



August 24, 2015

Dear Colleague:

We invite you to attend the upcoming Missouri Rides to Wellness Executive Summit (October 14, 2015, from 11:00 a.m. to 3:30 p.m., at the Capitol Plaza Hotel in Jefferson City, Missouri). The Summit is being hosted by the Missouri Rural Health Association in cooperation with the Missouri Foundation for Health and Missouri Public Transit Association and is in response to the national summit held in Washington DC on March 11, 2015.

A primary objective of the national Rides to Wellness initiative and Missouri's Rides to Wellness Summit is to build understanding of the needs and challenges health and transportation providers face in providing access to healthcare services. To give all attendees an introduction to this important topic, we have compiled and attached the following background materials for your review:

1. Rides to Wellness Health and Transportation Initiative Summary
2. Expanding Specialized Transportation: New Opportunities under the Affordable Care Act
3. Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community
4. HealthTran: A Missouri Pilot Putting One Model to the Test

Lastly, as we finalize the Summit agenda and seek to ensure that the content reflects a valid picture of health and transportation needs and challenges, we ask for your thoughts. Please take a few minutes to respond by September 5 to this brief survey available at:

https://www.surveymonkey.com/r/R2W_Summit

You may also email your responses to the following questions to mpta@cablrc.com.

- What are the key needs related to healthcare access and transportation for your community?
- What are key barriers (e.g., how is the system “not working”?)
- If key barriers were removed, what could you do?
- Are there any promising practices or innovative programs in your region related to health care access through transportation? If so, please describe.
- What would encourage your participation in local planning and connecting?

Rides to Wellness

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Your feedback is critical to help us begin to think about appropriate national, state-level and organizational strategies. Thank you in advance for your thoughtful feedback.

We ask that you RSVP your attendance to the summit to ensure adequate space. You may RSVP your attendance by indicating your attendance on the survey, or by email to mpta@cabllc.com, or calling 573-634-4314. We look forward to your participation on October 14.

Sincerely,



Doris Boeckman
Missouri Rides to Wellness

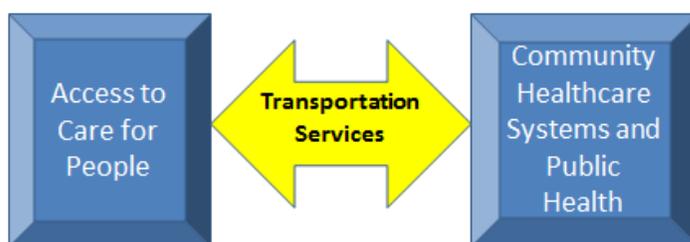
Attachments

1. Rides to Wellness Health and Transportation Initiative Summary
2. Expanding Specialized Transportation: New Opportunities under the Affordable Care Act
3. Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community
4. HealthTran: A Missouri Pilot Putting One Model to the Test
5. Preliminary Missouri Rides to Wellness Summit Agenda

Rides to Wellness
Federal Transit Administration Ladders of Opportunity
Health and Transportation Initiative

Wellness depends upon many factors, including making sure people can get a ride to the healthcare they need. Today, in many communities, public transportation is a coordinated and multi-modal system with significant capacity for on-demand services. Especially since the passage of the Americans with Disabilities Act, our nation's transportation infrastructure has been developed to ensure that people who depend upon public transportation and require accessibility can utilize these services to live with independence in the communities of their choice. With the health services industry's current focus on preventive services and other methods to increase the efficiency and effectiveness of medical care there is an emerging awareness of the need to increase partnerships between health/wellness providers and transportation providers. As a result, the U.S. Department of Transportation's (DOT) Federal Transit Administration (FTA) launched the "Rides to Wellness Initiative."

Federal Transit Administration
Rides to Wellness
Ladders of Opportunity
Health and Transportation Initiative



Vision: through rides people and community health thrive

Why Access to Transportation is Important for Health

Public transportation can be an important enabler of access to health services – resulting in greater preventive care, fewer unnecessary hospital readmissions, and lower costs. This can lead to improved health for those with chronic conditions, and reduced health disparities by ensuring that at risk populations can get to care, including to preventive services screenings that many insurers track as part of their quality ratings. Additionally, missed appointments are a major issue in the medical community with one study noting that approximately 3.6 million Americans miss or delay medical care due to transportation issues.¹ By improving access we may be able to reduce hospital readmissions, as 18 percent of patients discharged from the hospital are readmitted within 30 days, one third within 90 days.² Medicare spends \$15 billion annually for hospital readmissions.³

Who needs access? Almost half of the population – 145 million Americans - lives with at least one chronic condition.⁴ While 38 million people are living with disabilities in the community and 36 percent of adults over 65 have a disability (14 million in 2010).⁵ Transportation concerns among older adults are rising as this population segment is projected to grow from over 40 million in 2010 to over 88 million by the year 2050.

¹ TCRP, 2005 Retrieved 12/05/2014 http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf

² CMS Office of the Actuary, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," (2010).

³ Medicare Payment Advisory Commission. 2007. "Report to the Congress: Promoting Medicare Payment Advisory Commission," Chapter 5, page 103.

⁴ Robert Wood Johnson Foundation, "Chronic Care: Making the Case for Ongoing Care," February 2010, Retrieved 01/27/2015 www.rwjf.org/pr/product.jsp?id=50968

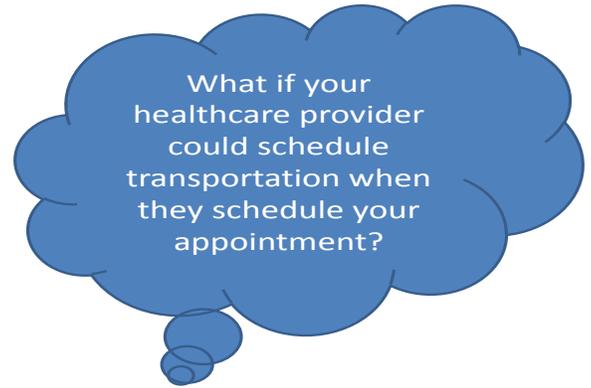
⁵ Administration on Aging, Administration for Community Living, U.S. Department of Health and Human Services, "A Profile of Older Americans: 2012," Retrieved 01/28/15 http://www.aoa.gov/Aging_Statistics/Profile/2012/docs/2012profile.pdf

Rides to Wellness Goals and Strategies

The goals of the “Rides to Wellness” initiative are to:

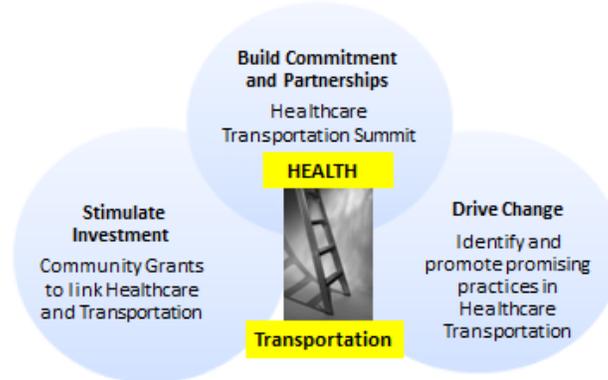
- increase access to care,
- improve health outcomes, and
- reduce healthcare costs.

Through this initiative the transportation community will become a recognized partner with the health/wellness and medical community. This initiative will demonstrate how partnerships across the transportation and health industries can reduce healthcare costs by leveraging public transportation assets.



There is a three-pronged strategy for this access to care initiative, with activities supporting the use of well-known activities such as coordination and an effort to find other innovations through community grants.

Three-pronged Strategy for Rides to Wellness Ladders of Opportunity Health and Transportation Initiative



There are also opportunities to stimulate investments in technology building upon the results of the FTA-led Veterans Transportation Community Living Initiative (VTCLI) program where over eighty grants were awarded for projects such as one call/one click centers. These centers are now connecting our nations Veterans and their families to critical transportation services. “Rides to Wellness” partnerships may build upon these efforts and find new ways to innovate using smartcards, smartphone applications and other technology.

