is substantially different than the 40% of Medicaid enrollees cited by HCFA and other sources. There differences here may be that for the purposes of CTAA's transportation survey, state Medicaid agencies only counted actual enrollees in HMOs and other managed care organizations.

hard to come by. Throughout the course of CTAA's study, we tried to collect such data from both federal and state Medicaid agencies, and from mailed surveys to more than 400 federally-recognized HMOs, but very few gather such information. Only one state agency, Rhode Island, had complete records. For instance, most Medicaid capitation contracts in which transportation is "carved in" do not require health plans to set up a separate, capitated sub-rate for transportation services. It is usually simply included in the overall monthly fee paid to provide all required or covered services.

Occasionally, the specific costs of transportation under managed care are broken out separately. The following are intended as illustrative examples. In Rhode Island, the monthly capitation rate for HMOs enrolled in the state's Rite Care program includes \$2.25 per member per month (PMPM) to pay for transportation.² In Arizona, the Pima Health Care System (PHCS), a county-operated Medicaid managed care organization, uses estimated transportation costs to help build its overall capitation rate. Currently, PHCS earmarks \$3.25 per month for each of its 11,600 Medicaid enrollees for non-emergency transportation services. That's equal to 2% of its overall monthly capitation rate of \$163.52.³

Fixed or capitated payments for medical transportation vary considerable between states. In New Mexico, HMOs participating in the state's new Medicaid managed care program have established a capitation rates of \$1.30 per enrollee, per month for non-emergency medical transportation, and a rate of \$2.20

² Rite Care Transportation Service Agreement, Office of Managed Care, Rhode Island Department of Human Services, July 1996.

³ Interview with Silver Darmer, Contracts Administrator, Pima Health System, Tucson, AZ, April 29, 1997.

for emergency ambulance services.⁴ Oklahoma's Health Care Authority adds 54 cents pm/pm to each HMO contract to cover essential medical transportation services.⁵ And in upstate New York, where transportation is included as a covered service, HMOs are reportedly offering to subcontract with transportation providers at a capitated rate of \$2.00 pm/pm.⁶

NEMT EXPENDITURES

Until now, there has been little reliable data available about actual outlays for non-emergency Medicaid transportation (NEMT). In a 1994 casual review of Medicaid expenditures, federal expenditures for NEMT were projected to be equivalent to 1% of the total Medicaid budget.⁷ But it was just a guess. Subsequently, the 1% figure was widely used by both advocates and federal officials when discussing the size and importance of the Medicaid transportation program. At the time, total federal Medicaid expenditures were approximately \$75 billion, so the generally accept assumption was that annual federal NEMT spending was at least \$750 million. This was close enough for Medicaid to be recognized as the largest client transportation program within DHHS.

Until now, practically nothing was known about the total price tag for providing basic medical transportation to Medicaid recipients, especially the size of state NEMT expenditures. In

⁴ Interview with James Murnane, Integrated Transport Management, Inc., Mesa, AZ, September 26, 1997.

⁵ Telephone interview with Debra Johnson, OK Health Care Authority, October 2, 1997.

⁶ Telephone interview with Terry Eisenman, CCTM, Rides Unlimited of Niagara, Inc., Niagara Falls, NY, November 11, 1997.

⁷ CTAA's 1994 Analysis of Non-Emergency Medicaid Transportation, which was prepared for the U.S. Department of Health and Human Services (DHHS), was the source of the original "1%" estimate.

1995, the Alaska Medicaid agency surveyed 36 states and produced a first of its kind analysis of non-emergency Medicaid transportation.⁸ The Alaska study seemed to confirm the 1% theory, and provided useful, partial data about a number of state programs.

As reflected in the attached state-by-state profile of Medicaid transportation expenditures, we now have a much more complete picture about spending levels and services in all but two states.⁹ The following is a brief summary of the NEMT data:

- **Total Expenditures:** Nationwide, CTAA's survey documented roughly \$1.2 billion in combined (federal & state) NEMT expenditures. This figure represents slightly less than 1% of the \$176 billion national Medicaid budget.
- **Per Capita Expenditures:** State and federal governments are currently spending the equivalent of \$40 per Medicaid recipient per year on transportation to basic medical services. Individual state differences in annual per capita spending are enormous, ranging from a low of \$2 per recipient in Wyoming to \$95 in New York and \$123 in the District of Columbia.
- **Costs Per Trip:** An attempt was made to gather information about the number of medical trips provided to Medicaid recipients and to project a national average cost per trip. However, only 14 state Medicaid agencies were able to report such data, so no meaningful national projections can be made. Again, individual state variations were significant, ranging from less than \$1 dollar per trip in

Rhode Island, to more than \$36 in Louisiana and \$43 in the District of Columbia. The average per-trip cost for the states reporting was \$16.

- **Utilization Rates:** In the managed care era, accurate data about utilization of service rates is extremely important in estimating costs and setting capitation rates. However, accurate data on the use of non-emergency Medicaid transportation is generally nonexistent. Nearly half the state agencies have no information about how many recipients depend on or require transportation assistance to get to medical services. At least five states reported that more than NEMT services were used by more than 15% of their Medicaid populations. On the other hand, 14 states said that utilization was less than 10%.
- **Medicaid and Public Transit:** Historically, one of the charges made against the management of state Medicaid programs has been failure to actively include public transit agencies as providers of transportation services. That weakness remains largely true today, but the use of lower-cost providers—both nonprofit community and public transit agencies—is growing. Among the states reporting such data, approximately one-fifth (20%) of all NEMT trips are by public transit.

⁸ Local Transportation: A State Medicaid Agency Survey, Alaska Division of Medical Assistance, September 1995.

⁹ Only Arizona and Tennessee were unable to estimate what they were currently spending on non-emergency Medicaid transportation.

Background

Nationally, an estimated 3.4 million recipients, roughly 10% of the covered population, depend on Medicaid transportation to get to doctors and medical appointments.¹⁰ These are people who either are unable to drive or too poor to own and operate their own car and do not have access to affordable public transportation. Medicaid transportation is particularly crucial in rural areas, where distances to health facilities are often greater and where public transit alternatives are frequently nonexistent. Medicaid-funded transportation assistance varies from state to state and according to need, ranging from modest individual mileage reimbursement and gas voucher programs in some areas, to the development of elaborate networks of medical transportation providers in others.

Expenditures on non-emergency Medicaid transportation have risen significantly over the years and today represent the second largest single federal expenditure for public transportation.¹¹ Roughly 1% of the entire Medicaid budget is devoted to non-emergency transportation. Currently, that amounts to approximately \$1.5 billion. At the same time, participation by community transit agencies in the Medicaid transportation program has grown steadily. As a result, Medicaid reimbursement has become a major source of revenue today for community providers in many states.

¹⁰ Innovative State Medicaid Transportation Programs, Elizabeth Hayes and Jon Burkhardt, Ecosometrics Inc., February 1995.

¹¹ Medicaid Transportation Fact Sheet, CTAA, February 1996.

LEGISLATIVE HISTORY

Established by President Lyndon Johnson in 1965, Medicaid is a federal entitlement program that pays for basic health care services for low-income people and long-term care for the elderly and disabled. It is a joint federal/state-run program that covers more than 36 million people -- roughly one in eight Americans.¹² States administer their own Medicaid programs, in conformity with federal requirements. For instance, coverage is mandated for certain disadvantaged groups, including young children from poor families and welfare recipients, and must be accessible to all eligible state residents. The federal government provides between 50% and 80% of Medicaid funds, with poorer states receiving a larger percentage. For fiscal year 1997, total Medicaid expenditures were expected to reach \$176 billion, with the federal government picking up over \$100 billion, or roughly 57% of the total.¹³

Federal Medicaid regulations require states to "ensure necessary transportation for recipients to and from providers." Traditionally, most states have met this requirement by enrolling transportation providers—usually taxis and private medical vans, and paying them whenever they transported Medicaid recipients. However, transportation was never mentioned in the original legislation establishing Medicaid (Title XIX of the Social Security Act). It exists today only because of a few landmark court decisions.¹⁴

¹² Medicaid Managed Care for the Disabled, General Accounting Office (GAO), 1996.

¹³ Growth Rates of Medicaid Medical Assistance and Administrative Payments, Health Financing Administration (HCFA), July 3, 1997.

¹⁴ "Medicaid Transportation's Future Uncertain," Scott Bogren and Gail Hyman, Community Transportation Association of America (CTAA), *CTR Magazine*, April 1994.

