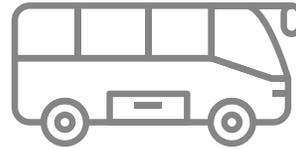
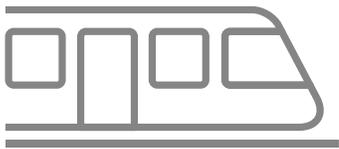


ISSUE BRIEF

June 2018

Non-Emergency Medical Transportation:

PAST, PRESENT, AND FUTURE OF A CRITICAL SERVICE



PART I:

An Introduction to Non-Emergency Medical Transportation

About the Authors:

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

Lung Cancer Alliance serves and listens to those living with and at risk for lung cancer to reduce stigma, improve quality of life and increase survival. Lung Cancer Alliance empowers its community by helping people navigate the paths of early detection, diagnosis and treatment. Insights allow Lung Cancer Alliance to improve care, amplify awareness, drive advocacy and lead research with the vision of tripling the number of survivors in the next decade.



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I. Introduction

For 3.6 million Americans, a lack of reliable and affordable transportation makes it prohibitively difficult to access essential health care.¹ For these individuals, routine preventive care and effective disease management are out of reach, resulting in the need for later, higher-cost interventions and, ultimately, poor health outcomes.

States have historically worked to bridge this gap through the provision of **non-emergency medical transportation (NEMT)**, a Medicaid benefit that provides beneficiaries with transportation to and from necessary non-emergency medical appointments and services.² However, ongoing concerns regarding Medicaid funding and administrative challenges in service delivery are placing increased pressure on states to reexamine their approach to the NEMT benefit. As a result, some states are reinforcing their NEMT programs through the adoption of innovative strategies and partnerships. In contrast, other states are looking to cut NEMT benefits by limiting or eliminating NEMT entirely for certain populations.

This issue brief is **Part I** of a series of resources that will describe these trends and provide tools and strategies for stakeholders interested in working to protect or expand NEMT services in their states. This initial resource will make the case for NEMT based on its impact on health outcomes and costs, and describe the basic legal framework that states must operate within to deliver NEMT services. Future issue briefs (**Parts II–IV**) will focus on the following topics:

1. **Current trends, challenges, and innovative practices in NEMT;**
2. **Medicaid Section 1115 Demonstration Waivers: responding to efforts to limit NEMT benefits; and**
3. **Looking beyond NEMT: additional approaches to address transportation and healthcare access challenges.**

For links to all of the latest resources in this series, please visit www.chlpi.org.

II. The Case for NEMT

Multiple studies indicate that access to NEMT is a cost-effective approach to improving patient health outcomes.

Access to NEMT can impact patient health outcomes: NEMT services can play a significant role in driving health outcomes for millions of Americans who lack access to reliable transportation. About 3.6 million Americans miss or delay essential, non-emergency medical care because of transportation-related difficulties.³



Transportation-based barriers disproportionately affect vulnerable populations such as:

- o Individuals living with chronic conditions (including behavioral health conditions),
- o Older adults,
- o Women,
- o Minorities, and
- o Low-income individuals.⁴

Individuals that fall into more than one of these categories (or who are living with multiple chronic conditions⁵) experience even greater difficulty in accessing transportation and, thus, necessary care.⁶

Patients with chronic conditions are particularly likely to miss appointments or delay care due to transportation barriers.⁷ Because chronic diseases require ongoing management to prevent the escalation of symptoms, this trend can have a negative impact on patient health outcomes.⁸ For example, poor access to transportation has been shown to be associated with underuse of chemotherapy among lung cancer patients,⁹ and a number of studies have indicated that greater travel burdens (i.e., distance or time to care) are associated with later diagnosis, less appropriate treatment, and worse health outcomes for cancer patients more broadly.¹⁰ Similarly, according to a study of diabetes patients in Northern California, individuals who missed more than 30% of their scheduled appointments experienced poorer glycemic control, glucose self-monitoring, and medication refill adherence.¹¹

NEMT is a cost-effective approach to improving patient care: Providing access to NEMT is cost-effective approach to improving patient care because the costs associated with delivering NEMT are relatively low in relation to the resulting improvements in patient health outcomes.¹² NEMT services cost roughly \$3 billion a year to administer, which is less than 1% of the total yearly cost of the Medicaid program.¹³ In addition, by providing NEMT, states can help patients avoid the need for expensive health services. For patients living with chronic conditions such as asthma,¹⁴ diabetes,¹⁵ and congestive heart failure,¹⁶ consistent access to care allows for cost-effective or cost-saving treatment by preventing the need for late, high-cost interventions and promoting better disease management.¹⁷

