Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies

DETAILS

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IMPACT OF THE AFFORDABLE CARE ACT ON NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT): ASSESSMENT FOR TRANSIT AGENCIES

This digest presents the results of TCRP Project J-06/Task 81, "Impact of Non-Emergency Medical Transportation on Transit Agencies." The research was conducted by Richard Garrity and Kathy McGehee, RLS & Associates, Inc., Dayton, Ohio.

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Background

The Patient Protection and Affordable Care Act of 2010, and the related Health Care and Education Reconciliation Act of 2010 (jointly referred to as the "Affordable Care Act" or ACA), complete a massive overhaul of the nation's health insurance and health delivery systems. For the first time, the ACA will provide universal access to health coverage, through various methods, including expansion of the Medicare program, expansion of eligibility under the Medicaid program, the establishment of state-level insurance exchanges, and expansion of the Children's Health Insurance Program (CHIP). Moreover, the act attempts to coordinate these actions to provide efficiency in service delivery.

The ACA will have significant impact on Medicaid. One of the primary mechanisms that would be used under the act to ensure universal health care access is a substantial expansion in eligibility under the Medicaid program. The ACA will increase the number of individuals who will be eligible for Medicaid by expanding existing eligibility categories and creating new eligibility categories. The most notable addition is that non-disabled individuals, ages 19 to 64 with incomes at 133% of the Federal Poverty Level (FPL) or less, and who are not pregnant and otherwise covered under Medicaid or Medicare, will become eligible for Medicaid effective January 1, 2014.

A recent Supreme Court decision found that the requirement for Medicaid expansion exceeded Congress' constitutional authority. Despite this ruling, the Medicaid expansion remains an integral component of the ACA. However, the ruling creates a variety of implementation efforts that makes an overall assessment of the act's impact on public transportation more difficult.

Medicaid originated in 1965 with passage of Title XIX of the Social Security Act. Undertaken as a funding partnership between the federal government and the states, Medicaid is a program designed to provide medical assistance to needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Medicaid is one of more than 60 different programs that fund passenger transportation. Outside of major transit programs funded by the Federal Transit Administration (FTA), Medicaid is by far the largest single source of funding to support human services transportation. One recent report estimates that Medicaid transportation

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expenditures in FY 2006 were $1,171,400,000, comprising more than 43.5% of the estimated $2,691,605,000 used to support transportation disadvantaged individuals—the elderly, low income persons, and individuals with disabilities (*1*). It is likely this figure has increased since 2006, even as states have implemented measures to control transportation costs. It is not unreasonable to conclude, based on recent overall Medicaid growth rates, that non-emergency transportation (NEMT) accounts for about $3 billion in outlays each year. Yet this amount represents less than 1% of total Medicaid expenditures.

The requirement to provide transportation under Medicaid can be traced to the *Handbook of Public Assistance* (Supplement D), the program's earliest comprehensive federal interpretive guidance. First published in 1966, the supplement stated that criteria to assure high quality of care and services would be determined by the "provision of necessary transportation of recipients to and from suppliers of medical and remedial care and service."

Many states, however, did not provide full access to medical services and the program has a long history of legal challenges to what has become known as the transportation assurance. Courts have generally ruled that states must provide this service. Five key provisions of NEMT stipulate that such services be:

- Available in all political subdivisions of the State;
- Provided with reasonable promptness to all eligible individuals;
- Furnished in the same amount, duration, and scope to all individuals in a group;
- Provided in a manner consistent with the best interests of the recipient; and
- Available to eligible recipients from qualified providers of their choice.

Historically, states were given the option of providing transportation as an administrative expense or as a form of medical assistance. When states elect to provide NEMT as an administrative expense, the federal matching rate, known as the FMAP rate, is 50%, which may be less than the state's reimbursement rate for other services. However, this option negates one potential obstacle to coordination in that requirement for freedom of choice of service providers does not apply. This enables the state to direct NEMT users to specific providers or permits the state to bid the service in an effort to find lower cost methods of service delivery. If a state opted to provide transportation as a medical service, it could potentially receive more federal funding if the state's FMAP rate was higher than 50%, but it would have to adhere to statewide service delivery and freedom of choice provisions. (States may seek waivers of nearly all Medicaid regulations in order to experiment with different methods of service delivery and to seek more efficient methods of providing health care to eligible populations.)

More recently, the Deficit Reduction Act of 2005 provided a new method of implementing a statewide NEMT transportation brokerage, permitting a state to claim transportation at the FMAP rate while limiting the freedom of choice in transportation providers. Moreover, states no longer had to apply for waivers to implement such programs.

A review of state practices found a variety of service delivery models, including:

- Brokerage models,
- Fee-for-service models,
- Mixed models,
- Public transit models, and
- Managed care models.

The ability to analyze the potential impact of the ACA on public transportation is hindered by events that have transpired since passage. First, *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* (*2*) created a scenario where states could reject Medicaid expansion.

Based on projections in participating states, it is estimated that nearly 9 million individuals will enroll in the Medicaid program because of the ACA. Based on the experience of states that have utilized waiver authority to expand their Medicaid programs in ways similar to those required in the ACA, it is anticipated that new enrollees will be more ambulatory and less transit-dependent than the traditional Medicaid-eligible population, and that only about 270,000 new enrollees will require NEMT.

Similarly, because of eligibility criteria associated with Medicaid expansion, it is anticipated that fixed-route transit services, where available, will meet most NEMT needs of the newly enrolled population.

Annual expenditures to meet the NEMT demand of this population are estimated at just under $90 million per year.

In areas where traditional fixed-route services are unavailable, it is anticipated that non-urbanized area community transportation systems and existing Medicaid brokerages will see some increases in NEMT usage directly related to expansion. Additionally, as states continue to seek the lowest-cost transportation method appropriate to client needs, it is likely that new enrollees will prefer alternative methods of personal transportation—including the state's making mileage payments directly to clients, friends and family, and volunteers—to brokered and community transportation approaches.

Despite Medicaid's being a significant funder of NEMT transportation, there is little documentation on the scope, extent, and methods of NEMT service delivery. The transportation industry would benefit from future research in this area, as follows:

- Number of Medicaid eligible individuals who require NEMT, by Medicaid population and/or program segment;
- Method of NEMT service delivery when transportation services are required (e.g., mileage reimbursement, volunteer, bus pass for fixed-route, community transportation);
- Efforts to model NEMT trip-making, enabling state agencies to better estimate the costs of program and waiver decisions; and
- Impacts of NEMT on mode selection in broker-managed programs.

CHAPTER 1 INTRODUCTION

The Affordable Care Act (ACA) and the technical corrections incorporated into the Health Care and Education Reconciliation Act, complete a massive overhaul of the nation's health insurance and health delivery systems. For the first time, the ACA will provide for universal access to health coverage, through various methods, including expansion of the Medicare program, expansion of eligibility under the Medicaid program, the establishment of state-level insurance exchanges, and expansion of the Children's Health Insurance Program (CHIP). Moreover, the act attempts to coordinate these actions to provide efficiency in service delivery.

More notable, however, were the legal challenges to the law. A recent Supreme Court upheld the individual mandate but found that the requirement for Medicaid expansion exceeded Congress' constitutional authority. Despite the ruling, the Medicaid expansion remains an integral component of the act. However, the decision creates a variety of implementation efforts that makes an overall assessment of the act's impact on public transportation more difficult.

The ACA will have substantial impact on Medicaid, as one of the primary mechanisms that would be used under the Act to ensure universal health care access is a substantial expansion in eligibility, both in existing eligibility categories and in newly mandated ones. The most notable addition is that non-disabled individuals, ages 19–64 with incomes at 133% of the Federal Poverty Level (FPL) or less, and who are not pregnant and otherwise covered under Medicaid or Medicare, would become eligible for Medicaid effective January 1, 2014 (*3*).

The expansion in the number of individuals eligible for Medicaid is the factor that impacts Non-Emergency Medical Transportation (NEMT); any increase in the number of Medicaid individuals could potentially trigger the Medicaid "transportation assurance"—a term that been used to describe federal and state practices that assure that eligible Medicaid recipients are provided with access to covered services (*4*).

Given the broad discretion afforded to states in structuring their Medicaid programs, projecting the actual impact of expanded categories of eligibility under Medicaid is difficult. The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary estimates in the "2010 Actuarial Report on the Financial Outlook for Medicaid" that the ACA will increase medical enrollment by 20 million persons by 2019 (*5*). It is further estimated that the federal government will be responsible for 95% of the project cost increases brought about by the addition of these new enrollees. (CMS added that state-by-state assessment of impact is impossible because of the unavailability of demographic, macroeconomic, health care, and program assumptions specific to each state.)

Importantly, it should be noted that CMS has recently issued final rules for Medicaid eligibility changes brought about by ACH (*6*). This rule codifies policy and procedural changes to the Medicaid and CHIP programs related to eligibility, enrollment,

renewals, public availability of program information and coordination across insurance affordability programs.

These changes could bring both positive and negative impacts to the public transportation industry. Positive changes include the fact that newly eligible individuals will require NEMT services, and state and local officials will turn to public and community transportation organizations to deliver these services. The increased demand for both fixed-route and demand-response transportation services could bolster revenues for public transit in a period of few funding increases.

Conversely, there may be potential adverse impacts. Rate setting policies—viewed as a credible means of cost containment in the Medicaid program—may result in transit providers being asked to perform services at less than fully allocated rates. New NEMT service delivery providers, some operated by for-profit companies, may view public transit as an opportunity to shift expensive NEMT paratransit to complementary Americans with Disabilities Act (ADA) paratransit services in circumstances where there is dual eligibility for both services, thereby increasing corporate profits. This could increase the costs and deficits of paratransit services for fixed-route systems.

Moreover, the potential for wholesale paradigm changes in overall statewide Medicaid service delivery—and the pace of these changes that may be brought about by the ACA—have created much uncertainty, particularly in the transit industry. The relatively slow pace of state implementation, in part due to the legal uncertainty about the status and constitutionality of the ACA, have slowed many state implementation efforts further limiting the public's understanding of these changes. Finally, despite the fact that the CMS is the second largest funder of passenger transportation behind the Federal Transit Administration (FTA), many transportation providers knew little about the scope and scale of Medicaid, let alone key regulatory elements that impact NEMT.

Objectives of this Research

The objectives of this research are to: (1) assess the potential impact on a state-by-state basis of implementing the ACA on the provision of NEMT and (2) gather information that can be used to inform the transit community on how public transit and NEMT providers have in the past and can in the future integrate or effectively use their respective resources and services.

Project Scope

Overview

The project scope was organized based on the original work program developed by the project committee. Work elements for the synthesis include:

- Conduct a state-by-state survey of current implementation efforts. A key parameter to be determined is whether the state has made any estimate of the number of projected new enrollees who will also qualify for transportation assistance given current rules.
- Determine those states that routinely compile NEMT service and financial data.
- Determine the current NEMT service delivery model employed by the state and determine if the state is contemplating any changes in service delivery because of anticipated increased use by new enrollees.
- Determine if the state places any cap on transportation under its NEMT program.
- Compute average utilization rates for those states that:
  - Have formulated their approach to the 2012 CMS rulemaking;
  - Plan to accommodate expansion in NEMT usage by new enrollees through existing service delivery networks; and
  - Have reliable service and financial data.
- Draw conclusions about potential impacts from the previous step.
- Focus study efforts on a sampling of states that provide a range in:
  - Geographic diversity; and
  - NEMT service delivery models.
- Conduct case studies and surveys of transportation providers to gain additional insights on impacts, the role of public funding, and service issues.

This gave rise to a project definition that encompassed the following tasks:

Task 1: Conduct a literature review
Task 2: Collect data

Task 3: Identify key trends in NEMT service provision
Task 4: Draft interim report
Task 5: Conduct detailed case studies
Task 6: Prepare Final Report.

Issues

The initial work program was developed prior to the Supreme Court decision in *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* As discussed more fully in Chapter 3, this decision essentially gave the states the alternative to "opt out" of Medicaid expansion. Moreover, CMS did not issue any guidelines to the states regarding a timetable for opting in or out of Medicaid expansion.

