STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

OCT 0 1 2008

The Honorable Thomas M. Middleton
Chairman
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chairman
House Health and Government Operations Committee
241 House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 235 (Ch. 651 of the Acts of 2008) – Maryland Medical Assistance Program – Transporters

Dear Chairmen Middleton and Hammen:

In accordance with Section 2 of HB 235 (Chapter 651 of the Acts of 2008) – *Maryland Medical Assistance Program – Transporters*, I am enclosing a study on the feasibility of creating a uniform non-emergency statewide transportation program to serve enrollees of the Maryland Medical Assistance Program.

The study contains four main components: (1) the feasibility of creating a uniform statewide non-emergency transportation program; (2) any cost-savings that might arise from the creation of a statewide program; (3) any potential for quality improvement that would result from the creation of a statewide program; and (4) the impact that a statewide program would have on local health departments. Stakeholders – including providers, consumers and local health departments – were consulted and their comments were incorporated into the report.

If you have any questions about this study, you may contact Mark Leeds, Director of Long-Term Care and Community Support Services, at (410) 767-1443.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Susan Tucker
Mark Leeds
Sam Colgain

The Hilltop Institute

analysis to advance the health of vulnerable populations

Non-Emergency Medical Transportation (NEMT) Study Report

September 26, 2008

UMBC
AN HONORS UNIVERSITY IN MARYLAND

The Hilltop Institute was formerly the Center for Health Program Development and Management.

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Non-Emergency Medical Transportation Study Report

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Executive Summary

In accordance with the requirements of HB 235 from the 2008 legislative session, The Hilltop Institute conducted a study for the Maryland Department of Health and Mental Hygiene (Department) of the creation of a uniform statewide non-emergency medical transportation (NEMT) program to serve enrollees of the Maryland Medical Assistance Program (Medicaid). The study assessed four elements:

- The feasibility of creating a uniform statewide NEMT program
- Any cost savings that might arise from the creation of a statewide program
- Any potential for quality improvement that would result from the creation of a statewide program
- The impact that a statewide program would have on local health departments

Hilltop and the Department consulted with appropriate stakeholders—including providers, consumers, and local health departments—and incorporated their comments into the report.

While the Maryland Medicaid program is in the position to implement a different statewide uniform NEMT program, The Hilltop Institute found no compelling indication that Maryland would necessarily realize cost efficiencies and/or quality improvement by merely creating and implementing a different NEMT system. An analysis of other state data as well as historical Maryland data indicates that Maryland's current NEMT program is comparatively cost-effective. The Department currently monitors quality through a customer service survey and through complaints tracking, which both indicate a high level of satisfaction among Medicaid enrollees accessing NEMT services. The Maryland Medicaid program may wish to build upon its current quality monitoring and improvement program by incorporating additional quality assurance elements. The Department could implement this either through the current county-level model or via a different statewide NEMT program model. The optimal model for Maryland depends, in part, on the state's priorities and values with respect to NEMT service provision.

Transitioning management of the NEMT system to a different NEMT program design would impact the local jurisdictions by eliminating funding for at least 85 full-time equivalent positions and $5.6 million in total administrative funds. However, these impacts would not be felt uniformly across counties due to the variety of ways in which the counties manage the current NEMT broker program.

Introduction

In the 2008 legislative session, the Maryland Legislature passed HB 235, requiring, among other things, the Maryland Department of Health and Mental Hygiene (Department) to conduct a study of the creation of a uniform statewide non-emergency medical transportation (NEMT) program to serve enrollees of the Maryland Medical Assistance Program (Medicaid). The bill requires the Department to report findings of the study to the Senate Finance Committee and the House Health and Government Operations Committee of the Maryland legislature on or before October 1, 2008. On May 22, 2008, Governor Martin O'Malley signed HB 235 into law.

The legislation requires the NEMT study to address four elements: 1) the feasibility of creating a uniform statewide NEMT program; 2) any cost savings that might arise from the creation of a statewide program; 3) any potential for quality improvement that would result from the creation of a statewide program; and 4) the impact that a statewide program would have on local health departments. The provisions of the bill also require that in conducting the study, the Department consult with the appropriate stakeholders, including providers, consumers, and local health departments.

To assure adequate consultation, the Department convened three opportunities for public participation. On July 22, 2008, the Department accepted written and oral public testimony at a stakeholder meeting specifically convened for the purpose of discussing the mandated study. Over seventy individuals representing consumers, county health departments, managed care organizations (MCOs), health care providers, advocates, transportation providers, and other Maryland state agencies participated in this stakeholder meeting. The Department also presented the study design and sought feedback at the regularly scheduled Medicaid Advisory Committee meeting on July 24, 2008, and at the Money Follows the Person Stakeholder Committee meeting on August 5, 2008. Comments were then accepted and incorporated into the study methodology. A survey was also sent to the local health officers to obtain input about the impact of converting to a statewide program on their departments.

Background

The federal Medicaid Program is one of 62 federal programs that fund transportation services at the state and local levels. Such programs provide federal funds for transportation so that eligible individuals have access to a variety of government programs, including health care programs. The United States Government Accountability Office recently found that the coordination of transportation services across government programs not only improves the quality but also increases the cost-effectiveness of service.[1] In administering a Medicaid NEMT program, a state Medicaid agency generally does not operate its program in isolation but rather in the environment of multiple, overlapping transportation funding streams. Each of the funding streams has its own rules.

Federal Medicaid rules require that states "ensure necessary transportation for recipients to and from providers" based on a described method in the Medicaid state plan.[2] These federal rules are designed to assure access to health care services provided under Medicaid. It can be argued that the goal of Medicaid can only be met if Medicaid recipients are able to actually get to providers in order to receive covered services. Provision of transportation is also a federal requirement under states' implementation of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) in Medicaid for individuals eligible for EPSDT services.[3]

States have considerable flexibility in designing and implementing NEMT programs that meet federal requirements. Federal law, however, requires the state to administer the Medicaid state plan properly and efficiently while providing services in a way that is efficient, economical, and conducive to quality care.[4] Based on these requirements, states must use the least costly mode of transportation if multiple modes are available, including maximizing available free resources.[5] States provide NEMT for individuals to whom no other transportation is available and Medicaid necessarily serves as the payer of last resort. For these individuals, states provide transportation to covered Medicaid services and may limit provision of transportation to only those services that are actually covered by Medicaid for that individual. States provide the least expensive mode of transportation available that is appropriate for the client. Transport is generally provided to the nearest qualified provider.

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[1] U.S. Government Accountability Office. (2003, June). *Transportation-disadvantaged populations: Some coordination efforts among programs providing transportation services, but obstacles persist.* (Publication No. GAO-03-697). Retrieved August 12, 2008, from www.gao.gov/new.items/d03697.pdf

[2] 42 CFR 431.53

[3] 42 USC §1396d(r) requires states to cover certain services to correct, or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid state plan.

[4] Sections 1902(a)(4) and 1902(a)(30) of the Social Security Act.

[5] The Health Care Financing Administration (currently CMS) and the National Association of State Medicaid Directors. (1998, August). *Designing and operating cost-effective Medicaid non-emergency transportation programs: A guidebook for state Medicaid agencies.* Washington, D.C.: Non-Emergency Transportation Technical Advisory Group, 13.

While states must provide transportation under federal Medicaid rules, they have two alternatives for classifying expenditures for these required NEMT services: as an "optional medical service" expense or as an "administrative" expense. In order to provide NEMT as an optional medical service, a state's program must meet certain criteria. Traditionally, the state has been required to make a direct vendor payment to the transportation provider. The program must also meet freedom of choice requirements with respect to such a provider as well as comparability of services across the entire state. Expenses for NEMT as an optional medical service are matched by the federal government at the state's federal medical assistance percentage (FMAP), which in many states is higher than the federal match for administrative services.

Alternatively, states may provide NEMT services as an administrative service. This option provides a great deal more flexibility in the provision of such services, largely because the freedom of choice requirement does not apply. This option does not require states to pay transportation providers directly and allows states to restrict providers available to recipients. Expenses incurred under the administrative services option are matched at the 50 percent administrative services rate, which is typically lower than the FMAP rate for most states. Maryland's FMAP rate at 50 percent is equal to the administrative services rate.

In addition, when providing NEMT services, states have options that allow them to preserve the FMAP rate for NEMT while embracing some of the flexibilities under the administrative services option. Until recently, states were only able to take advantage of this option by covering such services under 1915(b) waiver authority. The 1915(b) waiver option allows states to receive a waiver of the freedom of choice requirement while claiming NEMT services at the higher FMAP rate as an optional medical service. Under such waivers, states may restrict participation by service providers, provide services that are not statewide, and restrict recipient choice. States have used this option to implement brokered services, capitated payment systems, and managed delivery arrangements. In order to receive approval for a 1915(b) waiver authority, the state must submit a proposal and demonstrate cost-effectiveness under the NEMT program every two years. This process can be labor- and resource-intensive. Therefore, states with an FMAP rate exceeding the 50 percent administrative match rate have been the leaders in taking advantage of the 1915(b) waiver option.

The enactment of the Deficit Reduction Act of 2005 (DRA) created a new option for states to limit freedom of choice through a brokerage program while covering NEMT as an optional medical service in the state plan.[6] This new Medicaid state plan option, available to states beginning March 2006, allows states to preserve the FMAP rate for NEMT services while embracing most of the flexibilities that previously could be realized only by providing NEMT through a 1915(b) waiver program or via the administrative option. In addition, this option does not require the state to prove cost-effectiveness for the NEMT program or reapply every two years. On August 24, 2007, The Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicare and Medicaid programs, promulgated a notice of proposed rulemaking, which included criteria CMS applies to state programs to determine whether the

[6] Section 6083 of the DRA added section 1902(a)(70) to the Social Security Act, providing states the authority to establish a NEMT brokerage program under the Medicaid state plan.

program qualifies for approval under the DRA option.[7] In the proposed rule, CMS affirmed its intent to include most of the flexibilities of the 1915(b) option within the state plan. However, due to a statutory limitation specific to the language added by the DRA, the agency has interpreted the new option to exclude from approval under the DRA option brokerage programs where the broker provides transportation services directly.[8] As of February 2008, eight states had used the DRA option to provide NEMT services under the Medicaid state plan.[9]

The options discussed above impact not only how states choose to provide NEMT services, but also how much states may be required to expend to provide these services. States that have an FMAP rate equal to the administrative match rate are more likely to use the administrative services option to provide NEMT. Maryland is one of these states and uses the administrative services option. Other states, especially those with FMAP rates considerably higher than the 50 percent administrative rate, are more likely to pursue the medical services option, including the use of either the 1915(b) waiver authority or the DRA state plan. With the advent of the DRA option, the ease with which states may now utilize the broker arrangement under the Medicaid state plan while retaining the FMAP matching rate has greatly motivated states to evaluate options. Changing from the administrative services option to the medical services option would alone bring savings to the state portion of Medicaid spending for those states with FMAPs higher than 50 percent. However, Maryland, with an FMAP equal to 50 percent, cannot generate state savings simply by transitioning the provision of NEMT to the medical services option.

Maryland's NEMT Program

History

Maryland Medicaid has four transportation program areas: 1) Medicare ambulance services for individuals who are eligible for both Medicare and Medicaid, where Medicare co-pays and deductibles are paid for by Medicaid; 2) transportation services under the Individuals with Disabilities Education Act, where the Department reimburses for the transportation of school children from the school setting to the medical service and back; 3) emergency transport services, which provides reimbursement for 911 ambulance services; and 4) NEMT provided under the Medicaid Transportation Grant program. The scope of this study focuses on the NEMT services portion of the Medicaid Transportation Grant program.

Prior to 1993, NEMT was operated as an optional medical service with Medicaid reimbursing providers directly on a fee-for-service basis. In response to rising costs at that time, the Department changed the structure of the program to a model utilizing local jurisdictions to oversee Medicaid transportation in each county. Maryland also converted from providing NEMT

[7] To date, CMS has published neither an Interim Final Rule nor a Final Rule to interpret section 6083 of the DRA.
[8] Federal Register. (August 24, 2007). Medicaid program; State option to establish non-emergency medical transportation program. [CMS–2234–P]. CMS Proposed Rule, 42 CFR 440.170(a)(4)(ii), Vol. 72, No. 164. Retrieved August 13, 2008, from http://edocket.access.gpo.gov/2007/pdf/E7-16172.pdf
[9] Kulkarni, M. P. (2008, February). *Fact sheet: Medicaid transportation services.* National Health Law Program. Retrieved August 11, 2008, from www.healthlaw.org/library/item.184592-Fact_Sheet_Medicaid_Transportation_Services_Feb_08

as an optional medical service to providing it as an administrative service. Maryland created a local broker program in which the local health departments receive grants to arrange screening and provide transportation.[10] The Department worked with the local jurisdictions by providing them grants to administer the program at the local level. In a 2001 report, Maryland's local jurisdiction broker model was recognized by the Community Transportation Association of America as a best practice model for other Medicaid programs to review when trying to reform transportation programs.[11]

A historical analysis of expenditures in Maryland's NEMT program indicates that the state achieved considerable savings from the transition to the local jurisdiction broker program. In fiscal year (FY) 1993, the first year that local jurisdictions provided transportation services using grant funds, total costs were $19 million. In FY 1994, these costs decreased to $13.1 million and average cost per Medicaid enrollee decreased by over 34 percent (see Table 1). Assuming that average case mix and needs of Medicaid enrollees had not changed substantially between FY 1992 and FY 1995, the state realized approximately $10.5 million in total savings by providing NEMT services through the local jurisdictions in FY 1995.

Table 1. Historical Expenditures on Maryland Medicaid Transportation Services and Average Cost per Enrollee

Fiscal Year	Total Costs (In Millions)	Medicaid NEMT Eligible Average Monthly Enrollment	Average Cost per Enrollee	Annual Growth Rate Average Cost Per Enrollee	Annual Growth Rate Total Costs
1990	$14.40	323,928	$44.45		
1991	$17.50	352,644	$49.63	11.6%	21.5%
1992	$19.10	393,599	$48.53	-2.2%	9.1%
1993	$19.00	415,464	$45.73	-5.8%	-0.5%
1994	$13.10	435,788	$30.06	-34.3%	-31.1%
1995	$11.40	451,394	$25.26	-16.0%	-13.0%
1996	$12.80	437,994	$29.22	15.7%	12.3%
1997	$12.70	433,074	$29.33	0.3%	-0.8%
1998	$13.60	426,960	$31.85	8.6%	7.1%
1999	$13.91	439,343	$31.66	-0.6%	2.3%

[10] Maryland Department of Health and Mental Hygiene. (2006, July). *Maryland Medical Assistance program guide to the administration of the transportation grant program.*

[11] Raphael, D. (2001, January). *Medicaid transportation: Assuring access to health care—a primer for states, health plans, providers and advocates*. Washington, D.C.: Community Transportation Association of American (CTAA), 13. Retrieved August 12, 2008, from www.ce.berkeley.edu/~yuli/ce259/reader/NEMT.pdf

Current NEMT Program

The Transportation Grant program provides services to all Maryland Medicaid recipients, in both HealthChoice and fee-for-service, who do not have restricted eligibility.[12] The Transportation Grant program provides funds to the 24 local jurisdictions (the 23 counties in Maryland and the city of Baltimore). The grantee in each jurisdiction is the local health department, except in Montgomery County where the grantee is the county department of transportation. NEMT services are carved out of the managed care agreements under HealthChoice with very limited exceptions.[13] Local jurisdictions use these funds to: "screen recipients' requests for transportation to assure recipient eligibility and necessity of transportation; arrange for and/or provide the most efficient means of transportation where no other transportation is available to the recipient and without the provision of transportation, the recipient would not be able to access medical care; and ensure that Medicaid-funded transportation is used in a manner consistent with" Maryland's state regulations governing the administration of NEMT services at COMAR 10.09.19.[14]

At their discretion, local jurisdictions may arrange for screening and/or transportation services directly or provide these services through a subcontractor. The local jurisdictions ensure recipients' access to transportation for the purpose of receiving medically necessary medical care in an efficient and cost-effective manner. Transportation is provided to Medicaid-covered services at the nearest appropriate Medicaid provider who has the training and skills necessary to provide the needed care and who is willing to accept the recipient as a patient. NEMT services include trips to and from scheduled medical services as well as return trips from hospital emergency rooms, return trips from hospital stays, and medically necessary inter-hospital transfers. All trips—except hospital discharges occurring on weekends—require prior authorization in advance of the trip. The Medicaid program provides all modes of transportation as appropriate, including but not limited to ambulance, wheelchair van, sedan/van, taxi, public transportation, and air transport. The Medicaid program will not cover a more expensive mode of transportation than is required.