Example - Asthma: Lack of transportation makes it difficult for individuals diagnosed with asthma to receive maintenance care prior to an attack or to receive follow up care after an attack.¹⁸ Without proper disease management, individuals living with asthma are more likely to require expensive emergency room visits and/or hospitalization.¹⁹ One study therefore estimated that providing NEMT to asthma patients and allowing them to follow recommended management care routines could result in cost savings of **\$333** per patient per year.²⁰

Ensuring consistent access to transportation, and therefore care, also provides greater opportunities to screen, diagnose, and treat chronic conditions early in their progression or prevent such conditions altogether. For example, early diagnosis—usually associated with consistent screening—and regular care are both necessary to treat cancer and improve mortality and morbidity outcomes.²¹ Thus, research indicates that increasing access to transportation for services such as breast and colorectal cancer screening is a cost-effective approach to improve patient health.²² Additionally, ensuring access to prenatal care is a cost-effective way to improve long-term health outcomes for children and mothers and is associated with decreased incidence of high cost chronic conditions including diabetes²³ and HIV.²⁴

III. NEMT in Medicaid — An Overview of the Legal Framework

Given the important role that transportation plays in patient care, it has long been built into our nation's Medicaid program as a covered benefit. This section provides a brief overview of the legal framework surrounding the NEMT benefit. Like the information in the section above, it is crucial to understand this framework in order to be able to respond to current challenges and develop effective proposals to protect or expand upon NEMT services.

Federal regulations require state Medicaid agencies to provide NEMT to beneficiaries: NEMT is mandatory

Medicaid benefit.²⁵ This means that all state Medicaid agencies are required to cover NEMT as a Medicaid benefit unless the state has received federal approval to eliminate coverage under a Medicaid waiver (a topic that will be discussed further in **Part III**). NEMT as a mandatory benefit is as old as Medicaid itself, dating back to the publication of the first source of federal interpretive guidance for Medicaid in 1966.²⁶ Later, regulations clarified the requirement to provide NEMT and have evolved over time.²⁷

However, states have a great deal of flexibility in how they administer NEMT: While all state Medicaid programs are generally required to provide coverage NEMT, states have a great deal of flexibility in determining *how* to administer their NEMT programs. As a result, states vary greatly in how they limit, manage, and fund NEMT services.

1. **Limiting eligibility for NEMT:** State Medicaid agencies have the flexibility to place some limitations on eligibility for NEMT services in order to “safeguard against unnecessary utilization of such care and services.”²⁸ Nebraska, for example, has made it so that a Medicaid recipient may qualify for NEMT benefits if the recipient “does not have access to a working licensed vehicle [or] . . . a current valid driver’s license” or if the recipient cannot “drive due to a documented physical, cognitive, or developmental limitation; . . . travel or wait by him/herself due to a documented physical, cognitive, or developmental limitation; or . . . secure free transportation.”²⁹
2. **Determining which entities manage NEMT:** State Medicaid agencies can also choose whether to administer their NEMT programs directly or contract with another organization to do so. Typically states take one of four approaches to administering NEMT services: **fee-for-service, managed care, brokerage, or public transit.**³⁰
 - **Fee-for-Service:** Under a fee-for-service model, states typically contract with an independent transportation provider to provide NEMT at a set reimbursement rate per ride.
 - **Managed Care:** In states that delegate the administration of Medicaid benefits in whole or in part to managed care organizations (MCOs), these MCOs may be responsible for providing NEMT to beneficiaries.
 - **Brokerage:** States or MCOs may contract with transportation brokers to administer NEMT. These brokers may provide transportation themselves or subcontract with various transportation providers.
 - **Public Transit:** In some states, patients may be required to use public transit to reach medical appointments and may either receive a voucher beforehand or be reimbursed after the fact.

Each of these approaches has its own potential challenges and benefits, which will be discussed in more detail in **Part II** of this series.