Thus, this work program began with the assumption that all states would be expanding their NEMT programs; however, the Supreme Court's decision has resulted in a complex matrix of states that have opted in, have not made a decision, or have formally announced the state will not expand. As of the date of issuance of this report, the status of individual states was changing on a weekly basis; the status of any state may change prior to the publication of this research.

Finally, discussions with individual state Medicaid agencies indicate that some states are moving forward with expansion; however, they have used waiver authority to change the parameters of services and service eligibility. This factor must also be taken into account when assessing ACA impact. In summary, ACA impact on NEMT has become considerably more difficult to assess, and in some cases impossible to document.

Organization of this Report

This chapter supplied an outline of the scope and approach of this synthesis. The second chapter provides fundamental information about the Medicaid program and the various service models employed by the states to delivery NEMT. The third chapter describes the ACA, the legal challenges to the act, and states' responses to Medicaid expansion. The fourth chapter addresses potential impacts on public transportation, while the final chapter offers conclusions and recommendations for avenues of further research.

CHAPTER 2 OVERVIEW OF THE MEDICAID PROGRAM AND NEMT SERVICE DELIVERY MODELS

Brief Overview of the Medicaid Program

Origins

Medicaid originated in 1965 with passage of Title XIX of the Social Security Act. Undertaken as a funding partnership between the federal government and the states, Medicaid is a program designed to provide medical assistance to needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

Within rules established by CMS, states are required to provide Medicaid coverage for certain individuals who receive federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. Generally, individuals eligible for Medicaid include:

- Limited-income families with children, as described in section 1931 of the Social Security Act, if they meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their state on July 16, 1996;
- Children under age 6 whose family income is at or below 133% of the FPL;
- Pregnant women whose family income is below 133% of the FPL (services limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care);
- Infants born to Medicaid-eligible women for the first year of life, with certain restrictions;
- Supplemental Security Income (SSI) recipients in most states (or aged, blind, and disabled individuals in states using more restrictive Medicaid eligibility requirements that predate SSI);
- Recipients of adoption or foster care assistance under Title IV-E of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance under Title IV-A or SSI because of earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time);
- All children under age 19, in families with incomes at or below the FPL;
- Certain other Medicare beneficiaries (*7*).

States may elect to expand on the definition of eligible persons, addressing groups categorically related to the list above. Additionally, many states have developed programs that parallel Medicaid, augmenting the coverage in a variety of ways. Thus, a state has broad discretion in defining how its Medicaid plan will address coverage, services provided, and populations served. Generally, a state must offer the following services under its Medicaid program to categorically needy persons:

- Inpatient hospital services;
- Outpatient hospital services;
- Pregnancy-related services, including prenatal care and 60 days postpartum pregnancy-related services;
- Vaccines for children;
- Physician services;
- Nursing facility services for persons aged 21 or older;
- Family planning services and supplies;
- Rural health clinic services;
- Home health care for persons eligible for skilled nursing;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioners;
- Nurse-midwife services;
- Federally qualified health center (FQHC) services and ambulatory services of an FQHC that would be available in other setting; and
- Early and periodic screening, diagnostic, and treatment (EPSDT) for children under age 21 (*7*).

Medicaid regulations require that services, once stipulated in a state plan, be provided in the lowest cost manner appropriate to client needs; that services be provided to all eligible persons throughout the state; and that eligible individuals be allowed to attend the service provider of their choice.

Federal Medical Assistance Percentages (FMAP)

The rate of federal participation in Medicaid services varies by whether the activity is classified as a program service or an administrative service. Program services are reimbursed at the Federal Medical Assistance Percentage (FMAP), established annually by CMS. These rates of participation vary by state. In FY 2012, rates varied between 50% (many states) to a high of nearly 73% for West Virginia (*8*). Generally, any activity classified as an administrative activity is reimbursed at the 50% FMAP level.

There is also an "Enhanced Federal Medical Assistance Percentages" which applies to the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. This rate is equal to the FMAP for the state increased by 30% of the amount by which such FMAP is less than 100%; but in no case shall the enhanced FMAP for a state exceed 85%. These rates range from 65% to 81% (for Mississippi).

Transportation or access to a medical provider is not specifically listed as a Medicaid service. Historically, many states recognized the need to provide transportation service and began funding this activity as an administrative activity. Providing transportation as an administrative activity negated the need to adhere to the "freedom of choice" option, and Medicaid agencies could provide transportation service using a provider of the state or local agency's choosing. This often involved purchase of bus passes or tokens for use on fixed-route systems (where available) or use of local community transportation or specialized transportation providers. Not all states opted to provide transportation, and there is a long history of legal challenges demanding those states comply. Ultimately, federal regulations were changed to ensure access to services, and again states were given broad authority to determine how transportation was provided. If included as a program service, the state could obtain the typically higher FMAP rate for the service, but had to adhere to the "freedom of choice" provision (*4*).

Medicaid Waivers

Many transportation professionals understand that various FTA regulations allow grant recipients to submit a waiver request to the FTA Administrator that would permit some local practice not addressed or otherwise prohibited under a regulation. For example, 49 CFR part 604.6(c), permits a transit system to petition the FTA for a special exception to permissible charter services. Such waivers requests are infrequently requested within the transit industry, and even less frequently granted.

Waivers in the Medicaid program, on the other hand, are used by nearly every state to implement innovative ways to deliver and/or pay for health care service or the CHIP program. There are four primary types of waivers and demonstration projects:

- Section 1115 Research & Demonstration Projects: States can apply for program flexibility

to test new or existing approaches to financing and delivering Medicaid and CHIP.
- Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all federal requirements for both programs are met (*9*).

Transportation in the Medicaid Program

NEMT has always been a part of the Medicaid program; however, for various reasons, many states did not always provide this service. Indeed, it may be useful in looking at the origins of NEMT to explore the issue from three perspectives: (1) the early years of Medicaid implementation; (2) years when states operated under the "transportation assurance"; and (3) years since passage of the Deficit Reduction Act of 2005, which substantially changed the NEMT service delivery model.

Basis for Transportation as a Component in the Medicaid Program

Overview of the Transportation Assurance. Codified as Title XIX of the Social Security Act, the earliest versions of Medicaid made no reference to a requirement to provide transportation. Rosenbaum et al. note that the history of the program can be traced to *Handbook of Public Assistance* (Supplement D), the program's earliest comprehensive federal interpretive guidance (*4*). First published in 1966, the supplement stated that criteria to assure high quality of care and services would be defined as the "provision of necessary transportation of recipients to and from suppliers of medical and remedial care and service" (*7*). However, many states treated the handbook as guidance, not as a regulation. In addition, the Reagan administration announced in the early 1980s that it would no longer rely on the supplement as controlling program guidance.

Nevertheless, there is long-standing regulatory basis for the transportation assurance. The requirement to provide transportation was included in initial rulemaking issued by CMS, then the Department of Health, Education, and Welfare (HEW) in 1968 (*10*). These regulations were ultimately codified, periodically revised, and re-located to U.S.C. § 431.53 by 1978 (*11*). The regulation, as presently configured, is relatively simple in scope and reads as follows:

> § 431.53 Assurance of transportation.
>
> A state plan must—
>
> (a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and
> (b) Describe the methods that the agency will use to meet this requirement.

Additional Considerations. Title XIX law and regulations mandate the medical care and services which must be covered in a State Medicaid program, as well as the administrative requirements necessary to operate the Medicaid program efficiently.

Rosenbaum *et al.* elaborate that requirements to have the state describe the methods to be used in meeting the transportation assurance stem from the Social Security Act regulations that stipulate that medical assistance must be:

- Available in all political subdivisions of the state;
- Provided with reasonable promptness to all eligible individuals;
- Furnished in the same amount, duration, and scope to all individuals in a group;
- Provided in a manner consistent with the best interests of the recipient;
- Available to eligible recipients from qualified providers of their choice; and
- Provided in accordance with methods of administration found necessary by the Secretary for proper and efficient operation of the state plan (*4*).

Elaboration of necessity was addressed in 1998 by a working group of 10 state Medicaid agencies (*12*). These requirements have been interpreted more recently to mean the following when determining necessity:

- Transportation provided is to/from a Medicaid-covered service;

- The least expensive form of transportation available is used and is appropriate for the client;
- Transportation is provided to the nearest qualified provider; and
- No other transportation resource is available free of charge (*13*).

Two of the original provisions have proven problematic with respect to the coordination of public transportation and NEMT. The first criterion requires that the state provide NEMT to all parts of the state (often referred to the "state-wideness" criterion). Few states have public transportation operations in all areas of the state. This requires Medicaid to find alternative transportation in those areas not served by public transportation. Second, the criterion that requires "freedom of choice" in the selection of service providers often was contrary to coordination plans that attempted to consolidate services under the auspices of a single entity (which eliminated consumer choice).

Transportation as an Administrative Service

In 1978, HEW issued additional guidance on how states could bill for necessary NEMT, giving them the option of providing transportation as an administrative expense or as a form of medical assistance.

Regardless of the method of billing, Medicaid regulations require that when several modes of transportation are available, states must use the least costly means that is appropriate to the medical needs of the client. Additionally, Medicaid considers itself to be the "payer of last resort" (*14*). The General Accounting Office (GAO) has explained Congressional intent in this regard as follows:

> *If Medicaid beneficiaries have another source of health care coverage—such as private health insurance or a health plan purchased individually or provided through an employer—that source, to the extent of its liability, should pay before Medicaid does (15).*

While envisioned as a precaution against Medicaid's reimbursing a provider for medical services that could be paid from an individual's private health insurance, this concept of payer of last resort has been extended to transportation services. In other words, if a Medicaid client was dually eligible under Medicaid and some other funding program for transportation, Medicaid looks to the other funding source to pay for the trip.

This concept has presented challenges to those entities seeking to create coordinated transportation service delivery networks involving multiple funding programs.

NEMT as an Administrative Expense. When states elect to provide NEMT as an administrative expense, the federal matching rate is 50%, which may be less than the state's FMAP rate. However, this option negates one potential obstacle to coordination in that the freedom of choice provision does not apply. This enables the state to direct NEMT users to specific providers or permits the state to solicit bids in an effort to find lower-cost methods of service delivery.

States that opted to treat transportation in this manner still must adhere to other guidelines. The 1978 HEW guidance, contained in the *Medicaid Assistance Manual*, states that proper and efficient operation of a state Medicaid plan requires:

- The state is obligated to first investigate use of free services that may be available to the client;
- In the absence of free services, the state should seek the least costly transportation alternative; and
- States should consider use of volunteers, gas vouchers, bus tokens, and/or use of public and private transportation companies.

NEMT as a Medical Service Expense. One key distinction if a state elects to provide NEMT as an optional medical service is that the state has a direct vendor relationship with the transportation service provider. The provider bills the Medicaid agency directly and payment is received from the state. Another important factor is that the service can be billed at the state's current FMAP rate, which may be higher than the 50% federal participation rate for administrative services.

If provided as an optional medical service, NEMT must meet the requirements of § 42 CFR 440.170(a), as follows:

- Transportation must be defined to include expenses for transportation and other related travel expenses determined to be necessary by the state Medicaid agency to secure medical examinations and treatment for a recipient;

- Transportation services must be provided by a vendor to whom a direct vendor payment can appropriately be made by the agency;
- The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;
- The cost of meals and lodging en route to and from medical care, and while receiving medical care; and
- The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary (*14*).

Additionally, within these regulatory parameters, a state could utilize its waiver authority if the request was approved by CMS. States could seek what was commonly referred to as a "1915(b) waiver." The Secretary of Health and Human Services had broad authority to grant waivers of various provisions that effectively structured coverage, controlled costs, or resulted in more efficient service delivery. Under such waivers, states could restrict participation by service providers, provide services that are not statewide, and restrict recipient choice. States have used this option to implement brokered services, capitated payment systems, and managed delivery arrangements. In order to receive approval for a 1915(b) waiver authority, a state must submit a proposal and demonstrate cost-effectiveness of the proposed waiver provisions every two years.

Legal Challenges to the Obligation to Provide NEMT. Despite the obligation to provide transportation on behalf of eligible individuals, Medicaid regulations have been subject to numerous legal challenges. For more than a decade, disparate practices across the country resulted in numerous lawsuits regarding a state's failure to provide medical transportation.