The NEMT program is a scheduled, shared ride program. Curb-to-curb and door-to-door service is provided as medically necessary.[15] The bulk of the services are scheduled, shared rides

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[12] Those with restricted eligibility in Maryland Medicaid include enrollees such as Qualified Medicare Beneficiaries, Primary Adult Care enrollees, or Family Planning enrollees.

[13] It is the MCO's responsibility to furnish and pay for needed transportation in limited circumstances in which the MCO's network is inadequate to provide access to primary medical providers within a local jurisdiction's geographic access area (in urban areas, within a 10-mile or 30-minute drive of the recipient's home; in rural areas, within a 30-mile radius or 30-minute drive of the recipient's home). For specialists, MCOs are responsible for furnishing and paying for transportation to a specialist provider outside of the recipient's county of residence when other appropriate specialist providers are available within the county but are not in the MCO's provider network. Alternately, the MCO may arrange for services from an out-of-network provider within the local jurisdiction's service area.

[14] Maryland Department of Health and Mental Hygiene. (2006, July). *Maryland Medical Assistance program guide to the administration of the transportation grant program.*

[15] Door-through-door service is provided only for ambulance transport as medically necessary.

provided Monday through Friday during normal business hours. By regulation, NEMT services require at least 24 hours advance notice for scheduling; but if such notice is not possible (e.g., in the case of a sick child appointment), the county tries to work with the recipient to provide same-day transportation. All medically necessary air transport is arranged statewide through Baltimore City Health Department.

As noted above, local jurisdictions are responsible for the following functions: screening, arranging for transportation services, and assuring appropriate use of funds. The local jurisdictions are required to screen requests to assure eligibility and necessity of transportation. In the screening process, the local jurisdiction determines whether: the individual receiving medical care is a Maryland Medicaid recipient and is potentially eligible for transportation; the transportation is necessary in order for the recipient to receive needed medical care; the medical service is coverable by Medicaid; the most efficient mode of transportation necessary to meet the need is being used; and the requested transportation is not covered by another segment of the program or otherwise prohibited by regulation. Local jurisdictions are also required to ensure sufficient resources to provide transportation either through contracts with transportation providers or by providing transportation services directly. Local jurisdictions must take necessary steps to ensure that Medicaid funds are used appropriately for transportation that is necessary to assure recipient's access to needed medical care. In doing this, the local jurisdictions are required to operate the grant in an efficient, cost-effective way by maximizing the use of ride sharing, directing recipients to public transportation when feasible, and limiting scope of transportation when appropriate. Additionally, local jurisdictions must ensure that the least expensive appropriate mode of transportation is provided. The grantees may grant exceptions to general policies based on physician documentation that explains the medical reason the recipient cannot use such transportation.

Trends in the Operation of Medicaid NEMT Programs: National View

There is considerable variation in how states provide NEMT services to Medicaid recipients. According to a recent survey of all state Medicaid programs, "The single most compelling finding is the range and diversity of NEMT program construction, and the pace of NEMT program evolution."[16] States design programs in line with operational needs stemming from differing circumstances in the state. Many factors influence the design and implementation of NEMT programs. Some of the most influential factors include: state geography (urban vs. rural), patterns of care, population and population density, history and operation of managed care in the Medicaid program, availability of transportation to Medicaid recipients, availability of transportation providers, volume of NEMT trips, and extent of coordination among transit programs. NEMT service provision takes into account these and other factors to create a system that best meets the needs of the state. NEMT programs vary by payment (capitation vs. fee-for-service reimbursement); coordination with other programs; the extent to which states incorporate the program into existing comprehensive managed care programs; and whether the program utilizes a broker to manage and provide NEMT services. Each structure for providing NEMT creates its own incentives.

Financing

The financing structure for an NEMT program may influence service provision by creating certain incentives. In general, states may design programs that are reimbursed on a fee-for-service basis or paid on a capitated per member per month basis. A fee-for-service reimbursement structure may also include an additional fixed administrative fee. A risk-based capitated payment structure allows the states to better predict NEMT expenditures. This structure also creates incentives for the contractor to manage service provision so that costs do not exceed revenue. State oversight of such contracts, however, is necessary to ensure that service provision is not too restrictive, resulting in inadequate service provision for program recipients. Under a fee-for-service financing structure, the state is at risk if utilization increases. Because of this risk, states that operate fee-for-service NEMT programs benefit from strong front-end screening processes to ensure appropriate utilization of services and effective review of provider claims to limit opportunities for fraud and abuse.

Coordination with Other Programs

The Medicaid Program is only one of the numerous programs that funds transportation services at the state and local levels. Coordination across these programs may allow states to maximize federal funding to support integrated transportation service delivery. A number of states have found efficiencies in coordinating with other transportation programs, such as aging, education, and job training programs and providers of welfare-to-work transportation. Although coordination can be challenging, some states have found that it reduces costs while increasing

[16] Stefl, G., & Newsom, M. (2003, December). *Medicaid non-emergency transportation: National survey 2002-2003.* Washington, D.C.: National Consortium on the Coordination of Human Services Transportation, 1. Retrieved August 14, 2008, from http://cwd.aphsa.org/publications/docs/NEMT_survey_report_Dec2003.pdf

quality and serving clients in a better, more comprehensive way. It has been found that coordination can be a sound business practice, creating wide-ranging benefits, including increased funding, improved productivity, and economies of scale.[17] Medicaid is often the largest single funder of transportation in the local or regional area. Greater efficiencies that result from transportation coordination, which includes the Medicaid NEMT program, have the potential to greatly affect the wellbeing of a local transportation system.

Managed Care Programs

State Medicaid NEMT programs also differ in the extent to which such transportation is included in or carved out of the services provided by Medicaid MCOs. While states have increasingly embraced some form of managed care for health care services in Medicaid, they have been somewhat less enthusiastic to fully integrate NEMT services into comprehensive managed care. A number of states have opted to carve out NEMT services from the services for which they contract with MCOs. This program design element is likely to impact MCOs' incentives and behavior, coordination of care for the individual, and coordination among transportation programs.

States including NEMT payment within the MCOs' scope of services have the option of pursuing this as either a risk-based or non-risk based portion of the contract. States opting to use the risk-based option pay MCOs for NEMT services under a capitated arrangement, paying a per member per month fee to the MCO. States opting for the non-risk based arrangement do not put the MCOs at financial risk for the NEMT services. In this case, plans are reimbursed on a fee-for-service basis for transportation services. States may also provide NEMT services via managed care on a limited basis (e.g., only for specific populations or in certain geographic areas).

Potential Advantages/Disadvantages of Incorporating NEMT Services into Contracts with MCOs

States must consider a number of competing concerns in determining whether to include NEMT services as a part of MCO contracts.[18] Capitation may serve as a way to control utilization. States opting to include NEMT services within the MCO's responsibility may do so to create overall efficiencies, including better coordination of care and/or lower program costs. The MCO may be best prepared to coordinate NEMT services as well as to resolve issues such as "no shows" or timing the transportation with the medical appointment. Including NEMT services in the MCO scope of responsibility may alleviate issues related to MCO provider networks and Medicaid NEMT access requirements.

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[17] Hosen, K. I., & Fetting, E. (2006). *Transit agency participation in Medicaid transportation programs: A synthesis of transit practice.* TCRP Synthesis #65. Washington, D,C: Transportation Research Board of the National Academies, 1. Retrieved August 11, 2008, from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_syn_65.pdf

[18] The Health Care Financing Administration (currently CMS) and the National Association of State Medicaid Directors.

However, states may feel that the agency coordination, outside of MCO involvement, provides a cost-effective regional approach promoting integration across public, private, and non-profit entities. The provision of NEMT services by MCOs is at times inefficient, leading to unnecessary duplication within local areas. With multiple MCOs coordinating transportation for different individuals living in the same geographic area, a state would not realize the efficiencies of shared rides across MCOs. States operating cost-effective NEMT programs may choose not to include such transportation services in managed care plans, as they anticipate realizing little or no additional savings from such a transition. Additionally, Medicaid agencies with NEMT programs that effectively coordinate with local transportation and/or healthcare programs may decide to carve NEMT services out of MCO contracts to maintain high levels of local coordination. States may also have concerns that providing NEMT services through MCOs on an at-risk basis could create incentives for MCOs to withhold transportation services as a way to reduce costs. States must also gauge MCO experience in providing NEMT services as well as MCO preference in being responsible for providing such services.

Use of Broker Programs

Across the country there has been a growing interest in the use of NEMT brokers in Medicaid programs, in part because of the additional options available under the DRA. States have increasingly begun using transportation brokers to manage NEMT in response to rapidly growing expenditures and as a means of controlling perceived fraud and abuse. States contract with brokers to conduct a variety of functions. While there is wide variation among broker programs, brokers generally perform administrative and coordinating services, such as screening and scheduling,[19] but in some instances also provide transportation. Brokers may be private for-profit companies, private non-profit organizations, or public governmental agencies. States use a variety of models within the broker program option, including use of a single statewide broker, use of regional brokers, and use of county-level broker programs.

Each state utilizing a broker program designs the program to meet the specific needs of its Medicaid program. While the broker has the potential to perform all Medicaid transportation operations, each state Medicaid agency specifies the transportation services it requires of its broker as well as the structure of the relationship between the state and the broker. For this reason, it is difficult to find two brokerage programs that are identical. Typical contracted NEMT functions include but are not limited to: educating recipients about available transportation services and how to access them; verifying Medicaid eligibility status; establishing that the requested trip is eligible for the NEMT benefit; authorizing transportation and selecting least costly, most appropriate mode of transportation; establishing a network of transportation providers and coordinated transportation resources; providing transit passes/tickets, reimbursement for miles, etc.; assuring uniform quality services and access to needed health care; and tracking and reporting quality, costs, and utilization.[20] Generally, the broker performs some combination of the above functions. In some states, the broker performs all of these functions.

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[19] Stefl & Newsom. *National survey*, 9.
[20] Raphael.

Potential Advantages/Disadvantages of Brokers

The use of brokers has increasingly become of interest to states that perceive such programs as a way to increase efficiencies in the provision of NEMT services. States may realize efficiencies to the extent a broker program can change the provision of transportation services in such a way to sufficiently decrease costs. Brokers may potentially create efficiencies and lower costs through competitive bidding and by assuring the scheduling of the least costly, most appropriate method of transportation for a client.[21] A broker model may also allow states to tap into advanced technologies of transportation coordination.[22] Brokers may be able to lower provider costs by establishing agreements with operators of transportation services to provide services at lower costs. A broker may also be able to optimize use of the most cost efficient way to provide specific trips through scheduling or great scrutiny of the appropriateness and eligibility of trips. A broker with strong ties to local medical and human service providers can be valuable in promoting coordinated service for clients.

The use of a broker to provide NEMT services may also have potential disadvantages. The costs of the administrative services within the contract may be too high to find economies of scale for programs with a low number of NEMT trips. Transition costs may be extensive and possibly disruptive. In addition, brokers must be monitored for quality assurance; this monitoring function may require as much Medicaid staff time to ensure cost-effective implementation as other types of administration. The broker may also be open to criticism as to use of favored subcontractors or providers. Additionally, brokers who are not familiar with the local environment and human service providers may be unable to coordinate services for clients.

[21] The Health Care Financing Administration (currently CMS) and the National Association of State Medicaid Directors.
[22] Raphael, 16.

Methodology and Models

Mandated Elements of the Study

HB 235 required the Department to include four elements in its study of the creation of a uniform statewide NEMT program to serve Medicaid enrollees. These elements are: 1) the feasibility of creating a uniform statewide NEMT program; 2) any cost savings that might arise from the creation of a statewide program; 3) any potential for quality improvement that would result from the creation of a statewide program; and 4) the impact that a statewide program would have on local health departments.

Methodology

To assess the feasibility of creating a uniform statewide NEMT program, we reviewed Maryland's current NEMT program and the historical development of this model. We assessed the impetus to and financial impact of the 1993 transition to the current county-level broker system. We conducted an analysis to estimate the effect of transitioning to a statewide or regional broker model. We evaluated current quality initiatives and assessed the potential for quality improvement. We also evaluated the potential impact on local jurisdictions (primarily the local health departments). To inform the analysis, and to assist in determining the potential impact based on a change in the way NEMT is provided, we looked to the implementation of NEMT programs in other states.

We relied, in part, on Maryland Medicaid NEMT operations data. The components used in this part of the analysis included data on services, utilization, costs, and quality in the current NEMT program. Local jurisdictions routinely provide reports of utilization to the Department, including data related to number of trips provided and type of transportation. The Department also maintains information on total NEMT costs, transportation costs, and administrative data related to staffing levels and costs for stakeholders, including each jurisdiction. Finally, to assure a comprehensive analysis, we surveyed all local jurisdictions for current and historical data related to operations, expenditures, additional quality initiatives, and potential impact (see Appendix A: NEMT Survey to Local Jurisdictions). We also requested any additional information from jurisdictions that they felt would be critical to the study.

We also solicited information from other states. A survey was sent to 10 states, representing a variety of models of NEMT service provision (see Appendix B: NEMT Survey to States). The survey was designed to gather information and evaluate experiences in those states relating to utilization, cost savings, quality measures and/or improvement, and the impact on local stakeholders. Whenever possible, we conducted interviews with officials in other states to gain additional information related to national trends and state-specific NEMT implementation and findings. We focused not only on states that recently transitioned to a brokerage program, but also on states with considerable experience with brokers. A comparative analysis of the information gathered from these states was performed to assist in determining the projected impact of a change in NEMT service provision in Maryland. The data from these states served as benchmarks to gauge the Maryland NEMT program's relative utilization and cost effectiveness.

In response to public comments and suggestions provided by other states, we augmented our review to include South Carolina and three other states (Wisconsin, Iowa, and Idaho) that had recently undertaken feasibility studies with respect to implementing different NEMT models.

Consultation

The provisions of HB 235 also required that the Department consult with appropriate stakeholders, including providers, consumers, and local health departments. To assure adequate consultation, the Department initiated three opportunities for public participation. On July 22, 2008, the Department accepted written and oral public testimony on the study design at a stakeholder meeting specifically convened for the purpose of discussing the mandated study. The Department also presented the study design and proposed survey instruments at the regularly scheduled Medicaid Advisory Committee Meeting on July 24, 2008, and at the Money Follows the Person Stakeholder Committee meeting on August 5, 2008.

At all of these meetings, the Department provided an overview of the current NEMT program and The Hilltop Institute provided a presentation of the proposed study design. Attendees were encouraged to provide feedback on the study design, as well as to assist the Department in reaching additional stakeholders to assure inclusion of comments from a wide range of interested parties. The Department sought input from stakeholders, including health care providers, transportation providers, local jurisdictions, Medicaid consumers, advocates, and other interested parties. Information gained from the consultation process was used to inform both the study design and the final report. The Department accepted written and oral comments not only at the three meetings, but also by telephone, fax, and e-mail throughout the period of July through September 2008. A list of attendees, including individuals who provided testimony with respect to the study, at the July 22, 2008, meeting is available in Appendix C. Membership lists of the 2007-2008 Maryland Medicaid Advisory Committee and the Maryland Medicaid Money Follows the Person Stakeholder Advisory Group are available in Appendices D and E.

Models Considered

In our research, we found wide variation across states in how NEMT services are administered. Even among states that use broker programs, a wide variety of service models exist within the broker framework.[23] To assess the likely impact of the creation of such an NEMT program in Maryland, we analyzed a number of models that states currently employ to provide NEMT services. The models reviewed included both fee-for-service and capitated payment systems. One model we examined carved NEMT into managed care contracts, using a single statewide broker for Medicaid enrollees in fee-for-service but requiring MCOs to provide NEMT services for their enrollees. The other models we reviewed all carved NEMT services out of comprehensive managed care contracts. These models included: a) a single statewide broker program; b) a single statewide broker program in which the broker provides transportation as well as administrative and coordinating services; c) a regional brokerage program with multiple county regions; d) a county-level brokerage program; and e) a regional brokerage program mixed

[23] Hosen & Fetting, 10.

model (with county- and region-level areas). The analysis of these models provides a relatively comprehensive review of the potential feasibility of a new NEMT program design.

State Medicaid NEMT Programs

The evaluation of each model is based in large part on the actual operational experiences of states that have employed that model of NEMT service provision in Medicaid. States were selected for this evaluation based on a number of criteria. The primary criterion was the ability of the state's Medicaid NEMT program to demonstrate a particular model of how Medicaid programs provide NEMT services. Approximately 24 states use some type of broker system in lieu of direct fee-for-service reimbursement for NEMT services administered by the state Medicaid agency.[24] This necessarily limited the states to which Maryland could look in order to assess various NEMT options. An attempt was made, when possible, to review states with models that provided some approximation of that state's Medicaid program to the Maryland Medicaid program. The study also sought to include a strong sample of Mid-Atlantic states, in part because of the likelihood that the realities and considerations facing these states in providing NEMT services to the Medicaid population would be similar to those faced by the Maryland Medicaid program. We also assured the inclusion of states that have models in which NEMT services were brokered through some counties/local departments to provide transportation in one part of the state as well as through a commercial broker in another portion of the state. It was anticipated that such states could provide insight into the comparative cost-effectiveness and quality between a commercial broker program and county/local department broker program.