FTA has a treasured place in our nation’s history with many movements:

- access to jobs,
- access to affordable housing,
- access to education and training, and
- connections to suburban, rural and intercity communities.

With “Rides to Wellness,” we will build upon these successful models of collaboration to demonstrate how a stronger partnership between the healthcare sector and public transportation and other transportation networks in communities can improve health, increase access to care and reduce healthcare costs.

For more information on this initiative or to get involved, please contact Danielle Nelson at Danielle.Nelson@dot.gov.

Expanding Specialized Transportation: New Opportunities under the Affordable Care Act

Wendy Fox-Grage and Jana Lynott
AARP Public Policy Institute

The Affordable Care Act (ACA) provides new but limited opportunities to promote or fund specialized transportation services for older people and adults with disabilities. This paper explains how states can use these largely untapped options to expand services for targeted low-income populations with mobility needs. It also presents two case studies illustrating how the Atlanta region and the state of Connecticut are making this work.

Many states are taking advantage of new options within the Affordable Care Act (ACA) to improve access to care for the chronically ill and to promote community living for older adults and adults with physical disabilities. However, relatively few states are expanding transportation services through these new initiatives for low-income people with mobility limitations. This paper explores the ACA options that could expand specialized transportation for Medicaid and Medicare beneficiaries, and for people who are dually eligible for both forms of coverage. It also provides state examples and two case studies to illustrate how these options can work.

Growing Need for Specialized Transportation

Transportation is vital to helping people with mobility limitations live as independently as possible. Many older people and adults with physical disabilities need specialized transportation—such as door-to-door paratransit or escorts into doctors' offices—that can be provided upon request by van, small bus, or taxi. Specialized transportation is especially critical for high-risk, low-income

populations who do not drive and have difficulty taking public transportation because of disability, age-related conditions, or income constraints.

In a given year, about 3.6 million Americans miss at least one medical trip for lack of transportation; this population is disproportionately female, older, poorer, and has a higher rate of multiple conditions.¹ Many people ages 70 and older will outlive their driving years; on average, men for 7 years and women for 10 years.²

Without transportation, the ability to live in one's home and community is compromised. Also, improving access to care for transportation-disadvantaged populations can reduce national health care costs, possibly offsetting the increase in transportation costs.³

Specialized transportation can help states and communities achieve the ACA's goals. Transportation is an important element for states balancing their Medicaid programs toward home- and community-based services (HCBS); enabling people to access preventative care; improving health outcomes; and avoiding unnecessary hospital readmissions.

Medicaid Options for Expanding Specialized Transportation

Medicaid covers transportation to and from medical appointments as a *mandatory* benefit for a beneficiary who has no other means of accessing necessary medical services. The least costly mode of transportation that is appropriate for the physical condition of the consumer must be used. Medicaid also covers emergency medical transportation, such as an ambulance.

State Medicaid programs also can choose to cover nonmedical, community transportation. Most of this funding is provided under Medicaid waivers that allow states to provide HCBS to beneficiaries rather than requiring services to be provided in institutions such as nursing homes.

In 2010, 28 states had Medicaid HCBS 1915(c) waivers that provided optional transportation services to 65,542 older adults or adults with physical disabilities at a cost of nearly \$62 million⁴ (see table 1). Transportation under these waivers can be limited by geographic area and targeted disability group, and the scope, enrollment, and amount of trips can be capped.

States can cover nonmedical, community transportation as an optional Medicaid home and community service in the following

Box 1
ACA Initiatives to Expand Medicaid Nonmedical, Community Transportation

- ✓ Money Follows the Person
- ✓ Community First Choice
- ✓ Balancing Incentive Program
- ✓ Section 1915(i) State Option

ACA initiatives (see box 1). This paper describes these initiatives and explains how they can support new transportation benefits to targeted low-income populations with mobility needs (see table 2).⁵



Money Follows the Person (MFP)

MFP is a grant program for states to shift Medicaid funds toward more HCBS and to identify and transition Medicaid beneficiaries who are living in an institution and want to return to the community. A total of 44 states plus the District of Columbia receive an enhanced federal match for the services provided to Medicaid participants for the first 12 months after the beneficiary's transition back into the community.

More than 40,000 people have moved from institutions to the community under this program.⁶ MFP was established before the ACA, but the ACA extended the program through 2016 and made some programmatic revisions, bringing the total funding for MFP to \$4 billion.

MFP participants from 16 states—out of 25 that provided service expenditure data—utilized transportation during 2012.⁷ When MFP participants receive transportation, the state receives the enhanced federal Medicaid matching rates under the MFP demonstration.

About 1,700 participants (13 percent of 12,839 MFP participants from the 25 grantees with data available for analysis) used the transportation benefit during 2012.⁸ The MFP program is slated to end in 2016, but states awarded grants in 2016 can use their unused funds until 2020.

Table 1
Medicaid 1915(c) Waiver Expenditures on Community, Nonmedical Transportation for
Older Adults and Adults with Physical Disabilities: FY 2010

State	Waiver	Transportation Participants	Transportation Expenditures
AK	Older Alaskans	808	\$1,726,128
AK	Adult Disabled	646	\$2,252,571
CA	MSSP	3,026	\$1,048,447
CO	Elderly, Blind, Disabled	2,309	\$5,910,937
CT	Elderly	212	\$40,162
IA	Physical Disabilities	103	\$103,071
IA	Elderly	1,599	\$1,078,060
ID	PCS for Aged and Disabled	1,069	\$239,418
IL	Disabled	43	\$27,379
IL	Elderly	1,974	\$2,731,374
IN	Aged and Disabled	1	\$2,481
MA	Frail Elders	921	\$289,677
ME	Aged/Disabled	46	\$10,762
MI	Elderly and Disabled	2,109	\$694,984
MN	Elderly	170	\$53,043
MN	Disabled	4,832	\$5,219,009
MN	Community Alternative Care	18	\$14,572
MS	Elderly and Disabled	472	\$517,372
MT	Elderly/Physically Disabled	881	\$305,051
ND	HCBS	24	\$15,065
NE	Aged and Disabled	623	\$412,678
NJ	Global Options LTC	13	\$13,205
NM	Mi Via Nursing Facility	306	\$314,100
NY	Aged and Disabled	1,323	\$3,186,543
OH	Passport	10,782	\$10,837,778
OR	Aging & Disabled	15,283	\$3,611,650
PA	Elderly	2,457	\$2,113,922
PA	Independence	1,803	\$1,865,405
SC	Community Choices	1,757	\$3,717,908
UT	Elderly	2,682	\$3,163,611
UT	New Choices	258	\$148,457
WA	COPES Aged/Disabled	196	\$2,683,646
WI	Community Options Program (Aged/Disabled)	2,012	\$2,908,691
WV	Aged/Disabled	4,550	\$4,583,739
WY	Elderly/Disabled	234	\$45,122
Total		65,542	\$61,886,018

Source: Analysis of 2010 Medicaid 372 waiver reports by the University of California, San Francisco, for the AARP Public Policy Institute.