In most cases, the courts have ruled that the transportation assurance, which then existed only by administrative rule, is an enforceable right, and that NEMT must be provided to eligible recipients by the states. Among the more notable cases is *Morgan v. Cohen*, a class action suit filed by Medicaid eligible clients authorized to participate in partial hospitalization services in Philadelphia, Pennsylvania (*16*). At the time, the Pennsylvania Department of Public Welfare (DPW) was navigating changes to its Medicaid transportation plan, and plaintiffs felt their assurance and *right* to transportation was placed in jeopardy based on newly formulated transportation strategies. The absolute right to transportation was recognized by the court, and DPW's specialized transportation plan was found invalid. The plaintiffs prevailed in this case.

There are a number of other cases in different jurisdictions where the courts have also upheld the transportation assurance. Another noteworthy case is *Smith v. Vowell*, a suit filed on behalf of a single individual but expanded to a class action. In this Texas case, the court ruled that the state and its Department of Public Welfare failed to promulgate a state plan and failed to provide transportation to an individual with disabilities. The case involved other issues articulated by the plaintiffs, who sought both injunctive relief and the payment of retroactive benefits (both denied). The court found for the plaintiff on the central issue of transportation, and ordered the State of Texas to provide transportation to the plaintiff within 30 days and to all members of the class within 60 days; and to develop a state plan for medical assistance with regard to medical transportation (*17*).

Daniels et al. v. Tennessee Department of Health and Environment et al. is another case that started as an individual suit and was expanded to a class action. This suit was settled by consent decree and incorporated a unique element: The plaintiffs actually proposed a solution to the state's failure to provide transportation. Although the suit first addressed ambulance transportation, it was expanded to include NEMT. With minor exceptions, the court ordered the state to follow the plaintiffs plan for remedy (*18*).

Other cases, all generating opinions that upheld the transportation assurance, can be cited in Kentucky, Oregon, and North Carolina (*19*).

The one common theme in these cases involved the fact that the transportation assurance was only part of the regulatory framework for Medicaid, as the law itself did not address transportation. Most courts in these decisions cited *Wright v. City of Roanoke Redevelopment and Housing Authority* (a case that went to the Supreme Court, which ultimately ruled that rights defined in part by a statute and in part by a federal agency regulation were enforceable) as the basis for upholding the validity of the transportation assurance. Thus, the regulatory construct of the transportation assurance in 42 U.S.C. 431.53 was upheld and enforced in virtually every case.

Yet, at least one notable case found otherwise. In *Harris v. James*, the court recognized the transportation assurance, but developed a different conclusion with respect to the enforceability of the regulatory component of the rule. This case involved a class action filed on behalf of clients receiving dialysis services. Filed in 1994, the suit claimed that the State of Alabama violated Medicaid regulations that required the provision of transportation, as the state provided dialysis service but not a means of transport to these treatments. A district court found in favor of the plaintiffs and ordered Alabama to provide NEMT. Alabama appealed the decision and a Court of Appeals overturned the decision, finding that transportation assurance does not create an enforceable right to transportation (*20*).

The Deficit Reduction Act of 2005. As noted previously, states could request waivers of existing Medicaid regulations. States generally described the waiver process—in particular, the need to re-file and justify a Section 1915(b) waiver every two years—as administratively burdensome.

Partially in response to these complaints, Congress created new permissive language that simplified waivers for NEMT transportation in the Deficit Reduction Act of 2005 (DRA). The act was projected to generate $39 billion in federal entitlement reductions between 2006 and 2010 and $99 billion between 2006 and 2015. The DRA includes net reductions from Medicaid of $4.8 billion over the next five years and $26.1 billion over the next 10 years. Many of the policy changes in the DRA would shift costs to beneficiaries and have the effect of limiting health care coverage and access to services for low-income beneficiaries (*21*).

A small provision of the DRA, however, had a monumental impact on NEMT service delivery. Section 6083 of the act was entitled "State Option to Establish Non-Emergency Medical Transportation Program." That section of the law contains four provisions that enable and/or require a state to:

- Select an NEMT broker through a competitive bidding process, provided the factors of experience, performance, references, resources, qualifications, and costs be used in the evaluation process;
- Monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;
- Audit and provide oversight to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and
- Comply with the prohibitions on referrals and conflict of interest as the Secretary shall establish (*21*).

CMS issued a Notice of Proposed Rulemaking in the *Federal Register* on August 24, 2007; final rules were published on December 19, 2008 (*22*). Many have argued that the rules favor use of a private sector broker (in lieu of use of existing governmental public entities and/or community transportation systems).

In the preamble to the 2007 proposed rules, CMS stated "we are proposing that state and local bodies that wish to serve as brokers compete on the same terms as non-governmental entities." The agency explains:

> *We did not wish to prevent a government entity that is awarded a brokerage contract through the competitive bidding process from referring an individual in need of transportation service to a government transportation provider that is generally available in the community. Therefore, we have included an exception to allow such a governmental broker to provide an individual transportation service or to arrange for the individual transportation service by referring to or certain conditions have been met that will assure an arms-length transaction (23).*

The final rules created new options for states to implement an NEMT brokerage without having to seek a waiver of the freedom of choice, eliminated the "state-wideness" requirement, and provided that such systems would be reimbursed at the FMAP rate. Moreover, the rules did away with the states' need to justify the cost effectiveness of the proposed waiver and the need to re-apply every two years.

A key provision of the policy, and one central to public transportation, was the prohibition against self-referral. This means that a broker could not assign a trip where the provider has some organizational or financial relationship with the provider. As public entities are usually the operators of public and community transportation services, the inability to assign trips to its own services was seen as an issue by many public entity transit providers.

The basis to include this provision was a matter of law, but was to be implemented at the discretion

of the Secretary. The law directed the Secretary of Health and Human Services to embrace conflict of interest rules issued for physicians to prevent doctors from making referrals to other health care providers where the physician has some type of ownership interest. Given this direction from Congress, the Secretary modified a rule implemented to enforce Section 1877 of the Social Security Act as it applies to the Medicare program (*24*).

There are some exceptions to these provisions on self-referral. Four waiver options were included in the rulemaking. The first three waivers assume that the broker is a non-governmental entity. The self-referral and conflict of interest provisions can be waived if:

- Transportation is provided in a rural area (defined elsewhere in Medicaid regulations) and there are no other available Medicaid providers determined to be qualified except the nongovernmental (*e.g.*, private entity) broker;
- Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the state to be qualified except the non-governmental broker; and
- Except for the non-governmental broker, the availability of other Medicaid participating providers or other providers determined by the state to be qualified is insufficient to meet the need for transportation.

A fourth waiver exists and is designed, with limitations, for a governmental entity serving as the broker, including circumstances where a governmental broker directly provides service or subcontracts/refers trips to another governmental-owned transportation service provider. These limitations include:

- The contract with the governmental broker provides for payment that does not exceed the actual costs calculated as though the broker were a distinct unit, and excludes from these payments any personnel or other costs shared with or allocated from parent or related entities;
- The governmental unit that acts as a broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program;
- The governmental broker must document that its services (or those services contracted to another governmental entity) are the most appropriate and the lowest cost alternative; and
- The governmental broker documents that in terms of charges to Medicaid, the entity charges no more than:
  - Fixed-route services—the standard fare charged to the public; and
  - Paratransit—the rate charged to other state human service agencies for comparable services.

The first and second conditions mandate several elements. The broker would first be required to be a distinct governmental unit, and the contract could not include payment of costs other than those unique to the distinct brokerage function. The implication is that the governmental unit's central services costs and/or indirect costs could not be charged as costs of NEMT brokerage operations.

The third condition, found at 42 § 440.170(a)(4)(ii)(B)(*4*)(*ii*), is more problematic. This requires the governmental entity to document that its services are the most appropriate and are the lowest-cost alternative for the Medicaid client. This suggests some type of trip-by-trip analysis.

The fourth limitation establishes caps on Medicaid participation rates by mode of service. In a brokered operation run by a governmental entity, the amounts paid for NEMT cannot exceed the standard fare for fixed-route services and cannot exceed the rates charged to other state human service agencies (or their substate units) for paratransit services.

Impacts of the DRA of 2005. The brokerage provisions have two definitive impacts. By greatly simplifying the requirements to establish a brokerage, the DRA has allowed the number of states that utilize privately operated brokerages in NEMT service delivery to expand.

Additionally, the legislation essentially corrects that primary obstacle cited in *Harris v. James;* this act provided evidence of Congressional intent of a transportation assurance in the Medicaid program (*4*).

Human Services Transportation Delivery Methods

In examining service delivery models, it is important to understand that public transit service

delivery models differ substantially from those used for effective human services transportation delivery. A recent TCRP report suggested that a greater understanding of human services transportation will occur if transit professionals recognize that such services represent four distinct types of transportation or "modes," as follows:

- Community transportation,
- Case management transportation,
- Travel services for individuals, and
- Managed care transportation.

This typology is important, as NEMT can comprise all four different forms of human services transportation (*25*).

Community Transportation

This category includes the following functions and their related costs:

- Trips provided for clients of human service agencies who could travel on a group basis (even if they are the only traveler on the vehicle at the moment);
- Trips provided by paid staff and volunteers who have been trained to provide transportation services;
- Efforts associated with eligibility determination, scheduling, arranging, or billing for transportation;
- The purchase of specific individual transportation services from existing public or private transportation providers via contract or other arrangements;
- The purchase of bus tokens, passes, or tickets for distribution to riders;
- Personal care by attendants or interpreters who accompany eligible riders while traveling in the community transportation mode;
- Payments made to riders to help defray the costs of their travel using community transportation services; and
- Other activities and expenses if authorized and applicable. For example, Medicaid sometimes reimburses expenses for long-distance intercity bus and commercial air fares and lodging and subsistence expenses when these expenses are required to obtain out-of-town medical care. Expenses such as these are not common for other programs.

Case Management Transportation

This category includes transportation in which agency staff transport individuals and provide other services while the individual or group is being transported. Trips are typically provided in agency-owned vehicles or staff-owned vehicles. This category is distinguished from directly operated community transportation, in which the staff member providing case management transportation may perform specifically planned case management or therapeutic functions while providing the transportation services. Generally the person providing the transportation is a social worker or case worker whose primary role is not that of providing client transportation but of providing case management or therapeutic functions. This type of transportation includes the following:

- Transportation of clients in staff-owned vehicles;
- Transportation of clients in agency-owned vehicles that are not specifically dedicated to community transportation; and
- Lodging, meals, and parking expenses associated with case management transportation, as well as other expenses if authorized and applicable.

Travel Services for Individuals

This category includes the following:

- Transportation services designed to be offered to one individual at a time (although careful analysis might show that community transportation could be a more cost-effective option in a number of cases);
- Any direct payment to an individual client to subsidize his or her use of a private automobile to facilitate program-related purposes, including
  - Gasoline subsidies paid directly to the client, family member, friend, or volunteer;
  - Car maintenance or repair expenses;
  - Cost of vehicle modifications to incorporate adaptive technologies;
  - Purchase of vehicle liability insurance on behalf of clients, and
  - Financial stipends to support an individual's ongoing transportation needs (e.g., payments for employment and employment-related transportation for a specific amount of time);

- Mileage reimbursements or other fixed-rate reimbursements paid directly to clients;
- Mileage reimbursements paid to family, friends, or volunteers for providing transportation to eligible clients;
- Car rental expenses;
- Costs associated with personal care attendants or interpreters who accompany the eligible client while traveling in specific individual transportation mode;
- Lodging, meals, and parking expenses associated with specific individual transportation; and
- Other expenses if authorized and applicable.

The key element about this category is that this often represents the least-cost transportation option for Medicaid clients. In order to efficiently administer an NEMT program, the entity must have the capability to assess this mode and potentially utilize this method as part of the mix of service options.

Managed Care Transportation

This category includes transportation provided as part of an overall client health care plan (either a short-term or long-term care plan), under which the provider agency is obligated to provide client transportation. Transportation expenses often are part of a fixed payment or capitated payment made to the service provider by the funding source. Examples of this type of transportation include the following:

- Direct operation of provider-owned vehicles to provide transportation services to individual clients;
- Purchase of transportation from public or private transportation service providers;
- Lodging, meals, and parking expenses associated with managed care transportation; and
- Other expenses if authorized and applicable (*26*).