Finally, among the states that met these criteria, we looked at the availability of information and data on the NEMT program. Given that surveying would be done in a very short timeframe, when choosing between two apparently equal candidates of a particular model, we selected the state with an evaluation report or other data publicly available and readily accessible. The information below reflects data gathered from a variety of sources, including but not limited to state Medicaid websites, national reports, state audits, state evaluations, press releases, and interviews with state officials.

[24] As of December 2003, 21 states had implemented some type of broker program for all or part of the Medicaid NEMT program (Stefl & Newsom. *National survey,* 12-13*)*. At least three additional states have implemented broker programs since that time: South Carolina, Mississippi, and Washington, D.C.

Table 2. Overview of State NEMT Programs

State	Carved Out of Managed Care?	Type of Broker Model	Number of Regions	Number of Brokers	When Broker System was Implemented	Annual NEMT Expenditures* (FY)
District of Columbia	No	Single Statewide	1	1	Oct 2007	$16.3 (FY 06)
Virginia	No	Regional	7	1	2001	$64 (FY 07)
Delaware	Yes	Single Statewide	1	1	2002	$7 - $8
Mississippi	Yes	Single Statewide	1	1	Nov 2006	$28.8 (FY 06)
Utah**	Yes	Single Statewide	1	1	2002	N/A
Kentucky	Yes	Regional	12	7	1998	$48.8 (FY 04)
Washington	Yes	Regional	13	8	1989	$58 (FY 05)
Pennsylvania	Yes	County	67	66 county; 1 private	1983***	$118 (FY 08)
Florida	For most MCO enrollees	State Commission contracts with regional brokers	55	N/A	2004	$72 (FY 08)
Colorado	Yes	County and Regional	57	56 counties; 1 broker for the 8-county region	2006	$7.1 (FY 07)
South Carolina	Yes	Regional	6	2	2007	$44.8 (FY 07)

*In millions

**State retained administrative responsibility for bus pass distribution and individual mileage reimbursement; these services are not provided by the broker.

***In 1983, state legislation authorizing the county system was adopted and some counties began providing NEMT; other counties began managing the NEMT programs in later years.

N/A = data not available.

Broker Model for Medicaid Fee-for-Service Enrollees Only

District of Columbia

The District of Columbia Department of Health's Medical Assistance Administration (MAA) is responsible for the administration of the NE[M]T program, which provides transportation to Medicaid participants by van, taxicab, or bus. Recipients qualify for NEMT services upon completion of a form by either a doctor or other medical facility staff member certifying medical necessity. Effective October 19, 2007, the Medicaid program contracted with a broker to provide NEMT services for recipients enrolled in Medicaid fee-for-service. MCOs are primarily responsible for the provision of NEMT services for Medicaid managed care enrollees.

Under the contract, the broker is responsible for establishing a network of providers, operating a central call center, implementing screening to validate eligibility of recipient and trip for coverage, determining the most appropriate mode of transportation, maintaining quality assurance, reporting encounter data, and paying transportation claims.[25] MAA oversees the program to provide efficient and effective transportation services consistent with the delivery standards of the contract and in compliance with district and federal laws and regulations. Transportation providers subcontract with the broker.

The Inspector General of the District of Columbia criticized the Department of Health's implementation of the contract, finding that its "officials attempted to outsource NE[M]T Program services without evaluating the costs to perform the services and providing documentation to support doing so was in the best interest of the District of Columbia government."[26] Additionally, the Inspector General's report highlighted the need of the Department of Health "to establish sound NE[M]T program patient-participation and financial data before attempting to outsource this service to a Broker."[27] The broker has come under scrutiny lately for implementing a cost containment strategy that critics say "downsized its pool of contract drivers, leaving some clients to complain that the service is too unreliable to get them to important health-care appointments."[28]

MAA believes that the NEMT program will not only save money, but also provide safer and more reliable transportation for recipients. It is using the broker to increase the quality and integrity of the NEMT program. Through the broker, MAA now collects additional data that enables it to "make better decisions and produce more targeted approaches to improving" the

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[25] Government of the District of Columbia's Office of the Inspector General. (2008, February 22). *Audit of the non-emergency transportation provider compliance with license and certification requirements.* OIG No. 05-2-18HC(d). Washington, D.C., ii.

[26] Government of the District of Columbia's Office of the Inspector General. (2007, March 13). *Audit of the Department of Health's contracting for non-emergency transportation services.* OIG No. 05-2-18HC(c). Washington, D.C., i.

[27] Ibid., 9.

[28] Bhanoo, S. N. (2008, August 16). Medicaid transport firm trims drivers: Patients say service has become unreliable. *The Washington Post*, p. B01. Retrieved August 18, 2008, from http://www.washingtonpost.com/wp-dyn/content/article/2008/08/15/AR2008081503301_pf.html

provision of NEMT services.[29] MAA believes that a transition to such a broker system should be undertaken after a thorough and accurate analysis of a state's current workload and costs. Additionally, MAA highlighted the importance of being cognizant of the impact a transition may have on current transportation providers.

During FY 2005 and 2006, MAA's costs for services under the NEMT program were $16.3 and $16.2 million, respectively. In 2007, a contract of $10.6 million was awarded to a broker for these services. MAA estimates that approximately 45,000 Medicaid recipients were eligible for services in FY 2007 and that 10,000 of these recipients actually utilized the NEMT services.

Virginia

In Virginia, a single broker in seven regions manages all NEMT services for individuals enrolled in Medicaid fee-for-service, including individuals in waiver programs. For managed care enrollees, NEMT is carved into the MCO responsibilities and included in the capitation rate for each health plan. Many of the MCOs subcontract with brokers to provide NEMT services. Virginia officials indicate that "a high incidence of fraud and spiraling NEMT costs prompted the implementation of a brokered system."[30] During FY 2007, the contract with the NEMT broker totaled approximately $64 million.

The commonwealth contracts for NEMT services on an at-risk basis, with the broker receiving a per member per month payment for each Medicaid enrollee, regardless of whether that individual accesses NEMT services. The broker performs comprehensive coordination and administrative services but does not directly provide transportation. The broker verifies eligibility, screens and determines the most appropriate mode of transportation, provides prior authorization, recruits providers, reviews claims, negotiates rates with each provider, and tracks and monitors quality. Currently, transportation reservations must be made within 48 hours, excluding verifiable urgent trips. However, the state anticipates lengthening the timeframe in the near future.

Virginia identified the following as advantages to NEMT brokers: cost-savings, reduced incidence of fraud, and expanded coverage.[31] However, the state highlighted the importance of the familiarity of a broker with the region. It cited federal requirements to coordinate transportation services as a reason to closely consider use of human services agencies at the local level, or state/regional brokers with great familiarity and good relationships with local healthcare and transportation programs, in order to maximize coordination. The state is increasing efforts to realize additional savings via increased use of public transportation for those recipients for whom this mode of transportation would be appropriate and maybe even preferred.

The state monitors quality through a variety of measures, including complaint logs, "no show" rates, utilization data on number of trips and number of miles, and staffing levels and call

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[29] Cano, C. (2008, January 29). Department of Health response to OIG No. 05-2-18HC(d). Letter to Charles J. Willoghby, Inspector General of the District of Columbia. In *Audit of the non-emergency transportation provider compliance with license and certification requirements*. Washington, D.C., p. 24.
[30] Stefl & Newsom. *National survey*, 119.
[31] Stefl & Newsom. *National survey*, 118.

volumes at the call center. The state also monitors calls for accuracy and customer service. Additionally, the broker reports to the state on vehicle and transportation provider inspections as well as any provider sanctions or fines. The broker also contracts with a third party to complete an annual customer service satisfaction survey conducted via telephone to a random sample of Medicaid enrollees.

Single Statewide Broker Program

Delaware

To achieve cost containment and efficiency and control suspected fraud and abuse, Delaware transitioned to a single statewide NEMT broker model in October 2002. NEMT services are carved out of Medicaid managed care and provided by the broker through a capitated delivery system. After evaluating a number of models used in other states, Delaware opted to implement a single statewide broker primarily due to the small geographic size of the state. Officials believed the single broker provided the greatest economies of scale and made sense for a state made up of only three counties. Prior to the implementation of the broker system, NEMT services were provided on a reimbursement basis, generally without prior authorization or other utilization management controls.

NEMT services are provided for Medicaid recipients who have no other means of transportation to a medically necessary health care appointment or service. Delaware's model utilizes a centralized toll-free call center for eligibility verification, and determination of the most appropriate and least expensive mode of transportation, as well as scheduling transport.[32] The broker provides administrative and coordinating services. All Medicaid NEMT trips must be arranged with and confirmed by the broker. In Delaware, NEMT services include DART First State public bus and paratransit services, private provider transport, and gas reimbursement. To be covered, a reservation must be made at least 48 hours prior to the scheduled medical appointment, with some exceptions for verifiable urgent trips. Unless the individual is using the DART First State transport, there is a $1 copay each way for a trip. The state requires the broker to conduct outreach and education and to enroll providers. The broker collects, maintains, and reports data related to quality and customer satisfaction.

Delaware Medicaid officials report satisfaction with the results of the broker system, which now assures that individuals are transported effectively. The system has led to not only cost savings, but also higher quality services. Before the implementation of management and utilization controls in the broker system, the state predicted nearing annual expenditures of $20 million by 2007. As a result of the gatekeeping and efficiencies realized with the current system, the state expends on average between $7 and $8 million per year on NEMT services, depending on enrollment levels. Delaware's NEMT broker program serves about 128,250 total clients,

[32] Stefl, G., & Newsom, M. (2003, October). *Medicaid non-emergency transportation: Three case studies.* Washington, D.C: National Consortium on the Coordination of Human Services Transportation, 6. Retrieved from http://cwd.aphsa.org/publications/docs/Medicaid_NEMT_Case_Studies.pdf

including approximately 125,700 Medicaid enrollees.[33] In FY 2007, the broker provided approximately 568,000 one-way trips. In the future, Delaware plans to focus on strengthening aspects of management and performance measures and is considering a more incentive-based contracting approach.

Mississippi

The Mississippi Division of Medicaid (DOM) implemented a broker program to begin providing NEMT services to all Medicaid enrollees in November 2006. Prior to this, Medicaid operated the NEMT program as an in-house program with state officials determining eligibility, scheduling trips, and arranging for payment to providers through a fiscal agent. The state was divided into 30 regions with a single provider in each region selected through a competitive bid process.

The current NEMT broker is paid through a capitated, fixed rate for each eligible beneficiary. Additionally, the total NEMT program cost is capped each year. The broker is responsible for operating a call center; screening eligibility; authorizing and coordinating transportation; ensuring use of the most appropriate and least costly mode of transportation; contracting with, monitoring, and reimbursing providers; addressing complaints; conducting beneficiary surveys twice a year; and assisting beneficiaries. Through the contract, the state provides transportation to Medicaid-eligible individuals to medically necessary covered services. Transportation must be scheduled at least three days prior to the scheduled appointment, with exceptions for special trips such as hospital discharges.

Multiple factors played a role in Mississippi's decision to transition to a broker program. Using the 1915(b) authority, the state had been claiming direct transportation services at the FMAP rate and administrative services related to NEMT at the 50 percent administrative rate. The enactment of the DRA provided the state with an impetus to change its system so that it could claim administrative services related to transportation at the higher FMAP rate. The state also took into consideration recommendations from federal and state reports that cited broker systems for NEMT as effective ways for states to control costs. Mississippi Medicaid officials felt the broker system would result in greater stability of costs, reduce administrative expenses, and route out fraud and abuse.[34] Medicaid officials also highlighted the benefit of reduced administrative burden on the state for coordinating and monitoring transportation.

During FY 2008, there were 731,814 one-way trip requests. Total expenditures for FY 2005 and FY 2006 were approximately 1 percent of the Medicaid budget (not including administrative costs). Figures were not available for the year Mississippi transitioned to the single broker.

The Division of Medicaid believes that the broker system is an effective means of operating the NEMT program and has a positive impact on service delivery and costs. A January 2008 report

[33] Delaware's NEMT program also serves individuals unable to receive Medicaid due to immigration status as well as individuals in the Chronic Renal Disease Program.

[34] Joint Legislative Committee on Performance Evaluation and Expenditure Review. (2008, January 7). *A review of the Mississippi Division of Medicaid's non-emergency transportation program.* A report (#510) to the Mississippi Legislature. ix-x.

by the Joint Legislative Committee on Performance Evaluation and Expenditure Review to the Mississippi Legislature estimated that the implementation of the broker system produced approximately $1.1 million in cost avoidance in the last 8 months of FY 2007. While noting administrative issues in timeliness of data and accuracy of coding, the Committee found no basis for concern that service delivery suffered under the broker system. The state estimated a $4 million savings in FY 2008—in part due to improved gatekeeping and also because the costs were locked in the contract, with the broker assuming the risk for the recent increase in gas prices.

Mississippi Medicaid officials found the most significant benefits of the broker system to include the cost predictability in the capitated payment with an upper limit, the reduction of administrative costs, and the reduction in waste, fraud, and abuse. The state indicated that its biggest implementation challenge was ensuring assistance to state employees impacted by a reduction in force, which stemmed from the transition to the broker system.

Single Statewide Broker Program – Broker Provides Transportation

Utah

Utah moved to a brokered NEMT system in 2002, following a determination that such a system would provide cost savings. The state also did not have the staff to appropriately monitor and screen the use of transportation provided to individuals needing and eligible for NEMT transportation. Utah anticipated that the broker would improve the state's ability to determine medical necessity of trips and identification of the least expensive, most appropriate mode of transportation. A single statewide broker was selected through a contracting process. The state implemented a statewide capitated broker system under a 1915(b) freedom of choice waiver in 2001. This broker provides the majority of administrative and direct transportation services.[35] Bus pass distribution and individual mileage reimbursement is carved out of the contract and is managed by the Medicaid agency as an administrative service.

In Utah, the Medicaid program pays medical transportation for its enrollees under three specific conditions: 1) the individual who needs transportation is eligible for Medicaid; 2) the individual has a medical appointment or needs a health service covered by Medicaid; and 3) the individual has no transportation to get to the appointment or service.[36] These conditions are verified prior to the provision of transportation services. Transportation is not provided if these conditions cannot be verified or if an appointment for a Medicaid-covered service cannot be confirmed. Utah Medicaid limits medical transportation for Medicaid-covered services to the nearest Medicaid participating provider or the nearest appropriate facility that can provide the needed services. Additionally, Utah's Medicaid program provides transportation by taxi only when the individual cannot use public transportation and does not have a private vehicle. The state requires a check of vehicle ownership and substantiation of medical necessity with the health care provider before

[35] Stefl & Newsom. *Three case studies*, 8.
[36] Utah Medicaid Program website. Medical transportation for Medicaid clients. Retrieved August 18, 2008, from http://health.utah.gov/medicaid/provhtml/med_transportation.html

approving taxi cab services. Transportation must be scheduled at least 24 business hours prior to the appointment. Exceptions to this advance notice requirement include post-operative or follow-up appointments in less than 48 hours, urgent care, hospital and emergency room discharges, and appointments made to replace appointments missed by the broker's inability to provide service.

The state has reported cost savings and high customer satisfaction as a result of this model. The state's customer service survey yielded an 87 percent satisfaction rating of NEMT services among those who have used such services. As of 2003, the state's broker averaged a quarterly rate of 0.3 percent grievances per number of trips, an indication of relatively high customer satisfaction with the program.[37]

Benefits of the broker system cited by the state include "greater focus on determinations of medical necessity and determination of least expensive appropriate mode of travel, and consequent cost savings."[38] The Utah NEMT program demonstrated $435,000 in savings in the first year of its implementation and saw a decline in the number of rides from 62,809 to 53,789. Officials attribute these decreases to better "adherence to policies specifying that paid modes will not be used if free transport is available and that the least costly mode appropriate to the individual's situation be used."[39] State officials also note that the degree of cost savings realized by the state is reflected in the fact that NEMT costs have remained constant since 2002. Additionally, the state feels that the broker arrangement successfully relieved workload issues for state staff. State officials indicate that the broker has been able to improve access to medical services, particularly in rural areas of the state, with a shorter timeframe needed to schedule services. Clients are assured of more timely response to their needs and appropriate vehicle resources than they had under the previous system.

