Medicaid Coverage of Non-Emergency Medical Transportation

Lack of transportation can be a barrier to accessing health care, particularly for elderly, disabled, or low-income individuals. To address this concern, federal Medicaid regulations require that states ensure transportation to and from providers, a benefit known as non-emergency medical transportation (NEMT).[1] Although the scope of the benefit varies by state, NEMT generally covers a broad range of transportation services including trips in taxis, buses, vans, and personal vehicles belonging to beneficiaries and their family or friends.

Recently, policymakers at the state and federal levels have begun to reexamine the use of the NEMT benefit. Some states have received approval from the Centers for Medicare & Medicaid Services (CMS) to waive the benefit for the new adult group made eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) as part of their Medicaid expansion waivers.[2] The President's most recent budget for fiscal year (FY) 2020 included a proposal to change the NEMT benefit from a mandatory Medicaid benefit to an optional one (HHS 2019). The Administration also announced plans to publish proposed regulatory changes in May 2019 to give states more flexibility around NEMT (OIRA 2018).

This issue brief describes the NEMT benefit, including who uses it, delivery models, financing, and spending. We also review issues related to program integrity, waivers of NEMT, and possible restructuring through regulatory changes.

Benefit Overview

Authorized in federal regulations at 42 CFR 440.170, the NEMT benefit provides transportation to and from medical appointments for Medicaid beneficiaries with no other means of accessing services. States are required to ensure necessary transportation and to use the most appropriate form of transportation for the beneficiary (42 CFR 431.53, CMS 2016b). States are also required to provide assistance with transportation to children and their families as part of Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit (42 CFR 441.62).

Covered services, eligibility, co-payments, and limits on trips

The NEMT benefit varies from state to state but typically includes transportation by taxi, wheelchair van, private vehicle, and public transportation. In general, Medicaid beneficiaries are eligible for the benefit, as long as the transportation is necessary and the beneficiary does not have another means of transportation. For example, beneficiaries with no other means of transportation may not have a driver's license or may be physically or intellectually disabled (CMS 2016a). Some states rely on public

transportation to provide NEMT; however, this approach varies considerably both within and across states given that public transportation is not available in all areas. Another approach is the use of companies like Uber and Lyft. Data are limited on use of these options, but one pilot program documented improvements in beneficiary experience and reduced costs (Powers et al. 2018).

States may limit the benefit based on medical necessity or utilization control (42 CFR 440.230(d)). For example, some states require prior authorization from the state for trips or place limits on the number of trips Medicaid will cover. For example, Indiana limits the benefit to 20 trips per 12 months (FSSA 2019). Others charge co-payments. For example, Missouri charges a $2 co-payment for each NEMT trip with exceptions for children, pregnant women, individuals living in nursing facilities, and others (DSS 2019).

Delivery models

States have discretion over which models they use to deliver NEMT, and may use more than one approach to accommodate varying beneficiary needs, delivery systems, and geographic areas. States typically choose one or more of the following models:

- paying for NEMT on a fee-for-service (FFS) basis;
- contracting with managed care plans to provide NEMT and other services; and
- arranging for transportation brokers to manage the benefit (GAO 2016a).

The most commonly used NEMT model is the brokerage model, authorized under Section 1902(a)(70) of the Social Security Act. Brokerage can take several forms. Most states using this model arrange for private brokers to provide the service, while other states use a brokerage run by a state agency or a nonprofit organization. For example, OATS, Inc. is a rural public transportation service in Missouri operating in 87 counties. It provides transportation services to county residents including individuals age 65 and older and people with disabilities (Edrington et al. 2018, Ganuza and Davis 2017). Brokers may receive a capitated payment from the state or be paid on a FFS basis. In 2015, 34 states used some form of the brokerage model (Ganuza and Davis 2017).

A study conducted for the state of Maryland found that the brokerage model is cost effective for some states, primarily because it may ensure that Medicaid only pays for rides for eligible individuals and for appropriate trips, which could be a deterrent to fraud and abuse. Further, some state officials interviewed for the study credited the brokerage model with enabling better data reporting and quality measurement (Hilltop 2008).