State NEMT Service Delivery Models

There are no federal Medicaid requirements for the methods a state must use to deliver NEMT services. A state is obligated to define how it will provide such service in the state plan submitted annually to CMS. However, given Medicaid rules, all four human service transportation methods of transportation are typically involved in NEMT.

A review of the literature suggests that there is no common approach to the classification of NEMT service delivery models. Service delivery models may be statewide, regional, or local in nature; however, there may be various combinations within these levels of responsibilities for trip request intake and actual service provision. Finally, various brokerage models have been implemented at the state or regional level, but the prohibition on self-referral has created a vast network of actual service providers.

Many states have worked diligently to coordinate NEMT services with existing public and community transportation and/or other human services transportation. These approaches tend to be local or regional in nature, although some state level initiatives have been used to foster these local initiatives. A previous TCRP report has described local examples of successful coordination between public transit and NEMT services. As noted in that report, coordination of public transit and NEMT has proven problematic for a number of reasons, including:

- Differing service standards for ADA complementary paratransit and NEMT;
- Differing laws applicable to transit and NEMT (*e.g.*, drug testing);
- Jurisdictional issues (*e.g.*, public transit operating within specific jurisdictional units while NEMT may extend beyond these boundaries; and
- Funding interpretations (*e.g.*, Medicaid will only pay the public paratransit fare, not the fully allocated cost of service) (*25*).

These challenges have given rise to different service models in NEMT at the state level. This report has documented whether a state provides formal transit/human service agency coordination structure and, if so, the type of service delivery model used by the state Medicaid agency (Table 1).

Brokerage Models

NEMT Statewide Private Brokerage. Medicaid brokerages are common and take on various forms. The broker's services are generally competitively bid with various private for-profit companies participating in the procurements. Within this category the following models have been implemented:

- Competitively selected private broker, statewide coverage; and

Table 1 Summary of state service delivery models for NEMT transportation.

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Alabama	4,779,736	1,015,576	21.25%	Legislation was proposed in 2010 to create a United We Ride (UWR) Commission in statute but was deferred to the existing Commission, which will continue operating under the Governor's Executive Order 28	The Alabama Medicaid Agency. The Agency is represented in the Commission but, to date, does not take an active role in decision making.	Eligible NEMT recipients must call a state-operated centralized trip intake line. Ten (10) NEMT coordinators work on a regional basis to assign trips to providers.
Alaska	710,231	136,959	19.28%	The Community and Public Transportation Advisory Board (CPTAB) was legislatively established within the Department of Transportation & Public Facilities by the Alaska Legislature in late 2012 (AS 44.42.090).	Alaska Department of Health and Social Services is a member of CPTAB.	Third-party vendor approves transportation requests that focus primarily on travel outside the resident community. State has contracts with air carriers so that Medicaid clients can work with State Travel Office for air travel.
Arizona	6,412,700	1,783,289	27.81%	No state-level coordinating council, executive order, or legislation.		MCOs typically utilize a mix of private and public operators for NEMT. Arizona has recently cut back funding for NEMT in Maricopa and Pima Counties.
Arkansas	2,915,918	778,997	26.72%	2010 legislation led to short-lived council activities. Currently the state transit association leads coordination efforts.	No formal coordination of regional brokers with other agencies, although it was reported that some coordination of NEMT and aging sponsored trips does occur.	There are 10 competitively selected Medicaid-only regional brokerage programs that arrange for all NEMT in the state.

California	37,253,956	11,168,140	29.98%	Longtime legislatively mandated coordination requirement. In 2010 the California Department of Transportation (Caltrans) Division of Mass Transportation (DMT) completed the Mobility Action Plan (MAP) Implementation Study that identified and assessed impacts of human services coordination legislation and regulations and detailed recommended strategies that can be implemented by the DMT and other California entities.	NEMT clients use public transit services where available.	Clients unable to use available public transit services utilize private NEMT providers.
Colorado	5,029,196	702,239	13.96%	The Colorado Coordinating Council of Transportation Access and Mobility (CCCTAM) that was formed through a Governor's initiative in 2006.	Mixed brokerages in specific but limited number of regions. Individual counties handle NEMT in other areas of the state.	Competitively selected NEMT broker in Denver region. Two regions of six counties each contract NEMT out. One uses a private company, and one uses a nonprofit that also provides transportation.
Connecticut	3,574,097	712,350	19.93%	State statute on coordination rescinded in 2003. Coordination between ConnDOT and other state agencies takes place on formal and informal bases.	Transportation is available to eligible clients who have no other means of transportation, and who reserved a ride with at least 48 hours' notice and the trip is to and from a Medicaid covered medical service and that service provider is the closest appropriate provider of service.	Non-emergency medical transportation is managed within the Managed Care Division, a unit with the Medical Care Administration. The Fee for Service Non-Emergency Medical Transportation (NEMT) program is administered by DSS according to five geographic districts, with each district having an assigned transportation broker. The State pays according to a capitated rate (per member, per month) that reflects the number of eligible Medicaid enrollees covered. Transportation is included in the capitated rates paid by the State.

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Table 1 (Continued)

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Delaware	897,934	225,458	25.11%			One statewide Medicaid broker selected through a competitive process.
District of Columbia	601,723	175,678	29.20%			
Florida	18,801,310	3,421,911	18.20%	Commission for Transportation Disadvantaged (CTD) and the Transportation Disadvantaged (TD) Trust Fund are used to administer and fund coordination.	In 2004, the Florida Agency for Health Care Administration (AHCA) contracted with the CTD to transfer the administration and management of NEMT to the CTD. The agreement stated that NEMT was to be provided by the CTD, certain Medicaid Health Maintenance Organizations, and Medicaid Reform Provider Service Networks.	County-based coordinated systems delivery of NEMT services.
Georgia	9,687,653	2,048,362	21.14%	The Georgia Coordinating Committee for Rural and Human Services Transportation (RHST) of the Governor's Development Council (GDC) was established by the passage of HB 277 and SB 22 (2010).	The Georgia Department of Community Health (DCH) is an active participant in state level coordination efforts but strongly believes current brokerage strategy is best service delivery option.	Public and privately operated brokerages operating in 5 regions of the state.
Hawaii	1,360,301	267,002	19.63%			Two brokers began NEMT service delivery in 2010 after a transition from a fee-for-service delivery model.

Idaho	1,567,582	251,494	16.04%	The Division of Public Transportation assists local mobility stakeholders to facilitate coordination efforts. A large part of the coordination effort is handed off to the Community Transportation Association of Idaho (CTAI).	Longstanding issues of payment rates for NEMT transportation when coordinated with public transportation.	Transitioned to statewide, private broker on September 1, 2010.
Illinois	12,830,632	3,017,131	23.52%	The Illinois Interagency Coordinating Committee on Transportation (ICCT) was created by state Public Act 93-0185 in 2003	Medicaid is a participant in the ICCT. Illinois has a private, statewide broker for Medicaid trip authorizations and assignment; this broker does not coordinate with other programs.	Statewide NEMT brokerage (one broker)
Indiana	6,483,802	1,243,051	19.17%	Interactive state-level coordination council. INDOT	Indiana's Rural Transportation Assistance Program (RTAP) facilitates regional coordination activities.	County-based fee for service model.
Iowa	3,046,355	574,625	18.86%			Transitioned to statewide, private broker in 2010.
Kansas	2,853,118	372,522	13.06%	A state-level coordination committee was established in 2004. Now, it is very active. It is a partnership with Kansas University Transit Center and Kansas DOT while other State agencies participate and have voting authority.	The Medicaid brokerage firm for Kansas is active in the local committees and contracts with local non-profit transit providers to provide non-emergency medical transportation	Statewide NEMT brokerage (one broker)

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Table 1 (Continued)

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Kentucky	4,339,367	960,776	22.14%	The Coordinated Transportation Advisory Committee (CTAC) is codified in section 281.870 of the Kentucky Revised Statutes. Within the Office of Transportation Delivery, the Human Services Transportation Delivery Branch (HSTD) is responsible for the oversight of the HSTD program.	NEMT is fully coordinated under this program.	Network of nonprofit and public brokerage systems on a regional level.
Louisiana	4,533,372	1,312,335	28.95%			State agency approval of providers (public and private providers only) and eight regional trip request intake centers. Fee for service delivery model.
Maine	1,328,361	366,735	27.61%	MaineCare's current service delivery system is coordinated with 10 existing transportation providers, known as Full Service Regional Transportation Providers (FSRTPs) providing service in eight regional jurisdictions.	MaineCare reports that CMS "required" the agency to revamp its NEMT system.	MaineCare will initiate a regional brokerage model. In January 2013, MaineCare selected one broker to serve six regions, and two other brokers to serve the remaining two regions.
Maryland	5,773,552	960,915	16.64%	The State Coordination Committee for Human Service Transportation (SCCHST) was formed in 1997. The committee was established to evaluate needs, improve inter-agency cooperation, develop a five-year plan, and serve as a clearinghouse for transportation coordination issues.		Local service delivery model. Transportation grant managers in each county select providers. Services are provided by public transportation, bus, taxicab, or van. Clients call designated providers in their respective counties.
Massachusetts	6,547,629	1,568,182	23.95%	Highly coordinated regional transportation authority structure	NEMT is fully coordinated under this program.	Six RTAs provider transportation services in nine HST regions in the state.

Michigan	9,883,640	2,124,018	21.49%	Long history of local coordination. Due to a severe budget crunch in the State legislature, the funds granted to create a Coordinating Council were returned to the FTA in 2010.	Medicaid is not coordinated with other programs on a State level.	State Medicaid is testing a pilot project with a private broker in Wayne, Oakland, and Macomb counties. NEMT is administered on a county-by-county basis in other parts of the State.
Minnesota	5,303,925	885,311	16.69%	The State legislature decided to solidify coordination efforts and created the Minnesota Council on Transportation Access by statute in 2010.	Department of Human Services has been a participant in state coordination efforts.	An RFP for a statewide brokerage was rescinded in 2011 based on issues with existing private NEMT providers. The DHS is looking into other means for service delivery, including regional brokers.
Mississippi	2,967,297	772,166	26.02%	Informal efforts by MDOT to encourage local coordination efforts.		Mississippi moved from a local agency fee-for-service model to a single statewide broker on November 1, 2006.
Missouri	5,988,927	1,146,897	19.15%	Statewide coordination council inactive.		The Missouri Department of Social Services currently contracts with one competitively selected statewide broker.
Montana	989,415	151,422	15.30%	The Human Services Transportation Coordinated Council was formed in 2007. The Council functioned for two years before it was dissolved by the Governor in 2009 because of budget constraints. Since that time, a Transportation Coordinator position has been created to oversee coordination efforts within the State.		The Montana Department of Public Health and Human Services contracts with a statewide broker.
Nebraska	1,826,341	286,887	15.71%	Informal efforts led by the Metro-Area Planning Agency, AARP of Nebraska, and Easter Seals Nebraska in response to the lack of effort directed at coordination at the state level.		The Nebraska Department of Health and Human Services transitioned to a statewide brokerage with a single broker on July 1, 2012.

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Table 1 (Continued)

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Nevada	2,700,551	290,758	10.77%	The State's coordination of programs has been limited to Sections 5310, 5316, and 5317.		Nevada's Department of Health Care and Finance Policy (DHCFP) has operated a statewide brokerage with a single broker since 2003.
New Hampshire	1,316,470	166,363	12.64%	New Hampshire's State Coordinating Council for Community Transportation was created by state statute in 2007.	The Department of Health and Human Services is actively involved in the State Coordinating Council.	Fee for service model with enrolled/qualified providers.
New Jersey	8,791,894	1,231,456	14.01%	New Jersey has been actively involved in the coordination of services since the 1980s. A recent executive order furthering these goals sunset in 2010.	New Jersey Transit is currently exploring methods by which it can increase coordination with the state's Medicaid broker.	New Jersey Department of Human Services has operated a statewide brokerage with a single broker since 2009.
New Mexico	2,059,179	637,856	30.98%			State uses a mixed model where some managed care organizations utilize brokers while other components use direct client reimbursement and fee for service model.
New York	19,378,102	5,208,143	26.88%	The State had an Interagency Coordinating Committee on Rural Public Transportation that was created in the early 1990s by statute.	County-based programs have strong relationships with coordinated community transportation programs.	Current brokerage operation begun in New York City in late 2012. New York State is currently conducting a pilot project to test a regionalized brokerage model for other areas in the state.