Regional Broker Program

Kentucky

In response to spiraling costs related to providing transportation services, and in an effort to better coordinate trips among social services agencies in the state, Kentucky established the Human Service Transportation Delivery (HSTD) program in 1998. HSTD is composed of two main state agencies: the Transportation Cabinet, which administers the program, and the Cabinet for Health and Family Services. Medicaid is the largest participant in the HSTD brokers' contracts for transportation services.

Prior to the creation of HSTD, Kentucky used an NEMT system in which individuals received vouchers and arranged transportation. Providers would submit the voucher to the Medicaid program for payment following the provision of transportation to the individual. Kentucky Medicaid officials sought to transform this voucher system, which was "fragmented, increasingly

[37] Stefl & Newsom. *Three case studies*, 8.
[38] Stefl & Newsom. *National survey*, 118.
[39] Stefl & Newsom. *Three case studies*, 10.

costly, and vulnerable to fraud and abuse" and did not provide transportation in an easily accessible manner in some more rural parts of the state.[40]

Kentucky's NEMT program provides transportation for Medicaid members who do not have access to free transportation that suits their medical needs and need to be transported to a Medicaid-covered service. For transportation outside of a member's medical service area or for specialty care, the state requires a referral from a member's primary care physician. NEMT services in Kentucky—depending on the level of eligibility of the rider—include private automobile, taxi service, bus services, non-profit transit system, specialty carrier certified to transport non-emergency ambulatory disoriented persons, and specialty carrier using lift-equipped vehicles to transport non-emergency, non-ambulatory individuals.[41]

Kentucky originally operated the NEMT broker system under a 1915(b) waiver authority, but recently transitioned to the DRA state plan option. Regional brokers are responsible for scheduling and dispatching transportation services directly or coordinating services through subcontracted providers. NEMT services are paid on a capitated per member per month basis. The commonwealth uses this payment basis to create incentives to reduce costs and better coordinate services.[42] Brokers are responsible for assuring utilization of the most cost-effective and appropriate mode of transportation as well as the provision of medically necessary and timely services. Brokers oversee vehicle inspection and maintenance of equipment in addition to provider enrollment, monitoring, and verification. Routine transportation services must be scheduled at least 72 hours in advance, with exceptions for urgent needs. After-hours paging is available on weekends and state holidays for urgent care transportation needs.[43]

The program uses the following tools to monitor quality and customer satisfaction: rider surveys, field/site visits for contract compliance, review of monthly broker/provider invoices, review of encounter and other transportation data, and annual financial report.[44] A recent report by the Kentucky Legislative Research Commission found that overall satisfaction with the HSTD system was high. However, the Commission report also indicated that additional work needs to be performed in order to fully inform recipients of their rights and to ensure that brokers are not "limiting transportation services unnecessarily."[45]

Kentucky Medicaid officials anticipated that a broker system would increase access to medical care, control spiraling service costs, reduce fraud and abuse, reduce administrative costs, increase

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[40] Kentucky Transportation Cabinet Website. Retrieved August 18, 2008, from http://transportation.ky.gov/transportationdelivery/

[41] Hewlett, T., Atchley, L., Otto, S., & Hager, G. *Human services transportation delivery: System faces quality, coordination, and utilization challenges*. Research Report No. 319. Kentucky Legislative Research Commission, 7.

[42] Ibid., 1.

[43] Human Services Transportation Delivery Program Brochure. Retrieved August 18, 2008, from http://chfs.ky.gov/NR/rdonlyres/0624C9C1-505D-4310-9F71-7FD3D617A42E/0/HUMANSERVICETRANSPORTATIONDELIVERYPROGRAMHSTD.pdf

[44] CMS Website. Kentucky 1915(b) non-emergency transportation fact sheet. Retrieved August 18, 2008, from http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Kentucky&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS028421&intNumPerPage=10

[45] Hewlett, T. et al., 19.

program accountability, and improve quality.[46] The Medicaid officials in Kentucky are satisfied that their current program has been successful, due in large part to its brokers and providers.[47] Additionally, Kentucky officials feel that a brokerage program is a cost-effective way of providing transportation, with the potential to save the state millions of dollars while simultaneously increasing the quality of service.[48] Without cost containment measures, Kentucky Medicaid officials predicted that the Medicaid NEMT budget would have grown from $23.1 million in 1996 to over $69 million in 2002. Through the use of the NEMT broker system, the state's FY 2004 expenditures for such transportation services was $48.8 million.

Washington

In Washington, the Medicaid NEMT services are provided as a part of a statewide transportation coordination model. In 1989, Washington began using regional transportation brokers to act as gatekeepers in coordinating NEMT for eligible Medicaid enrollees. The state uses a statewide broker arrangement with eight brokers contracting to serve 13 regions. Washington's broker organizations are a mix of public agencies and private non-profit entities. Prior to the regional broker model, the state found that its NEMT service program, provided on a fee-for-service basis in which trip coupons were distributed at the local level, resulted in a lack of NEMT coverage in certain areas of the state. The transition to the broker system allowed the state to increase access by assuring coverage statewide.

Under the NEMT contracts, brokers receive an administrative fee plus reimbursement for the direct trip costs. Brokers are required to arrange the least costly appropriate method of transportation. NEMT services within this brokered program include: public bus, gas vouchers, enrollee and volunteer mileage reimbursement, non-profit providers, taxi, ferry, and commercial bus and air. Brokers perform comprehensive NEMT administrative and coordinating services, including verification of Medicaid eligibility, determination of medical necessity of transportation, and assignment of transportation providers. Except in instances in which a lack of transportation options necessitates it, brokers may not provide transportation directly. The state's contracting requirements with NEMT brokers includes extensive quality monitoring and reporting on the part of the broker.

In 2005, Washington's Medicaid expenditures totaled over $5.7 billion. NEMT services comprised approximately 1 percent of the Medicaid budget, or $57,954,386. Five percent of eligible Medicaid enrollees utilized NEMT services provided through the brokers in 2005.[49] Prior to the implementation of the broker program, NEMT services in Washington cost, on

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[46] Ibid., 9.

[47] Wise, N. (2007, September 21). Comments to Proposed Rule-Federal Register August 24, 2007. From the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services. Retrieved August 18, 2008, from http://www.cms.hhs.gov/eRulemaking/downloads/CMS-2234-PEC1-32.pdf

[48] Bourne, V. S. (2007, September 18). Comments to Proposed Rule-Federal Register August 24, 2007. From the Kentucky Transportation Cabinet, Office of Transportation Delivery, Non-Emergency Medical Transportation. Retrieved August 18, 2008, from http://www.cms.hhs.gov/eRulemaking/downloads/CMS-2234-PEC1-32.pdf

[49] Agency Council on Coordinated Transportation. *Washington State summary of community and brokered transportation – 2005*. Olympia, WA: Author, 165. Retrieved August 18, 2008, from: http://www.wsdot.wa.gov/acct/library/reports-studies/Com.%20Trans%20Providers_Complete.pdf

average, $38 per trip in 1988, with public transportation rarely used for transportation to Medicaid services.[50] By 2001, this average cost dropped to $17.63, with public transportation being utilized for almost 40 percent of all trips.[51] In 2005, brokers coordinated a total of 3,239,485 trips.[52] The statewide average per trip cost in 2005 of $17.89 was just slightly higher than the cost in 2001.[53] In 2006, Washington State's brokers coordinated 3,226,536 trips for Medicaid clients.[54]

Washington Medicaid officials assert that both quality and efficiency of transportation services has increased as a result of this regional brokerage system.[55] In particular, the state indicates that its brokers' local knowledge and experience in the local areas has allowed it to reap benefits of the regional broker model. This allows the broker to provide value-added solutions in the face of unique, local challenges. State officials indicate that the broker assures access to health care for all Medicaid recipients though an increased utilization of appropriate providers within the regions. Prior to the implementation of the brokered system, NEMT was neither centrally reviewed nor coordinated.[56] The advent of the NEMT broker system brought the benefit of statewide coordination, but with contact at the regional level. A state official noted that the regional system's local call centers are of vital importance, assuring that individual needs are attended to while decreasing the chance of that individual's needs becoming lost in the system. The state also notes that its current design allows the NEMT program to support other Medicaid initiatives. Additionally, Washington prides itself on the model's ability to enhance the marketplace in creating resources that are then available for other needs.

County-Level Broker Program

Pennsylvania

The Pennsylvania Medical Assistance Transportation Program (MATP) provides NEMT services through a county-based broker program, utilizing local transportation providers and direct, local management. In 66 of the 67 counties, the commonwealth funds the local county government. Depending on the transportation resources available in a given geographic area, counties determine how to best administer the NEMT grant through the direct provision of NEMT services by the county, via a contract with an independent transportation entity, or through a local human services agency. The commonwealth contracts directly with a private broker in the remaining county— Philadelphia County—in the Philadelphia metropolitan area. Brokers also coordinate transportation for other commonwealth agencies, such as the Departments of Aging

[50] Stefl & Newsom. *National survey*, 121.
[51] Texas Comptroller of Public Accounts. *Use transportation brokers to improve the state's medical transportation program. HHS 3*, p. 3. Retrieved August 11, 2008, from www.window.state.tx.us/etexas2003/hhs03.html
[52] Agency Council on Coordinated Transportation, 165.
[53] Ibid., 14.
[54] Agency Council on Coordinated Transportation. *Coordinating transportation with brokerages.*. Retrieved August 18, 2008, from http://www.wsdot.wa.gov/acct/documents/Brokerages6_18_08_001.pdf
[55] Raphael, 18.
[56] Stefl & Newsom. *National survey*, 121.

and Transportation, to assure a streamlined transportation system.[57] County governments determine the degree of integration of programs based on cost-effectiveness criteria.[58] In early 2008, the commonwealth released a request for information (RFI) to assist in evaluating the possible implementation of a regional transportation model as well as to suggest improvements to the current county-level broker model.[59] Through this RFI, MATP sought not only to explore possible economies of scale that might be realized through regional management of services and the potential impact of a regional versus county-level system, but also to generate ideas from stakeholders on how MATP might better assure the provision of NEMT services. Pennsylvania is currently reviewing and assessing the responses to the RFI.

MATP provides NEMT services for Medicaid consumers without other transportation available to assure medical care provided through the Medicaid program. The NEMT program provides transportation services to Medicaid enrollees in both fee-for-service and managed care arrangements. Enrollees receive NEMT services via least expensive mode of transport that is appropriate for and meets their needs. NEMT services include tickets or tokens to ride public transportation, mileage reimbursement for use of a privately owned vehicle, and/or paratransit services. In FY 2008, MATP expenditures totaled $118 million, or approximately 0.8 percent of total Medicaid expenditures, which equaled $14.4 billion.[60]

Counties in Pennsylvania are responsible for comprehensive NEMT operational and administrative services. These responsibilities include outreach to and education of consumers; operating an NEMT telephone line; ensuring the provision of cost-effective, appropriate transportation services; optimizing cost-effectiveness and quality via coordination with local programs; eligibility screening; assessing transportation needs; authorizing transportation services; scheduling and assuring transport; maintaining and monitoring transportation provider networks; and ensuring quality of services through a complaint tracking system.

The commonwealth contracts with a private broker to provide the above NEMT services for the approximately 450,000 Medicaid enrollees in Philadelphia County. During FY 2003, about 2.86 million one-way trips were provided to more than 18,000 unique Medicaid enrollees in this county, for a total cost of about $26 million dollars.[61] In 2005 in the Request for Proposals for NEMT service administration in Philadelphia County, Medicaid officials stated that their goals for the broker program were to improve access to healthcare for Medicaid recipients through

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[57] Stefl & Newsom. *National survey*, 102.

[58] Commonwealth of Pennsylvania, Department of Public Welfare, Office of Medical Assistance Programs. (2008, July, revised). *Medical assistance transportation program: Instructions & requirements.* Retrieved August 18, 2008, from http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/MATP_Handbook.pdf

[59] Pennsylvania Medical Assistance Advisory Committee (MAAC). (2008, February 28). Meeting minutes. Retrieved August 20, 2008, from www.dpw.state.pa.us/partnersproviders/medicalassistance/advocatesstakeholders/advisorycommittees/meetingminutes/003677592.htm

[60] Ward, S., & Lave, J. *Fact sheet: Medicaid spending in Pennsylvania.* Pittsburgh, PA: Pennsylvania Medicaid Policy Center, 4. Retrieved August 19, 2008, from www.pamedicaid.pitt.edu/documents/pabudgetfs_format-pak_5_.pdf

[61] Philadelphia Medical Assistance Transportation Program (MATP). RFP #24-05. Retrieved August 19, 2008, from www.dpw.state.pa.us/omap/rfp/MATP/MATPrfp2405TOC.asp

increased client attendance or reduced "no show" rates at medical service and other health care appointments; increase use of lower cost transportation modes such as public transportation in order to lower program costs; and ensure customer satisfaction.[62] The commonwealth also sought to improve data collection through procurement in order to better analyze utilization, cost, and quality.

MATP promotes and monitors quality through a variety of means. Medicaid officials indicate that the program benefits from higher quality with local jurisdictions providing services in a manner responding to the unique needs of their service areas. To assist local jurisdictions, the program provides resources to the counties to best assure cost effectiveness and quality. Best practices in operations such as policies, quality measurement, contracting language, forms, and provider monitoring strategies are strategically shared across jurisdictions. MATP reviews provider rates negotiated across counties to assure cost-effectiveness. Additionally, MATP monitors counties through performance review instrument assessments and by conducting comprehensive onsite reviews assessing not only utilization and costs trends within and across years, but also policies, procedures, forms, and other operations. The contract with the private broker includes mandatory reporting of quality metrics as well as a required third-party customer service survey.

Florida

Prior to 2004, Florida operated a fee-for-service NEMT system in which services were coordinated through local community transportation coordinators and providers billed the Medicaid program directly.[63] Because of concerns over spiraling costs and the desire to implement fraud controls, Florida transferred the administration and management of the Medicaid NEMT program to the Commission for the Transportation Disadvantaged (CTD) in 2004.[64] The CTD, an independent commission housed within the state Department of Transportation, coordinates an integrated transportation system serving vulnerable populations. The CTD was created by statute to assure the coordination of an integrated, cost-effective transportation program to vulnerable populations.

Florida implemented its NEMT program through 1915(b) waiver authority to accommodate its unique contracting arrangement while allowing the state to claim the higher FMAP rate. To date, the CTD received a lump sum payment for provision of NEMT services for Medicaid enrollees. In the future, this arrangement will transition to a per member per month capitated payment. Under the Medicaid NEMT arrangement with the Florida CTD, the CTD then contracts through

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[62] Ibid.

[63] Snipes, D. (2008, January 24). *Medicaid non-emergency transportation.* Presentation to the Senate Health and Human Services Appropriations Committee, 4. Retrieved August 18, 2008, from http://www.fdhc.state.fl.us/medicaid/deputy_secretary/recent_presentations/non-emgergency_transportation_senate_hhs_012408.pdf

[64] The Agency for Health Care Administration. (2004, June 11). *Agency signs contract for non-emergency transportation: Mandates high service levels, implements fraud controls and yields savings.* Press release. Retrieved August 13, 2008, from http://www.fdhc.state.fl.us/Executive/Communications/Press_Releases/archive/2004/06_10_2004.shtml

a competitive bidding process with regional community transportation coordinators in 55 regions.[65] Currently, the regional community transportation coordinators are primarily public entities, but may also be private non-profit organizations or private firms. Reimbursement arrangements with the community transportation coordinators are determined by contractual agreement in each region. In FY 2007/2008, the Medicaid NEMT program budget was approximately $72 million; in FY 2008/2009, the budget for NEMT services totals about $68 million. The FY 2008/2009 total Medicaid budget is just over $15 billion. In FY 2007/2008, the CTD oversaw the delivery of 1.9 million trips for approximately 1.8 million Medicaid enrollees, 64,000 of whom used NEMT services.