Federal courts have consistently ruled that states must assure that recipients access to covered Medicaid services.¹⁵ These "access rights" entitle recipients to receive needed medical transportation assistance, and require states to pay for it. Non-emergency transportation benefits are not available to Medicare beneficiaries, in part, because Medicare coverage is recognized as an insurance program and not an entitlement.

States have considerable freedom and flexibility in designing Medicaid "access" services. They can elect to claim federal reimbursement for Medicaid transportation either as an optional medical or administrative expense. As a medical expense, states are reimbursed at the prevailing federal matching rate (50% to 83%), but are subject to federal freedom of choice and other requirements. As an administrative expense, states have greater flexibility in structuring transportation services, but give up the more the favorable reimbursement rate. According to CTAA's survey of Medicaid agencies, non-emergency transportation is treated as a medical service today in 80% of the states. (See Appendix I, Profile of State Medicaid Programs.)

GROWTH OF MANAGED CARE

Nationally, health care financing and delivery are going through a period of rapid and dramatic change. Nowhere is that more evident and nowhere is the speed of change more apparent than in state Medicaid programs. The push is to shift to "managed care", which is being touted as a way of addressing two national concerns: 1) containing medical costs and 2) reducing (or at least capping) federal outlays for health care for the elderly and the poor.

¹⁵ "Medicaid Recipients Win Suit in Alabama," Scott Bogren, article in *CTR Magazine*, published by CTAA, September/October 1995.

Managed care plans are designed to deliver medical services for a fixed (or "capitated") per-person fee. By emphasizing primary and preventive care, and limiting access to hospitals and medical specialists, managed care is seen as a device for controlling spiraling Medicaid costs. It is common for capitation rates to be set at between 90% and 100% of projected fee-for-service costs.¹⁶ The initial step is to project fee-for-service costs for the applicable geographic area or population group. The next step is to multiply projected costs by some percentage that reflects the desired managed care savings.

The trend in Medicaid is for states to *mandate* enrollment in local HMOs or other managed care plans. At the same time, Medicare beneficiaries are being *encouraged* to join HMOs, but, so far, their participation is voluntary. As a result, both Medicaid and Medicare enrollment in managed care plans is growing rapidly. In Medicaid's case, fewer than 1.5 million recipients—less than 6% of the eligible population—belonged to managed care plans in 1987.¹⁷ Since that time, Medicaid enrollment in managed care has grown much more rapidly than total Medicaid enrollment. For example, the number of Medicaid beneficiaries increased from 33.4 million to 36.2 million in 1995.¹⁸ However, Medicaid managed care enrollment grew by more than 400%, and today includes more than 40% of the Medicaid population.¹⁹

¹⁶ Understanding Medicaid: Managed Care Approaches, Milliman & Robertson, Inc., 1995.

¹⁷ Recent Trends in the Medicaid Program, Statement of Mark Merlis, Congressional Research Service, before the Senate Committee on Finance, March 24, 1994.

¹⁸ Trends in Medicaid Managed Care Enrollment and Plan Arrangements, Jocelyn Guyer, Center for Health Care Strategies, (undated).

¹⁹ Questions for States as They Turn to Medicaid Managed Care, Stephen Zuckerman, Alison Evans and John Holahan, The Urban Institute, 1997.

Forty-nine states have now established Medicaid managed care plans. Enrollment is mandatory in some, voluntary in others. The groups most commonly enrolled in managed care programs have been children, low-income pregnant women and families receiving AFDC or similar assistance.²⁰ Generally, older and disabled enrollees and Medicaid recipients of long term care have not been forced into managed care programs.

MANAGED CARE AND MEDICAID TRANSPORTATION

According to CTAA's survey of state Medicaid agencies, which is summarized in Appendix I, there are considerable differences in the way states approach transportation and managed care. Almost half of the states *do not include* non-emergency transportation services under the Medicaid managed care plans. These 23 states continue to rely on traditional fee-for-service arrangements to fulfill their federal obligations to assure access to care.

However, transportation is "carved in" to managed care contracts in at least 26 states. CTAA's Medicaid survey found that most of these states are running dual reimbursement programs, including both capitated and fee-for-service transportation operations. In three states, Arizona, Rhode Island and Tennessee, HMOs are responsible for providing virtually all non-emergency transportation to Medicaid recipients. In others with only partial HMO coverage, dual systems are common. In New York, each county can decide whether or to "carve in" transportation benefits to managed care contracts.²¹

²⁰ Managed Care and Medicaid, Families USA Foundation, 1996.

²¹ Wasting Medicaid, A Report by Mark Green, Public Advocate for the City of New York, November 1996.

MEDICAID WAIVERS

In order to force Medicaid recipients to enroll in managed care programs, states must receive approval from the Health Care Financing Administration (HCFA), the federal agency that administers both Medicaid and Medicare. Most state managed care programs operate under one of two types of waivers. Section 1115, or research and demonstration waivers allow states to implement broad changes in the traditional Medicaid program. As of October 1997, 15 states were implementing comprehensive Section 1115 waivers. Only one such waiver request has been denied by HCFA.²²

In addition to research waivers, there are two types of program waivers, which are more limited in scope. Home and community-based waivers encourage states to develop alternatives to institutional care such as nursing homes. Freedom of choice waivers, also called Section 1915(b) waivers, allow states flexibility in establishing prepaid medical transport plans, Medicaid transportation brokerages, or other programs that may restrict the choice of medical service providers. All but 12 states have obtained 1915(b) waivers, including a handful (Louisiana, Oregon & New York) that have sought specific transportation freedom of choice waivers.²³ The waiver process does not allow states to abandon their federal obligations to assure access to Medicaid services.

²² Comprehensive Health Care Reform Demonstrations, Health Care Financing Administration (HCFA), DHHS, October 3, 1997.

²³ Medicaid Managed Care Program Summary, HCFA, June 30, 1996.

Best Practices

EMERGING APPROACHES

In response to a number of factors, including desires to reduce NEMT costs; pressures to reduce billing fraud and abuse in the Medicaid transportation program; and the shift to managed care, state Medicaid agencies are developing new approaches to meeting federal access to care requirements. To an increasing extent in recent years, states have begun moving away from the traditional medical transportation model, that relies on the traditional patchwork of fee-for-service providers, and adopting improved techniques for "managing" non-emergency Medicaid transportation.

These newer approaches to Medicaid transportation can be grouped into three general categories:

- **Transportation Brokerage** - an entity established to coordinate the screening of recipients, determining eligibility and arranging and paying for actual transportation.
- **Administrative Manager** - an initiative in which state Medicaid agency staff assume the gatekeeper's role and/or contract out some administrative responsibilities.
- **Capitated Transport Services** - an arrangement through which responsibility for transporting Medicaid enrollees is transferred to managed care provider.

Each of these approaches reflects an attempt to structure the management of NEMT services. Seldom does the pure form exist in nature. There is usually some overlap here and there as states try to mix their approach to a growing need. Each of these models is described further below.

TRANSPORTATION BROKERAGE MODEL

Brokerages represent the best known and most successful approach to managing Medicaid transportation to have emerged in recent years. Increasingly, state Medicaid agencies see the transportation brokerage as superior to the old, patchwork of freelance medical transportation providers and uncoordinated services. Even the federal watchdog agency that oversees state Medicaid expenditures has endorsed this approach. In a major report issued in 1997, the Department of Health & Human Services' Office of Inspector General (OIG) concluded that using brokers could help control costs.²⁴ The OIG study found that, in addition to saving money, brokerages were also effective in controlling fraud and abuse by both providers and beneficiaries, and that they promoted the use of the least costly modes of transportation and providers.

Regional or statewide Medicaid transportation brokerages have been established or are being proposed in the following states: Arkansas, Florida, Georgia, Kentucky, Maryland, Massachusetts, Missouri, Oregon, Vermont and Washington. As gatekeepers, brokerages can operate effectively in either prepaid, managed care or traditional fee-for-service medical environments. Two examples of this approach are outlined below:

²⁴ Controlling Medicaid Non-Emergency Transportation Costs (OEI-04-95-00140), Office of Inspector General, DHHS, April 1997.

Washington State

Washington operates one of the most comprehensive brokerage operations in the nation. The state Medicaid agency has established 13 medical transportation service districts, and contracts with a network of regional transportation brokers to serve the entire state. Brokers receive an administrative fee of roughly \$1.70 per trip to coordinate the program, plus reimbursement for the direct trip costs.²⁵ Each broker assures that Medicaid recipients are transported to covered medical services by the most appropriate, least costly level of transportation.