Table 2
Programs within the Affordable Care Act That Could Promote Transportation

Program	Purpose	Total Funding	Enhanced Medicaid Federal Match	State Participation in Program	Timing	States That Provide Transportation through This Option
Money Follows the Person (MFP)	To provide transition funding for Medicaid beneficiaries leaving institutions for community settings and to fund initiatives that improve the balance of funding for HCBS	\$2.25 billion appropriated by the ACA through FY 2016, totaling \$4 billion	For first 12 months after a Medicaid beneficiary goes back into the community; and federal matching available for a wide range of balancing activities, such as nursing home diversion and staff; leverage for other ACA tasks	44 states + DC: AL, AR, CA, CO, CT, DE, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, VA, VT, WA, WI, WV	FY 2008–FY 2020	MFP participants in 16 states (out of the 25 states that submitted services data) utilized transportation during calendar year 2012
Community First Choice	To enhance HCBS attendant services and supports under a Medicaid state plan option	Estimates of \$1.585–\$3.7 billion, depending on the # of states and people receiving services under this option	Funds HCBS attendant services and supports at 6 percentage points enhanced federal Medicaid match	4 states: CA, MD, MT, OR	It is not time limited	2 states: MT & OR*
Balancing Incentive Program	To encourage states to balance their Medicaid spending on LTSS toward HCBS	Up to \$3 billion in competitive grants	2–5% federal matching increase (depending on state Medicaid characteristics) to raise HCBS spending by October 2015	21 states: AR, CT, GA, IA, IL, IN, KY, LA, MA, MD, ME, MO, MS, NE, NH, NJ, NV, NY, OH, PA, TX	October 2011–October 2015	1 state: CT is known*

Expanding Specialized Transportation: New Opportunities under the Affordable Care Act

Table 2 (continued)

Program	Purpose	Total Funding	Enhanced Medicaid Federal Match	State Participation in Program	Timing	States That Provide Transportation through This Option
Section 1915(i) State Option	To provide HCBS under a Medicaid state plan to individuals whose income does not exceed 300% of SSI. Can place limits on the type, amount, duration, population, and scope of services, but services must be offered statewide	No enhanced funds, but it allows states to offer these limited HCBS without Medicaid waivers	None	12 states + DC: CA, CO, CT, FL, IA, ID, IN, LA, MT, NV, OR, WI (several are for people with mental illness)	It is not time limited	1 state: CT is known*
State Demonstration to Integrate Care for Dual Eligible Individuals	To provide better coordinated care for people with Medicare and Medicaid	No set amount	CMS will share Medicare savings with each state in this financial alignment demo	12 states: CA, CO, IL, MA, MI, MN, NY, OH, SC, TX, VA, WA—with signed MOUs	No published end date	CA and MA are known*
Community-based Care Transitions Program	To test models for improving care transitions from hospitals to other settings and reducing readmissions for high-risk Medicare beneficiaries	Up to \$500 million	Community-based organizations paid one rate per eligible discharge for a 180-day period per beneficiary	102 sites	2011–2015	Only some sites provide transportation, such as the Atlanta Regional Commission

ACA = Affordable Care Act

CMS = Centers for Medicare & Medicaid Services

HCBS = Home- and Community-Based Services

LTSS = Long-Term Services and Supports

MOUs = Memorandums of Understanding

SSI = Supplemental Security Income

*At the time of publication, these were the identified states. More states could likely take up these options in the future.



Community First Choice (CFC)

CFC gives states the option to add a new Medicaid benefit that allows consumers to direct much of their own care by choosing service providers and timing of care to meet individual preferences. States receive an enhanced federal match of 6 percentage points for the provision of such “participant-directed” services and supports to eligible Medicaid recipients. This option is not time limited.

As of July 2014, four states—California, Maryland, Montana, and Oregon—had received approval from the federal government for CFC. Of these states, only Montana and Oregon specifically provide Community Transportation as a CFC permissible service. Montana will provide mileage reimbursement for travel in conjunction with medical escort, and community inclusion service transportation approved in the person-centered plan is reimbursable. Oregon already had the benefit in place and was able to continue the benefit in the CFC waiver (see box 2).⁹



Balancing Incentive Program

The Balancing Incentive Program is a grant initiative designed to encourage states to balance their Medicaid spending toward HCBS. This program is for states that rely predominantly on nursing homes and other institutions for Medicaid beneficiaries with long-term care needs. To receive funding, the state must have spent less than 50 percent of its total Medicaid long-term care dollars on noninstitutional services in FY 2009. States, in turn, must agree to make structural changes and meet a target spending commitment toward HCBS by the end of the balancing incentive period, October 1, 2015. As of October 2014, 21 states had received these grants.¹⁰

An official with the Centers for Medicare & Medicaid Services (CMS) said that she did not know of any states that are using Balancing Incentive Program grants to fund community transportation.¹¹ However, at least one state is using these funds for strategic planning that includes transportation (see Connecticut case study).

Box 2

Oregon: Community First Choice Covers Community Transportation

According to Oregon’s Medicaid state plan,

Community Transportation is provided to eligible individual[s] to gain access to community-based state plan and waiver services, activities, and resources. Trips are related to recipient service plan needs, are not covered in the 1115 medical benefit, are not for the benefit of others in the household, and are provided in the most cost-effective manner that will meet needs specified in the plan. Community Transportation services are not used to: 1) replace natural supports, volunteer transportation, and other transportation services available to the individuals; [and] 2) compensate the service provider to travel to or from the service provider’s home.

Section 1915(i) State Option

This ACA option allows states to provide Medicaid-funded HCBS to individuals whose income does not exceed 300 percent of Supplemental Security Income (SSI).¹² This 1915(i) state option is similar to the 1915(c) waivers described above in that the state can limit the type, amount, duration, population, and scope of services.

However, unlike the 1915(c) waivers, services must be offered statewide and enrollment cannot be capped. States do not receive enhanced federal matching funds, but this option allows them to offer these limited HCBS without Medicaid waivers. The advantage of the 1915(i) option is that an individual need not meet the more stringent institutional level of care requirements to qualify for HCBS.

Twelve states plus the District of Columbia—California, Colorado, Connecticut, Florida, Idaho, Indiana, Iowa, Louisiana, Montana, Nevada, Oregon, and Wisconsin—had 1915(i) state plan amendments as of August 2014.¹³ There is no time limit to this option. Of these states, only one known state—Connecticut—specifies community transportation for older adults or adults with physical disabilities¹⁴ (see box 3). Several of the state 1915(i) options are only for people with mental illness.

Like other new ACA initiatives, the 1915(i) option is very limited. This option is targeted toward specific and small populations. However, it could potentially reach those who are most in need of transportation to help them avoid institutions and remain in the community.

Box 3

Connecticut: Medicaid 1915(i) Covers Community Transportation for Older Adults

Connecticut's 1915(i) state option is for Medicaid recipients who are 65 years of age or older and require assistance with one or two critical needs, such as bathing, dressing, toileting, eating, transferring, meal preparation, and medication administration. People who have more than two critical needs are served under a Medicaid HCBS 1915(c) waiver. In 2014, the 1915(i) program served 550 clients.¹⁵

Transportation services in the Connecticut state option provide access to social services, community services, and appropriate social or recreational facilities that are essential to help some individuals avoid institutionalization. This service is offered in addition to medical transportation under the state plan and does not replace it. Taxis, buses, volunteers, or other individuals or organizations can provide transportation when necessary to provide access to needed community-based services or community activities as specified in an individual's plan of care. To receive reimbursement, commercial transportation providers must meet all applicable state and federal permit and licensure requirements, as well as vehicle registration and Medicaid program enrollment requirements.¹⁶

Unfortunately, this service is underutilized. The state has had trouble securing transportation providers because of the low reimbursement rates. Aides sometimes drive their clients, but the state does not pay an additional fee to reimburse them. Home care agencies, however, sometimes pay their aides for this service.¹⁷

Demonstrations for Dual Eligible Individuals That Could Expand Specialized Transportation

In 2011, roughly 10.2 million people were dually eligible for Medicare and Medicaid services; of this total, 7.4 million were eligible for both Medicare and full Medicaid benefits, commonly referred to as full-benefit duals.¹⁸ These “dual eligibles” are typically poorer and sicker than other Medicare beneficiaries, use more health care services, and therefore have much higher health care costs. Dual eligibles often struggle to navigate a complicated system of providers.

Established by the ACA, the CMS Medicare-Medicaid Coordination Office is providing financial incentives for states to coordinate care for the dual eligibles who may need acute, chronic, or long-term care for physical and mental health conditions.

As of September 2014, 12 states—California, Colorado, Illinois,

Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia, and Washington—had signed memoranda of understanding¹⁹ on services for dual eligibles. Most are testing risk-based, capitated, managed care models where health plans receive a per member, per month fee.

CMS does not require that the states expand transportation in these demonstrations beyond what is currently covered in the Medicaid program.²⁰ However, some states are doing this²¹ (see box 4).

In addition to expanded transportation benefits, another advantage of the dual demonstrations is the emphasis on care coordinators who can help ensure access to transportation as well as schedule trips for treatment and follow-up. At the time of publication, these programs were in the early stages of implementation, making it too early to assess the impact of these transportation benefits.