Transportation services may also be provided by certain MCOs and Medicaid Reform Provider Service Networks. Earlier this year, the state reversed its policy to allow Medicaid MCOs to provide NEMT services for their enrollees. In the last few years, Florida's Medicaid agency, the Agency for Health Care Administration, has been transitioning to fully integrate health services, including NEMT services, within MCOs. At their discretion, Florida Medicaid MCOs are allowed to either provide NEMT services to their enrollees or to carve NEMT out of contracts with the state. The state requires those MCOs providing coverage under Florida's section 1115 Medicaid Reform program to provide NEMT services to enrollees. In FY 2007, as MCOs opted to provide NEMT to their enrollees, funds transitioned from the CTD contract to MCOs for providing these additional NEMT services. In FY 2007, MCOs were responsible for providing NEMT services to approximately 600,000 of the state's Medicaid enrollees. Following discussions with stakeholders and stemming from the "potentially detrimental impact the loss of Medicaid funds could have on Florida's coordinated transportation system for the disadvantaged," the decision was made to discontinue providing NEMT services through MCOs.[66] As of March 2008, Florida allows only those MCOs that had contracts in place prior to the Agency for Health Care Administration's 2004 contract with CTD to provide NEMT services to their enrollees.[67]

NEMT services are provided to individuals who are unable to transport themselves or purchase transportation due to physical or mental disability, income status, or age. These services are available to eligible recipients for trips to/from any Medicaid-covered service for the purpose of receiving treatment, medical evaluation, or therapy.[68] Florida provides medically appropriate transportation based on the medical needs of the client. Types of transportation include public transit (bus), multiple passenger van, taxi, wheelchair van, and stretcher van.[69] Florida requires a copay of $1 per one-way trip for non-exempt Medicaid enrollees.

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[65] In Florida, there are 67 counties that make up the 55 regions. Generally a region consists of a county or several counties spanning a single metropolitan area.
[66] Snipes, 10.
[67] Ibid., 11.
[68] Agency for Health Care Administration. (2007, July). *Florida Medicaid Summary of Services FY 2007 – 2008,* 105. Retrieved August 18, 2008, from http://www.fdhc.state.fl.us/Medicaid/pdffiles/SS_07_070701_SOS.pdf
[69] Harper, G. D. (2007, June 14). *Non-emergency medical transportation family café.* PowerPoint presentation. Agency for Health Care Administration. Retrieved August 18, 2008, from

The Agency for Health Care Administration partners with the CTD to develop and improve quality measures and standards that will ensure medically necessary trips for Medicaid beneficiaries. The broker contract requires CTD to submit quarterly reports on quality indicators, including quality improvement activities and findings, grievances, transportation statistics, complaints regarding quality control issues, and provider monitoring activities.[70] The Florida Medicaid program also uses the contractor to oversee and report on issues related to recipient access, recipient eligibility, and appropriateness of services provided. The Agency for Health Care Administration analyzes encounter data from CTD as another means of assessing quality.[71]

Overall, Medicaid officials report that the system has been successful, especially in creating cost efficiencies through strong gatekeeping and screening activities. The Medicaid program saw a greater-than-expected decrease in costs early in the contract. The Agency for Health Care Administration continues to work with the CTD to assure that the unique needs of Medicaid enrollees are met through the coordinated model. Specific attention is being paid to improving transportation across county and state lines. The agency is also collaborating with the CTD to add clarity to reporting, quality measures, and oversight activities.

Regional Broker Program – Mixed Model

Colorado

Colorado utilizes a unique mixed county-level and regional broker program to provide NEMT services for Medicaid enrollees. In 56 counties, the Colorado NEMT program is administered by county-level brokers, the local departments of social/human services. The remaining eight counties form a single region for which the state contracts with a regional broker to provide NEMT services.[72] The county-level and regional brokers are responsible for arranging and approving all NEMT services for Medicaid clients. In the 56 counties, each county has the option of contracting out administrative and coordinating services to other entities if it poses no additional costs to the Medicaid program.[73] NEMT services have been provided as an administrative service since July 2004.

In 2006, after increasing concerns related to increasing administrative burden, fraud and abuse, and conflicts in staffing priorities, the Colorado Medicaid agency requested input from the counties as to the future administration of NEMT services through a statewide broker arrangement. At that time, eight counties, generally in the Denver metropolitan area, opted to

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http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/family_cafe_non-emergency_transportation_061408.pdf

[70] State of Florida Auditor General. (2007, November). *Agency for Health Care Administration Medicaid non-emergency transportation services.* Report No. 2008-033, p. 3. Retrieved August 18, 2008, from http://www.myflorida.com/audgen/pages/pdf_files/2008-033.pdf

[71] Ibid., 6.

[72] The eight counties are generally in the Denver metropolitan area, the "front range" counties, and include: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, and Larimer counties.

[73] Colorado Department of Health Care Policy and Financing. *Non-emergent medical transportation specialty workshop.* PowerPoint presentation. Retrieved August 18, 2008, from http://www.chcpf.state.co.us/ACS/Pdf_Bin/Transportation_May_2008_Web.pdf

convert to the current regional broker program in which a broker contracts directly with the state to provide services. However, 56 counties opted to maintain the NEMT administration at the county level. The regional broker is contracted on a captitated per member per month basis. Under the county-level broker system, providers are paid on a fee-for-service basis with the fee schedule established by the Medicaid agency. The initial request for proposals resulted in a failed procurement attempt due to a lack of good data related to actual utilization and costs in the NEMT program for the region. A second procurement incorporated better data and was ultimately successful.

Colorado Medicaid provides NEMT services to and from medical services for Medicaid enrollees who have no other means of transportation. Each NEMT service is assessed on a case-by-case basis to assure that documentation verifies that the client requires the service, actually utilized the Medicaid-covered service, and transportation was provided to the nearest appropriate Medicaid provider.[74] Transportation provided through the county-level and the regional brokers includes mobility vehicles, wheelchair vans, ambulance, taxi, stretcher van, private vehicle, train, air transport, and reimbursement for gas, bus tokens, and bus passes.[75] All brokers, county and regional, must screen enrollees requesting transportation to assess eligibility and the need for NEMT services. Brokers must assure that all eligible individuals have transportation to medically necessary Medicaid-covered services and that such individuals have exhausted all other means of free transportation prior to accessing the Medicaid NEMT benefit. The regional broker performs comprehensive NEMT administrative services such as recruitment of adequate transportation networks; outreach and education to Medicaid enrollees and providers; authorizing, scheduling, assigning and dispatching transport; administering a 24-hour call center; and maintaining and submitting NEMT quality measures and assurances. Because much of the state is rural and has a lack of coordinated public transportation and other designated NEMT service providers, a large portion of NEMT provided for in the state is in the form of reimbursement for privately owned vehicles.

In FY 2007, Medicaid NEMT expenditures for Colorado were approximately $7.1 million. The state estimates that there were approximately 388,000 Medicaid enrollees in that timeframe and that the total Medicaid budget for FY 2007 was about $3.2 billion. The state notes a potential for under-utilization of NEMT services due to a lack of available providers in certain areas.

Colorado indicates that quality monitoring has improved in the eight-county region due to the implementation of specific quality monitoring efforts. From the regional broker, Medicaid officials report that quality is monitored through receipt of quality information and utilization data in monthly reports, random trip audits, and monitoring of the broker's call center. The Medicaid Agency works to improve quality through educational efforts and training conference calls with counties when a lack of consistency is found in how county-level brokers provide NEMT services. While the state does collect data on complaints received in the state Medicaid

[74] Colorado Department of Health Care Policy and Financing. (2007, September 21). *Non-emergent medical transportation*. HCPF Agency Letter 07-020.
[75] Colorado Medicaid Non-Emergent Medical Transportation (NEMT) brochure. (2008, May). Retrieved August 18, 2008, from http://www.chcpf.state.co.us/HCPF/Web/NEMT0508.pdf

office, Colorado Medicaid has not recently conducted a statewide customer service survey on Medicaid NEMT services.

Other State Initiatives

South Carolina

A review of the South Carolina Medicaid NEMT program was added to the study based on feedback from stakeholders and contacts at other states. The South Carolina Department of Health and Human Services contracted with two regional brokers to provide all NEMT services in six regions effective May 1, 2007. The new system was implemented to increase accountability, control inflationary growth in the provision of services, and improve services.[76] Previously, South Carolina's Medicaid Agency managed NEMT services centrally, contracting with county-level NEMT local transport entities in each region. The state transitioned to the broker system to have more management controls in place by using a gatekeeper to assure the provision of NEMT services in the least costly, most direct and appropriate manner to eligible individuals. At a July 2007 hearing called by the state's lieutenant governor, Andre Bauer, a Department spokesman reported that costs in the Medicaid NEMT program increased by 50 percent from 2002 to 2006.[77] In South Carolina, approximately 56,000 Medicaid enrollees use NEMT services each year. In FY 2007, Medicaid expenditures for NEMT services equaled $44.8 million.[78]

Brokers are responsible for establishing a network of providers, verifying enrollee eligibility, assessing the need for NEMT services, determining the most appropriate and cost-effective method of transport, and providing education to both enrollees and providers on NEMT services.[79] The brokers provide routine NEMT services to medical appointments, basic life support transportation that are planned trips (e.g., transport from nursing home to medical appointment), and non-emergency wheelchair transportation that requires use of lift vehicles but not the use of medical personnel.[80] Modes of transportation include van, automobile, bus, or other appropriate methods. Transportation via ambulance for non-emergency transport is not included in the brokers' scope of work. Brokers coordinate and schedule all NEMT services statewide for enrollees who reside within their assigned region(s).

The results of a November 2007 customer service survey revealed that 88 percent of Medicaid enrollees utilizing NEMT services were either very satisfied (65 percent) or somewhat satisfied

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[76] Osby, L. (2007, July 18). Transport system faces audit: Department says it changed procedures to improve accountability, efficiency. *Greenville News,* p. 1.
[77] Osby, L. (2007, July 17). Patient transport blasted: State's new Medicaid system puts people at risk, witnesses say at hearing. *Greenville News*, p. 1.
[78] South Carolina Department of Health and Human Services. (2007, November 27). *New study shows Medicaid beneficiaries satisfied with transportation services.* Press release.
[79] South Carolina Department of Health and Human Services. (2007, March 28). *Emergency ambulance services outside the brokerage model.* Medicaid Bulletin 07-04.
[80] South Carolina Department of Health and Human Services. (2007, March 28). *Medicaid transportation update.* Medicaid Bulletin 07-02.

(23 percent) with services. Fifty-two percent of respondents felt that the new NEMT system provides better service than the previous system. In 2007, Medicaid officials reported receiving 499 complaints against one broker and 259 complaints against the second broker in the first month of operation. This represented less than 1 percent of the 47,534 and 140,000 trips provided in that timeframe, respectively.[81]

South Carolina cites that the change had a positive impact on NEMT service provision. The Medicaid Agency reports that the broker system has allowed the state to realize the benefits of expanded transportation hours, heightened inspection of vehicles, and reduced fraud and abuse.[82] Medicaid officials highlight the importance of accurate data in the procurement and contracting process as well as the need for clearly articulated performance and quality measures within contracts with brokers to assure cost effectiveness and quality improvement. Officials also indicate that the transition to the broker system may have been more streamlined with a phased-in implementation schedule or by starting with a pilot region prior to statewide implementation.

State NEMT Studies

Based on public comments, we also looked at other states that were considering alternative models of proving NEMT services to Medicaid populations or had performed feasibility studies of systems for providing NEMT services.

Wisconsin

The Wisconsin Medicaid program has undertaken efforts to examine the establishment of a statewide Medicaid broker program. As part of this effort, the state initiated a request for information in April 2005, seeking input on issues regarding the possible implementation of a broker program.[83] After initially seeking a statutory change it considers necessary for implementation of such a system, the state's Medicaid agency, the Department of Health and Family Services (DHFS), put the effort on hold in the spring of 2006. The agency also considered—but did not move forward with—the implementation of a pilot program at that time. DHFS continues to explore options for providing brokered Medicaid NEMT services. Several models are under consideration in the state, including a Department of Transportation proposal for a statewide model that would coordinate all transportation services, including Medicaid NEMT services.

Wisconsin currently delivers Medicaid NEMT services through two separate programs: a common carrier component, provided as an administrative expense, and a Specialized Medical Vehicle component, which is an optional medical benefit. The common carrier services, using buses, vans, cars, and taxicabs, are provided under contracts with county and local tribal agencies. Common carrier NEMT services are provided on a fee-for-service basis for the entire

[81] Osby, L. Patient Transport Blasted, 1.
[82] South Carolina Department of Health and Human Services. (2007, November 27). *New study shows Medicaid beneficiaries satisfied with transportation services.* Press release.
[83] Wisconsin Legislative Fiscal Bureau. (2005, May 26). Non-emergency transportation services. LFP 2005-07 Budget Summary. Paper #372. p. 8.

Wisconsin Medicaid population, regardless of managed care enrollment status. Counties have had varied reactions to the proposed transition to a statewide broker program. Wisconsin provides Special Medical Vehicle services through a separate delivery system. For Medicaid fee-for-service enrollees, DHFS directly reimburses providers of these services on a fee-for-service basis. Managed care enrollees receive Special Medical Vehicle services through their MCOs. Such services are included in MCO capitation rates. The state estimated that in FY 2007, NEMT costs would total about $39.3 million.[84]

Iowa

The state of Iowa is currently undertaking an evaluation of its Medicaid NEMT system and reviewing other possible NEMT service provision models. As part of the study, officials hope to assess whether a broker model is a cost-effective and efficient model for the state. This study will provide the state with specific recommendations as to what type of NEMT service model would improve access for clients while providing cost-effective services. It is anticipated that the findings and final report will be available in the fall of 2008.

Idaho

In 2006, Idaho enacted Medicaid reform legislation that authorized and mandated selective contracting of Medicaid services. After securing input from Medicaid providers and consumers, the state's Interagency Working Group for Public Transportation, and other stakeholders,[85] the state Department of Health and Welfare (DHW) proposed a transportation brokerage model for the coordination of NEMT services to Medicaid enrollees. The state legislature approved the proposal in 2007. Under DHW's model, a single broker will be responsible for NEMT services in all seven regions of the state, for which the state will pay a specified fee calculated on a per member per month basis. Direct delivery of NEMT services will be accomplished almost exclusively through qualified providers subcontracted by the broker. DHW will select a statewide NEMT broker through a competitive bidding process; the state anticipates releasing the RFP for this procurement in mid-September of 2008. Idaho hopes to realize the following benefits from the broker system: increased efficiency through transportation coordination, improved NEMT access, expansion of NEMT services into previously underserved areas; and improved safety and training requirements for providers.[86]

Maryland NEMT Program: Analysis of Cost Effectiveness, Quality, and Impact on Local Jurisdictions

As described earlier, in 1993, Maryland transitioned from a statewide fee-for-service transportation program run by the Department to a county-based transportation grant program

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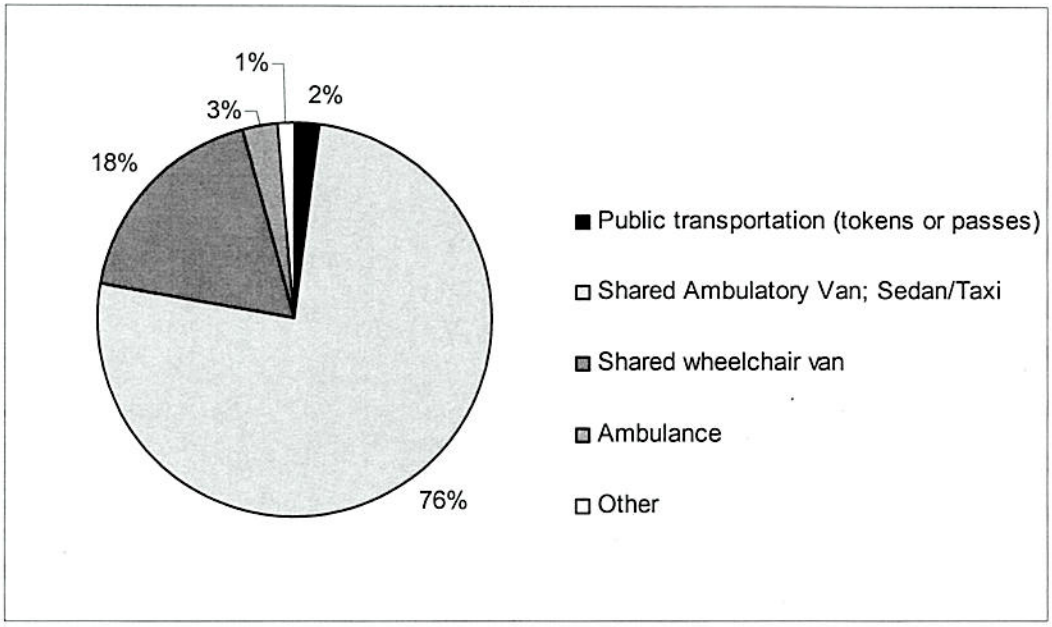
[84] Ibid.

[85] Idaho Interagency Working Group for Public Transporation Systems. (2007, January). *2006 annual report to the state legislature.*

[86] Idaho Department of Health and Welfare. (2008). *Medicaid non-emergent transportation brokerage fact sheet.* Retrieved August 26, 2008, from http://itd.idaho.gov/PublicTransportation/IWG/References/What%20is%20a%20Brokerage.doc

where administration and service provision are the responsibility of local counties. The Maryland counties vary considerably in the amount of screening and transportation services that they either provide directly or contract out. Over 700,000 one-way transports are covered each year by the transportation grant program in Maryland for the over 600,000 individuals who are eligible for the benefit. Shared ambulatory vans and sedans/taxis are the most common mode of transportation provided through the program (see Figure 1). The distribution of trips by type of transportation has remained steady for the past three years.