North Carolina	9,535,483	1,974,287	20.70%	Long-standing coordination framework articulated in Executive Order since 1978. State has 80 coordinated regional or county-based community transportation systems.	Through Fiscal Year 2013, local county departments contracted with the coordinated community transportation services on a fee for service basis.	County-based fee for service model. Moving to a regional brokerage model in FY 2014.
North Dakota	672,591	80,262	11.93%	No response		
Ohio	11,536,504	2,427,052	21.04%	Ohio completed new mobility study that called for re-establishment of state level coordination council to be established by the legislature.	County-based community transportation systems actively involved in coordination with Medicaid in those counties with public transit services.	County-based fee for service model.
Oklahoma	3,751,351	851,674	22.70%	Executive Order 2006-20 established the United We Ride Governmental Council (UWRGC) in 2006. After completion of United We Ride's Report to the Governor and ODOTs publication of the revised Locally Coordinated Public Transit/Human Service Transportation Plan, the Council expects to devise a new Strategic Action Plan that will include the Council partnering with other entities to encourage collaborations that will enhance public transportation in Oklahoma.		The Oklahoma Health Care Authority uses a statewide brokerage with a single broker.
Oregon	3,831,074	643,941	16.81%	While no formal structure exists, Oregon has a longstanding history of promoting coordination through its Specialized Transportation Fund program.	The Oregon Department of Human Services contracts with public transit agencies to broker NEMT services throughout the state in eight regions of the state.	The Oregon Department of Human Services using 1915(b) waiver authority contracts with public transportation agencies to manager eight regional brokerages.

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Table 1 (Continued)

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Pennsylvania	12,702,379	2,303,775	18.14%	The state has a long history of service development and support through its lottery funding program.	Extensive coordination exists between coordinated public transit agencies and Medicaid.	County-based system. Brokerages in Alleghany (public agency broker) and Philadelphia Counties (private broker) and a county based fee for service system in other counties.
Rhode Island	1,052,567	224,282	21.31%	The Rhode Island Public Transit Authority (RIPTA) is a statewide public transit provider and works closely with other human service agencies to coordinate services.	The Rhode Island Public Transit Authority (RIPTA) and Department of Human Services (which administers Medicaid) have been working closely together to address a range of human service transportation issues.	The Department of Human Services refers NEMT client to RIPTA or the Ride, a paratransit program for elderly persons and individuals with disabilities, or will work with other community services to arrange for NEMT transportation.
South Carolina	4,625,364	971,969	21.01%	Executive Order 2009-13 established the South Carolina Interagency Transportation Coordination Council.		The South Carolina Department of Health and Human Services uses a regional brokerage model. At present, the same vendor manages all three regions.
South Dakota	814,180	142,173	17.46%	The Departments of Transportation, Social Services and Human Services have moved toward a more coordinated transportation system benefiting all individuals in the community.		The South Dakota Department of Social Services provides reimbursements for NEMT on a mileage and expense basis only. The agency works with other transportation networks on a referral basis, primarily through senior and public transit organizations.

Tennessee	6,346,105	1,531,074	24.13%	Tennessee DOT coordinates service through a network of regional transportation providers operating in all counties of the state.	There has historically been a high level of coordination in service delivery of NEMT services by regional public transit programs.	A county-based system with regional public transit entities uses one broker operating in three regions for specific managed care populations.
Texas	25,145,561	4,488,188	17.85%	No current formal structure or mechanism for coordination in place; TxDOT fosters coordination through administration of FTA programs.	Texas has had a long history of coordination efforts between public transit and NEMT with varying degrees of success.	Brokerages exist in two urbanized areas (Dallas and Houston) while the state handles all trip requests for the remainder of the state. In the past, TxDOT staff brokered NEMT transportation. Today, the Texas Health and Human Service Commission works with human service agencies, public transportation provides, and privet transportation providers to provide transportation.
Utah	2,763,885	294,904	10.67%		The Utah Department of Health coordinates with the Utah Transit Authority.	The Utah Department of Health relies on the Utah Transit Authority (UTA) and provides bus passes and offer specialized transit services on ADA paratransit in Salt Lake, Ogden, and Weber Counties. Outside these service areas, the state contracts with a contractor to provide NEMT services.
Vermont	625,741	199,434	31.87%	A Public Transit Advisory Council was established by statute and is housed within the state public transit association.	NEMT is managed/ brokered by existing public transit operators throughout	Seven public transit agencies broker services in seven regions of the state.
Virginia	8,001,024	1,039,298	12.99%	An interagency working group supports the Virginia Department of Rail and Public Transportation.		The Virginia Department of Medical Assistance Services (DMAS) contracts with one statewide broker to manage NEMT. The broker has established seven regional offices.

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Table 1 (Continued)

State	Total Population	Medicaid Enrollment[1]	%	State-Level Coordination Efforts[2]	NEMT Involvement with State Coordination Efforts[3]	NEMT Service Delivery
Washington	6,724,540	1,159,333	17.24%	The Agency Council on Coordinated Transportation (ACCT) was established by the state legislature to facilitate a statewide approach to coordination.		The Washington State Health Care Authority (HCA) utilizes existing nonprofit and public agencies to operate brokerages in 13 regions throughout the state.
West Virginia	1,852,994	429,578	23.18%			The West Virginia Department of Health and Human Services uses a county-based fee for service model.
Wisconsin	5,686,986	1,086,801	19.11%	An Interagency Council on Transportation Coordination (ICTC) was formed in 2005. The ICTC is less active than in prior years due to staffing issues at WisDOT. The state's network of mobility managers is currently active and promoting coordination throughout the state.		The Wisconsin Department of Health Services transitioned to a statewide brokerage system using a single broker on July 1, 2011. This broker terminated the contract effective in early 2013. Current status unknown.
Wyoming	563,626	82,365	14.61%			The Wyoming Department of Health, Division of Healthcare Financing manages the Medicaid program. The program is operated on a fee for service basis with only registered providers eligible to participate.
Total	**308,766,221**	**65,895,394**	**21.34%**			

NOTES:

[1]Enrollment counts include all ever enrolled, with or without Medicaid services rendered during the fiscal year. Counts are for Federal Fiscal Year 2009 or 2010 (where available), with the exceptions of Massachusetts, Utah, and Wisconsin, which are 2008 enrollment data.

[2]If blank, no known active coordination efforts exist (*e.g.*, executive orders, legislation, or informal efforts) at the state level to coordinate public transit with human services transportation. It should be noted that all state administering agencies of Federal Transit Administration Section 5310, Section 5316, and Section 5317) were actively engaged in a locally developed public transit/human services transportation coordination plans within their respective states.

[3]If blank, no known coordination efforts exist with the state Medicaid agency.

SOURCES: U.S. Census of Population, 2010; Medicaid Statistical Information System (MSIS) and Medicaid Financial Management Report; National Council of State Legislatures, Ohio Mobility Improvement Study, prepared for the Ohio Department of Transportation by RLS & Associates, Inc. and Nelson\Nygaard Consulting Associates, December 2012; Georgia Governors Development Council Task 3 Report (Draft) 2012 RHST Reporting Services, prepared by Nelson\Nygaard Consulting Associates; and direct telephone interviews with state agency officials.

- Competitively selected private broker, regional coverage:
  - No limits on regions operated by any one broker; or
  - Limits on the number of regions to be operated by any one broker.

This is becoming the most common form of brokerage.

NEMT Statewide Public Brokerage. In several cases, states have achieved the benefits of an NEMT brokerage while maintaining a high degree of coordination with existing public transportation. These brokerages are typically established via a competitive process that may restrict for-profit company participation. Generally, these types of brokerage must adhere to the prohibitions on self-referral noted in 42 U.S.C. § 440.170(4)(ii)(B).

NEMT Regional Brokerages. In this model, the state creates regions with the intent of creating a competitive procurement for each region; in some cases, a state may elect to limit the maximum number of regions any single vendor may be awarded under the procurement.

Similarly, some states permit public or nonprofit corporations to bid on the region, potentially creating a mix of broker types.

NEMT County Brokerages. This is exemplified by the Florida model, where individual counties (or groups of counties) broker transit-disadvantaged trips, including Medicaid NEMT, to the most appropriate provider.

Fee for Service Models

Historically the most common model for service delivery, this typically involves local offices of the state Medicaid program in handling all eligibility, trip authorization, and trip arrangements. Variations on this model include:

- Centralized intake of trip requests at the state level/local assignment of trips to registered providers; and
- Regional call centers for intake of trip requests and assignment to registered providers.

Mixed Models

In several states, a combination of brokerage and fee-for-service models are used. In some cases, a state has opted to implement a brokerage model in the state's most populous urbanized areas (Colorado–Denver, Pennsylvania–Pittsburgh and Philadelphia, New York–New York City, and Texas–Houston and Dallas) where presumably the supply of capable providers is adequate to meet broker requirements. In other cases, a state may experiment with brokerage on a regional basis to test the concept before making a decision whether to use this service delivery model on a larger scale basis.

Public Transit Models

In some states, public transit is so pervasive and readily available that state Medicaid agencies have relied almost exclusively on this mode to provide NEMT service. In those instances where public transportation is unavailable or inappropriate, the state or local Medicaid office will focus on personal transportation options.

Managed Care Organization (MCO) Models

A relatively new service delivery model, and one that is expected to see increasing application in the future, is the managed care model. In this model, a state relies exclusively on the services of a managed care provider or insurance firm that offers the range of covered Medicaid services, including NEMT, typically with a capitated payment rate per enrolled individual per period of time. Experience has shown that MCOs tend to use providers as a matter of convenience and tend not to be subject to most Medicaid rules typically applied to other service models.

Table 2 summarizes this schematic classification and indicates an initial classification of the states. Figure 1 graphically depicts the diversity of NEMT service delivery models.

CHAPTER 3 THE AFFORDABLE CARE ACT (ACA) AND LEGAL CHALLENGES

An Overview of the ACA

The ACA, signed by President Barack Obama on May 23, 2010, represents a massive overhaul to the nation's health care and insurance systems. The primary purpose of the ACA is to ensure quality health care to United States citizens and legal immigrants. The ACA focuses on expanding health care coverage, controlling health care costs, and improving health care delivery systems with an emphasis on wellness and preventative care programs.