Box 4

State Examples of Dual Eligible Demonstrations with Nonmedical Transportation Benefits

California

The state’s three-way contract is the most direct in requiring participating plans to offer an expanded transportation benefit. Plans have to offer up to 30 one-way nonmedical trips per year to individuals in the demonstration.²² This benefit is in addition to what is available under the MediCal (state Medicaid) program.²³

Massachusetts

The state provides enhanced supplemental services in the demonstration, including nonmedical transportation. The contract explains that the plans must offer “nonmedical transportation services within the community to enable the enrollee to access community services, activities, and resources in order to foster the enrollee’s independence and integration and full participation in his/her community.”²⁴ This transportation benefit is a “new community-based services” benefit. Plans are required to offer this package of benefits, but the beneficiaries’ receipt of these services is dependent on demonstration of need in the assessment and care plan.²⁵

Medicare Options That Could Incentivize Specialized Transportation

The ACA created a number of programs designed to improve care for Medicare beneficiaries with chronic conditions that could expand access to transportation. Medicare covers ambulance trips but only if the patient is either bed-bound or has a medical condition that requires it.²⁶ Unlike Medicaid, Medicare does not cover nonemergency medical transportation or community transportation.

About 5 percent of people with the highest health care needs account for nearly half of health care spending in the United States.²⁷ Older adults and people with chronic conditions make up a disproportionate part of this highest needs group. In addition, billions of dollars are spent on avoidable hospital readmissions each year. People who use many different health care providers to treat multiple conditions often experience duplication and fragmentation of services.

Although the ACA does not pay for specialized transportation for Medicare clients, it does provide monetary incentives aimed at reducing hospital admissions, improving care, and containing costs for vulnerable, high-cost Medicare populations. The following programs offer opportunities to increase transportation services for certain Medicare populations that have lacked access to these services.



Care Transition and Coordinated Care Programs

The ACA has several initiatives to improve care transitions when patients move between one care setting or provider to another. Smooth care

transitions are essential for ensuring that people receive good care when they move, for example, from hospital to home. Another major reason for focusing on better care transitions is to prevent costly hospital admissions and readmissions, particularly for people who are at high risk and who often have multiple chronic conditions. The health care system has been focused on acute medical care, but there is now recognition that critical elements for improved care transitions should include nonmedical services such as family caregiver supports and transportation.²⁸

The Partnership for Patients, Community-based Care Transitions Program (CCTP), Hospital Readmissions Reduction Program, and Accountable Care Organizations (ACOs) are initiatives committed to improving care transitions. The Partnership for Patients initiative aims to prevent hospital-acquired conditions and improve transitions from one care setting to another by reducing readmissions. Twenty-six hospital engagement networks are partnering with nearly 3,700 hospitals that are working with health care providers and facilities to identify promising practices and solutions.

Within the umbrella of the Partnership for Patients, CCTP tests models for improving care transitions and reducing hospital readmissions for high-risk Medicare beneficiaries. CCTP works in sync with the Hospital Readmissions Reduction Program, which penalizes and reduces payments to hospitals for excessive readmissions.

Implemented in 2011, 102 sites are participating in the CCTP.²⁹ The CCTP awardees receive a 2-year agreement that may be renewed for 5 years based on successful outcomes of a 20 percent, 30-day readmission reduction.³⁰ Total funding for CCTP is \$500 million.

The focus is on community-based organizations working collaboratively with hospitals to manage Medicare beneficiaries' transitions and to improve their quality of care. Only some sites provide transportation. The following Atlanta case study is an example of a site that provides supplemental transportation.

The ACA is encouraging doctors, hospitals, and other providers to join together voluntarily as ACOs to provide coordinated care to their Medicare patients. The goal is to ensure that patients, especially those with chronic conditions, receive high-quality care while avoiding unnecessary services and preventing medical errors. Successful ACOs receive some of the savings achieved from the Medicare program.

Case Studies

The following two case studies illustrate how a region and a state have leveraged a variety of ACA grants, state money, and other federal funding to maximize limited funds. They provide insight into the types of transportation being used and the consumers receiving the services.

The case studies also illustrate how both Atlanta and Connecticut have relied upon partnerships to serve more people with mobility needs in their own homes and communities. Both currently are working on efforts to map transportation services within their regions and to better understand gaps in these services.



**Atlanta Regional
Commission**

Atlanta Regional Commission (ARC) is the regional planning and intergovernmental coordination agency for the 10-county area in and around Atlanta, Georgia. It serves as an Aging and Disability Resource Center that

Box 5 **Atlanta Initiatives to Expand Transportation**

- ✓ Community-based Care Transitions Program
- ✓ Money Follows the Person
- ✓ Regional One-Click System

provides information, referral, and counseling for long-term care services. ARC also administers Older Americans Act services such as meals and transportation throughout the region.

ARC has two ACA initiatives—Community-based Care Transitions Program (CCTP) and Money Follows the Person (MFP)—that are helping older adults and adults with disabilities transition into the community. Also, ARC received funding from the Veterans Transportation and Community Living Initiative grant (which was not part of the ACA) to help launch a One-Click System, so participants in the above two programs—and others such as people with disabilities, low-income workers, older adults, and veterans—can access transportation. The One-Click System is an Internet system that can connect riders to transportation.

Community-based Care Transitions Program (CCTP)

To reduce hospital readmissions, ARC received a CCTP award 2 years ago to coach Medicare beneficiaries who were recently discharged from hospitals. ARC partnered with Emory University Hospital, Gwinnett Medical Center, Piedmont Hospital, Southern Regional Medical Center, WellStar Cobb Hospital, and WellStar Kennestone Hospital to reduce 30-day avoidable hospital readmissions. Their “coaches” visit patients at home within 3 days of discharge and follow up by telephone

over 30 days. Coaches help with medication and symptom management and follow-up visits. As needed, they also provide a short-term supportive services package that can include:

- 14 home-delivered meals;
- transportation: two round trips for medical appointments, including dialysis; and
- up to 6 hours of homemaker services.³¹

As of April 2014, ARC had coached roughly 6,000 patients in their homes. They found that 20 percent of them could benefit from supportive services that include transportation.³² These supportive services were necessary because of poor medication management and lack of follow-up with physicians and community supports.³³

ARC uses transportation providers with Older Americans Act contracts in most counties. ARC coaches can authorize transportation services. Counties then bill ARC for the rides. ARC pays the transportation providers their negotiated rate under the Older Americans Act services contract. However, some counties give patients \$200 vouchers to use for any type of transportation. Administrators note that patients can usually receive more than the two round trips with the \$200 vouchers.³⁴

ARC received the initial 2-year agreement, and it has been renewed for another year. This contract can be renewed for 2 additional years for a total of 5 years based on successful outcomes of a 20 percent, 30-day readmission reduction.³⁵

Money Follows the Person

Georgia has had an MFP program for many years, but ARC has administered this program in the Atlanta region for only the past 2 years. The goal was

for ARC to transition 29 people from institutional settings such as nursing homes to the community each year. ARC exceeded that goal with 48 transitions in FY 2013 and 32 in FY 2014.³⁶

To be eligible, participants must have been nursing home residents for at least 90 consecutive days, and their care must be covered by Medicaid. Although MFP participants have different disabilities and needs, many participants in the Atlanta region are younger adults with physical disabilities who do not have a circle of support. MFP participants are generally more isolated and have higher levels of need. ARC has two full-time equivalent transition coordinators for the MFP program and two options counselors who work with MFP participants and others.³⁷

MFP funds cover transition costs for 1 year after the participant moves back into the community. As part of these funds, each participant has a \$500 transportation budget to use during the year. The program director has found that this \$500 allocation is usually quickly used right after the transition because Medicaid eligibility takes 30–60 days to switch from institutional to HCBS waiver coverage. During this 1- to 2-month period, participants usually spend their transportation benefits on transportation to doctors' appointments, from nursing homes to new homes, to the Social Security office, and sometimes to government agencies to receive identification in order to move into apartments. To maximize the tight \$500 budget, transition coordinators try to schedule several trips back-to-back rather than schedule multiple round trips.³⁸

ARC contracts with a variety of transportation providers, but most MFP participants need paratransit or specialized transportation, especially if they are in wheelchairs or use medical equipment. Because the MFP funds can be used for only 1 year, coordinators try

to find participants affordable housing that is located on or near transit or within paratransit service areas.