Under the brokerage system, clients call brokers for rides. The broker verifies Medicaid eligibility, determines the medical necessity of each trip and that the recipient has no other way to reach medical care, and assigns the appropriate transportation provider. Depending on individual needs and trip destinations, brokers can utilize a variety of resources and payment systems, including mileage reimbursement, volunteer drivers, transit bus-passes, paratransit agencies, shared-ride taxis, and intercity carriers. Providers are reimbursed for each trip, based on an agreed-upon fee.

Brokerage agreements have been established with a variety of public and private entities, including local planning agencies, councils on aging and human service agencies, and several community transportation operators.²⁶ In addition to coordinating services and assigning trips to individual carriers, some

Medicaid brokers also operate as transportation providers within their districts.

As in other states, the Medicaid transportation program in Washington has grown dramatically. In the last six years, the number of medical trips almost quadrupled, rising from 485,000 in 1990, to 1.8 million in 1996. During the same period, annual NEMT expenditures grew from \$3 million to almost \$25 million, while the average cost per trip increased only modestly—from \$8.40 to \$13.53. It is also significant to note that public transit's share of all Medicaid trips provided has gone from 10% in 1990, to 40% last year.

Medicaid officials in Washington State credit the brokerage system with helping to control medical transportation costs while assuring needed access to health care for all Medicaid recipients. Both the quality and efficiency of transportation services has increased through utilization of the full range of providers within each region. They also claim that managing transportation this way has greatly helped to reduce fraud and abuse.²⁷ Because of its success in managing medical transportation, some in the state consider the brokerage model to be an effective structure for coordinating other client and public transportation services.

For additional information, contact Dottie Ford or Paul Meury, Medicaid Access Program, Medical Assistance Administration (MAA), Olympia, WA. Tel: 360/586-2598 or 360/664-2306.

²⁵ Analysis of Washington State Medical Assistance Administration Transportation Program, Medical Assistance Administration, 1997.

²⁶ Medical Assistance Administration Transportation Program, report by the Washington State Department of Social & Health Services, 1995.

²⁷ Interview with Patrick While and Dottie Ford, Medical Assistance Administration, Department of Social & Health Services, March 6, 1997.

Oregon

More than 80% of Oregon's Medicaid recipients are enrolled in the state's managed care program, known as the Oregon Health Plan. Non-emergency transportation has been "carved out" of the capitation rate paid to each local HMO. In most counties, Medicaid transportation is handled by local field offices of the Office of Medical Assistance Programs (OMAP). Those areas rely on a traditional fee-for-service reimbursement system, utilizing a network of volunteers and certified local transit providers. In the Portland area, however, all Medicaid transportation is coordinated by the regional transit authority, TRI-MET, which has established a regional brokerage.

TRI-MET's brokerage began in late-1994, following federal approval of the state's request for a 1915(b) waiver of freedom of choice requirements regarding medical transportation providers. The waiver was extended for an additional two years beginning in January 1997. TRI-MET, which has set up a centralized dispatching operation for the three-county area, receives requests for medical transportation, and assigns trips to more than 40 taxi and other contract providers.

Each provider operates on the basis of a separately-approved fare structure. Trips are assigned to the lowest cost provider for a particular trip. TRI-MET makes every effort to include smaller, private operators in its provider network. As Medicaid broker, TRI-MET also tries to maximize the use of its own fixed-route bus service to meet the needs of Medicaid clients. It is estimated that 60% of all Medicaid trips are provided by bus or light rail.²⁸ However, ADA paratransit and Medicaid

²⁸ Independent Assessment of Non-Emergency Medical Transportation Brokerage in the Tri-County Area, Jean Palmateer, Public Transit Section, Oregon Department of Transportation, May 15, 1996.

paratransit services are administered separately. TRI-MET General Manager Tom Walsh says he is interested in explore how the two specialized services could be better coordinated.²⁹

Both the state OMAP officials and the Oregon DOT researcher who evaluated the TRI-MET program consider the regional Medicaid brokerage to be an "unqualified success."³⁰ It is claimed that the brokerage has 1) resulted in an actual dollar savings of 15%—accommodating more rides at a lower cost; 2) increased access to medical services; and 3) helped to reduce service and billing abuses of the system. In addition, the very existence of the program is also seen as improving the delivery and quality of private transportation services within the region by raising awareness and encouraging the purchase of fully accessible vehicles. TRI-MET officials also seemed pleased, pointing to an increase in transit ridership and at least \$330,000 in Medicaid revenue generated last year from bus passes distributed to Medicaid recipients.

For additional information, contact Joan Frye, Office of Medical Assistance Programs (OMAP), Oregon Department of Human Resources, Salem, OR, 503/945-6493, or Nancy Thomas, ATP Programs Manager, TRI-MET, Portland, OR, 503/233-5715.

²⁹ Interview with Tom Walsh, TRI-MET, Portland, OR, January 23, 1997.

³⁰ Interview with Joan Frye, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, March 12, 1997.

Vermont

One of the oldest and most innovative Medicaid brokerages has been established in Vermont. Organized more than 10 years ago by Vermont's Office of Health Access, the Medicaid transportation program represents a unique partnership between state government, local community transportation providers and their state association. In cooperation with the Vermont Public Transportation Association (VPTA), the Office of Health Access has established a system of nonprofit brokerages to manage Medicaid transportation statewide.

The keys to success of Vermont's program include: 1) assuring universal access to medical services by supporting a statewide network of transportation providers; 2) fully utilizing volunteer drivers and other economical solutions; and 3) maximizing available state and federal resources by actively promoting participation by all existing public and community transportation providers. As a result, in Vermont today there is a seamless network of medical, human service and public transit services that operates in both the rural townships and villages, as well as in Burlington and the state capitol of Montpelier.

Under this unique Vermont arrangement, VPTA provides centralized coordination, management, and fiscal services to nine regional medical transportation brokers. Each brokerage is responsible for identifying volunteer drivers and local transportation providers; screening ride requests from eligible Medicaid recipients; and finding the most appropriate, cost effective and available transport for the Medicaid population in its own service area. Regional brokers receive an administrative cost-per-trip fee of \$3.65 for managing the system, and are reimbursed for transport services directly provided or subcontracted. Billing and reporting is handled centrally by

VPTA, which reimburses regional brokers out of prepaid fees received from the state Medicaid agency.

The results are impressive and substantial. In sharp contrast with many state programs, almost half of the Medicaid trips in Vermont this year will be provided by public transit systems. Community transportation agencies relying on volunteer drivers will provide an additional 30% of the medical trips.³¹ The projected 400,000 Medicaid trips are further broken down as follows: Bus - 47%, Volunteers - 28%, Taxi - 16%, Van - 1%, Hardship - 3%, and Other - 5%. The statewide average cost per direct trip reported F'96 was about \$6.00. However, there was considerable variation between regional brokers, ranging from a low of \$2.83 to a high of \$11.80.³²

For over a decade, Vermont's Medicaid agency has promoted a medical transportation vision that assures low income Vermonters in all corners of the state access to health services, while also strengthening the state's overall transit infrastructure. The program has enhanced mobility and livability for all the residents of the state, while not compromising its primary mission of assuring economical access to high quality medical services for all Medicaid recipients.

For additional information, contact Bob Butts, Office of Vermont Health Access, Waterbury, VT. Tel: 802/241-2880, or Patricia Crocker, Executive Director, Vermont Public Transportation Association (VPTA), White River Junction, VT. Tel: 802/296-3103.

³¹ 1997 Annual Report, Vermont Public Transportation Association

³² VPTA Table comparing administration and direct trip costs, 9/17/96.

ADMINISTRATIVE MANAGER MODEL

With increasing frequency, state Medicaid agencies are turning to in-house brokerages and experimenting with a variety of other new or modified administrative structures in order to better manage non-emergency transportation services and control costs. In some instances, specially-detailed Medicaid staff members are assigned as gatekeepers to monitor transportation providers and the utilization of services (Alabama, Louisiana & Mississippi). In others, other public agencies are enlisted to administer transportation services for Medicaid (Maryland, New York & Oregon). And in still others, private groups are contracted with to manage the medical transportation program (Idaho, Montana & New Mexico). It's too early to tell whether or not these new approaches are just stop-gap measures, or if they represent effective and sustainable tools for managing the NEMT program. The following are two examples of the model:

Maryland

In 1993, the State of Maryland launched a new and untried approach to providing non-emergency transportation services to Medicaid recipients. Each year, the state allocates specific funding to each jurisdiction in the form of *Human Service Contracts*. Local jurisdictions—usually through their departments of health—assume responsibility for managing medical transportation for Medicaid recipients in their areas. Some cities and counties become directly involved in overseeing Medicaid transportation, actually operating as brokers by arranging trips and monitoring operations.