As of January 1, 2014, nearly all legal residents of the United States are required to obtain minimum

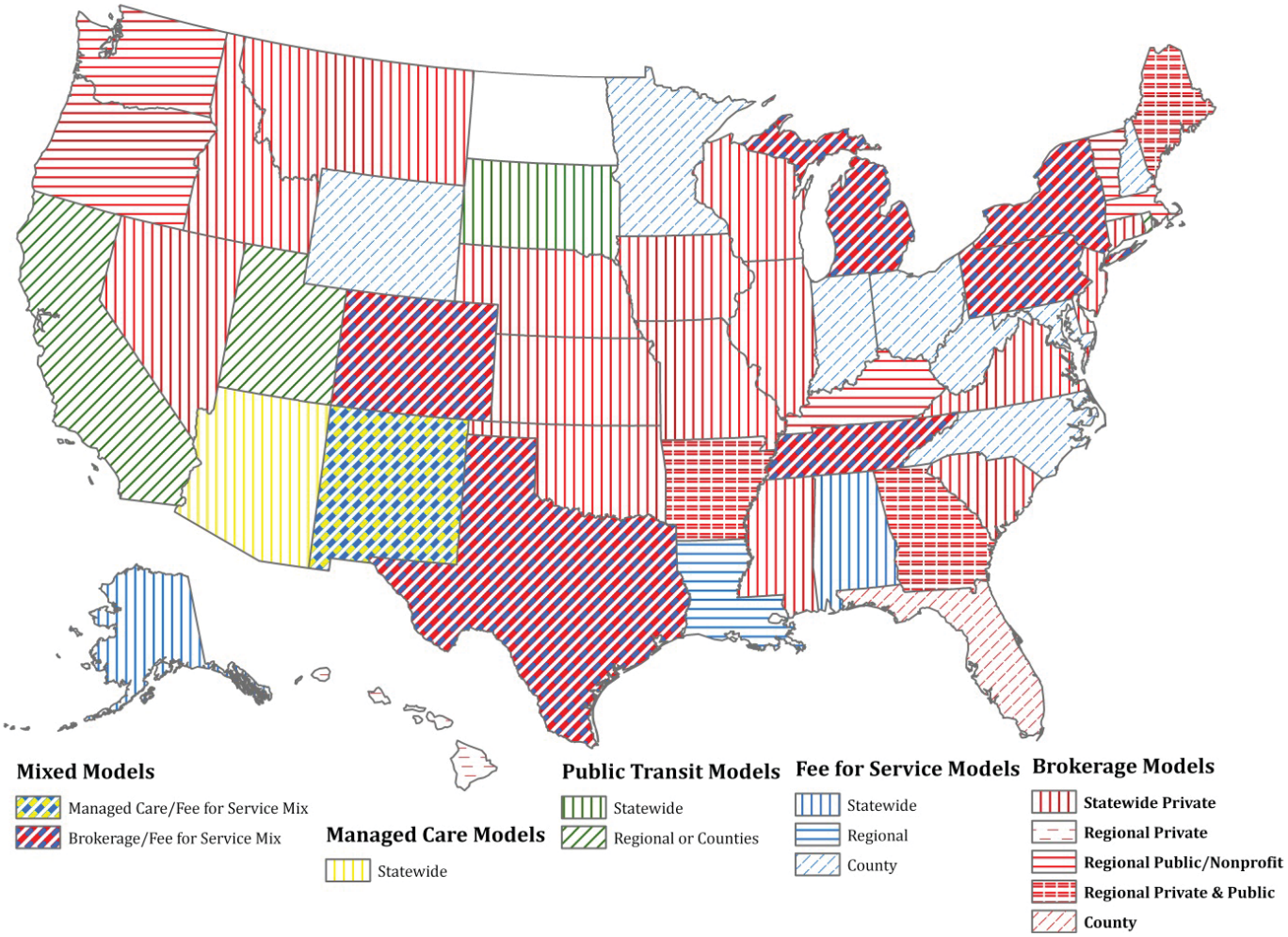
Table 2 NEMT state service delivery models.

Service Delivery Model Type	Geographic Coverage	Entity/Broker	Responsibility	States
Brokerage	Statewide	Private broker	Trip intake and trip assignment	Connecticut, Delaware, Idaho, Illinois, Iowa, Kansas, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, Oklahoma, South Carolina, Virginia, Wisconsin
	Region	Private broker	Trip intake and trip assignment	Hawaii
		Public/nonprofit broker	Trip intake and trip assignment	Kentucky, Massachusetts, Oregon, Vermont, Washington
		Mix of private and public/nonprofit brokers	Trip intake and trip assignment	Arkansas, Georgia, Maine
	County	Mix of private and public/nonprofit brokers	Trip intake and trip assignment	Florida
Fee for Service Models	Statewide	State	Trip intake/provider assignment to regional coordinators	Alabama
		Private entity	Trip intake/provider assignment to enrolled providers	Alaska
	Regional	Regional trip intake centers	Trip intake and trip assignment	Louisiana
	County	County unit of state Medicaid agency	Eligibility, provider assignment	Indiana, Maryland, Minnesota, New Hampshire, North Carolina, Ohio, West Virginia, Wyoming
Brokerage/Fee for Service Mix	Brokerages in selected area, fee for service model in other areas	Private or public/nonprofit broker	Trip intake and trip assignment	Colorado, Michigan, Pennsylvania, New York, Tennessee, Texas
Public Transit Models	Statewide	State or local Medicaid agency refers NEMT clients to public transit or other human service agencies	Referral	South Dakota
	Regional or Counties	State or local Medicaid agency refers NEMT clients to public transit	Eligibility, referral, arrangements with other modes when public transit is unavailable or inappropriate	California, Utah, Rhode Island

Table 2 (Continued)

Service Delivery Model Type	Geographic Coverage	Entity/Broker	Responsibility	States
Managed Care Organization	Statewide	Comprehensive Health Care/ Insurance Organization	Arranges transportation within capitated rate structure	Arizona
	Mixed MCO and Fee for Service Model	Comprehensive Health Care/ Insurance Organization	Arranges transportation within capitated rate structure	New Mexico

SOURCE: RLS & Associates, Inc. December 2012.



Source: RLS & Associates, Inc., August 2013.

Figure 1 NEMT service model typology.

essential health care coverage or pay a penalty unless found exempt from the individual responsibilities mandate. Exemptions will be granted for:

- Financial hardship;
- Religious objections;
- Native Americans;
- Individuals without coverage for less than three months;
- Undocumented immigrants;
- Incarcerated individuals;
- Individuals for whom the lowest cost plan option exceeds 8% of his/her income; or
- Individuals with incomes below the tax-filing threshold.

Also beginning January 1, 2014, health insurance exchanges will be established in each state whereby individuals and employers may purchase qualified health plans.

The ACA, along with the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act) signed by President Obama on March 30, 2010, set out numerous additional taxes, fees, and penalties on individuals, employers, hospitals, health insurance providers, and pharmaceutical companies. The ACA provides funding opportunities to improve the health care delivery system by enhancing patient safety, increasing home and community care services, and prevention and wellness services. The act provides funding for loans and grants to support education and training activities for students, direct care workers, and professionals in the health care field, and seeks to expand health care services in low-income rural areas. The act also places significant emphasis on the need for increased accountability, compliance, and oversight of public programs and health care plans to reduce waste, fraud, and abuse.

While the ACA does not require employers to provide health insurance coverage, tax penalties will be imposed on those that do not offer coverage to their employees. Employers with fewer than 50 employees are not required to provide health care coverage. As of January 1, 2014, employers with more than 50 full-time employees that do not provide health care coverage will be assessed a tax liability.

Fines are calculated based on the number of full-time employees in the business. As defined in the ACA, a full-time employee is one who is employed on average at least 30 hours per week. Employers with more than 200 employees are automatically required to enroll their employees into health insurance plans; however, employees may opt out of the coverage. Employers may offer "free choice vouchers" to their employees in order to obtain qualified health care coverage.

The ACA seeks to control health care premium costs and limit the amount of compensation to health insurance providers that do not comply with requirements. The need for expanded consumer outreach and protection is noted throughout the ACA, particularly in marketing requirements, uniform enrollment forms, standardized presentation formats, and enrollment assistance for qualified health care plans offered through the exchanges.

Multiple incentives for improving the nation's health care delivery system are reflected throughout the ACA, such as special bonuses to hospitals and Medicare Advantage Plans based on performance. A 10% bonus payment will be available to primary care physicians and general surgeons practicing in areas with health professional shortages.

The ACA is an extremely complex piece of legislation that directly affects multiple state, federal, and local public programs, non-profit organizations, tax reporting requirements, employers, insurance companies, health care providers, workforce development, long-term care services, and most U.S. citizens and legal residents. Since the purpose of this study is to assess the potential impact of implementing the ACA on the provision of NEMT, discussion of specific provisions of the act are restricted to this issue.

Immediate Changes Resulting from the ACA

Many of the provisions of the ACA have already been implemented or are in the process of being implemented. Listed below are a few of the most significant changes:

- Small business tax credits for employees with health insurance expenses:
  - Tax credits were issued to small employers with no more than 25 employees with average wages of $50,000 that provide health insurance to their employees.
  - In order to be eligible, the small business employer must contribute at least 50% of the cost of health insurance of its participating employees.
- Temporary national high-risk pool to provide health coverage for individuals who are uninsured because of a pre-existing condition:
  - Individuals must have been uninsured for at least six months.

    - Individuals must be eligible for subsidized premiums.
- Temporary reinsurance program for early retirees:
    - ACA creates a temporary reinsurance program for employers providing health insurance for retirees over age 55 who are not eligible for Medicare.
- No discrimination against children with pre-existing conditions:
    - Beginning in 2014, all health plans will be required to eliminate pre-existing condition exclusions.
- No lifetime limits on coverage:
    - ACA prohibits individual and group insurance plans from placing lifetime limits on the dollar value of coverage.
- Coverage for young persons until age 26 through parents' insurance:
    - All individual and group policies must provide dependent coverage for children up to age 26.
- A $250 rebate to Medicare beneficiaries who are affected by the "doughnut hole:"
    - In June 2010, the first checks were sent to the applicable Medicare beneficiaries.
    - Additional subsidies and discounts will eventually close the coverage gap.
    - Pharmaceutical manufacturers are now required to provide a 50% discount on all brand name prescriptions filled in the Medicare Part D coverage gap.
- Free preventative care services:
    - New health plans offered on or after September 23, 2010, must provide for, and eliminate cost-sharing for, certain recommended preventative health services.

American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges

As a result of the ACA, each state must establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program ("SHOP Exchange"). Exchanges are one-stop centers where consumers can choose a private health insurance plan that fits their individual health needs. Starting in 2014, state-based exchanges will be administered by governmental agencies and/or private organizations. Individuals and small businesses with up to 100 employees will be able to purchase qualified health care coverage through the exchanges. Businesses with more than 100 employees will be able to purchase health care coverage in the SHOP exchanges beginning in 2017. Qualified health plan providers will be selected to offer coverage, consumer assistance, and enrollment.

States may choose to establish multiple exchanges within the state or only one exchange that provides both exchange and SHOP services. An exchange may operate in more than one state. States that intend to administer state-based exchanges had until November 16, 2012 (later amended to December 14, 2012) to submit a blueprint of their plan to the U.S. Secretary of Health and Human Services (HHS) providing strategies for meeting all legal and operational requirements as set forth in the ACA (*28*). The Secretary of HHS will establish and operate a federally facilitated exchange in any state that elects not to operate a state-based program.

Access to healthcare coverage through the exchanges will be restricted to U.S. citizens and legal immigrants who are not incarcerated. If an individual is not, or is not reasonably expected to be, a lawful resident for the entire enrollment period; a citizen or national of the United States; or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not purchase health care coverage through an exchange.

Various levels of health care coverage will be available through the exchanges (Bronze, Silver, Gold, Platinum, and Catastrophic Plan levels). Costs will be based on the amount of coverage provided within the applicable health care plan. Premium tax credits and reduced cost-sharing credits will be available to individuals/families with incomes between 100% and 400% of the FPL. Based on 2012 FPL guidelines, premium tax credits and reduced cost-sharing credits would be available to individuals earning between $11,170 and $44,680, and families of four with a household income between $23,050 and $92,200. Employers of individuals receiving premium tax credits and cost-sharing credit may be assessed a tax liability if it is determined that the employer does not provide minimum essential coverage through an employer-sponsored plan, or if the employer does provide the coverage but it is not affordable.

In order to streamline procedures for enrollment, each state must utilize a single uniform enrollment form that may be used to apply for all health subsidy programs within the state. Eligibility information pertaining to the state Medicaid program and CHIP or any other applicable state or local program will be provided through the exchanges. Enrollment in these programs will be facilitated based on program eligibility requirements.

Essential Health Care Benefits

The essential health benefits offered in any qualified healthcare plan available through an Exchange must include the following general categories and the items and services covered within the categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative services and devices;
- Preventative and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Medicaid Expansion Under the ACA

One of the most significant provisions in the ACA requires states to expand Medicaid eligibility coverage to non-disabled adults under the age of 65, without dependent children, with incomes at or below 133% of the FPL ($14,856 per year for an individual and $30,657 for a family of four in 2012). The bill, as originally passed, called for the Secretary of HHS to withhold all of a state's Medicaid payments if it did not meet the expansion requirements cited above.

This provision did not provide new authority for DHHS in this regard. Section 1396c of the Medicaid Act, adopted when Medicaid was first passed in 1965, contained language that would permit the Secretary to withhold all or a part of a non-compliant state's federal Medicaid matching funds. In order to exercise this authority, DHHS must first issue notice and provide an opportunity for a hearing (all subject to judicial review) before imposing a sanction. According to the Kaiser Foundation, there are no documented cases of the agency ever exercising this power (*29*). Nevertheless, opponents seized on this authority and argued against the constitutionality of the provision. As discussed later in this chapter, the Supreme Court left intact most of the ACA, but found the mandatory provisions of participating in an expanded Medicaid program to be a constitutional violation. Thus, expansion of the Medicaid program is now at the option of each state.