Medicaid in Georgia covers medical transportation for eligible participants, but it does not cover optional nonmedical transportation. Therefore, ARC has found that it is important to work with the Centers for Independent Living that conduct travel training on how to take public transportation and connect participants to the One-Click System.

Regional One-Click System

ARC is creating a new regional One-Click system that will allow people easier access to an array of transportation services through the Internet. Consumers can also call agencies' call centers, which will utilize the new system as well.

ARC is partnering with Atlanta Regional Workforce Board, RideSmart/Georgia Commute Options Carpool/Vanpool, Cobb Community Transit, Department of Veterans' Affairs, Disability Link, and Goodwill Industries (for job training) to develop the software and launch the website to help older adults, adults with disabilities, and their families access mobility options. This system will help inform them of the different mobility options, including public transit; community-based services from senior centers, volunteer drivers, and vouchers; commuter services; and nonemergency medical transportation. The system allows users to pinpoint the best option for planning trips based on time and costs.

The software will also enable ARC to have a better understanding of the existing types of transportation needs. With this information, ARC will be able to make more efficient use of transportation resources in the Atlanta region by facilitating regional scheduling, booking, payment, and dispatching of vehicles.



Connecticut

Connecticut is in the beginning stages of reforming transportation services for people with disabilities. The state is working on this issue primarily through its Medicaid “balancing” planning process.

The governor and General Assembly are committed to expanding long-term care options and helping the nursing home industry diversify. In January 2013, the state published an initial 3-year plan for 2013–2015 to balance its Medicaid long-term care services toward HCBS.³⁹ To support these balancing efforts, the state has optimized federal funding opportunities under the MFP program and Balancing Incentive Program. The MFP program has supported both strategic planning and efforts to transition people from institutions into the community. The Balancing Incentive Program brought in \$72.8 million in funding through September 2015, which will be used for implementation efforts. The governor provided an additional \$30 million in state funding.

Strategic Plan

The state’s 2013–2015 strategic plan establishes a framework for changing the design of HCBS, housing and transportation, workforce development, discharges from institutions to community, and nursing homes. The

Box 6

Connecticut Initiatives to Expand Transportation

- ✓ Strategic Plan
- ✓ Money Follows the Person
- ✓ Balancing Incentive Program

plan is based on a partnership with local communities and stakeholders.

The strategic plan acknowledges that transportation is central to helping Medicaid consumers successfully remain in or return to the community. However, the report notes that transportation is “one of the greater unmet needs in communities, [and] it is frequently not accessible or affordable.”⁴⁰ Among the metrics suggested for improving transportation options for Medicaid consumers living in the community are:

- increasing the number of Medicaid HCBS 1915(c) waivers with nonmedical transportation as a service option; and
- increasing the numbers of community transportation coalitions and alternative transportation options through the use of Zipcars and school buses.

Currently, Connecticut is working on a second strategic plan to balance Medicaid at a town level through 2025 by focusing on mapping and projecting housing and transportation needs of people who need long-term care.⁴¹

Money Follows the Person

In addition to supporting the planning efforts, this program has helped from January 2008 through June 2014 more than 2,100 people in the state move from institutions into the community, where they receive Medicaid long-term care; 988 of the transitions were older adults.⁴² The state received approval from the CMS in April 2014 to add mobility management training for its MFP participants who transition out of institutions and into communities. Mobility managers will train them on how to ride the bus.⁴³ Transportation, however, must be a service that is documented as needed in a participant’s care plan.⁴⁴

MFP participants are also eligible to receive transportation services. Although Medicaid can use a variety of transportation providers, ranging from taxis to stretcher vans, the type of transportation usually depends on the town where the participant lives. For example, in some towns, it is difficult to hire a taxi.

Conclusion

Without transportation, it is difficult for people with long-term care needs to “age-in-community,” which is what most people want to do.

The primary method for states to expand community, nonmedical transportation for low-income people with mobility limitations is through Medicaid waivers. However, states can expand Medicaid community transportation benefits to targeted and limited populations through the ACA. Although Medicare does not pay for community transportation or medical trips, except ambulances, the ACA provides opportunities to improve care for Medicare beneficiaries with chronic conditions, which could lead to better access to transportation.

This paper sheds light on the opportunities to expand transportation and tap new funds within the ACA options and demonstrations. Although new funding for transportation in the ACA is restricted and often targeted to specific low-income populations with mobility needs, these new programs could add to a “broad tapestry of funding sources” available to states.⁴⁵ States and regions will need to leverage multiple sources of funding and partnerships with other agencies, as well as transit and health care communities, to tackle the increasing unmet needs for transportation.

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NON-EMERGENCY MEDICAL TRANSPORTATION

A Vital Lifeline for a Healthy Community

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Approximately [3.6 million Americans](#) miss or delay medical care because they lack appropriate transportation to their appointments.¹ Many low-income Americans lack the disposable income necessary to have access to a working automobile, and may lack public transit options to get to and from medical appointments. Medicaid provides a non-emergency medical transportation benefit that pays for the least costly and appropriate way of getting people to their appointments whether by taxi, van, public transit, or mileage reimbursement.

This brief provides an overview of the differing ways states are dealing with the increase in individuals who need transportation to medical services, due to age, chronic conditions or income. It is intended to provide guidance for state lawmakers to consider the vital role transportation plays in positive health outcomes for citizens.

The Increasing Need for Non-Emergency Medical Transportation Services

Medicaid funds are the single largest transfer of federal money to states, representing an average of 44 percent of all federal revenue received.² The transportation component is about [\\$3 billion of that yearly fund transfer](#), comprising less than 1 percent of total Medicaid expenditures.³ Though a small percentage of Medicaid overall, consistent transportation access to healthcare helps enhance the medical outcomes of Medicaid recipients and lead to cost-savings.

With more medical care provided on an outpatient basis, and an increasing number of people with chronic conditions, trips to medical appointments are the lifeblood of a sustainable healthcare system. Non-emergency medical transportation (NEMT) provides trips to and from scheduled medical appointments, return trips from hospital emergency rooms and transfers between hospitals for individuals without access to transportation. By providing consistent and efficient access to medical appointments, states can save money by helping these individuals avoid costly ambulance trips or emergency room visits.

Medicaid Expansion

Under the Affordable Care Act, the population of people eligible for Medicaid is expanding. Based on projections from the 25 states where coverage expansion is underway, it is estimated that [9 million individuals](#)⁴ will be added to the Medicaid program; Medicaid and the Children's Health Insurance Program (CHIP) have over [6 million new enrollees](#) as of April 30, 2014.⁵ Because the expansion includes people who are 133 percent of the

¹ Raphael, D. *Medicaid Transportation: Assuring Access to Health Care: A Primer for States, Health Plans, Providers and Advocates*. 2001. Quoted in *Medicaid Non-Emergency Medical Transportation (NEMT) Saves Lives and Money*, Community Transportation Association, 2014.

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⁵ Clemans-Cope, Lisa, et. al. *Increase in Medicaid under the ACA Reduces Uninsurance, According to Early Estimates* Health Reform Monitoring Survey, 2014. <http://hrms.urban.org/briefs/Increase-in-Medicaid-under-the-ACA-reduces-uninsurance.html>

federal poverty rate, they are expected to have relatively fewer NEMT transportation needs. A study from the Transportation Research Board estimates that only [270,000 new enrollees will require NEMT](#), which nevertheless could potentially strain systems in some states.⁶

Providing Health Care Access

Non-emergency medical transportation is essential for disadvantaged Medicaid recipients, those who are older, or have disabilities or low incomes who have no transportation to access healthcare services.

Medicaid recipients who own a car or can provide their own transportation may receive travel service reimbursement for costs related to getting to their care, including gasoline, car maintenance or repair, cost of vehicle modifications for adaptive technologies and other financial stipends to support ongoing transportation needs. For those who are unable to provide their own transportation, whether due to income, age or disability, other methods of NEMT service delivery are necessary.