3. **Classifying NEMT as an administrative or medical expense:** Finally, states also have some flexibility in determining how to classify NEMT benefits for the purposes of federal funding. States can categorize NEMT services as either administrative or medical service expenses.³¹ When a state classifies NEMT as a medical service, the federal government reimburses the state for the costs of delivering NEMT based on the state’s Federal Medical Assistance Percentage (FMAP). FMAPs vary by state, ranging from 50% (the federal minimum found in states like Massachusetts) to 76.39% (found in Mississippi³²).³³ If the state opts to list NEMT as an administrative expense, federal reimbursement is capped at 50%.³⁴ However, by classifying NEMT as an administrative expense, states can avoid some of the stricter requirements applied to medical services. Typically, if claiming NEMT as a medical service expense, state Medicaid agencies must ensure that the benefit is available statewide,³⁵ NEMT services are comparable across beneficiary groups,³⁶ and that beneficiaries have the freedom to choose their own transportation provider.³⁷ The impact of these restrictions has lessened in recent years, though, as the Deficit Reduction Act of 2005 allowed states to waive these requirements by establishing a brokerage program.³⁸ Alternatively, states can pursue broader waivers—such as the Section 1115 Demonstration Waivers that will be discussed in **Part III**—to avoid these requirements.

IV. Conclusion

For millions of Americans, NEMT provides a cost-effective way to access care and improve long-term health outcomes. Federal regulations require states to provide NEMT but place few restrictions on how states administer these services. As a result, NEMT programs vary widely in their structure and overall success in meeting patient needs. The next resource in this series will therefore take a closer look at the topic of state flexibility, examining current trends, challenges, and innovations in the delivery of NEMT services across the United States. By examining these trends, interested stakeholders can begin to develop potential strategies to improve access to NEMT services in their states.



Endnotes

- ¹ Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 Transportation Research Record: J. Transportation Research Board 76, 79 (2005).
- ² *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 2–3 (2016) (available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>).
- ³ Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 Transportation Research Record: J. Transportation Research Board 76, 79 (2005).
- ⁴ P. Hughes-Cromwick et al., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transportation Research Board, 4-5, 10-12 (2005).
- ⁵ Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 Transportation Research Record: J. Transportation Research Board 76, 79 (2005); Brian Ward, *Barriers to Health Care for Adults with Multiple Chronic Conditions: United States, 2012–2015*, Nat’l Ctr. H. Statistics, 3 & 6 (2017).
- ⁶ See, e.g., Fay Gordon, *Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults*, Justice in Aging, 3, October 2016.
- ⁷ P. Hughes-Cromwick et al., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transportation Research Board, 12-13, 27-28 (2005).
- ⁸ Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. Community Health 976, 989 (2013).
- ⁹ Ramzi G. Salloum et al., *Factors Associated with Adherence to Chemotherapy Guidelines in Patients with Non-Small Cell Lung Cancer*, 75(2) Lung Cancer 255, 259 (2012).
- ¹⁰ Massimo Ambroggi et al., *Distance as a Barrier to Cancer Diagnosis and Treatment: Review of the Literature*, 20 (12) The Oncologist 1378, 1379-82 (2015).
- ¹¹ Andrew J. Carter et al., *Missed Appointments and Poor Glycemic Control: An Opportunity to Identify High-Risk Diabetic Patients*, 42(2) Medical Care 110, 113–14 (2004).
- ¹² P. Hughes-Cromwick et al., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transportation Research Board, 2-3 (2005).
- ¹³ Richard Garrity & Kathy McGehee, *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*, Transportation Research Board of the National Academies, 2 (2014).
- ¹⁴ See, e.g., Simone Ebbinghaus & Abdul H. Bahrainwala, *Asthma Management by an Inpatient Asthma Care Team*, 29:3 Pediatric Nursing 177, 178–79 & 182 (2003).
- ¹⁵ Rui Li et al., *Cost-Effectiveness of Interventions to Prevent and Control Diabetes Mellitus: A Systematic Review*, 33:8 Diabetes Care 1872, 1874 - 1890 (2010).
- ¹⁶ David C. Chan et al., *Heart failure disease management programs: A cost-effectiveness analysis*, 155:2 American Heart Journal 332, 336 (2008).
- ¹⁷ Richard Wallace et al., *Cost-Effectiveness of Access to Nonemergency Medical Transportation Comparison of Transportation and Health Care Costs and Benefits*, 1956 Transportation Research Record 86, 90 (2006) (“For three of these conditions (asthma, heart disease, and diabetes), the results show a net cost saving, whereas for the other four (depression, hypertension, chronic obstructive pulmonary disease, and end-stage renal disease), improvements in life expectancy or quality of life are sufficient to justify the added expenses.”).
- ¹⁸ See, e.g., Simone Ebbinghaus & Abdul H. Bahrainwala, *Asthma Management by an Inpatient Asthma Care Team*, 29:3 Pediatric Nursing 177, 178–79 & 182 (2003).
- ¹⁹ See, e.g., Michelle M. Cloutier et al., *Use of Asthma Guidelines by Primary Care Providers to Reduce Hospitalizations and Emergency Department Visits in Poor, Minority, Urban Children*, 146(5) The Journal of Pediatrics 591, 594-95 (2005).
- ²⁰ Richard Wallace et al., *Cost-Effectiveness of Access to Nonemergency Medical Transportation Comparison of Transportation and Health Care Costs and Benefits*, 1956 Transportation Research Record 86, 91 (2006).
- ²¹ See, e.g., Lisa C. Richardson et al., *Vital Signs: Colorectal Cancer Screening, Incidence, and Mortality — United States, 2002–2010*, 306(7) J. Am. Medical Assoc. 701, 701 (2011); Linda L. Humphrey et al., *Breast Cancer Screening: A Summary of the Evidence for the U.S. Preventive Services Task Force*, 137(5) Annals of Internal Medicine, E–347, E–355 (2002).
- ²² P. Hughes-Cromwick et al., *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transportation Research Board, 2, 58-60 (2005).
- ²³ Gestational diabetes mellitus (GDM) is “a common medical complication of pregnancy, [and] is defined as ‘any degree of glucose intolerance with onset or first recognition during pregnancy.’” GDM is associated with “adverse pregnancy outcomes,” such as preterm birth or high birth weights, as well as long term adverse health outcomes for the children and mothers, particularly a greater risk of diabetes. Early diagnosis and treatment of GDM is a cost-effective way to decrease the incidence of diabetes and