Maryland's system was instituted in 1993 because of failures to manage medical transportation services effectively, which

resulted in skyrocketing costs and widespread abuses. Between 1988 and 1992, non-emergency transportation payments increased 241%, from \$5.6 million to \$19.1 million.³³ Faced with a serious statewide revenue shortfall in 1992, the state eliminated the Medical Assistance program and drastically reduced funding. The current "safety net" system of Human Service Contracts was substituted in order to assure the provision of essential transportation services to Medicaid recipients. Funding is expected to reach \$13.1 million in 1997. As Maryland's Health Secretary sees it, "we reduced our budget by 50%, eliminated fraud and abuse and now have a very efficient transportation service."³⁴

Human Service Contracts are flexible. State funds are used to:

- Encourage new transportation resources in areas where they are limited;
- Screen calls from recipients for possible recipient conditions that impair their ability to use public transportation or alternatives; and
- Provide transport in the most efficient and cost-effective manner possible by using the least expensive, appropriate providers, including volunteers and nonprofit agencies.

For additional information, contact James Glover, Medical Care Policy Administration, Maryland Department of Health & Mental Hygiene, Baltimore, MD 21201. Tel: 410/767-1475.

³³ Medical Assistance Transportation Program, report by the Maryland Department of Health and Mental Hygiene, 1997.

³⁴ Letter dated July 3, 1997, Martin P. Wasserman, Secretary, Maryland Department of Health and Mental Hygiene.

Idaho

Several states use outside contractors to manage their Medicaid transportation programs. Beginning in 1995, Idaho's Bureau of Medicaid Policy and Reimbursement switched from a regional Medicaid transportation program that had been staffed internally, to a statewide administrative manager system. Integrated Transport Management (ITM) was awarded a multi-year contract to implement the statewide, coordinated system.

ITM handles all Medicaid trip requests over 800 phone lines that are answered at the company's headquarters in Mesa, Arizona. In addition, the management company verifies eligibility, obtains trip authorization, and refers eligible recipients to approved medical transportation providers. ITM also is responsible for handling mileage reimbursement arrangements for Medicaid recipients, volunteer drivers, and/or family members who transport clients to health services.

As the statewide program manager, ITM receives an administrative fee for handling Medicaid trip requests. The contract also includes certain incentives designed to control and reduce overall NEMT expenditures. However, unlike full brokerage operations, ITM does not reimburse individual transportation providers. They are paid directly by the state Medicaid agency on a fee-for-service basis. ITM's chief executive, who operates similar programs in Arizona, Kentucky, Montana and New Mexico, says that ITM would be interested in entering into capitated risk contracts with states and Medicaid HMOs as soon as more accurate information about utilization and trip costs was available.³⁵

³⁵ Interview with James Murnane, Integrated Transport Management, Mesa, AZ, September 26, 1997.

For more information, contact Sharron Knutson, Bureau of Medicaid Policy & Reimbursement, Department of Health and Welfare, Boise, ID. Tel: 208/334-5795, or James Murnane, Integrated Transport Management, Inc., Mesa, AZ. Tel: 602/835-9580.

CAPITATED TRANSPORTATION SERVICES MODEL

The most radical change in the financing of medical transportation is happening in states where NEMT responsibility has been assigned to managed care organizations (MCOs). About half the states now have some capitated transportation, but generally only a small portion of their Medicaid recipients are covered by such agreements. New Mexico and Kentucky have recently begun experimenting with capitated service by transferring NEMT responsibilities to some of the HMOs participating in the states' Medicaid programs. However, in only four states—Arizona, Missouri, Rhode Island and Tennessee—is there any significant experience with this approach.

Under the capitated model, non-emergency medical transportation is "carved in" to Medicaid managed care contracts, just as dental care, mental health and other medical services are. The projected costs of providing transportation benefits to Medicaid enrollees are built into the monthly capitated rate paid to the MCO. In effect, the health plan assumes responsibility for providing all medically-necessary transportation to its Medicaid enrollees for a fixed monthly fee. The following narrative summaries represent examples of the most effective and successful practices utilizing this approach.

Rhode Island

A unique approach has been developed under Rhode Island's RItE Care program, where a local public transit agency has statewide responsibility for handling all Medicaid transportation. Under this capitated arrangement, the Rhode Island Public Transit Authority (RIPTA) provides both regular bus and paratransit service to Medicaid recipients.

Since 1994, 75,000 of the state's nearly 114,000 Medicaid recipients have been enrolled in one of five statewide managed care plans participating in the RItE Care program. Each plan is responsible for providing basic medical and hospital coverage for their members, plus assuring that all Medicaid eligible members have transportation access to medical services and facilities. The plans, in turn, contract with RIPTA, which is based in Providence, to provide all non-emergency transportation to their Medicaid clients. Under a capitated rate agreement, each of the five health plans pays \$2.25 per enrollee/per month to RIPTA for medical transportation services.³⁶ Ambulance and urgent transportation services are handled separately by the health plans.

RIPTA offers two basic types of transportation services to RItE Care members: fixed-route bus service and paratransit van or taxis service. One of the keys to the success of the program is that over 90% of the state's Medicaid population live within 1/2 mile of an existing bus route and can be accommodated through RIPTA's regularly-scheduled service. Another seems to be flexibility. When asked how the transit system handles a group of RItE Care enrollees in neighborhoods currently without bus service, agency officials respond that they simply

³⁶ 1996 RItE Care Transportation Service Agreement, RI Department of Human Services.

establish a new route to meet the identified needs.³⁷ Enrollees who cannot be served with regular bus service are assigned to the transit authority's RIDES program. RIDES, which was initially established as RIPTA's ADA paratransit service, provides 24-hour, door-to-door service anywhere in the state through agreements with local taxis and paratransit operators.³⁸

Because of the heavy reliance on scheduled, fixed route service, RIPTA offers and encourages the use of "Free Bus Passes" to all eligible RItE Care member families. The passes allow participants unlimited use of RIPTA's bus services. Paratransit service is restricted to medically-necessary trips, and must be authorized by each health plan in advance. As is the case with most other state Medicaid managed care programs, Rhode Island's RItE Care program does not cover disabled persons receiving SSI benefits or low-income elders. Their medical transportation is provided by local senior centers, operating on a fee-for-service basis under an agreement between the state Medicaid agency and the Department of Elderly Affairs.

State Medicaid officials consider the RItE Care medical transportation service, which was first tested as a demonstration program to gather utilization data and experience, a huge success. In fact, from the standpoints of virtually everyone—the state, Medicaid enrollees and the public transit system—the initiative is considered a "win-win-win" opportunity.³⁹

³⁷ Interview with Henry Kinch, RIPTA, October 1996.

³⁸ RItE Care Transportation Program, Report of the Office of Managed Care, Rhode Island Department of Human Services, November 30, 1994.

³⁹ Interview with Ronald W. Ek and staff, Office of Managed Care, RI Department of Human Services, October 1996.

The state has turned over most of its responsibility for Medicaid transportation to the five participating health plans, while "capping" transportation expenditures and outlays. Medicaid recipients now participate in RIPTA's simplified, one-stop transportation service. Most receive free bus passes, enabling them to use the entire public transit system and access other community services. For RIPTA, the program appears to be a financial success. The transit agency also has benefited, receiving almost \$2 million annually through RiTe Care—with most medical trips taken on regularly schedule bus routes.

For additional information, contact Ronald Ek, Office of Managed Care, Cranston, RI. Tel: 401/464-3113, or Henry Kinch, Rhode Island Public Transit Authority (RIPTA), Providence, RI. Tel: 401/784-9560.

Missouri

When Missouri implemented its Medicaid managed care program in 1995, the state required participating health plans in the St. Louis area to assume responsibility for all medically necessary transportation. Each of the six HMOs serving St. Louis' 150,000 Medicaid recipients have contracted with a private transportation provider—Medical Transportation Management, Inc. (MTM). According to Missouri's Medicaid Director, hiring one vendor to manage all non-emergency transportation in the St. Louis area "makes sense" by allowing local health plans to "pool resources with just one contractor." State Medicaid officials saw the approach as a way of combating the "ills" of an uncoordinated, fee-for-service medical transportation system.⁴⁰

⁴⁰"Capitated Transportation Service Eases Headaches for Members, Plans," article in *Medicaid Managed Care Strategies*, newsletter of St. Anthony's Publishing Company, August 1996.