Growth of Chronic Conditions

Many individuals with chronic conditions which include arthritis, asthma, cancer, cardiovascular disease, chronic obstructive pulmonary disease and diabetes need medical services frequently. Treatment of chronic conditions, account for three-quarters of all U.S. healthcare spending. As of 2009, the Centers for Disease Control estimate that 78 percent of the adult population age 55 and older has [at least one of these chronic conditions](#).⁷ Additionally, estimates predict that states will add [over half a million adults who have serious behavioral health issues](#) that impair their everyday functioning to the Medicaid population.⁸ These people will need NEMT to access life sustaining treatments and health care services.

For the nearly [20 million adults with chronic kidney disease](#) who are undergoing dialysis three times a week, NEMT is a reliable way to get to appointments and avoid going to the emergency room if appointments are missed.⁹ [Sixty-six percent of dialysis patients](#) rely on others for transportation to their appointments, only 8 percent relied on public transportation or taxi services, and 25.3 percent drove or walked to the clinic themselves.¹⁰ A [recent study examining Florida's NEMT costs](#) found that if one percent of total medical trips resulted in avoiding an emergency room visit, the state could save up to \$11 for each dollar spent in non-emergency medical transportation.¹¹

⁶ Garrity, R and Kathy McGehee. *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*. Washington, D.C.: Transportation Cooperative Research Program, 2014.

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State Solutions to Increasing Need for Non-Emergency Medical Transportation

Coordinating Human Transportation Services can Reduce One-Purpose NEMT Trips

One strategy for NEMT cost savings is to [coordinate medical trips with other community transportation providers who are serving similar populations](#).¹² However, few states have successfully coordinated their Medicaid trips with their entire transportation network. This may be due to differing service standards for ADA paratransit and NEMT, differing requirements for drivers of transit and NEMT, jurisdictional issues or restrictive interpretations of federal regulations.

In what has developed as a complex and often fragmented system, transportation services can be difficult to understand, access and navigate for users. Public and private agencies that administer or refer clients to human service transportation programs may have different goals and serve different populations. These agencies also receive funds from different sources, each of which comes with its own rules and restrictions. Eligibility and accountability standards, vehicle needs, operating procedures, routes and other factors also may vary greatly across organizations. At the local level, programs can differ across city or county boundaries. The large number, diversity and dispersion of coordinated transportation programs can lead to underutilization of resources, inconsistent safety standards, customer inconvenience and inadequate transportation service.

Services can overlap in some areas and be entirely absent in others. Funding shortfalls, policy and implementation failures and lack of coordination can leave many who need transportation with few or no options. The result is that many who need transportation to access essential services and to participate in community activities may be left unserved or underserved. Fortunately, technology developments related to coordination and mobility management have helped maximize resources by successfully managing eligibility standards and shared rides with multiple funding sources.

Yet, in many states, one of the largest human services transportation providers does not have a seat at the coordination table. State Medicaid agencies provide a substantial proportion of NEMT rides to populations that would benefit from coordinated transportation, however, with Medicaid regulations against self-referrals, barriers to effective coordination exist. The [Medicaid rules on governmental brokerages](#) provide that if, after winning the competitive bid, a governmental entity provides a brokerage service, the brokerage must be a distinct governmental unit, and it could not be paid for costs other than those unique to the brokerage function.¹³

Additionally, the administrative burden for governmental brokerages is high. For every ride provided through another governmental entity, the broker must provide assurances that sending someone on a state or local transportation service was the most appropriate, effective and lowest cost. In addition, for each individual transportation service, the broker must document that the Medicaid program is not paying more than the rate

¹² Rall, Jaime. *State Human Service Transportation Coordinating Councils: An Overview and State Profiles*. Denver: National Conference of State Legislatures, 2010. <http://www.ncsl.org/research/transportation/state-coordinating-councils-overview-and-profiles.aspx>.

¹³ Medicaid Program; State Option to Establish Non-Emergency Medical Transportation Program. 73 Fed. Reg. 77521. (Dec. 19, 2008) (to be codified at 42 C.F.R. pt. 440).

charged to the general public. The rules were proposed so that state and local bodies would play on an equal playing field as private entities; however, they may be preventing effective coordination with other agencies because of administrative hurdles.

Because of the complexity of Medicaid NEMT regulations for eligibility and prohibitions on self-referrals, many Medicaid agencies prefer to put the obligation of complying with regulations on a private broker instead of risking losing their funding because of non-compliance.

Some states are finding ways to coordinate their Medicaid transportation with other agencies. Eighteen states coordinate with the Medicaid agency at some level by having them on the state coordinating council. In three states—Kentucky, Massachusetts and Vermont—non-emergency transportation is fully embedded in their coordinated transportation approach. In Vermont, rides are coordinated through the Vermont Public Transportation Association (VPTA), which is composed of non-profits, municipalities, para-transit providers and members of the general public. VPTA has a contract with the Agency of Human Services, and facilitates coordinated transportation services between nine public transportation providers using fixed route, demand response, taxis and volunteer driver services. VPTA also has recently partnered with a technology provider to increase its transit agencies' scheduling and dispatching efficiencies and reporting capabilities.

Twenty-eight states do not coordinate transportation with their Medicaid agency at all, because they do not have a state coordinating council. This means that several agencies which are facilitating rides in one neighborhood may be sending a separate vehicle to a disabled veteran, a Medicaid patient, and someone who needs ADA paratransit, who all live a block from one another.

To combat these problems, governmental bodies, human service organizations and transportation planners have advocated improved coordination among human service agencies, providers of public transit and specialized transportation services and other stakeholders. This process, called [human services transportation coordination](#), generally means better resource management, shared power and responsibility among agencies and shared management and funding.¹⁴ When key entities work together to jointly accomplish their objectives, they can achieve more effective, efficient and accessible transportation options for those who need it most: **effective**, in that they get people where they're going; **efficient**, in that they use public dollars economically; and **accessible**, in that services are easy for travelers to navigate and use.

Although coordination of transportation services can benefit more than just the NEMT population, many Medicaid agencies contract out their transportation services. The contract typically does not include a requirement to coordinate with other state transportation agencies, creating a barrier for efficient use of state transportation funding and effective service for underserved populations. Opportunities exist for states to coordinate services with Medicaid agencies to maximize efficient transportation funding.

Mobility Management for NEMT Trips

Some communities are utilizing Mobility Management in an attempt to better coordinate transportation options. Mobility Management is administered by transit agencies in some communities to improve network

¹⁴ Burkhardt, J.; David Koffman; and Gail Murray. *Economic Benefits of Coordinating Human Service Transportation and Transit Services*. Transportation Research Board, 2003. http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_91.pdf

efficiencies, for example, through the utilization of a one-call one-click scheduling systems. Other communities utilize staff at human service organizations, such as Aging and Disability Resource Centers, as mobility managers to assist individuals to find the best transit options or provide instruction to people with disabilities on how to use public transit.

State Non-Emergency Transportation Delivery Options

After Congress passed the Deficit Reduction Act of 2005 (DRA), states had more options to deliver their non-emergency medical transportation. The DRA allowed states more flexibility in how they deliver NEMT, without requiring a burdensome administrative waiver process. All states are required to submit a plan to the Centers for Medicare & Medicaid Services (CMS) detailing how they will provide NEMT services and how it will be reimbursed—as either an administrative cost or a medical cost.

Requirements for NEMT under Medicaid regulations:

- Available in all political subdivisions of the state
- Provided with reasonable promptness to all eligible individuals
- Provided to all individuals in the same amount, duration, and scope
- Recipients must be allowed the “freedom of choice” of their transportation provider

Administrative Cost vs. Medical Cost

States can claim NEMT as either an administrative cost or a medical cost when submitting their state plans to the Centers for Medicare & Medicaid Services.¹⁵

When a state submits a request for administrative expenses, the amount of money reimbursed from [federal medical assistance percentage \(FMAP\)](#) is typically less, but the amount of cumbersome paperwork required for reimbursement is reduced as well.¹⁶ Submitting NEMT as an administrative cost also negates the requirement for a state to allow users “freedom of choice,” meaning that the state can direct NEMT users to specific providers, which could lower costs for service delivery. States providing NEMT as a medical service are eligible for a greater FMAP reimbursement, depending on the state’s per capita income and other factors. There are considerably more administrative costs to consider, and the freedom of choice of provider requirement requires states to be more flexible in the transportation providers they use, which might lead to increased costs.