Federal Participation Rates in Medicaid Expansion

Medicaid expenditures are substantial and have grown during nearly every year since implementation. Part of the national dialogue surrounding the implementation of the Medicaid expansion provided under the ACA is whether the states—even with the federal government paying for the majority of expansion costs—can sustain the growth of their share of costs. The rate of federal participation in Medicaid expansion is documented below (Table 3).

The Congressional Budget Office estimates that the net cost of implementation will be $1,168 billion over the years 2012–2022, although this represents a reduction over projections without the ACA. Overall, Medicaid spending was estimated to be $407.7 billion in 2011, or 15% of all money expended on health care in the United States (*30*).

Medicaid is among 62 different programs that fund passenger transportation. Aside from major transit programs funded by the FTA, Medicaid is by far the largest single source of funding to support human services transportation. One recent report estimates that Medicaid transportation expenditures

Table 3 Rates of federal participation in Medicaid expansion, 2013–2022.

Year	Federal Rate of Participation Under ACA
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and subsequent years	90%

SOURCE: *Summary of New Health Reform Law,* Kaiser Family Foundation, April 2011.

in FY 2006 were approximately $1,171,400,000, comprising more than 43.5% of the estimated $2,691,605,000 used to support transportation disadvantaged individuals: the elderly, low income persons, and individuals with disabilities (*1*). This synthesis could find no more recent estimate of transportation expenditures; however, like Medicaid expenditures in general, it is likely this figure has increased since 2006, even as states have implemented measures to control transportation costs. It is not unreasonable to conclude that, based on recent overall Medicaid growth rates, NEMT represents about $3 billion in outlays each year. Yet this amount represents less than 1% of total Medicaid expenditures.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program and Reauthorization Act of 2009 is also a key component of the ACA and Medicaid expansion. CHIP was established in 1997 to provide coverage to low-income children who were not eligible for Medicaid. The ACA expands and strengthens health benefits and insurance coverage for children, extending the authorization for CHIP through FY 2019 and extending funding for the program through FY 2015 (*29*).

The ACA also provides an additional $40 million in federal funding to promote enrollment in Medicaid and CHIP. The CHIP Reauthorization Act of 2009 provides additional funding and fiscal incentives for states to expand and strengthen the program. As of January 2012, all but four states covered children with family incomes up to at least 200% of FPL. It is estimated that 8 million children in the United States are currently uninsured, and that 5 million of these children are eligible for Medicaid and CHIP but are not enrolled (*31*).

CHIP recipients are eligible for a comprehensive set of benefits including prescription medications, screenings and treatments, check-ups, physician and hospital visits, immunizations, dental care, and much more. States have different program eligibility requirements; however, in most states, children under the age of 19 in families (of four) with incomes up to $45,000 qualify for services under Medicaid or CHIP. States may allow families with incomes that exceed the upper eligibility limit to pay the cost of the premium to purchase coverage for their uninsured children through CHIP. Children of working parents that have access to health care coverage for their children are not eligible for CHIP.

Legal Challenges to ACA

In a case that reached the U.S. Supreme Court, 26 states and a private business organization sued the federal government, seeking to overturn the Affordable Care Act based on the constitutionality of two key elements: the individual mandate and Medicaid expansion.

Oral arguments on the case were held over a period of three days beginning on March 26, 2012 and were organized by topic:

- The applicability of the Anti-Injunction Act (AIA) (Day 1);
- The constitutionality of the individual mandate (Day 2); and
- The expansion of Medicaid and the severability of the individual mandate (*e.g.*, if the individual mandate were unconstitutional, whether that would render the entire act unconstitutional) (Day 3) (*32*).

Anti-Injunction Act

Both the government and the plaintiffs' arguments were similar on the first day. Both sides argued that the prescribed penalty for not acquiring insurance is not a tax, and, accordingly, the Anti-Injunction Act, which prohibits legal action against a tax until it is actually levied, was not applicable to the case.

Individual Mandate

The ACA requires that all individuals, except those persons who fall into one of the exclusion categories listed above, obtain health insurance. The individual mandate can be satisfied by obtaining coverage through employer-sponsored insurance; an individual insurance plan (including those to be offered through the new health insurance exchanges); a grandfathered health plan; government-sponsored coverage such as Medicare or Medicaid; or similar federally recognized coverage.

Failure to adhere to the individual mandate may have consequences. Individuals will owe an additional tax with the filing of individual tax returns to the IRS. The penalty will be assessed based on a percentage of household income, subject to a floor and capped at a ceiling of a federally established cost that would represent what the individuals would likely pay had they obtained insurance. The tax increases in 2015 and 2016 and thereafter is adjusted in accordance with the cost of living.

There are some exclusions to the assessment of penalties for not obtaining insurance, including consideration of the cost of insurance against adjusted gross household income. Members of recognized American tribal organizations are exempt, as are people who are not required to file a federal tax return.

Expansion of Medicaid

The third and final day was devoted to arguments on the expansion of the Medicaid program. The details about the scope of expansion have been addressed above. The arguments in the case were the same as presented to the Eleventh Circuit Court of Appeals, i.e., that the Medicaid expansion exceeds Congress's constitutional powers.

The Ruling

The Court handed down its ruling, written by Chief Justice John Roberts, on June 28, 2012 (*33*). The Court essentially issued four rulings in the case:

In the first decision, the Court ruled unanimously that the individual mandate was not a tax for purposes of application of the Anti-Injunction Act but an assessable penalty.

The second decision was the crucial ruling in the case, and concerned the mandate to require individuals to acquire health insurance. Here, the justices ruled, on a 5 to 4 vote, that the individual mandate was constitutional. With the individual mandate confirmed, the issue of severability, or a determination that the entire ACA was unconstitutional, was rendered moot.

The third ruling pertained to whether the expansion of the Medicaid program was constitutional. On this matter, the Court ruled 7 to 2 that Congress had exceeded its authority in requiring the states to expand their Medicaid programs.

Finally, the Court addressed the severability associated with the ruling against the government in terms of forcing Medicaid expansion. In a 5 to 4 vote, the Court ruled that by limiting the power of the Secretary of HHS to withhold all Medicaid funding to a state, as called for in the ACA, the constitutionality of the Medicaid expansion could remain intact.

Summary

The Court's decision found the Medicaid expansion unconstitutional, but in removing the authority of the Secretary of HHS to withhold funds to the states for noncompliance, it essentially created a situation wherein Medicaid expansion is optional. The result is that researchers and industry watchers are unsure as to the status of many states in participating in the act's expansion of Medicaid. Thus, projecting potential impact on public transportation takes on a state-by-state perspective.

CHAPTER 4 THE ACA, MEDICAID EXPANSION, AND STATES' WAIVER EXPERIENCES

The ACA increases access to health insurance beginning in 2014 through a coordinated system of "insurance affordability programs" including Medicaid, CHIP, premium tax credits for coverage provided through new Health Benefit Exchanges, and optional state-established Basic Health Programs. On March 23, 2012, CMS issued a final rule to implement the ACA provisions relating to Medicaid eligibility, enrollment simplification, and coordination (*3*).

Most estimates say that in 2014 approximately 16 million new individuals would be eligible for Medicaid, with some reports suggesting this number could reach 21.3 million by 2022.

Status of Medicaid Expansion

Another factor in assessing the potential impact on transit of Medicaid expansion under the ACA is whether or not a jurisdiction has elected to participate in Medicaid expansion. One source tracking this issue has categorized each jurisdiction as participating, leaning toward participating, participating under an alternative plan, not participating, or leaning toward not participating (*1*). As of this writing, 28 states and the District of Columbia will announced they will expand the program, while four other states have indicated they will participate, but under some type of alternative plan to be submitted to CMS. Nineteen (19) states have declared they will not expand (Table 4). In states that have declared they will not expand Medicaid, transit providers can anticipate no impacts from the ACA.

The status as of this writing of the jurisdictions is graphically depicted in Figure 2.

Projected Enrollees in Participating States

Some experts have attempted to enumerate the potential enrollment. The number of potential

Table 4 Summary of participation in Medicaid expansion.

Status	No. of States
Participating	27
Leaning Toward Participating	1
Participating but Under Alternative Plan	4
Not Participating	13
Leaning Toward Not Participating	6
Total (including District of Columbia)	51

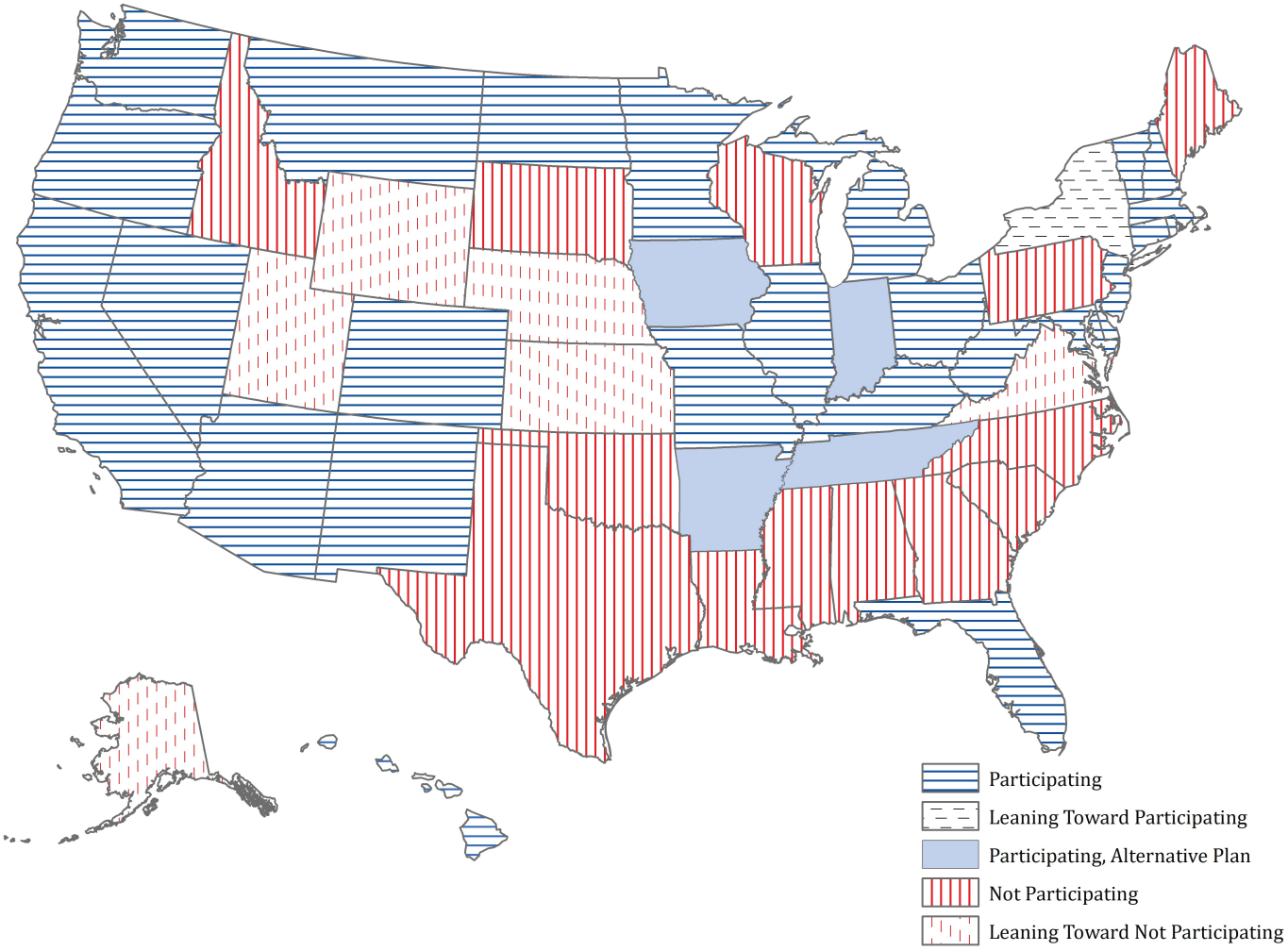
SOURCE: The Advisory Board Company, June 14, 2013. Updated and tabulated July 2014 by RLS & Associates, Inc.

new enrollees in the Medicaid program is uncertain because enrollment is voluntary; it is up to the individual to take advantage of newly accorded eligibility.