MTM was founded by Peg and Lynn Griswold. Lynn was the former director of contracting for Blue Cross of Missouri's HMO. Their objective in setting up the company was to relieve individual HMOs of the administrative problems of getting patients to appointments and coordinating medical trips. MTM serves as a broker or gatekeeper for transportation services offered by participating HMOs. It contracts with almost 40 local transportation providers, including local taxis and nonprofit groups like CTAA-member agency OATS in Columbia.

Currently, all MTM subcontractors are reimbursed on a per trip basis, but Lynn Griswold noted that he envisions entering into capitated contracts with transportation providers in the future. Such an arrangement would both help "share the risk" and provide more incentives to economize.⁴¹ Dispatching for medical transportation providers is handled centrally by MTM through a subcontract with a local dispatching firm.

MTM operates both full-risk and partially-capitated contracts with managed care plans in the St. Louis area. Under the partially-capitated arrangement, MTM is paid a fixed administrative fee, based on the number enrollees in the plan. Actual costs of medical trips are reimbursed on a fee-for-service basis. MTM's capitation rate for this administrative service is 40¢ per member, per month. Under its fully-capitated agreements, MTM receives a rate of \$1.50 per member, per month (pm/pm), which covers both administrative and direct operating costs. In 1996, MTM's average cost per trip was \$12.⁴²

⁴¹ Telephone interview with Lynn Griswold, Medical Transportation Management, Inc., April 14, 1997.

⁴² Ibid

According to MTM's Lynn Griswold, after looking at medical transportation usage in other states, he initially estimated that 10% of Missouri's Medicaid population would use NEMT services. But after the first 10 months of operation, it became clear that the projected utilization rate was too high, and could be safely lowered to about 4%. Now that MTM has the additional experience, Griswold says he would like to convert all of his Medicaid operation to fully-capitated contracts.⁴³

For more information, contact the Division of Medical Services, Missouri Department of Social Services, Jefferson City, MO. Tel: 314/751-6922, or Lynn Griswold, Medical Transportation Management, Inc., Lake St. Louis, MO. Tel: 314/561-5686.

Arizona

In Arizona, nearly all Medicaid recipients are assigned to a managed care organization participating in the state's "AHCCCS" program (Arizona Health Care Cost Containment System). All participating HMOs must provide transportation services to their Medicaid members. Two of the participating MCOs are public agencies—Maricopa County Health Plan and Pima Health Care System—the rest are private.

The Pima Health Plan was established in 1982 to assure that low income individuals and families in Tucson and Pima County had access to basic medical services. About 70% of its more than 16,000 members are Medicaid recipients. Non-emergency transportation services are available to all PHP

⁴³ Note: In October 1997, Griswold reported that MTM was awarded a contract by the Missouri Medicaid agency to operate a non-emergency transportation brokerage serving seven rural regions of the state.

members. The transportation program is run by county staff working for the Pima Health Care System.⁴⁴

The Pima Health Plan awards competitive contracts to transportation providers in each of several service categories — wheelchair, taxi, van, public transit and transportation from outlying or remote areas. It is estimated that between 10%-20% of PHP members currently utilize the medical transportation service, which provides about 1,200-1,500 medical trips per month. Transportation providers are reimbursed on a fee-for-service basis. According to PHP administrators, NEMT expenditures account for about 2% of the health plan's budget. That amounts to roughly \$1 million annually, or the equivalent of \$3.25 per member, per month.⁴⁵

Plan administrators seem generally quite satisfied with the way that the medical transportation program is working. However, they point out that, as a public agency, the Pima Health Care System is required to accept the lowest bidder on contracts, making it difficult to drop poor quality and undependable vendors. They also seem interested in experimenting with optional arrangements that might streamline or simplify current operations, including issuing travel vouchers to all members and/or capitating transportation contracts. However, it is not felt that any of the providers are prepared to enter into or handle capitation risk contracts.

For additional information, contact Silver Darmer, Pima Health Care System, Tucson, AZ. Tel: 520/512-5614.

⁴⁴ Interview with Silver Darmer, Pima Health Care System, 4/29/97.

⁴⁵ Pima Health Care System Ambulatory Income Statement, 2/12/97.

Least Effective Approaches

LACK OF COORDINATION

Alabama: In 1995, Medicaid recipients sued Alabama, charging that the state was ignoring federal obligation to provide medical transportation. Although the plaintiffs eventually won, implementing the court-ordered transportation service has been controversial. The concern is that the transportation plan now being implemented by the state concentrates on limiting fraud and abuse, while it ignores the needs of recipients and undermines public transit providers.⁴⁶

As the last state to comply with federal Medicaid transportation requirements, Alabama had an opportunity to learn from other states about the economical and equitable management of its program. Instead of seeking to integrate medical transportation with other transit resources, Alabama appears to have adopted a system that is administratively burdensome and designed mainly to control services and expenditures.

To get a ride anywhere in the state, Medicaid recipients must call a central toll-free number. Operators verify that callers are eligible for transportation assistance and that they have legitimate medical appointments. (Usually, recipients are put on hold, while doctors are called to verify appointments.) Once trips have been confirmed, the Alabama Medicaid Agency issues a voucher and requests a local bank to cut a check for \$3 or \$5, depending on the length of the trip. Checks are made out to individuals, and may be picked up in person or mailed.

⁴⁶ "Locking Out Public Transportation", article in July 1997 issue of *Community Transportation* magazine, CTAA.

Many community transit operators think that the state is wasting money. First, Medicaid pays 90¢ to process each voucher. They also point out that existing transit fares are in the \$1 and \$2 range. "We tried to tell them [Alabama Medicaid officials] from the beginning that we could do it for less," one local provider said, "but we got nowhere."⁴⁷

Contrasts between Alabama's Medicaid transportation program and other states are striking. For example, Alabama's Medicaid population is five times greater than Vermont's, however, Vermont spends one and a half times more on Medicaid transportation services. By contrast, Maryland, which has roughly the same size Medicaid population, spends 6 and 1/2 times more on medical transportation than Alabama. Alabama, which spends one-tenth of 1% of its Medicaid budget on transportation, ranks 46th in the nation. (See State Profiles)

Instead of seeking to use its Medicaid dollars to help complement other state transit investments, the Alabama Medicaid Agency has chosen to go it alone. Medicaid adamantly refuses to coordinate with public transit systems. Transit accounts for only 5% of Medicaid rides in Alabama, compared to 2% nationally. State officials see it another way: "The Alabama Medicaid Agency is quite pleased with the design of its non-emergency transportation system. It's cost-effective to the state and we have no interest in contracting with transportation providers that will run the tab way up."⁴⁸

For additional information, contact Andy Beckham, Alabama Medicaid Agency, Montgomery, AL. Tel: 334-242-5151.

⁴⁷ Doris Tidwell, CCTM, transportation program director, North West Alabama Council of Local Governments.

⁴⁸ Terri Beasley, director of Beneficiary Support Division, Alabama Medicaid Agency.

LOCAL OPERATIONS VS. CENTRALIZED SYSTEM

New York: New York State accounts for almost one-third of the \$1.2 billion that was spent nationally last year on non-emergency medical transportation. By comparison, New York's Medicaid population represented approximately 12% of the total number of recipients nationwide. For these reasons alone, how New York manages or mismanages its NEMT program is of substantial national interest.

Non-emergency Medicaid transportation in New York State is a highly localized operation that is operated differently in each of 57 counties and the city of New York. This approach has resulted in a system that lacks uniformity, resulting in divided responsibilities and fragmented services. While Medicaid transportation is big business, in New York, very little statewide data is available and individual performance is not being effectively monitored. There are complaints that no one is "minding the store", which, it is claimed, leaves the door open to fraud and abuse.

In a scathing 1996 report on the state Medicaid transportation system, respected consumer advocates conclude that the entire Medicaid program is "out of control", claiming that genuine reform could save taxpayers at least \$40 million annually.⁴⁹ Specifically, NEMT in New York is characterized as follows:

- **Failure to coordinate transportation services:** The lack of any centralized system, including administrative structures such as brokerages, results in costly duplication of services and excessively lengthy trips.

⁴⁹ Wasting Medicaid. A report by Mark Green, Public Advocate for the City of New York, November 1996.

- **Reliance on high-cost providers:** The absence of any requirement to use the least costly medical transportation options results in Medicaid typically paying \$30 and \$60 to medical ambulance companies for trips that could have been provided at 1/10th the cost by public transit or even at 1/2 the price on taxis.
- **Lack of Competition:** The failure to uniformly require competitively bid Medicaid transportation service contracts results in unnecessarily high fees, excessive profits, and loss of volume discounts.