Because of the administrative burden, many states submit NEMT as a line item in their overall administrative costs, creating barriers for CMS to analyze data on the prevalence of service delivery modes and their relative

¹⁵ As of 2003, 25 states and the District of Columbia submitted their NEMT as a medical expense, 12 states submitted parts of NEMT as both an administrative expense and a medical expense, and 13 states submitted their NEMT costs as an administrative expense.

¹⁶ [FMAP](#) varies by state based on criteria such as per capita income. The regular average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82 %). FMAPs are adjusted for each state on a three-year cycle to account for fluctuations in the economy.

effectiveness for health outcomes. These [modes of delivery](#) include brokerages, fee-for-service, public transit, managed care organization or a mixture of two or more of the above.¹⁷

MODES OF SERVICE DELIVERY

Brokerages

Following the DRA, many states chose to implement a brokerage system, where either a private company or a state agency connects riders with transportation providers in the most efficient and cost-effective way.

Regulations for brokerages in states that submit their plan as a medical expense are contained in the other [medical care regulations](#), 42 CFR 440.170. Requirements for brokerages include:

- Proof of cost-efficiency
- Competitive procurement process when selecting broker
- Procedures for auditing and overseeing brokerage for quality
- Brokerage will comply with the prohibition on self-referrals

Brokers confirm the Medicaid beneficiary's medical eligibility, and then assure their trip is to an approved Medicaid destination and that they are receiving a medically necessary service. Brokers also confirm that the transportation provider has the proper licensing and safety inspections to confirm eligibility before contracting for services. Once the broker contracts with the eligible companies, they schedule eligible Medicaid beneficiaries' transportation through one of the approved providers. Many brokers have leveraged industry technologies to facilitate trips with providers efficiently and effectively. States using a private broker can pass these responsibilities to the broker, and compensate them on a capitated, per-Medicaid beneficiary basis. Capitated payments are a common Medicaid payment where the rate of payment is based on the number of people served, not the amount of service that each individual receives.

Because of the restriction on self-referral, which creates administrative barriers for state agencies to broker transit services, a reduction in coordination of NEMT services with other community transportation options has arisen. This leads to inefficient use of transportation resources and poor service for users.

Many states use the broker model to keep costs consistent and predictable year-to-year, and to limit their liability and administrative costs when dealing with Medicaid regulations. In some states, a mixed model is used, oftentimes with brokerages in more populated areas and fee-for-service in less-populated areas. Colorado, Michigan, New York and Texas all have mixed models of NEMT service.

Public Brokerage

Some states broker rides for individuals through a state agency. This presents a unique issue, because one of the requirements for brokers is that they comply with requirements related to prohibitions on referrals and conflict of interest. If a public agency is brokering rides using a public transportation provider, there are hurdles to providing the service.

¹⁷ Garrity, R and Kathy McGehee. *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*. Washington, D.C.: Transportation Cooperative Research Program, 2014.

State agencies that want to run a brokerage service must insulate the broker service from the rest of the agency budget. For example, a transit agency may be well positioned to provide a broker service because their employees are the most knowledgeable about the public transit system and the connections that a rider could make in order to get to their appointment. This employee would need to be separated from the transit agency and placed into a new brokerage with a separate salary that could not share any funds from the public transit agency's budget. Once the employee is a separate brokerage employee, documenting the transit agency's cost and cost-effectiveness for competitive bidding becomes more complex, as overhead numbers need to be parsed from other operating expenses. This creates a barrier for effective, efficient coordination between state agencies and non-emergency medical transportation being provided through existing state, regional and local transportation resources.

However, in rural areas, waivers are available for places where procuring a private broker is not feasible.

Private Brokerage

Since 2001, the number of states that are using some sort of brokerage has increased from 29 to 40. It is one of the most popular ways that states provide their Non-Emergency Medical Transportation.

States that deliver NEMT through a private brokerage use a competitive bidding process to procure a private for-profit company to work as an intermediary between transportation providers and eligible riders. States usually pay capitated payments to the broker for each eligible rider. This is the most common form of brokerage because it provides financial certainty that the state will only pay a set amount to a broker each year, instead of facing variable costs from using their own brokerage. A capitated rate provides an incentive for the provider to streamline its operations—for example, by providing automated call-out reminders of upcoming rides and automating the billing import and export process to lower operating costs.

States using this method should be aware of certain contract provisions that may not benefit the Medicaid agency or the users in the long run. For example, in Milwaukee, Wisc., the broker and state entered into a contract with a stop-loss clause, where if the broker provided more assistance than they were getting paid to do under the contract, the broker could cancel the contract. With the expanded Medicaid population, the broker was negotiating more rides than the contract called for and canceled the contract, leaving Milwaukee NEMT users stranded until another provider could be procured.

Mix of Brokerage and Fee for Service

In some states where there are concentrated urban areas and sparsely populated rural regions, a mixture of brokered services and fee for service models are used. Other states that have more dispersed populations use regional brokers to provide rides, and people outside those regions use fee-for-service modes. Under this model, the regional Medicaid agency contracts with a broker with a capitated contract, keeping costs stable for the regions that may have larger populations. By apportioning resources to the populated regions, the state agency can focus the rest of their resources on providing trips on a fee-for-service basis.

Fee for Service

Under this model, local and regional state-run Medicaid agencies handle all eligibility, trip authorization and trip arrangements. States have a centralized intake for trip requests and then assign trips to registered providers at either a regional or local level.

Transportation providers submit reimbursement requests to the agency, which pays for the service used. This model leaves the cost for transportation variable year-to-year, which may be difficult to budget for yearly.

Public Transit

In some states, public transportation is readily available to Medicaid recipients. In these states, Medicaid agencies almost exclusively rely on public transportation to provide NEMT and the agency reimburses the user for their trip. Some communities are utilizing mobility management administered by transit agencies to improve network efficiencies, through things like one-call one-click scheduling systems. If public transportation is not available, the agency focuses on personal transportation options.

Managed Care

One of the newest delivery models is a managed care model, where transportation delivery is part of the responsibility of the managed care provider or insurance firm that offers the covered Medicaid services. Typically, the state offers a capitated payment per enrolled individual over a period of time. This model aligns the incentive to care for patients in the most cost-effective way with the financial incentive for better outcomes by having the insurance company pay for the consequences of missed appointments and decreased health outcomes. This method is aligning incentives for better care with the entity that would be paying the price for inadequate service.

Innovations through Managed Care Organizations

In 2014, Oregon and Florida both modified the way they provide NEMT. Oregon recently put [regulations in place](#) that require the Coordinated Care Organizations (CCOs) to provide non-emergency medical transportation.¹⁸ The regulations state that when the healthcare authority “provides a CCO with a global budget that includes funds to provide NEMT services for its members, the CCO shall provide NEMT services to its members,” and that “all transportation services must be coordinated through the member’s CCO or the CCO’s designated transportation provider.” Because the healthcare authority will be paying a global fee for each patient, “reimbursement is a matter between the CCO and its transportation providers.”

In 2011, the Florida Legislature established the Managed Medical Assistance program. As part of the program, it required Managed Care Organizations (MCO) to provide covered services, [including NEMT](#), except for those who are “excluded from participating in managed care, authorized to voluntarily opt out of managed care, or have not yet enrolled in managed care.”¹⁹ Those who are not participating in managed care will continue to receive

¹⁸ Oregon Health Authority, Division of Medical Assistance Programs. *Rule Adopting OAR 410-136-3010 Regarding the Relationship of Coordinated Care Organizations and Non-Emergent Medical Transportation*. Salem, OR, 2014. <http://www.oregon.gov/oha/healthplan/Policies/136-3010-070114.pdf>

¹⁹ Florida Agency for Health Care Administration. *Transitioning Non Emergency Medicaid Transportation Services in the Managed Medical Assistance Program*. Orlando, FL, 2014. <http://www.colliermppo.com/modules/showdocument.aspx?documentid=5326>

NEMT through Florida’s Commission for the Transportation Disadvantaged (CTD). This dual strategy minimizes the number of rides provided by the CTD and puts more emphasis on the MCOs to provide transportation.