In 2015, about 20 states used a FFS model, and 11 of these used other delivery models as well (Ganuza and Davis 2017). Of the four states that provided NEMT through contracts with managed care plans, only one, Arizona, exclusively used managed care.

Financing and spending

States can claim federal Medicaid matching payments for NEMT as either an administrative or medical assistance expense (GAO 2016a). States reporting NEMT spending as an administrative expense receive

payment at the federal medical assistance percentage (FMAP) for administrative expenses, which is set in statute at 50 percent. States claiming NEMT as a medical assistance expense receive payment at their regular FMAP which ranges from 50 percent to 76.98 percent for FY 2020, depending on the state (HHS 2018). If states choose to report NEMT spending as medical assistance, they are subject to additional statutory requirements, including giving Medicaid beneficiaries the free choice of providers from among any qualified Medicaid provider willing to provide the service (CMS 2008). One exception is the brokerage model. States contracting with a broker to provide the service are not subject to the additional statutory requirements that come with claiming NEMT as a medical assistance expense (CMS 2008). Such states may restrict a beneficiary's choice of provider.

In FY 2017, states and the federal government spent almost $2 billion on NEMT services provided through FFS. Spending on NEMT in managed care and brokerage models cannot be quantified with administrative data. This is because claims data in the Medicaid Statistical Information System (MSIS) and spending data in the CMS-64 does not distinguish among types of capitated arrangements in managed care. Thus it is not possible to determine whether such payments represent state contracts with brokers or state contracts with managed care plans that include NEMT.

Characteristics of Medicaid Beneficiaries who are Transportation Disadvantaged

Transportation-disadvantaged beneficiaries are unable to provide their own transportation due to age, disability or low income (GAO 2014). We used survey data to identify the characteristics of Medicaid beneficiaries who delay care because of a lack of transportation and claims data to describe beneficiaries using NEMT.

Delaying Care

In 2017, 2.1 million (or 4.4 percent) Medicaid enrollees under age 65 reported on the National Health Interview Survey that they had delayed care because of lack of transportation.[3] More than one-half (56.9 percent) were adults age 19–64 and the rest (43.1 percent) were children age 0–18. Income and health status were key factors. Almost two-thirds (65.7 percent) of those with a transportation barrier had income below 100 percent of the federal poverty level. The majority of Medicaid adults delaying care (99.2 percent) had limitations indicating varying levels of disability, including limits in movement and sensory, emotional, or mental functioning associated with a health problem.[4,5] Almost 25 percent of adults in Medicaid reporting a transportation barrier were enrolled in the Supplemental Security Income (SSI) program, which has an automatic eligibility link to Medicaid and provides assistance to adults with disabilities under age 65 and children.

Adults with Medicaid coverage are more likely than those with private coverage to delay care because of a lack of transportation (5.8 percent versus 0.7 percent). This may be due to differences in health status and income, as, in general, transportation disadvantaged individuals are age 65 and older, have disabilities, or have low incomes. Relative to individuals with private coverage, the Medicaid population is more likely to

have low incomes, have limitations related to physical and mental health, and to report poorer health status (MACPAC 2018).

Among children enrolled in Medicaid, 3.3 percent delayed care. Like the adult respondents, a significant share of these children had varying levels of disability. Almost half (46.9 percent) were classified as children with special health care needs who have disabilities or who have mild to severe chronic conditions such as asthma and diabetes.[6] About 5 percent of children with Medicaid who delayed care were enrolled in SSI.

Using NEMT

Analysis of Medicaid claims data for CY 2012, the most recent year for which data was available, indicate that 1.8 million NEMT users had at least one NEMT claim, either FFS or managed care during that year. Of the 1.8 million, about two-thirds had disabilities or were age 65 and older. Case studies of NEMT users in Indiana and Vermont, using state data, found that in CY 2015 more than 50 percent of individuals who used the benefit the most (that is, they had 30 or more trips in the calendar year) were either beneficiaries with disabilities or age 65 and older.

About 42 percent of NEMT users were dually eligible for Medicaid and Medicare. Dually eligible beneficiaries are likely to rely on Medicaid for transportation services because Medicare only covers ground ambulance services for individuals whose medical condition at the time of transport prevents them from using other means of transportation without jeopardizing their health (GAO 2016a).