High Medicaid trip costs and NEMT expenditures per capita are cited as examples of this wide-open and largely unmanaged system. In fact, compared with CTAA survey results from nine other industrial and populous states, the New York program is the most costly.⁵⁰ On a per capita basis, New York spends almost \$95 on NEMT services for each of its 3.8 million Medicaid recipients. That's almost three times the average among the other nine states of roughly \$32 per recipient. Because of its relatively high per trip costs, New York ranked the highest in terms of the percentage of its overall Medicaid budget allocated to non-emergency transportation among the 10 states. (See State Profiles in Appendix.)

For additional information, contact Tim Perry-Coon, Office of Medicaid Management, NY Department of Health, Albany, NY. Tel: 518/473-5564, or Mark Green, Public Advocate for the City of New York, NY. Tel: 212/669-4723.

⁵⁰ California, Florida, Illinois, Massachusetts, Michigan, New Jersey, Ohio, Pennsylvania and Texas.

Conclusion and Recommendations

SUMMARY

For millions of older, disabled and poor Americans, Medicaid transportation has been a lifeline to basic medical services and good health generally. And, to an increasing number of public and community transit agencies, Medicaid reimbursements make up a major part of their operating budgets. But historically, non-emergency transportation historically has barely been a blip on the radar screens of federal and most state Medicaid agencies—except when there's been a scandal.

This seeming paradox involving official neglect of a critically important public service reflects the so-called "1% problem" in government. While it represents the only way some people can get to doctors, and although it has become an increasing important part of the funding mix that supports community transit services, non-emergency transportation represents less than 1% of the national Medicaid budget and those of most states. Unlike skyrocketing long-term care and hospitalization cost, transportation is not where Medicaid is hemorrhaging. Consequently, the HCFA and most state Medicaid agencies devote only scant attention to the issue.

However, to paraphrase former Senator Everett Dirksen, "a billion dollars here, a billion there, and pretty soon you're talking about real money". State and federal agencies this year will spend well over \$1 billion on non-emergency Medicaid transportation services. Almost all of it will be spent in a policy vacuum. At the federal level, the problem is similar to what we found in New York, "nobody is minding the store." Over the years, HCFA has provided virtually no leadership to states in how to set up and manage economical but effective

medical access programs for Medicaid recipients. Numerous reports over the past decade by the Inspector General citing major waste, duplication and abuse in states' handling of the NEMT program have largely been ignored by the Feds and have not resulted to any meaningful reform.

As reflected in this manual, some states have begun to take seriously their responsibility to assure access to Medicaid services, and are developing efficient and innovative ways of managing their medical transportation programs. But most state Medicaid agencies today continue to rely on a combination of skimpy mileage reimbursement schemes and a patchwork of fee-for-service providers to transport the poorest of the poor to essential medical services. Belatedly, there has begun to be some sharing of information and experiences among state administrators of Medicaid transportation programs, but the National Association of State Medicaid Directors, for example, has not approached the issue in a systematic or sustained fashion.

The rapid shift to Medicaid managed care by states offers both risks and opportunities. On the one hand, just at time when a growing number of states have recognized and accepted their responsibilities to assure access to Medicaid services, managed care could offer some states an opportunity to wash their hands of an often thorny problem by turning over their responsibility to local health plans. Indeed, there is some evidence that that is happening. In states in which transportation has been "carved into" Medicaid capitation agreements, we find there is little concern about how NEMT services are provided or at what cost. In Arizona and Tennessee, the two states in which all Medicaid transportation has been turned over to HMOs, state Medicaid agencies were unable to provide any information about the level of transportation services

available to Medicaid enrollees, their cost or their adequacy and responsiveness to member needs. CTAA researchers were simply told that the contracted health plans were now responsible for all transportation, not the state.

At the other extreme, it is quite apparent from the Rite Care model in Rhode Island, and some of the experiences emerging in Missouri and other states, that Medicaid managed care can offer significant mobility benefits to Medicaid recipients and to the community transportation industry as well. The models and approaches that are emerging in a few states underscore the potential for positive change that managed care brings to the medical transportation field.

But change of this magnitude brings with it a number of challenges, especially for the network of community transportation agencies who have pioneered in this field. Funding relationships with state Medicaid agencies that had been carefully nurtured over the years are suddenly altered as responsibility for Medicaid transportation shifts to private HMOs. Transit's customers are changing as purchasing decisions about medical transportation shift from state Medicaid officials to local health plan managers. Medicaid transportation, often the exclusive domain of nonprofit organizations, has now become a big and growing commercial business, creating competition where there had been none, attracting serious, private sector competitors, and bringing about new, bottom-line oriented service models.

But there is no inherent reason why these changes and challenges should be threatening to the community transportation industry whose entire history is one of innovation and adapting change, of responding to challenges and obstacles creatively, and of creating efficient ways of

delivering special mobility services to people. Those skills, the years of experience and the reservoir of community support, particularly when coupled with a record of quality service and commitment to providing value to customers, are the foundations on which community transit operators can build an effective and collective response to these current challenges. And while operators should approach this evolving medical transportation terrain soberly and thoughtfully, they need to recognize their strengths and seize on these developments as an opportunity to advance the movement and to build a comprehensive national mobility agenda that includes medical and other essential transportation services.

RECOMMENDATIONS

Developing effective Medicaid transportation policies and practices will require on-going collaboration among three sectors—1) public officials and Medicaid administrators; 2) medical transportation providers and community leaders; and 3) Medicaid recipients themselves or people who can advocate on their behalf. At the national level, these groups are represented by HCFA's Medicaid Bureau; CTAA; and policy advocates such as the Center for Health Care Strategies, Families USA, the Robert Wood Johnson Foundation and the Kaiser Commission on the Future of Medicaid. By coordinating their efforts, these groups have a unique opportunity to influence how Medicaid transportation will evolve over the next few years. In the immediate future, there are a number of actions that can and should be taken by these key players:

Health Care Finance Administration (HCFA):

HCFA needs to recognize and institutionalize the understanding that transportation is an essential Medicaid

service and provide leadership and direction to states on this issue. Specifically, we recommend the following:

- Develop policies and procedures requiring effective state management of all non-emergency Medicaid transportation services, including fee-for-service and capitated models.
- Provide guidance and assistance to state Medicaid agencies in developing appropriate NEMT programs, including establishing brokerages and securing the active participation of public transit, community transportation and other low cost medical transportation providers; and
- Develop enforceable procedures for guaranteeing the Medicaid recipients have meaningful access to necessary medical services under both managed care and traditional fee-for-service environments.

Community Transportation Association of America:

As the recognized leader and national spokesman for the community transit industry, CTAA should take an active role in representing the interests of its members and assisting providers to prepare for the changes in the medical transportation field. Specifically, that role should include the following:

- Provide information, outreach and training to community transit and other medical transportation providers on all aspects of managed care, including estimating costs and utilization of services, risk management, and negotiating capitated service agreements;
- Develop and promote industry service standards to assure delivery of safe, economical and professional medical transportation; and

- Work with managed care industry leadership and state Medicaid agencies to develop educational/informational programs designed to improve understanding of Medicaid transportation issues, requirements and successful models.

Advocacy Community:

As the only effective voice for the poor and medically underserved, the philanthropic and advocacy community needs to become more active in addressing mobility and access issues among Medicaid populations. This can be done effectively through the following initiatives:

- Promote a NEMT Bill of Rights, along with a national education campaign designed to inform Medicaid recipients of their entitlement to needed transportation services;
- Sponsor workshops, seminars and other educational forums that bring together managed care practitioners, state Medicaid officials, consumers and transportation providers to explore effective options and strategies for assuring access to care; and
- Continue to support policy-oriented research and monitoring initiatives that increase accountability of state and federal Medicaid agencies, managed care organizations and other private providers.