Other Strategies to Mitigate NEMT Rides: Technology and Disease Management Education

States can minimize the number of patients who need NEMT by utilizing new telehealth technology, sending community health workers to people’s homes to deliver healthcare and providing training for those with chronic diseases so they can better manage their conditions.

TELEHEALTH

[Telehealth](#) is defined as “the use of technology to deliver health care, health information or health education at a distance.”²⁰ The two types of telehealth applications are real-time communication and store-and-forward. Real-time communication allows patients to connect with providers via video conference, telephone or a home health monitoring device, while store-and-forward refers to transmission of data, images, sound or video from one care site to another for evaluation. New telehealth technology can reduce the number of people who need rides to routine medical appointments by allowing people to have their checkups at home.

For example, [in Colorado](#), where most of the population and health care providers are located along the Fort Collins/Denver/Colorado Springs corridor, those who live in other areas of the state face long drives to access healthcare.²¹ By using telehealth, nearly 200 hospitals, clinics and behavioral health centers in rural areas of Colorado and nearby western states have connected through high-speed broadband into the Colorado Telehealth Network since 2008.

COMMUNITY HEALTH WORKERS

[Community healthcare workers](#), who can travel to many patients’ homes daily, may also reduce the need for in-person medical care at a doctor’s office.²² Their trips may be optimized through the use of a computer program to help them get to as many patients as possible in one day for maximum efficiency.

Community health workers are especially useful in rural areas where accessing a doctor requires a day or more of travel. [In Alaska](#), remote villages and small populations do not support having a year-round physician, so local health workers were trained in primary care.²³ The local community health workers work remotely with a physician who may only visit the village once or twice a year. This helps people who otherwise would have little to no healthcare access receive check-ups and care without traveling by boat or airplane to a physician’s office.

²⁰ Ewing, Joshua. *State Coverage For Telehealth Services*. Denver: National Conference of State Legislatures, 2014. <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>

²¹ *Health Care for a High-Tech World: The Potential for Telehealth in Colorado*. Colorado Health Institute. October, 2014.

²² Goodwin, Kristine, and Laura Tobler. *Community Health Workers: Expanding the Scope of the Health Care Delivery System*. Denver: National Conference of State Legislatures, 2008. <http://www.ncsl.org/print/health/chwbrief.pdf>

²³ Alaska Community Health Aide Program. *Overview of the Alaska Community Health Aide Program*. http://www.akchap.org/resources/chap_library/Referral_Physician/CHAM_CHAP_Overview.pdf

DISEASE MANAGEMENT EDUCATION

A third strategy to help people more effectively manage their health and reduce the need for NEMT is to teach them how to self-manage their chronic conditions. Chronic Disease Self-Management Education (CDSME) programs teach adults with chronic conditions how to better manage their chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS, chronic pain, and depression. These [programs are supported by the U.S. Administration on Aging](#) (AoA) and are active in 22 states, with 11 more currently rolling out pilot programs.²⁴ The AoA supports CDSME programs through grants to states since 2003. States can use these funds to develop an infrastructure to deliver these disease management education programs in their communities. Five programs are [available online](#), removing the need for transportation to attend the in-person classes held over six weeks.²⁵

Currently, there are thousands of non-profit organizations working together to help citizens learn how to handle their chronic conditions. However, many non-profit organizations have not added medical transportation as a curriculum component. Opportunities exist for states to incentivize these groups to add mobility as part of their chronic disease management education.

Vermont uses its NEMT funding to serve dual purposes for chronic care management. The state holds its chronic care management classes next to the physician's office, where patients can go to their regularly scheduled appointment and then go to chronic care management class. By combining patients' appointments into one trip, Vermont cost-effectively allocates scarce funding to provide two services in one trip.

By utilizing new technology for telehealth, sending community health workers to people's homes to deliver healthcare services and providing training on how best to manage their diseases, states can reduce the number of people who need to physically show up for their appointments. This will help minimize overall NEMT spending and allow states to focus on people who have the highest need for service: those with behavioral health issues, those on dialysis and chemotherapy patients.

Conclusion

States will continue to make adjustments to their Medicaid programs in response to changes from the Affordable Care Act. Opportunities for cost savings through NEMT programs and other new technologies must be included in the conversation on how states can cost-effectively provide transportation services to achieve better health outcomes.

²⁴ U.s. Administration on Aging. *Chronic Disease Self-Management Education Programs*. http://www.aoa.acl.gov/AoA_Programs/HPW/ARRA/PPHF.aspx

²⁵ Stanford Patient Education Research Center. *Internet Self-Management Programs*. <http://patienteducation.stanford.edu/internet/>



A NEW MODEL OF SERVICE

A PILOT PROGRAM IN SOUTH CENTRAL MISSOURI

PARTNERING TO IMPROVE HEALTH ACCESS IN MISSOURI

HealthTran is an innovative, progressive and collaborative approach to linking citizens to health resources by reducing the transportation barrier. The program facilitates networking and partnerships, education, creative solutions, and coordinating services for people with medical, dental, preventative, maintenance, and other health services. The 3-year pilot program covering 10 southern Missouri counties (Christian, Douglas, Howell, Oregon, Ozark, Shannon, Taney, Texas, Webster, and Wright) works to improve long-term health outcomes by improving health access through public and public/private transportation, gathering quality data, and creating a program that can be expanded throughout rural Missouri.

Beginning December 1, 2013, Health and Transit Partners in the region began working together to open windows of opportunity through the Missouri Foundation for Health Special Projects Grant Award. In May 2015, HealthTran received one of 16 National Ladders of Opportunity Design Challenge Grants, funded by Federal Transit Association with technical support provided by the National Center for Mobility Management (a partnership of Easter Seals, American Public Transportation Association and Community Transportation Association of America (CTAA). In July 2015, a MODOT Section 5310 grant award expanded funding for the pilot.

HealthTran accomplishments in the first 18 months have met or exceeded pilot goals.

- An electronic health provider and trip referral process - paperless system
- A web-based data collection system designed for expansion
- Over 1,500 Trip Referrals received
- Over 30 medical sites working in partnership to connect patients with transportation (hospitals, rural health clinics, and community health centers)
- Seven professional transit providers working to link routes and riders to health care services
- Expansion of transit options through ambulance district services
- Partnership with South Central Ozark Council of Government (SCOCOG) to facilitate HealthTran's Design Challenge sustainability solutions
- Expansion to Shannon County in July 2015
- Missouri Rides to Wellness Summit planned for October 2015 brings the federal initiative to Missouri's leaders
- Get Link'd Health & Transit Conference, October 13-14, 2015 will focus on building health & transit partnerships and collaboration to address barriers to accessing health care.

Sustainability: The federal Design Challenge grant received in 2015 will explore sustainability options through community stakeholder meetings. Expansion of HealthTran through financial support of medical providers utilizing HealthTran to provide access to healthcare for disabled, low-income, and seniors in need of transportation is one solution to be discussed. Additional federal funding may be tied to the results of the Design Challenge. The WIN-WIN approach of HealthTran makes sense to all participating partners and participants.

Why is HealthTran so important to rural Missouri? Almost half of the population (145 million Americans) live with at least one chronic condition. There are 38 million people who are living with disability; 36 percent of adults over 65 have a disability (14 million in 2010); and there are an estimated 10,000 adults turning 65 each day. Transportation concerns among older adults are rising — this age group is projected to grow from 40 million to over 88 million by year 2050. The rural HealthTran region encompasses some of poorest and most in need counties in Missouri. The distance to healthcare, especially specialty care, can be over 100 miles roundtrip for many.

HealthTran goals are to:

- Gather accurate data relating to transportation as a barrier to accessing healthcare.
- Provide transportation for those with a barrier to transportation.
- Build a sustainable program that could be duplicated and expanded throughout rural Missouri or statewide.