Figure 1. Maryland Medicaid NEMT Utilization: FY 2007 Total Number of Trips by Type of Transportation



Note: Based on the reporting of 23 out of 24 counties

Cost Effectiveness

Comparing Maryland data before and after FY 1993 shows that the Medicaid program initially realized significant savings by transferring the provision of NEMT services to local authorities. Additionally, the county-level broker program appears to continue to be effective in controlling cost increases over time. Between FY 1988 and FY 1992, Maryland's transportation expenditures increased 241 percent, from $5.6 million to $19.1 million.[87] The average annual increase in this four-year timeframe was 48.2 percent. Total NEMT costs decreased by 31.1 percent, from $19.0 million in FY 1993 to $13.1 million in FY 1994, or by close to $6 million in the first year Maryland implemented the county-level broker program (see Table 3). From FY 1993 to FY 1995, the state experienced a total decrease in NEMT expenditures of 40 percent, from $19 million to $11.4 million. Since FY 2000, the state has experienced an average growth

[87] Maryland Department of Health and Mental Hygiene. (1997). *Maryland assistance transportation program.* Executive summary.

rate of 10 percent for total NEMT expenditures and 6.8 percent for average cost per enrollee. Recent cost increases may be attributable, in part, to an increase in the cost of fuel.

Table 3. Historical Expenditures on Maryland Medicaid Transportation Services and Average Cost per Enrollee

Fiscal Year	Total Costs (In Millions)	Medicaid NEMT Eligible Average Monthly Enrollment	Average Cost per Enrollee	Annual Growth Rate Average Cost Per Enrollee	Annual Growth Rate Total Costs
1990	$14.40	323,928	$44.45		
1991	$17.50	352,644	$49.63	11.6%	21.5%
1992	$19.10	393,599	$48.53	-2.2%	9.1%
1993	$19.00	415,464	$45.73	-5.8%	-0.5%
1994	$13.10	435,788	$30.06	-34.3%	-31.1%
1995	$11.40	451,394	$25.26	-16.0%	-13.0%
1996	$12.80	437,994	$29.22	15.7%	12.3%
1997	$12.70	433,074	$29.33	0.3%	-0.8%
1998	$13.60	426,960	$31.85	8.6%	7.1%
1999	$13.91	439,343	$31.66	-0.6%	2.3%
2000	$15.13	488,753	$30.96	-2.2%	8.8%
2001	$16.95	509,151	$33.29	7.5%	12.0%
2002	$19.35	545,880	$35.45	6.5%	14.2%
2003	$21.10	575,983	$36.63	3.3%	9.0%
2004	$21.97	584,440	$37.59	2.6%	4.1%
2005	$24.21	596,405	$40.59	8.0%	10.2%
2006	$25.30	603,233	$41.94	3.3%	4.5%
2007	$29.50	602,703	$48.95	16.7%	16.6%

Nationally, NEMT service expenditures represent approximately 1 percent of state Medicaid budgets (see Table 4).[88] Based on a 2000 survey of all states, surrounding Mid-Atlantic states spend, on average, approximately 1.2 percent of their total Medicaid budgets on providing NEMT services to Medicaid enrollees. In comparison, Maryland spent approximately 0.5 percent of its total Medicaid budget on NEMT services provided through the county broker system. At that time, no state in the Mid-Atlantic region had a lower average cost as a percentage of total Medicaid expenditures.

As part of this study, we reviewed more current data for certain states to compare costs of NEMT services as a portion of total Medicaid expenditures. This analysis includes the states we studied for which data were available. While this estimate provides a gauge that may assist in comparing costs across states, it is important to note that the differences in how states provide NEMT services make it difficult to make an apples-to-apples comparison. For example, the populations that each state includes in the NEMT programs may vary considerably; some states may only include fee-for-service populations in these calculations, capturing MCO enrollees within MCO

[88] Flaherty, J. H., Stalvey, B., & Rubenstein, L. (2003). A consensus statement on nonemergent medical transportation services for older persons. *Journal of Gerontology, 58*(9), 826-831.

expenditures rather than NEMT expenditures. In this analysis, Maryland's NEMT costs of 0.5 percent of total Medicaid expenditures is lower than the average of 0.8 percent and exceeds only one state—Colorado—which indicates it may not have as much access to providers as it would like across the state (see Table 5).

We also evaluated data with respect to average cost per trip across NEMT programs for those states we reviewed in depth. Table 6 provides a summary of recent average cost per trip for those enrollees receiving NEMT services through the broker program in states we analyzed and for which the data were available. It is important to note that some of these calculated averages include administrative expenses as well as direct service expenditures, while others reflect only the average cost per actual trip (i.e., the direct transport service cost). Moreover, directly comparing the average trip costs across states is difficult due to differences in populations covered, geography, transportation provider availability, and so on. For example, some states do not include the managed care enrollees in the NEMT program, and therefore the costs reflect those of only the Medicaid fee-for-service population. Some states provide NEMT services to waiver populations within the NEMT broker program; in other states, transport to these populations is provided outside of the NEMT program. Additionally, states may rely almost entirely on mileage or gas reimbursement due a lack of availability of other types of transportation. In states with large rural areas, the average trip may be a considerable distance. Other states may utilize volunteers to provide very low-cost transportation alternatives or may integrate with public transportation systems to a larger degree. No one model appears to provide the lowest average cost per trip. However, despite the variation in programs, Maryland's costs appear to be on par with the NEMT programs of the other states we reviewed.

Table 4. National Summary of Medicaid NEMT Programs, 2000[89]

State	Medicaid Population	% of State Population	Medicaid Expenditures ($Billion)*	% of State Medicaid Budget for NEMT	Cost Per Trip ($)	Utilization Rate (%)
Alabama	527,078	12	2.4	0.3		13
Alaska	74,508	11	0.5	3.1		
Arizona	507,668	11	2	0.5	56	
Arkansas	424,727	16	1.5	0.8	34	8
California	7,082,175	22	20.3	0.4	75	3
Colorado	344,916	8	1.9	0.4	21	5
Connecticut	381,208	12	3	1.2		
Delaware	**101,436**	**13**	**0.5**	**1.2**	**21**	**<10**
D.C.	**166,146**	**32**	**0.9**	**2.1**	**44**	**>15**
Florida	1,904,591	13	6.7	0.9	17	9
Georgia	1,221,978	16	3.7	1.3	17	<10
Hawaii	184,614	15	0.6	2.7		3
Idaho	123,176	9	0.5	0.8		
Illinois	1,363,856	11	6.5	0.6		9
Indiana	607,293	10	3	0.9	27	16
Iowa	314,936	11	1.4	0.2		<10
Kansas	241,933	9	1.2	0.4	65	4
Kentucky	644,482	16	2.7	1.5		<10
Louisiana	720,615	16	3.3	0.4	37	
Maine	170,456	14	1.2	1.2		
Maryland*	***561,085***	***11***	***2.9***	***0.5***		***20***
Mass.	908,238	15	5.8	0.5	25	10
Michigan	1,362,890	14	6	0.2		
Minnesota	538,413	11	3.1	0.9		
Mississippi	485,767	17	1.8	0.8	36	<10
Missouri	734,015	13	3.6	0.3	38	7
Montana	100,760	11	0.4	0.4		
Nebraska	211,188	12	1	0.3	7	<10
Nevada	100,760	5	0.5	0.3		
New Hampshire	93,970	8	0.8	0.3		
New Jersey	813,251	10	5.8	1.5+	30	
New Mexico	329,418	18	1.1	1.1		<10
New York	3,073,241	17	28.8	1.09		
North Carolina	1,167,988	15	4.9	0.3		
North Dakota	62,280	9	0.3	0.3		<10
Ohio	1,387,581	12	7	0.6		
Oklahoma	342,475	10	1.5	0.4	27	<10
Oregon	511,171	15	2	0.6	8	
Pennsylvania	**1,523,120**	**12**	**7.3**	**0.5**	**8**	**4**
Rhode Island	153,130	15	1.1	0.2		20
South Carolina	594,962	15	2.5	0.9	14	15
South Dakota	73,150	9	0.3	0.5		3
Tennessee	1,355,733	24	4.2	0.4		
Texas	2,324,810	12	10.6	0.3	11	3
Utah	215,801	10	0.7	0.2	31	
Vermont	123,992	20	0.5	0.8	10	12
Virginia	**653,236**	**9**	**2.5**	**1.9**	**45**	**19**
Washington	728,794	12	3.6	1	17	
West Virginia	**342,668**	**19**	**1.3**	**0.5**		
Wisconsin	518,595	10	2.8	1.3		
Wyoming	46,121	9	0.2	0.05		<10
Nationwide	***38,546,395***	***14***	***178.6***	***1***	***16***	***10***

* In the above chart, the 2000 Maryland Medicaid enrollment is reported based on preliminary estimates of enrollment data provided for a national study conducted in that year. The enrollment number differs slightly from the 2000 Maryland Medicaid average monthly enrollment data reported in Table 3, which represents actual enrollment counts finalized after all data was submitted and verified for that year.

[89] Ibid.

Table 5. Comparison of Recent NEMT Program Expenditures as Percent of Medicaid Expenditures in Selected States

State (FY)	Broker Model	NEMT Expenditures as Percent of Medicaid Expenditures[90]
Colorado (FY 06)	County and Regional	0.3%*
District of Columbia (FY 06)	Single Statewide (FFS Enrollees)	1.2%**
Florida (FY 07/08)	State Commission contracts with Regional Brokers	0.5%
Maryland (FY 07)	*County*	*0.5%*
Mississippi (FY 06)	Single Statewide	1.0%**
Pennsylvania (FY 08)	County	0.8%
South Carolina (FY 06)	Regional	1.1%**
Virginia (FY 07)	Regional	1.0%
Washington (FY 07)	Regional	1.0%
Average		**0.8%**

* State officials indicate that a lack of transportation provider availability in certain areas of the state may contribute to lower-than-optimal expenditures on NEMT services..

** Based on expenditures reported prior to NEMT broker program implementation.

Table 6. Comparison of NEMT Program Average Cost Per Trip in Selected States

State (FY)	Broker Model	Average Cost per Trip
Delaware (FY 07)	Single Statewide	$13.20
District of Columbia (FY 06)	Single Statewide (FFS Enrollees)	$38.21*
Florida (FY 07/08)	State Commission contracts with Regional Brokers	$37.89
Maryland (FY 06)	County	$34.54
Mississippi (FY 07)	Single Statewide	$38.06
Washington (FY 05)	County	$17.89

* Based on expenditures reported prior to NEMT broker program implementation.

[90] Based on estimates from state sources, publicly available evaluations and reports, and information on total FY 2006 Medicaid Expenditures from www.statehealthfacts.org

Quality

Medicaid agencies use a variety of performance standards for NEMT programs. The degree to which NEMT quality is monitored differs considerably across states. Several of the states contacted for this study indicated that prior to implementation of their NEMT broker programs, they were collecting minimal, if any, data related to quality. Common measures include metrics related to client satisfaction, waiting-time, on-time record, accident frequency, and vehicle quality and maintenance. States often use client satisfaction surveys to evaluate NEMT assistance using criteria to measure timeliness, "no show" pick-ups, driver courtesy, ability to meet client needs, length required in route, condition of the vehicle, and the ability of the driver to find the pickup point. States also may use a measure of wait time or on-time performance as an NEMT quality indicator by evaluating the number of trips exceeding the required window of the scheduled pickup time, by evaluating the average pickup time prior to the scheduled appointment (measured against a benchmark), or via on-site reviews of providers' on-time performance. Other indicators of quality include reports of accident frequency, driver safety, vehicle safety, odometer readings, and vehicle maintenance. NEMT programs often also include periodic unannounced on-site audits and inspections.

The Department measures NEMT quality in the Maryland Medicaid program primarily through two methods: a statewide customer service survey and tracking and monitoring NEMT service complaints. In FY 2007, the Department sent a customer service survey by mail to randomly selected Medicaid enrollees who had used NEMT services that year. Results of the survey demonstrated that enrollees generally had positive experiences with Maryland Medicaid's NEMT program. Of those responding, 86 percent felt that the Maryland Medicaid NEMT program was adequate and met their needs. Within the survey, the Department specifically requested information about quality of customer service from individuals arranging and scheduling transport, satisfaction with arriving in a timely fashion for the medical appointment for which NEMT service was provided, driver safety and customer service, vehicle safety and cleanliness, and satisfaction with returning home from the medical appointment within a reasonable time.

The Department tracks and monitors, on a statewide basis, complaints related to NEMT services provided through Medicaid. The Department not only resolves issues as they are reported, but it also uses the data provided in the complaints as a management tool to improve overall quality. Medicaid officials regularly review information in the complaints, track complaints for trends, and address issues as they emerge. In FY 2007, the Department received a total of 211 complaints related to NEMT, including long wait times for return transport following an appointment, transportation providers not showing up at the appointed place and time, transport arriving too early, transport arriving late for an appointment, customer service concerns, and complaints about driving safety. This represents a complaint rate of less than .03 percent of Medicaid NEMT trips provided each year. In FY 2008, the number of NEMT-related complaints decreased to 155.

Several of the local jurisdictions reported conducting county-level quality monitoring in addition to the monitoring conducted by the Department. Thirteen of the 24 counties continue to conduct surveys of their riders even though the Department conducts a statewide survey. All of the jurisdictions are required to maintain a complaint log that is sent to the Department on a quarterly basis. Many counties reported that they follow up directly to resolve complaints as they are received. Local jurisdictions cited frequent direct contact with riders, medical providers, social workers, case managers, and transportation vendors as a primary method of gaining information about the quality of the program and issues that need to be addressed. One county sponsors an annual advisory luncheon with randomly selected customers, the transportation provider, and the local office to discuss feedback about the program. Five jurisdictions conduct random spot checks to assure the validity of medical appointments, appropriate transportation vendor training, and proper vehicle maintenance. One county denies reimbursement for trips with "poor service provision." Another county added a successful gas voucher program as an option at the suggestion of a customer. St. Mary's County's Medicaid transportation program was named a Model for Practice with regard to access to primary care in rural areas[91] and received the Outstanding Rural Health Program Award at the Maryland Rural Health Summit in 2007.[92]

Several counties review regular reports from their vendors to assess service quality and access. One county reported that on-time performance is tracked by the contractor and cross-referenced to consumer-reported on-time arrivals to verify accuracy. Another county reported that real-time global positioning devices can be used to monitor and verify transportation location and times to resolve discrepancies between a vendor and a recipient. One county conducts internal employee satisfaction surveys on the premise that staff satisfaction will translate to improved customer service.

Oversight, Accountability, and Operating Efficiencies

As part of its oversight activities, the Department collects utilization data from the counties such as the number of one-way trips provided, the mileage, and the number of individuals served according to each category of transportation. Counties also submit financial data to support the annual grant request. Databases and spreadsheets are the primary methods used by counties to store data related to their NEMT programs. The quality of the data varies considerably across counties.

While the Department requires counties to operate their programs in an efficient, cost-effective manner, counties have the freedom to implement whatever program integrity activities they choose. Maryland's local jurisdictions use a variety of operating practices to ensure accountability and achieve operating efficiencies in their NEMT programs. Several rural counties combine Medical Assistance transports with transports funded through other programs to

[91] Gamm, L. D., Hutchison, L. L., Dabney, B. J., & Dorsey, A. M. (Eds.). (2003). *Rural Healthy People 2010: A Companion Document to Healthy People 2010. Volume 1.* College Station, TX: The Texas A&M University System Health Sciences Center, School of Rural Public Health, Southwest Rural Health Research Center.
[92] Rural Maryland Council. (2007, October 1). *2007 Rural Impact Award Winners Announced.* Press release. Retrieved from http://www.rural.state.md.us/News/2007_Awards.pdf

improve efficiency and reduce costs. Others mentioned partnerships with the local public transportation system to prevent duplication of services. Three of the counties on the lower shore have engaged in a regional partnership since FY 2002 to coordinate long distance travel services for their clients; two southern counties have established a similar partnership. One county is partnering with a local university to develop a geographic information system (GIS) to help map out routes more efficiently.

Counties mentioned several oversight practices that are used to ensure accountability, including appointment verification (especially for clients who have previously abused the system), mileage audits, medical provider verification for ambulance transport, and careful review of vendors' bills and reports. Strong screening procedures are used to ensure client eligibility, verify the need for transportation, check for third party liability, and ensure that alternative sources of transportation are inadequate or unavailable. One county specifically cited evidence of cost containment (and in some years cost decreases) in 1997 when it implemented a screening process conducted by county staff. Another county ensures that riders have referrals for all specialty care providers and that they are being transported to the nearest participating provider.