Appendix

- Profile of State Medicaid Transportation Programs
- Managed Care Terms
- State Medicaid Agency Survey Form

COMMUNITY TRANSPORTATION ASSOCIATION OF AMERICA (CTAA)
50-State Profile of Medicaid Transportation Programs

State	State Medicaid Program							Non-Emergency Transportation					Service Characteristics				
	Medicaid Population	% of State Population	Medicaid Expenditures	Per Capita Expenditures	Federal Match	Managed Care Enrollment	NEMT Carved In	NEMT Expenditures	% of State Budget	NEMT Per Recipient	Cost Per Trip	Trips Per Recipient	Brokerage/Coordinated	NEMT as Medical Service	Utilization Rate	% Public Transit	
Alabama	498,006	12%	\$ 2,239.8	\$ 4,498	69%	11%		\$ 2,000,000	0.1%	\$ 4.02			X		13%	5%	
Alaska	87,550	14%	\$ 407.7	\$ 4,657	50%	0%		\$ 14,036,000	3.4%	\$ 160.32				X	NA	0%	
Arizona	460,802	11%	\$ 1,894.6	\$ 4,112	65%	93%	X	NA	NA	NA				X	NA	NA	
Arkansas	275,115	11%	\$ 1,330.1	\$ 4,835	73%	52%		\$ 9,440,532	0.1%	\$ 34.31	\$ 33.77	1.0	X	X	8%	3%	
California	2,400,000	8%	\$ 19,529.1	\$ 8,137	51%	79%	X	\$ 97,645,690	0.5%	\$ 40.69				X	<10%	NA	
Colorado	259,949	7%	\$ 1,607.6	\$ 6,184	52%	80%		\$ 6,526,000	0.4%	\$ 25.10				X	NA	NA	
Connecticut	311,884	10%	\$ 2,788.4	\$ 8,941	50%	61%	X	\$ 39,037,516	1.4%	\$ 125.17				X	NA	NA	
Delaware	72,329	10%	\$ 446.4	\$ 6,172	50%	75%		\$ 2,500,000	0.6%	\$ 34.56				X	<10%	13%	
DC	128,360	23%	\$ 1,067.2	\$ 8,314	50%	61%		\$ 15,770,603	1.5%	\$ 122.86	\$ 43.83	2.8		X	>15%	1%	
Florida	1,454,932	10%	\$ 6,437.1	\$ 4,424	56%	27%	X	\$ 63,884,544	1.0%	\$ 43.91	\$ 7.67	5.7	X	X	18%	NA	
Georgia	975,000	14%	\$ 3,733.2	\$ 3,829	61%	34%		\$ 55,997,820	1.5%	\$ 57.43				X	<10%	1%	
Hawaii	184,350	15%	\$ 623.9	\$ 3,384	50%	71%	X	\$ 15,598,300	2.5%	\$ 84.61				X	3%	0%	
Idaho	82,825	7%	\$ 422.5	\$ 5,101	70%	40%		\$ 3,090,565	0.7%	\$ 37.31				X	NA	NA	
Illinois	1,399,372	12%	\$ 7,247.5	\$ 5,179	50%	13%	X	\$ 31,000,000	0.4%	\$ 22.15				X	NA	NA	
Indiana	604,342	10%	\$ 2,909.3	\$ 4,814	61%	22%	X	\$ 22,123,000	0.8%	\$ 36.61	\$ 12.14	3.0		X	17%	NA	
Iowa	224,068	8%	\$ 1,325.1	\$ 5,914	64%	42%		\$ 3,211,243	0.2%	\$ 14.33					<10%	NA	
Kansas	142,213	6%	\$ 1,163.5	\$ 8,181	60%	50%	X	\$ 3,200,000	0.3%	\$ 22.50				X	<10%	NA	
Kentucky	531,131	14%	\$ 2,594.8	\$ 4,885	70%	54%	X	\$ 38,921,000	1.5%	\$ 73.28				X	<10%	19%	
Louisiana	656,929	15%	\$ 3,172.9	\$ 4,830	70%	7%		\$ 11,500,000	0.4%	\$ 17.51	\$ 36.72	0.5	X	X	NA	5%	
Maine	182,081	15%	\$ 1,109.8	\$ 6,095	66%	9%		\$ 12,675,983	1.1%	\$ 69.62				X	NA	50%	
Maryland	450,000	9%	\$ 2,951.8	\$ 6,560	50%	75%		\$ 13,100,000	0.4%	\$ 29.11				X	>15%	NA	
Mass.	660,000	11%	\$ 5,100.6	\$ 7,728	50%	61%		\$ 15,000,000	0.3%	\$ 22.73				X	<10%	45%	
Michigan	1,148,115	12%	\$ 6,056.8	\$ 5,275	54%	68%	X	\$ 8,400,000	0.1%	\$ 7.32					NA	NA	
Minnesota	477,000	10%	\$ 3,122.3	\$ 6,546	52%	33%	X	\$ 8,989,000	0.3%	\$ 18.84					NA	NA	
Mississippi	543,560	20%	\$ 1,775.0	\$ 3,266	77%	15%	X	\$ 4,437,560	0.3%	\$ 8.16				X	<10%	0%	
Missouri	587,322	11%	\$ 3,184.2	\$ 5,422	61%	45%	X	\$ 10,571,796	0.3%	\$ 18.00				X	XX	<10%	NA
Montana	79,000	9%	\$ 440.7	\$ 5,578	71%	2%		\$ 1,353,000	0.3%	\$ 17.13				X	X	NA	NA
Nebraska	144,115	9%	\$ 824.5	\$ 5,721	61%	26%	X	\$ 2,200,000	0.3%	\$ 15.27	\$ 4.85	3.1		X	<10%	NA	

COMMUNITY TRANSPORTATION ASSOCIATION OF AMERICA (CTAA)
50-State Profile of Medicaid Transportation Programs

State	State Medicaid Program						Non-Emergency Transportation						Service Characteristics			
	Medicaid Population	% of State Population	Medicaid Expenditures	Per Capita Expenditures	Federal Match	Managed Care Enrollment	NEMT Carved In	NEMT Expenditures	% of State Budget	NEMT Per Recipient	Cost Per Trip	Trips Per Recipient	Brokerage/Coordinated	NEMT as Medical Service	Utilization Rate	% Public Transit
Nevada	99,683	7%	\$ 532.4	\$ 5,341	50%	27%		\$ 1,157,371	0.2%	\$ 11.61				XX	NA	19%
New Hampshire	78,666	7%	\$ 755.4	\$ 9,603	50%	12%	X	\$ 1,888,435	0.2%	\$ 24.01				XX	NA	NA
New Jersey	736,976	9%	\$ 5,783.9	\$ 7,848	50%	52%	X	\$ 69,407,004	1.2%	\$ 94.18				XX	NA	NA
New Mexico	250,000	15%	\$ 1,084.8	\$ 4,339	73%	44%	X	\$ 12,192,827	1.1%	\$ 48.77				X	<10%	0%
New York	3,800,000	21%	\$ 30,000.0	\$ 7,895	50%	17%	X	\$ 360,000,000	1.2%	\$ 94.74	\$ 26.67	3.6		XX	9%	NA
North Carolina	818,364	11%	\$ 4,751.1	\$ 5,806	63%	37%	NA	\$ 9,502,159	0.2%	\$ 11.61				XX	NA	NA
North Dakota	45,000	7%	\$ 336.8	\$ 7,484	70%	57%	X	\$ 786,694	0.2%	\$ 17.48				X	<10%	0%
Ohio	1,600,000	14%	\$ 6,754.2	\$ 4,221	58%	22%	X	\$ 38,500,000	0.6%	\$ 24.06				X	NA	NA
Oklahoma	476,719	15%	\$ 1,311.1	\$ 2,750	71%	20%	X	\$ 3,719,928	0.3%	\$ 7.80				XX	<10%	5%
Oregon	368,082	12%	\$ 1,690.0	\$ 4,591	62%	80%		\$ 7,800,000	0.5%	\$ 21.19	\$ 8.91	2.4	X	X	NA	7%
Pennsylvania	1,478,117	12%	\$ 9,035.9	\$ 6,113	53%	45%		\$ 33,100,000	0.4%	\$ 22.39	\$ 7.36	3.0	X		<10%	32%
Rhode Island	113,891	12%	\$ 939.7	\$ 8,251	53%	63%	X	\$ 1,926,909	0.2%	\$ 16.92	\$ 0.87	19.6	X	X	20%	99%
South Carolina	390,558	11%	\$ 2,207.0	\$ 5,651	70%	1%		\$ 20,115,721	0.9%	\$ 51.51	\$ 22.27	2.3		X	<10%	40%
South Dakota	59,322	8%	\$ 336.8	\$ 5,677	68%	69%		\$ 924,847	0.3%	\$ 15.59				X	NA	NA
Tennessee	842,875	16%	\$ 3,740.6	\$ 4,438	63%	100%	X	NA	NA	NA				X	NA	NA
Texas	2,571,547	14%	\$ 10,274.2	\$ 3,995	62%	11%		\$ 28,767,620	0.3%	\$ 11.19				X	3%	26%
Utah	130,000	7%	\$ 669.7	\$ 5,152	73%	68%	X	\$ 1,175,693	0.2%	\$ 9.04	\$ 27.52	0.3		X	NA	50%
Vermont	101,000	17%	\$ 398.5	\$ 3,946	51%	0%		\$ 3,517,500	0.9%	\$ 34.83	\$ 9.32	3.7	X		NA	46%
Virginia	522,000	8%	\$ 2,391.4	\$ 4,581	52%	65%	X	\$ 25,176,000	1.1%	\$ 48.23				X	13%	2%
Washington	749,982	14%	\$ 3,368.0	\$ 4,491	52%	59%		\$ 24,706,469	0.7%	\$ 32.94	\$ 13.33	2.5	X		NA	40%
West Virginia	300,382	16%	\$ 1,316.9	\$ 4,384	74%	15%		\$ 5,757,682	0.4%	\$ 19.17				X	NA	NA
Wisconsin	427,571	8%	\$ 2,821.0	\$ 6,598	59%	48%	X	\$ 36,616,226	1.3%	\$ 85.64				XX	NA	NA
Wyoming	34,500	7%	\$ 217.4	\$ 6,301	63%	0%	NA	\$ 74,082	0.03%	\$ 2.15					<10%	6%
Nationwide	31,015,585	12%	\$ 176,223.2	\$ 5,682		24%		\$ 1,199,023,319	0.7%	\$ 38.66	\$ 16.14	3.5				20%