Program Integrity

Federal oversight authorities have identified NEMT as high risk for fraud and abuse, noting concerns related to enrolling providers, program inefficiencies, and verifying eligibility (GAO 2016a). For example, the U.S. Government Accountability Office (GAO) found that some states had difficulty identifying criminal conviction information for NEMT providers. GAO also reported that some states did not require brokers to maintain consistent trip data, which could lead to overbilling. In addition, some states had difficulty verifying beneficiary eligibility for NEMT and the need for NEMT services, which could result in improper billing for services. GAO concluded that updated CMS guidance could help states identify strategies to address these issues (GAO 2016a).

The Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) has found inadequate oversight and improper payments for trips that did not meet federal and state requirements (OIG 2016, OIG 2015). Since 2006, the OIG has conducted audits in multiple states. For example:

- In 2018, the OIG found that Michigan's NEMT brokerage program did not always comply with federal and state requirements for submitting NEMT claims and recommended that the state refund $4.5 million to the federal government (OIG 2018).

- In 2015, the OIG reviewed claims for NEMT services in Los Angeles County, California and found many were not in compliance with federal and state requirements related to billing at the lowest cost type of transportation adequate for the needs of the beneficiary (OIG 2015). The OIG recommended that the state refund $437,896 to the federal government.

Looking Ahead

States and the federal government have been reexamining the NEMT benefit. Two states have received waivers to eliminate the benefit for the new adult group established under the ACA. They argued that waiving NEMT makes coverage for the new adult group consistent with benefits offered through private health insurance. States with approval to waive the NEMT benefit for the new adult group as part of their Section 1115 waivers include:

Indiana. As part of the state's Healthy Indiana Plan 2.0 waiver, Indiana eliminated the NEMT benefit for the new adult group with exceptions for certain groups including pregnant women and the medically frail. The waiver is currently approved through December 31, 2020 (MACPAC 2019, FSSA 2019).

Iowa. As part of the state's waiver, the Iowa Health and Wellness Plan, Iowa received approval to waive the NEMT benefit for the new adult group with exceptions for the medically frail (GAO 2016b and DHS 2019). The waiver is currently approved through December 31, 2019.

The federal government is also expected to update regulations to permit increased state flexibility, possibly in line with recent proposals in the President's budget, to make offering the NEMT benefit optional for states.

Endnotes

[1] Although the NEMT benefit is not specified in Medicaid statute, statutory provisions including statewideness and comparability formed the legal basis for federal regulations requiring that all states "ensure necessary transportation" for Medicaid beneficiaries "to and from providers" (42 CFR 431.53). This assurance of transportation in the Medicaid program has been upheld in court cases such as *Smith v. Vowell* which was the first case to test whether the transportation assurance could be enforced (Rosenbaum et al. 2009).

[2] States seeking to expand Medicaid under terms different from those that exist in federal law may request waivers from CMS.

[3] The NHIS is a household survey that collects information on the health of the non-institutionalized civilian population in the United States. It is part of the National Center for Health Statistics which forms part of the Centers for Disease Control. The elderly (individuals age 65 and older) are excluded from this analysis because the sample size was too small.

[4] A basic action difficulty captures limitations or difficulties in movement (walking, standing, bending or kneeling, reaching overhead, and using the hands and fingers) and limitations or difficulties in sensory, emotional (i.e., feelings that interfere with accomplishing daily activities), and mental (i.e., difficulties with remembering or experiencing confusion) functioning that are associated with some health problems.

[5] A complex activity limitation reflects a limitation in the tasks and organized activities that, when executed, make up numerous social roles, such as working, attending school, or maintaining a household. Adults are defined as having a complex activity limitation if they have one or more of the following types of limitations: self-care limitation, social limitation, or work limitation.

[6] The term children with special health care needs, as defined by the federal Maternal and Child Health Bureau, refers to a group of children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson et al. 1998). The definition encompasses children with disabilities as well as children with mild to severe chronic conditions, such as asthma, juvenile diabetes, and sickle cell anemia.

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