In the public comment process, stakeholders provided both positive and critical feedback about the state's current NEMT system. From these critical assessments, a few key areas for oversight and operations improvement emerged including a need for additional training and quality assurance to assure consistent application of Maryland Medicaid NEMT policies across the state. Stakeholder concerns focused around variations in program operation and application of Medicaid policy across transportation providers and jurisdictions. Some stakeholders noted a lack of clear demonstrated understanding by county staff and transportation providers of Medicaid guidelines with respect to eligibility, transportation requirements across jurisdictions, and transportation for multiple children within the same family to appointments. Some stakeholders noted that a general lack of clear written guidelines accessible to providers and to consumers prevents the most effective administration of the program. Stakeholders also provided concern with the lack of oversight with respect to the reliability and timeliness of transportation providers in some jurisdictions.

Analysis/Assessment of Local Health Department Impact

Maryland counties use a variety of models to assure NEMT services to Medicaid enrollees in each county. The state allows the counties the flexibility to implement the NEMT program in a manner that best suits the circumstances in that county. In FY 2007, ten of the counties in Maryland performed all or most of the day-to-day NEMT administrative and coordinating tasks, such as operating a call center, scheduling transport, and screening eligibility. The remaining 14 jurisdictions contracted with vendors to perform all or a portion of these administrative and coordinating tasks. In these jurisdictions, county staff focus on administering and monitoring the subcontracts.

The elimination of the county NEMT service management responsibilities would impact approximately 119 positions in Maryland county governments. Of these, 85.4 full-time

equivalent positions would no longer be funded through the Medicaid program.[93] County governments would lose approximately $5.6 million currently used to fund these positions and cover county-level NEMT administrative costs. This loss of funding could impact local economies. Costs for administrative functions and staffing levels vary across counties, not only because of factors such as population density and geography, but also in accordance with the NEMT management model used. Some counties have liabilities for multi-year contracts. Counties that provide transportation services themselves have invested in the infrastructure needed to provide direct services.

Nearly all of the counties expressed concern about the impact that moving to a uniform statewide NEMT program would have on Medical Assistance enrollees. Familiarity with local geography, coordination with local providers and services, knowledge of other transportation programs, the ability to respond during weather-related emergencies, familiarity with client needs, and the impact on the local economy were all cited as benefits to the current NEMT structure involving local jurisdictions in Maryland.

The rural counties were concerned that a statewide vendor would not have strong knowledge of the geographic nuances in their counties. They expressed fear that clients would be late to appointments because a statewide vendor would underestimate travel times and that effective coordination of shared rides in rural areas would suffer. In addition to knowledge of geographic issues, county staff are aware of local resources, which allows them to serve the diverse needs of clients effectively. For example, counties reported that they were familiar with other local transportation resources and the local health care providers and therefore could assist clients as needed. Eastern shore counties reported collaboration with each other on trips to Baltimore and close working relationships with Baltimore-area hospitals to assure appropriate transportation.

Several counties cited the loss of coordination of services as a major concern with a statewide program. This includes the potential loss of coordination of non-MA transportation services with those services covered by Medicaid. County transportation staff also make referrals to other health department (or county-based, non-health department) services to meet client needs. In one county, a transportation coordinator reviews the daily schedules of multiple human service agencies and schedules transportation appropriately so as to maximize access and reduce costs. Several counties coordinate with other local transportation programs and with the cancer society for rides. County transportation staff also refer clients to other county programs such as aging programs, Healthy Start, Department of Social Services, Administrative Care Coordination Unit (ACCU), Adult Evaluation and Review Services (AERS), Personal Care Programs, immunization clinics, HIV case management, and the Ombudsman. County officials feared that changing to a statewide system would affect their ability to provide comprehensive, preventative, and direct care services to vulnerable individuals to address their unmet needs.

Transportation staff from the Baltimore City Health Department work with other city agencies to coordinate transportation during weather emergencies. The Baltimore City Health Department is especially concerned that converting to a statewide system would cause it to lose data about

[93] Based on FY 2007 data received from the Department.

recipients' locations and medical needs, which would impact its ability to anticipate and respond quickly during weather emergencies. A loss of funding would result in a loss of staff who coordinate such emergency operations. One county cited the potential loss of rapidly available transport services to non-Medicaid residents during emergency conditions if the county ceases to provide NEMT. Another rural county health department partners with the local fire department and other county agencies to address critical medical transport needs during weather emergencies or when roads flood.

One county expressed particular concern about the impact that a change in the transportation program might have on individuals with learning disabilities or mental health issues, as well as the elderly. This county reported working through a difficult transition in the late 1990s with the implementation of an interviewing/screening process for transportation requests. Clients were initially reluctant to participate, but the county reports that it has now built up years of trust and clients know to expect safe transportation and referrals to other needed services. Another county feared that clients with behavioral health needs would be forced to use more limiting transportation alternatives, which may impede this population from continuing to engage in care. Three other counties expressed concern that clients with language barriers would experience difficulty with a transition to a statewide program. Several counties mentioned that the relationships that the county staff and the local drivers build with clients allows them to notice changes in health status that they can then pass along to health care providers or case managers, as appropriate.

Counties were concerned about the negative economic impact of a statewide program on local transportation companies and communities. They were afraid that a large vendor could push smaller local providers out of business, severely impacting other non-MA public transportation systems or services. Clients and counties have developed strong working relationships and familiarity with local drivers, which may be lost in a statewide conversion.

Findings

To assess the feasibility of implementing a uniform statewide NEMT program for Medicaid enrollees in Maryland, The Hilltop Institute conducted an analysis of available literature; undertook an exhaustive review of available models of management NEMT services in Medicaid; conducted an evaluation of other states' experiences with these models; analyzed Maryland's current system using state data and information collected directly from local jurisdictions; and incorporated comments and data from stakeholders within Maryland.

Based on the results of this analysis, Maryland's Medicaid program is in the position to implement a statewide, uniform NEMT program. However, we found no compelling evidence that the state would realize substantial—or any—cost efficiencies and/or quality improvement merely by creating and implementing a different system than the current county-level NEMT broker program.

No "One Size Fits All" Solution

In our examination of possible systems Maryland could implement as a uniform, statewide NEMT program, we found that there is no one model that is clearly superior to other models. There is no "one size fits all" solution for Medicaid programs across the country. Every model we reviewed appeared to be capable of successfully managing and providing cost-effective, high-quality NEMT services to Medicaid enrollees. While many states, including Maryland, employ a broker model of NEMT service provision, each state's broker system is unique to the circumstances within that state. As one state official explained, each program is uniquely shaped by the needs, values, and priorities of the state. An examination of other states' experiences with NEMT program implementation confirms the truth behind this statement.

In exploring each state's management of NEMT programs within the study, we found that the specific issues that acted as the impetus of transformation very much shaped the model the state ultimately implemented. Those states primarily concerned with spiraling costs and/or fraud and abuse designed systems to specifically address these issues, often employing a capitated payment system. States that put much more emphasis on increasing coordination with other transportation programs to gain efficiencies created programs to assure increased coordination. These programs tended to specifically focus on coordination with or through state, regional, or local human services or transportation agencies. One program specifically valued use of more local agencies because it felt that knowledge of geography, culture, available services, and the people within the region allowed a broker to provide better service. Another state designed a single broker system for the entire state based primarily on its small geographic size.

Incentives are inherent in design elements. Decisions about elements such as reimbursement methodologies, centralization, and use of a broker all create different behavioral incentives and each has its own advantages and disadvantages. It is pivotal for a state to utilize a system that takes into account the priorities and circumstances of the state and manage the program with the design elements in mind. The impetus behind the move to a new system inevitably shapes the program design. That design takes care of the concerns behind the impetus but may create other

unintended consequences. As one state official indicated, one model may solve one problem or set of problems, but it often leads to the creation of other concerns in a competing area.

Considerations

Further consideration of several key factors is pivotal in determining whether it would be advantageous to Maryland to create a uniform, statewide system:

- What issues does the state plan to address through a transformation to a new system of providing NEMT services?
- Is it in the best interest of the state to create a different system or to focus on strengthening the current system to better meet its needs?
- What does the state hope to gain from a new system and could those gains be achieved equally through modifications to its current system?
- What are the state's key values and priorities in providing NEMT services and which model optimizes its ability to provide services in harmony with these?

Cost Savings that Might Arise from the Creation of a Statewide Program

HB 235 required the study to include an analysis of cost savings that might arise from the creation of a statewide program. The analysis indicates that Maryland's operation of its current NEMT program is relatively efficient when compared to other states and historical data. The Department might find savings at the margins, either through implementation of a new system or implementation of elements to gain additional efficiencies in the current system. There is no compelling evidence that the state would necessarily gain cost savings, such as those gained in the FY 1993 transition to the current system due to a change in how it provides NEMT. Recent increases in fuel costs are increasingly putting pressure on states to seek efficiencies in NEMT programs and control transportation costs regardless of the model in use. Maryland's NEMT expenditures as a percent of total Medicaid expenditures are considerably lower than that of national and regional averages. Additionally, Maryland's NEMT costs have not been increasing disproportionately to the state's total Medicaid expenditures and have actually remained at 0.5 percent since at least 2000. The national average is approximately 1 percent; in neighboring Mid-Atlantic states, average operating expenses in 2000 were about 1.2 percent of total Medicaid expenditures.

Many of the state programs we evaluated demonstrated that implementing broker programs proved to be a cost-effective strategy for those states. States indicated two main reasons for these savings: 1) the broker's essential role in performing the gatekeeping function, assuring rides only to eligible individuals for appropriate trips in the most cost-effective manner, and 2) the broker system acting as a deterrent to fraud and abuse. Some states benefited from rather substantial decreases in NEMT program expenditures. Maryland's current program utilizes local

jurisdictions to perform this gatekeeping role to assure rides for only eligible Medicaid enrollees to appropriate trips in a cost-effective manner.

However, we did not find an example of a state realizing substantial savings by moving from one broker model to another, although we attempted to find such examples so that we might estimate the impact that this could have in Maryland. States mentioned plans underway to improve their current NEMT broker systems by implementing additional management or quality controls or by adding incentives into the contracts. A number of states have begun exploring such a change and have requested public input into the concept. However, because we did not find a state that had implemented and evaluated the impact of such a change, we could not evaluate cost efficiencies created by such a transition.

The occurrence of states gaining significant initial savings with the implementation of a broker program appears to mirror the savings Maryland realized in transitioning to the county-level NEMT broker program in 1993, when NEMT expenditures decrease from $19 million to $11.4 million in FY 1995. Maryland's county-level brokers appear to be continuing to find ways to manage costs and create efficiencies. Several of these jurisdictions report an increasing focus on use of public transit as a cost-effective mode of transport when appropriate for the individual. Others report success in creating efficiencies through cross-coordination with other transportation programs in the county.

States highlighted the importance of combining the opportunities in creating operating efficiencies through broker systems with strong state oversight. Officials from a number of the state programs indicated challenges stemming from missed opportunities for creating savings and accountability in the initial Request for Proposals and resulting contract. Several states specifically highlighted the importance of accurate utilization and cost data going into the procurement process. These states had experienced the need to reassess rates or adjust terms of contracts based on NEMT programs designed with inaccurate or vague utilization, cost, and/or enrollment estimates. Some state officials also indicated that broker contracts that lacked performance benchmarks, specific sanctions, or incentives hampered the state's oversight ability to manage the program to assure the greatest cost efficiencies and the highest level of quality.

Potential for Quality Improvement with a Statewide Program

The Department's current system measures quality of NEMT services through complaint monitoring and a customer service survey. A number of other states also use these methods to assess quality and access with respect to their NEMT programs. While Maryland may benefit from a more rigorous quality measurement and assurance program, it may not require the Department to create a different system for providing NEMT services. It is likely that additional quality measures and quality improvement tactics could be readily incorporated into the current system. Furthermore, the state should address stakeholder concerns about the lack of consistent understanding and application of Medicaid policies across the state by incorporating stronger management oversight and quality assurance elements into the NEMT program, whether it changes the structure of the current system or not.

The implementation of quality measures differed across other states. Most of the states, regardless of current NEMT model, mentioned continuously striving for inclusion of better quality measures and implementation strategies. A number of state Medicaid officials highlighted one key element of the broker system: its ability to provide the state with additional and more detailed data on the provision of NEMT services across the state. Some states are currently considering incorporating elements of pay-for-performance and incentive-based contracting into their NEMT programs. States also used the broker system to increase reporting on utilization, cost, and quality data to strengthen the Medicaid agencies' ability to monitor performance. Transitioning to a broker system provided many states with systematic reporting of data that they were unable to monitor previously. As states gained experience with the broker model and with the data available, several began modifying reporting requirements and implementing benchmarks that brokers must meet. They are starting to use the data to create additional management monitoring resources and stronger accountability tools.

While the broker model creates the opportunity for states to better report and monitor quality, it is up to the state to capitalize on the management controls available to it through the model. Many states felt that standardized reports across the NEMT program were one of the strengths that could be garnered from a broker or uniform system. Other states preferred to leave room at the local level for development of best practices in quality monitoring best suited for each unique area. At least one state felt that flexibility in reporting at the local level produced overall better quality results than standardization across all jurisdictions. This state felt that strict standardization of quality measures may, in fact, lower quality assurance in some areas.

The Department could increase quality monitoring and management controls of NEMT services either through a new system altogether or in the current model. For example, the variability and inconsistency in data reporting across counties suggests that there is opportunity for improvement. The Department should address these inconsistencies in the reporting of cost and utilization data to improve program integrity. The Department should expand its quality monitoring program beyond the complaint data and customer service survey to require counties to report on access and timeliness measures such as the number/rate of "no shows" by transportation providers, the number/rate of transports in which the enrollee's waiting time exceeded the pickup window, and the number/rate of enrollees receiving NEMT services who were late for scheduled health care appointments. This standardization in quality monitoring will allow the Department to identify high-performing counties who may be able to assist other counties with the implementation of "best practices," as well as counties in need of improvement. While the quality measures implemented should reflect the state's priorities and values, Hilltop also recommends that the Department review "best practices" of quality measurement and program oversight from other states, some of which are highlighted within this report. A number of the local jurisdictions in Maryland have designed and implemented quality and access measurement and improvement programs as well. These innovative practices may be a natural starting point for discussion around improving the NEMT program's measurement of quality. Finally, to assure consistent application of NEMT policies across the state, the Department should incorporate some additional elements of assessing performance of local jurisdictions, such as site visits or desk audits of local policies and procedures. Expansions of quality improvement reporting efforts and implementation of additional management oversight

initiatives such as desk audits or periodic site visits may require additional resources at both the Departmental and jurisdictional level

Impact of a Statewide Program on Local Health Departments

The impact of creating a different NEMT program in Maryland would vary by county. Administrative costs and staffing levels vary across counties not only due to factors such as population density and geography, but also in accordance with the NEMT management model used. The elimination of the county NEMT service management responsibilities would affect approximately 119 positions in Maryland county governments representing 85.4 full-time equivalent positions.[94] County governments would lose approximately $5.6 million in Medicaid funding currently used to fund these positions and cover county-level NEMT administrative costs.

Beyond direct financial and staffing impacts, the counties expressed concern about the impact on Maryland Medicaid enrollees and providers. Counties cited the importance of familiarity with local geography, coordination with local providers and services, knowledge of other transportation programs, the ability to respond during weather-related emergencies, familiarity with client needs, and the impact on the local economy as benefits to the current NEMT structure involving local jurisdictions in Maryland. Any change to the current system would affect each of these aspects of NEMT service.

[94] Based on FY 2007 data received from the Department.

Conclusions

We found no compelling evidence that Maryland would necessarily realize cost efficiencies and/or quality improvement by merely transforming Maryland's current NEMT program from a county-based broker program to a uniform statewide program. Each NEMT broker model reviewed appeared to be capable of successfully managing and providing cost-effective, high-quality NEMT services to Medicaid enrollees. The optimal model for Maryland's NEMT program depends, in part, on the state's priorities and values with respect to NEMT service provision. While the Department may be in a position to implement a statewide uniform NEMT program, there is no evidence to suggest that any cost savings or quality improvements achieved through such a transition could not be achieved through focused efforts to improve the current system. Furthermore, it is clear that transitioning to a uniform statewide program would significantly impact the local jurisdictions who have managed the program since 1993. Recent increases in fuel costs suggest that NEMT budgets are likely to increase, putting pressure on states to seek efficiencies and control transportation costs regardless of the model in use.