Managed Care Terms

Appendix Item No. 2

AFDC - Aid to Families with Dependent Children: A federally-funded, state-administered public assistance program for families with children. Family must have income below a defined poverty line.

Brokerage: An entity that manages the use of medical transportation resources (usually on a regional level) and coordinates utilization of transportation services and providers. (See "Gatekeeper".)

Capitation: Payment method for health care and related services in which provider is paid a fixed, monthly fee for each enrollee regardless of the actual services provided.

Capitation Rate: The actual fee paid to health care and related service providers for each enrollee per month.

Carving In/Out Services: Practice of including or excluding certain services from managed health care plans. For instance, non-emergency transportation services may be "carved in" under certain plans, but "carved out" or omitted from others.

Covered Services: Medically necessary services that are specifically included under individual health plan.

FFS - Fee-For-Service: Payment method for health care and related services in which provider is paid a specific amount each time a covered service is provided.

Gatekeeper: An entity under managed care arrangements that controls utilization of services and refers enrollees to service providers.

Health Plans: Term frequently used to describe program of care offered by HMOs, MCOs and other provider groups.

HMO - Health Maintenance Organization: An entity that provides comprehensive health care services to a specified group of enrollees within a geographic area. The HMO is paid at a fixed, capitated rate based on the number of enrollees.

Managed Care: A health care system in which access to and utilization of medical services are managed or controlled by a primary care provider or other gatekeeper.

MCO - Managed Care Organization: An entity that assumes the risk and responsibility for arranging health care services for a specific population.

Medicaid: A state-run health care program with federal matching funds that entitles eligible low income, elderly and disabled individuals to medical care and access to services, including non-emergency medical transportation.

Medicare: A federally sponsored health insurance program that pays for certain hospital and physician care to individuals age 65 and older, and some younger persons who are covered under Social Security benefits.

Medically Necessary Services: Services that are reasonably calculated to diagnose, correct, cure, alleviate or prevent the worsening of conditions, and for which is no other equally effective or substantially less costly course of treatment suitable to a member's need.

PCCM - Primary Care Case Management: A program that allows states to contract directly with primary care providers (PCPs) who provide and/or coordinate medical services to Medicaid recipients enrolled in their program.

PCP - Primary Care Provider: A designated provider who has responsibility for supervising, coordinating and providing primary health care, including referring patients to specialists and maintaining continuity of care.

Physician Incentive Plan: Compensation arrangement that may have the effect of reducing or limiting services to members enrolled in managed care program.

PMPM - Per Member, Per Month: Usual basis for determining prepaid capitation rate. Rate based on monthly payment for each enrollee.

PPO - Preferred Provider Organization: A managed care arrangement by a group of hospitals, physicians and other providers who contract with an insurer, employer, third-party administrator or other sponsoring group to provide health care services to covered individuals.

Pre-paid Health Plan: An entity that either contracts on a pre-paid capitated-risk basis to provide services that are not comprehensive, or contracts on a non-risk basis.

Risk: The potential loss that may be incurred because the cost of providing services may exceed the agreed-upon payment for those services.

Stop Loss: Provision often included in capitation contracts to limit risk of provider in the event actual utilization rates exceed estimates.

Utilization Rates: Predictable patterns based frequency of actual use of health care services, including medical transportation. Utilization rates are usually expressed as the number of units per capita per month, such as number of one-way trips per member per month.

COMMUNITY TRANSPORTATION ASSOCIATION OF AMERICA

Transportation and Medicaid: New Models Emerging Managed Care

The move toward managed care is having a major impact upon the delivery and funding of non-emergency transportation under the federal Medicaid program. As many states adopt managed care options to meet the needs of Medicaid recipients, arrangements for assuring that enrollees have access needed medical services and facilities are changing as well. Some states are including or "carving in" transportation services as part of their capitated rates and services. Others continue to rely on conventional, fee-for-service transportation arrangements within a managed medical care environment.

Recently, the Center for Health Care Strategies in Princeton, New Jersey, with financial support from the Robert Wood Johnson Foundation, announced plans to study the changes that are taking place in the delivery and payment of non-emergency transportation to Medicaid recipients. The Community Transportation Association of America (CTAA), a nationally-recognized nonprofit organization that specializes in transportation alternatives for people who don't drive, will be carrying out the study for the Center, and may be contacting you directly in the future.

CTAA will be surveying state Medicaid agencies and local managed care organizations to identify innovative approaches to managing Medicaid transportation. The study will include an examination of new and emerging transportation brokerage arrangements, capitated or pre-paid payment arrangements for providing medically necessary transportation, and other approaches that might combine conventional fee-for-service transportation providers within a managed care environment. Because of the increasing participation of seniors in managed care plans, the CTAA project will also examine medical transportation services being offered to Medicare recipients. One of the products of the study is expected to be a report on "best practices" in the emerging managed transportation field.

In addition to gathering information, CTAA is offering to provide information about federal Medicaid transportation requirements and current practices to interested state and local agencies. CTAA will also make the results of the study available to participating organizations.

Attached will find a brief survey that describes the nature and scope of Medicaid or other medical transportation services you now provide. You can also use this survey also to alert us to your interest in learning more about the issue.

Thank you for your interest and participation.

CTAA's MANAGED MEDICAID TRANSPORTATION SURVEY

State Medicaid Agency: _____

Mailing Address: _____

City: _____ State _____ Zip _____

Telephone () _____ Fax: () _____ Internet _____

Contact Person: _____ Title: _____

General

1. Total Statewide Medicaid Population: _____
2. Number/Percentage of Medicaid Recipients Enrolled in Managed Care Plan(s): _____

Non-Emergency Transportation

3. In this state, medically-necessary transportation costs are treated as: (check one)
 - a. Medical service expenses _____
 - b. Administrative Costs _____
4. Under Medicaid managed care, transportation is: (check one)
 - a. Included in the capitation rate of each health plan _____
 - b. Reimbursed on a fee-for-service basis directly to transportation providers _____
 - c. Coordinated through a brokerage arrangement _____
 - d. Combination or Other (please describe) _____
5. Estimated annual expenditures for non-emergency Medicaid transportation total \$ _____
That's the equivalent of: (check one)
 - a. Less than 1% of total program cost _____
 - b. Between 1% & 2% of total program cost _____
 - c. Between 2% & 3% of program costs _____
 - d. Over 3% of total program cost _____
 - e. Don't know _____
6. Estimated number of non-emergency medical trips provided to Medicaid recipients annually _____
7. Percentage of Medicaid recipients utilizing non-emergency transportation services: (check one)
 - a. Less than 10% of recipients _____
 - b. Between 10% and 15% of recipients _____
 - c. Over 15% of recipients _____
 - d. Don't know _____
8. Breakdown of non-emergency medical *trips* by provider: (by percent)
 - a. Public Transit _____
 - b. Paratransit Van _____
 - c. Taxi _____
 - d. Volunteer Drivers _____
 - d. Mileage Reimbursement _____
 - e. Ambulette or Medical Coach _____
 - e. Other _____
9. Breakdown of non-emergency medical transportation *costs* by provider: (by percent)
 - a. Public Transit _____
 - b. Paratransit Van _____
 - c. Taxi _____
 - d. Volunteer Drivers _____
 - d. Mileage Reimbursement _____
 - e. Ambulette or Medical Coach _____
 - e. Other _____