other adverse outcomes. Boyd E. Metzger, *International Association of Diabetes and Pregnancy Study Groups Recommendations on the Diagnosis and Classification of Hyperglycemia in Pregnancy*, 33:3 *Diabetes Care* 676, 676-77 (2010); see also Erika F. Werner et al., *Screening for Gestational Diabetes Mellitus: Are the Criteria Proposed by the International Association of the Diabetes and Pregnancy Study Groups Cost-Effective?*, 35 *Diabetes Care* 529, 533 (2012).

²⁴ HIV can be transmitted from mother to child and is associated with high lifetime treatment costs. However, early screening allows health care providers to effectively treat mothers and prevent transmission to children. See, e.g., Naoko Ishikawa et al., *Should HIV Testing for All Pregnant Women Continue? Cost-effectiveness of Universal Antenatal Testing Compared to Focused Approaches Across High to Very Low HIV Prevalence Settings*, 19 *Journal of the International AIDS Society* 21212 (2016).

²⁵ 42 C.F.R. §§ 431.53(a) & (b) (“A State plan must . . . [s]pecify that the Medicaid agency will ensure necessary transportation for beneficiaries to and from providers; and . . . [d]escribe the methods that the agency will use to meet this requirement.”). Additionally, under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, state agencies are required to offer transportation assistance to children 21 and younger and their families. 42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.62(a).

²⁶ Sara Rosenbaum et al., *Medicaid’s Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform*, The George Washington University School of Public Health and Health Services, 4 (2009).

²⁷ Sara Rosenbaum et al., *Medicaid’s Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform*, The George Washington University School of Public Health and Health Services, 4 (2009).

²⁸ 42 U.S.C. § 1396a(a)(30)(A); see also 42 C.F.R. § 440.230(d) (“The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.”).

²⁹ 471 Neb. Admin. Code §27–002.

³⁰ Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2-3 (2017).

³¹ MaryBeth Musumeci & Robin Rudowitz, *Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers*, Kaiser Family Foundation (2016). Colorado, for example, categorizes NEMT as an administrative expense. *Colorado Medicaid Benefits Collaborative Policy Statement: Non-Emergency Medical Transportation*, Colorado Department of Health Care Policy & Financing, 1 (2017) (available at <https://www.colorado.gov/pacific/sites/default/files/NEMT%20Benefit%20Coverage%20Standard.pdf>).

³² *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, Kaiser Family Foundation, <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 24, 2018).

³³ 42 U.S.C. § 1396d(b).

³⁴ 42 U.S.C. § 1396b(a)(7).

³⁵ 42 C.F.R. § 431.50(b)(1) (“A State plan must provide that . . . [t]he plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the State.”). Without this requirement, states can limit the availability of NEMT to certain regions within the state rather than making it available to the entire state.

³⁶ 42 C.F.R. §440.240 (“The [State] plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and . . . that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group . . .”).

³⁷ 42 C.F.R. § 431.51(b)(1) (“[A] beneficiary may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is . . . [q]ualified to furnish the services; and . . . [w]illing to furnish them to that particular beneficiary.”). Without this requirement, states can require that beneficiaries obtain services from a pre-selected set of NEMT providers.

³⁸ Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6083 (2006); 42 C.F.R. § 440.170(a)(4).

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