Appendix A:
MEDICAID NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SURVEY TO LOCAL JURISDICTIONS
7/30/08

Name of local jurisdiction: _____

Part I. General Administration and Operations

What type of transport does the local jurisdiction provide either directly or through a contracted broker/provider? (Check all that apply.)

___ Public transportation (tokens or passes)
___ Shared ambulatory van
___ Sedan/taxi
___ Shared wheelchair van
___ Stretcher van
___ Ambulance
___ Air transport
___ Other (describe) _____

Does your local jurisdiction provide any transportation directly to recipients? If so, in what circumstances do you provide such transportation and what type of transportation is provided directly? _____
_____

What functions does your local jurisdiction perform related to Medicaid NEMT? (preauthorization of services, screening of eligibility, contracting with brokers/providers, etc.) (Note: The following question relates to any functions contracted out.)

_____
_____

Does your local jurisdiction contract out any NEMT functions? If so, what are the functions and to what type of entity are they contracted?

_____
_____

What are the operating days and hours for transportation? _____

What are the operating days and hours for customer service (e.g., reservations, complaints)?
_____

How far in advance must requests be made? Under what circumstances are exceptions to advance notice made? _____
_____

What proportion of services are provided within the community (e.g., from the individual's home to a medical service) and what proportion are provided to individuals moving between providers/institutions (e.g., from nursing home to hospital)? (You may provide an estimate if precise records are not available. Please label as an estimate):
_____
_____

What operating efficiencies have you found using your current system (e.g., coordination with another county-based transportation program)? _____
_____

Are there any restrictions on going across jurisdictions? If so, please specify what restrictions apply: _____
_____

What percent of trips are made to providers outside of your jurisdiction? _____
_____

Part II. Utilization/Costs

	FY 2005	FY 2006	FY 2007
Number of unduplicated Medicaid enrollees actually using NEMT	_____	_____	_____
Number of one-way trips reimbursed under NEMT	_____	_____	_____
Total expenditures for NEMT	_____	_____	_____

	FY 2005	FY 2006	FY 2007
Average cost per person	_____	_____	_____
Average cost per trip	_____	_____	_____
Average cost per mile	_____	_____	_____

How much of the total NEMT budget goes to administrative costs and how much goes to direct service costs? _____

_____

Please provide any data you may have of NEMT utilization by type of transportation (see attached spreadsheet).

Do you have data relating to utilization of NEMT by specific populations (e.g., by age or type of accommodation/disability)? If so, please share this data.

Please describe what type of data you keep about NEMT and how you maintain that information:

_____

_____

Part III. Quality

Other than the state customer service survey conducted by DHMH, has the local jurisdiction conducted any consumer satisfaction surveys? If so, please provide information about the survey measures and results.

_____

_____

How do you assure and measure quality related to access for eligible Medicaid recipients?

_____

_____

How do you measure and monitor quality in your NEMT program? Please describe what measures are used and how data is collected. _____

Do you have information you could share from a comments/complaints tracking system related to NEMT quality? _____

_____

Part IV. Impact

Please describe how the state moving to the creation of a uniform statewide non-emergency medical transportation program would impact your local jurisdiction in terms of:

Staffing: _____

_____

Coordination with other transportation programs (both for Medicaid enrollees and with respect to non-Medicaid populations):

_____

_____

Ability to serve the needs of Medicaid recipients: _____

_____

Other resources: _____

_____

Please share any other data or information about the potential impact of moving to a uniform statewide NEMT program to serve enrollees of the Maryland Medical Assistance Program.

Thank you for your input.

Local Jurisdiction - Attachment to NEMT Survey

Jurisdiction/County Name:

NEMT Utilization

	FY 2005			FY 2006			FY 2007		
Type of Transportation	**# of trips***	**# of recipients - unduplicated**	**total cost**	**# of trips**	**# of recipients - unduplicated**	**total cost**	**# of trips**	**# of recipients - unduplicated**	**total cost**
Public transportation (tokens or passes)									
Shared ambulatory van									
Sedan/taxi									
Shared wheelchair van									
Stretcher van									
Ambulance									
Air transport									
Other (describe)_____									

*Trip is a one-way transport to or from a medical service covered under Medicaid.

Appendix B:
MEDICAID NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SURVEY TO STATES
7/30/08

Part I. General Administration

Does your state cover NEMT as a medical service or an administrative service under Medicaid?

_____

If your state covers NEMT as a medical service, under what authority is the NEMT? (1915(b), state plan, DRA broker authority or 1115) _____

What type of entity administers NEMT?

___ State Medicaid agency
___ Other state agency
___ County/local agency broker
___ Private broker
___ MCOs provide transportation under capitation payment
___ Other (describe) _____

How long has the state used this type of administration system? _____

If the state has made a recent change in how NEMT is provided, what prompted the change and how was NEMT provided prior to the change?

_____
_____

What functions does the state Medicaid agency perform related to Medicaid NEMT? (preauthorization of services, screening of eligibility, etc.) _____
_____

For states using a broker system, please check the applicable breakdown of use:

___ Single broker statewide

___ One or more brokers according to county/region, brokers used in all counties/regions of the state

Number of counties/regions in state ___

___ One or more brokers according to county/region, brokers not used in all counties/regions of the state

Number of counties/regions in state ___
Number of counties/regions using a broker ___

___ Other (describe) _____

If the state has a statewide transportation broker program, what functions are provided by the broker(s)? Is any transportation provided directly by the broker(s)?

_____
_____

If the state uses a county-based or regional NEMT system, what functions do the counties or regional NEMT contractors perform directly? Is this uniform across counties/regions?

_____
_____

Why did the state choose the model(s) it is currently using? _____
_____

Has (have) the model(s) met expectations? _____

On what basis Is NEMT reimbursed: capitated, fee-for-service, or fee-for-service plus an administrative fee? _____

Part II. Operations

What populations are covered under each model used for NEMT? _____
_____

What type of transport is covered under each model? (Check all that apply.)

___ Public transportation (tokens or passes)
___ Shared ambulatory van
___ Sedan/taxi
___ Shared wheelchair van
___ Stretcher van/ambulette (not ambulance)
___ Ambulance
___ Air transport

___ Other (describe) _____

If available, please provide a breakdown of utilization by type of transportation.

_____
_____
_____

What are the operating days and hours for transportation? _____

What are the operating days and hours for customer service (e.g., reservations, complaints)?

_____

How far in advance must requests for transportation be made? Under what circumstances are exceptions to advance notice made?

_____
_____

What proportion of services are provided within the community (e.g., from the individual's home to a medical service) and what proportion are provide to individuals moving between providers/institutions (e.g., from nursing home to hospital)? You may provide an estimate if precise records are not available. Please label as an estimate.

_____
_____

What operating efficiencies have you found using your current system? (coordination with other county-based transportation programs, economies of scale, etc.)

_____
_____

Part III. Utilization/Costs

	FY 2005	FY 2006	FY 2007
Number of Medicaid beneficiaries for whom NEMT was a covered service	_____	_____	_____
Number of Medicaid beneficiaries actually using NEMT	_____	_____	_____
Number of one-way trips reimbursed under NEMT	_____	_____	_____
Total expenditures for NEMT	_____	_____	_____
Total Medicaid expenditures	_____	_____	_____
NEMT expenditures as percent of total Medicaid expenditures	_____	_____	_____

Does the state impose a co-payment for transportation? _____

If yes, what types of transportation require a co-pay? _____

_____

	FY 2005	FY 2006	FY 2007
If yes, amount per one-way trip	_____	_____	_____
Total amount of copayments collected	_____	_____	_____
Average cost per person	_____	_____	_____
Average cost per trip	_____	_____	_____
Average cost per mile	_____	_____	_____

If you have transitioned recently to a new model, have you found or do you anticipate cost savings? If so, what is the magnitude and source of that savings?

_____

_____

How much of the total NEMT budget goes to administrative costs and how much goes to direct service costs? _____

_____

Part IV. Quality

What are the benefits derived from the type of NEMT system your state currently uses, relating to:

Beneficiaries: _____

_____

Health care providers: _____

_____

Medicaid program: _____

_____

Local jurisdictions/health departments: _____

_____

Other: _____

_____

How do you measure and monitor quality in your NEMT program? Please describe what measures are used and how data is collected. _____

_____

How do you assure and measure quality related to access for eligible Medicaid recipients?

_____

_____

If you have transitioned recently to a new model, have you found or do you anticipate quality improvement? If so, what changes in quality have you found due to the change?

_____

_____

How do you measure the success of your NEMT program? What have your results been?

Have consumer satisfaction surveys been conducted? If so, please provide information about the survey measures and results.

Part V. Broker Programs

If your state uses an NEMT broker program:

Please describe what you believe to be the most significant benefits associated with using a broker

Please describe what you believe to be the biggest challenges associated with using a broker

What type of controls does the broker use to assure cost savings?

What were the biggest challenges in the transition to the broker system from how the state previously provided transportation? Do you have any "lessons learned" you could share with us about that transition?

If you have transitioned from a multiple broker system (including a local department/county-based system) to a single broker, please tell us about it. Why was the change made, what were the biggest challenges in making the change, have you found significant benefits (e.g., in cost-effectiveness or quality) in the new system, etc.?

If you use a county or regional broker system, how are inter-county or inter-region transportation needs met? _____

_____

After your state transitioned to a broker, what was the impact on budget and cost-effectiveness over the long term? _____

_____

Thank you for your input.

Appendix C:
Non-Emergency Medical Transportation Stakeholder Meeting
Attendees and Telephone Participants
July 22, 2008

#	Name	Affiliation
1	Vincent Ancona	Amerigroup
2	Benton Autser	Amerigroup
3	Marla Barrons	Calvert County
4	Joy Barrow	Montgomery County Transportation Program
5	Marlon Bates	Veolia Transportation
6	Carolyn Bonnett	GS Proctor Inc.
7	Elaine Boyd	DaVita Healthcare
8	Karen Brisiom	Queen Anne's County Department of Health
9	Childene R. Brooks	TCHD
10	Roxanna Brown	Baltimore City Health Department
11	Leona Brown	Cross Disability
12	Jenny Burns*	Queen Anne's County Department of Health
13	Linda Burrell	Maryland Department of Aging
14	Pat Cameron	MedStar Health
15	Ebony Carter	DHMH
16	Francine Childs*	Baltimore City Health Department
17	Simone Cook	DHMH
18	Chris Costello	TAW
19	Kevin Criswell	Amerigroup
20	Michael Day*	
21	Linda Dietsch	MPC
22	Amanda Elliott	Carroll County Health Department
23	Barbara Eppoliti	Somerset County Health Department
24	Hamid Fakhraei	UMBC – Hilltop Institute
25	Brenda Falcone	National Kidney Foundation of Maryland
26	Wiley Finch	Department of Aging
27	James Fowler	AAA Transport
28	Peggy Fraley	Frederick County Health Department
29	Alicia Gibson	Anne Arundel County Medical Assistance Transportation
30	Elaine Goldsmith	Carroll County Health Department
31	Charlene Hagan-Smith	Baltimore City Health Department
32	Penny Hamilton	Cecil County Health Department
33	K. Hartman	Baltimore City Health Department
34	Jackie Hines	Good Samaritan Dialysis
35	Brigham Johnson	Shore Transit
36	Linda Josephson	Anne Arundel County Department of Health
37	Claire Kelly	Children's National Medical Center
38	Mark Leeds	DHMH
39	Della Leister*	Baltimore County Department of Health

40	Kathleen Loughran	Amerigroup
41	Peggy Maher	Veolia Transportation
42	Ingrid McClam*	Silver Spring
43	Abby Menser	Allegany County Health Department
44	Bill Miller	Harford County Health Department
45	Alison Mitchell	Department of Legislative Services
46	Esther Moore	HFAM
47	Brian Nelson	DSC
48	Janice Newat	UHC
49	Katie Northrup	Caroline County Health Department
50	Toyin Oguntolaju	Children's National Medical Center
51	Will Peel	Consumer
52	John Pelton	DHMH
53	Sue Phelps	Personal Partners
54	Mike Piger	Bay Area
55	James Pixton*	AAA Transport
56	Denny Platt	Zolestart Response
57	Mark Puente	Rivers Consulting
58	Lois Pusinsky	Baltimore County Department of Health
59	Richard Reiches*	JTS Zachary – DaVita Dialysis
60	Laura Riley	Baltimore County Department of Aging
61	Scott Romanoski*	Anne Arundel County Medical Assistance Transportation
62	Ginger Rosetta	Coordinating Center– Living at Home Waiver Program
63	Karen Russum*	Kent County Health Department
64	Jane Sacco	DHMH
65	Teja Safai*	Para-Med
66	Stephanie Schapf	Jai Medical Systems
67	Andrew Sell*	LogistiCare
68	Nancy Smith	CCHD
69	Pamela Somers	Baltimore City Health Department
70	Cindy Spaulding	St. Mary's County Health Department
71	Christa Speicher	DHMH
72	Darlene Thomas	Frederick County Health Department
73	Latrina Trotman	Maryland Transit Administration
74	Robin Twilley	Dorchester County Health Department
75	Leser Wallace	MSFC
76	Andrea Waters*	Delmarva Community Services
77	Tana Wolf	Allegany County Health Department
78	Rhonda Workman	Elizabeth Coney Agency
79	David Zwerski*	MedStar Health
80	Chris Oladipo	Prince George's County

* Signed up to present comments

Appendix D:
Membership of the 2007-2008 Maryland Medicaid Advisory Committee*

Name	Organization
The Hon. C. Anthony Muse	Maryland State Senate
Ms. Grace Williams	Parent of Special Needs Consumers
Ms. Kathleen Loughran	Amerigroup, MCO
Mr. Floyd Hartley	Cross Dis. Rights Coalition/Consumer
Mr. Adam Brickner	Baltimore Substance Abuse System
Ms. Lori Doyle	Mosaic Community Services
Winifred Booker, D.D.S.	Pediatric Dentist/Private Practice
Mr. Kevin McGuire, Ex-Officio	DHR, Family Investment Administration
Virginia Keane, M.D.	Pediatrician/University of Maryland
The Hon. Delores G. Kelley	Maryland State Senate
Mr. Kevin Lindamood	Health Care for the Homeless
The Hon. Robert Costa	Maryland House of Delegates
Ms. Christine Bailey	Parent of Special Needs Consumer
Ms. Ann Rasenberger	Care Management Strategies
Mr. Miguel McInnis	Mid-Atlantic Assoc. of Comm. Health Ctrs.
Rex Cowdry, M.D., Ex-Officio	Maryland Health Care Commission
Ms. Donna Imhoff	Business Representative
The Hon. Shirley Nathan-Pulliam	Maryland House of Delegates
Ms. Tyan Williams	Consumer
Mr. Peter Perini	Perini Health Care Group
Ulder Tillman, M.D., Ex-Officio	Health Officer's Association
Mr. Stephen Wienner	Pharmacist
Mr. Sheldon Stein	Mt. Washington Pediatric Hospital
The Hon. Eric Bromwell	Maryland House of Delegates
Charles I. Shubin, M.D.	American Academy of Pediatrics
Mr. David Ward	Future Home Foundation
Ms. Michele Douglas	Alzheimer's Association
Charles Moore, M.D.	Monumental City Medical Society

*This list reflects the full membership of the Committee, not all members were present at the July meeting at which Hilltop presented information about the NEMT study.

Appendix E:
Membership of the Maryland Medicaid Money Follows the Person Stakeholder Advisory Group*

Elizabeth Boehner - Maryland Association of Area Agencies on Aging

John Burleigh - Facility Administrator, HFAM

Ken Capone - Co-leader, Cross Disability Rights Coalition

Michele Douglas - The Alzheimer's Association

Will Fields - New Directions Waiver Consumer

Jamey George - The Freedom Center

Gayle Hafner - Maryland Disability Law Center

Floyd Hartley - Waiver Consumer; The Sunshine Folks; ADAPT

Laura Howell - Maryland Association of Community Services for Persons with Developmental Disabilities (MACS); Developmental Disabilities Coalition

Teresa Jeter-Cutting - Baltimore City Commission on Aging and Retirement (CARE)

Danna Kaufman - LifeSpan Network

Carol Marsiglia - The Coordinating Center

Sylvia Matthews - Consumer Representative

Vicki Mills – DDA consumer, People on the Go

Ethan Moore - HFAM

Sarah Sorensen - The Arc of Maryland

Charles Thomas - United Seniors of Maryland

Diane Triplett - The Brain Injury Association

Rhonda Workman - The Elizabeth Cooney Personnel Agency

Mary Ann Wilkinson - Humanim Mental Health Center

Beth Wiseman - Baltimore County Association of Senior Citizens Organizations, Inc.

*This list reflects the full membership of the Stakeholder Advisory Group; not all members were present at the August meeting at which Hilltop presented information about the NEMT study.

The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org