Expansion of Medicaid Eligibility Prior to 2014

While most observers cite January 1, 2014 (the ACA's effective date for expansion of Medicaid eligibility) as a key milestone, states have had the option to expand eligibility since April 2010.

Expansion of eligibility can be accomplished through two primary means: a state Medicaid plan amendment, or submission of a Section 1115 Demonstration Waiver. Both of these options must be approved by CMS and the Secretary of HHS. States that choose to expand coverage using a Section 1115



Source: The Advisory Board Company, February 2013. Updated as of July 2014 by RLS & Associates, Inc.

Figure 2 Status of states' commitment to Medicaid expansion.

waiver have the opportunity to design a modified state Medicaid program incorporating some, but not all, of the provisions as set forth in the ACA.

Though not frequently cited in the transportation literature, several states have already expanded Medicaid eligibility, in part to address the expanded Medicaid eligibility standards set forth in the ACA. With the incentive of receiving 100% federal participation for the first three years, six states—California, Connecticut, Colorado, Minnesota, Missouri, New Jersey, Washington—and the District of Columbia have opted to expand Medicaid eligibility (*8*).

The State of Connecticut was the first to expand Medicaid coverage as a result of the ACA. Prior to the ACA, Connecticut provided state-funded medical assistance to low-income individuals through the State Administered General Assistance (SAGA) Program. Connecticut received a Section 1115 waiver approval on June 21, 2010, to incorporate parts of the ACA Medicaid expansion model into a new program that would be called the Medicaid for Low-Income Adults (LIA) Program. Given the uncertainty created by the Supreme Court's decision permitting the states to opt out of Medicaid expansion, states that have previously implemented some form of expansion in eligibility may provide some insights on what the national experience will be under the ACA's expansion.

States that Have Previously Expanded Medicaid Eligibility

Connecticut

Approach. In 1998, the Connecticut State Legislature established the SAGA Program to provide state-funded medical assistance to low-income, uninsured adults. Income eligibility for SAGA was set at 56% of the FPL, with an asset limit of $1,000. After the enactment of the ACA, the state decided to convert the SAGA Program into the new Medicaid LIA program.

This conversion would allow the state to receive partial Medicaid funding for the former SAGA recipients through December 31, 2013; beginning January 1, 2014, the Medicaid reimbursement rate would be at 100% (if the state decided to expand Medicaid eligibility to 133% of the FPL). Based on the ACA option to allow states to phase in the extension of eligibility for medical assistance to individuals prior to January 1, 2014, the State of Connecticut submitted a State Medicaid Plan Amendment. On June 21, 2010, Connecticut became the first state to receive approval to incorporate parts of the ACA Medicaid expansion model. This meant that approximately 45,000 former SAGA recipients would become eligible for Medicaid benefits.

The conversion to the LIA Program provided additional benefits to many of the former SAGA recipients, such as long-term care/skilled nursing facility services and home health care benefits. It also expanded the provider network available to participants and provided greater access to non-emergency medical transportation.

The LIA Program provides Medicaid benefits to non-disabled adults under the age of 65 with incomes at or below 55% of the FPL ($6,144 for individuals and $12,678 for a family of four in 2012). While the former SAGA Program included a $1,000 asset limit, the LIA Program does not limit assets.

The popularity and growth of the LIA Program has been significant, resulting in overwhelming and unsustainable costs to the state. With the elimination of the asset limit, the recent economic downturn, and the additional enrollment of individuals who formerly would not have been eligible under the SAGA Program, caseload growth for the Medicaid LIA Program caseload increased by 75% from June 2010 to July 2012 (Connecticut Department of Social Services, Section 1115 Waiver Application, "Medicaid Low-Income Adult Coverage Demonstration," August 20, 2012). Spending increased from $265.6 million in FY2009 to $575.6 million in 2011. The "newly eligible" caseload of 80,000 was not expected to be reached until May 2014; by December 2012, the LIA caseload had expanded to 86,503.

To combat the additional costs associated with the Medicaid LIA Program, the state submitted a Section 1115 demonstration waiver request to the Secretary of HHS on August 20, 2012 entitled "Medicaid Low-Income Adult Coverage Demonstration." As of the issuance of this report, the state was awaiting a decision on this request.

The Section 1115 demonstration waiver request proposes to:

- Initiate a $10,000 asset test on all LIA participants (excluding home property and one motor vehicle); and
- Count parental income and assets for individuals under age 26 who either live with the parent or are claimed as a dependent on the parent's tax return.

State officials believe that a $10,000 asset limit will help target funds to the most needy. There is also concern that more families with children ages

19–25 are shifting financial responsibility for medical coverage to the LIA Program, rather than purchasing individual policies or purchasing dependent coverage on the parent's policies.

Impact on NEMT. The State of Connecticut contracts with a company to provide NEMT services. An average of 300,000 NEMT trips are provided each month. Public transportation is the most frequently used mode of service; however, taxis are used when documentation from a doctor indicates that an individual is not able to use public transportation. Mileage reimbursements are sometimes provided to friends, relatives, and volunteers who agree to transport LIA participants to Medicaid-covered appointments. Mileage reimbursements are typically not provided to LIA participants who drive their own vehicles.

The significant increase in enrollment in the LIA Program has resulted in an increased need for NEMT. What is interesting to note is that, in general, most NEMT trips provided to individuals covered under the standard state Medicaid plan are to access primary care, specialty care, dialysis, etc. In contrast, the LIA population, which includes the same age range (19–64) as that proposed in the ACA expansion of Medicaid, has generated NEMT trip needs that are primarily related to outpatient alcohol/substance abuse treatment centers and mental health services. In some situations, daily trips are needed for urine testing and methadone doses. The sedative effects of methadone treatment can impair an individual's driving ability, so even if the patient owns a car, he or she may not be able to use it to access treatment services.

The ACA will expand Medicaid benefits to low-income adults who are not disabled. This newly eligible population will also have incomes higher than individuals who are already eligible for Medicaid; and based on traditional analysis, is expected to have a lower transit dependency than the current eligible population. The Connecticut experience, however, suggests that transit dependency may rest more on the range of services provided under the state plan than the age, disability, or income status of the newly eligible individual.

California

Approach. The State of California has been implementing health care reform since 2005 through various Section 1115 waivers and expenditure authorities which have allowed the state to expand Medicaid coverage to multiple populations. Prior to the passage of the ACA, Medicaid benefits were already available to many uninsured adults between the ages of 19 and 64 with incomes less than 200% of the FPL through the Medi-Cal Hospital/Uninsured Care Demonstration Waiver.

The Low Income Health Program (LIHP) is authorized under California's current Section 1115 demonstration, and is intended to provide health coverage to uninsured adults ages 19–64.

LIHP benefits are not available in every county. Each participating county establishes its own income eligibility requirements, policies and procedures for the program. No asset test is required for eligibility. Health care benefits available to adults participating in the LIHP are more limited than those identified in the standard state Medicaid plan. The LIHP includes two separate eligible populations:

- Medicaid Coverage Expansion (MCE) Population: Adults ages 19–64 with family incomes at or below 133% of FPL (or less depending on the participating county income eligibility standards). Since this population would otherwise be eligible under the ACA, there is no cap on federal funding; however, counties are allowed to establish enrollment caps.
- Health Care Coverage Initiative (HCCI) Population: Adults ages 19–64 with family incomes between 133% and 200% of FPL (or less depending on the participating county income eligibility standards). Participating counties receive limited funding allocations to serve the HCCI population.

Non-emergency medical transportation is identified as a core benefit available to the MCE population but not the HCCI population. Nevertheless, counties may choose to provide NEMT as an "add-on" service to the HCCI population.

As noted, the LIHP initiative is an optional program and is not available in every county in California. Some counties have chosen to limit the program to the MCE population. Policies regarding premiums, enrollment fees, and cost-sharing are made at the local county level. LIHP recipients access health care services through county health plans. They are assigned to a primary provider who will manage their access to health care services available through the local LIHP provider network.

Impact on NEMT. Because California permits individual counties to establish participation in the wavier programs, coverage is not uniform throughout the state. This is similar to the "opt-in" scenario established by the Supreme Court's ruling for the entire Medicaid expansion. This variation makes assessment of impact of California's waivers on NEMT difficult.

New Jersey

Approach. On April 14, 2011, the State of New Jersey received Section 1115 Demonstration Waiver authority to expand Medicaid benefits to childless adults 19 to 64 years of age with income up to 24% of the FPL. The New Jersey Childless Adults (NJCA) demonstration project provides Medicaid health care coverage to participants of the New Jersey Work First General Assistance Program, which is a state-funded program that provides cash assistance and community support services to individuals and couples without children.

Prior to the waiver approval, this population was eligible for state-funded health care coverage. In order to be eligible for the NJCA program, participants must cooperate with work requirements. Income cannot exceed $140 a month for individuals or $193 for couples. If the individual/couple has a medical deferral for the work requirements, countable monthly income (including some types of unearned income) is increased to $210 for individuals and $289 for couples. No cost-sharing is required for the fee for service Medicaid benefits.

On October 2, 2012, the State of New Jersey received an additional Section 1115 waiver to consolidate the delivery of Medicaid services provided under multiple programs and initiatives, and to expand Medicaid health care coverage to additional populations. The New Jersey Comprehensive Waiver demonstration includes all individuals currently receiving Medicaid services under the state Medicaid plan, the state CHIP, NJCA, the state-funded New Jersey Family Care (NJ FamilyCare) Childless Adults Program, and several Section 1915(b) and 1915(c) waiver demonstration projects.

The new waiver authority focuses on the expansion of eligible populations (e.g., increasing income levels); addressing the need for additional home- and community-based services for long-term care and mental health/addiction services; and expanding the availability of premium assistance options for low-income individuals with access to employer-based coverage. The expanded NJ FamilyCare Childless Adult program includes uninsured childless individuals ages 18 to 65, with household incomes between 25% and 100% of the FPL. Eligibility for this program is capped at 800 individuals.

Impact on NEMT. It is difficult to assess the impact of the ACA Medicaid expansion on NEMT in New Jersey because the state initiated a brokerage contract about the same time as the initial Medicaid expansion to 57,000 childless adults. Transportation costs in SFY 2011–12 would understandably be higher than costs in SFY 2010–11, but the extent attributable to the change in delivery systems rather than the increased Medicaid-eligible recipients is difficult to measure.

As of the issuance of this report, the brokerage contract is managing almost all of the state's NEMT needs at approximately 400,000 trips per month. Based on information from the New Jersey Division of Medical Assistance and Health Services, about 4% of the state's overall Medicaid population uses NEMT, and New Jersey officials estimated that 3–4% of the newly eligible population will also require NEMT. Thus, unlike Connecticut, New Jersey expects that the newly eligible Medicaid population is more likely to utilize traditional fixed-route transportation. However, as this state is well served by public transportation, the likelihood of substantial new burdens on existing countywide demand response providers is minimal. This assessment is consistent with the eligibility definitions provided in the ACA (e.g., newly eligible individuals are not disabled).

Colorado

Approach. On March 30, 2012, the State of Colorado received Section 1115 authority to expand Medicaid benefits to up to 10,000 adults, ages 19 to 64, who are not pregnant and do not have a Medicaid-dependent child living in the household.

Members of this newly eligible population were previously uninsured but received low-cost health care services through the state-funded Colorado Indigent Care Program. The official name of this Section 1115 demonstration is "Colorado Adults without Dependent Children (AwDC)." Income eligibility must be at or below 10% of the FPL (annual income of $1,117 for individuals and $1,513 for couples in 2012) and assets are not counted. According to

the terms of the waiver, Colorado may increase the state-established income eligibility standard to 60% of the FPL without amending the demonstration.

The demonstration population is required to enroll in and receive health care benefits through the state's Accountable Care Collaborative (ACC), which is a managed-care delivery system. Those with mental health and/or substance abuse disorders are required to enroll in the Prepaid Insurance Health Plan, which provides enhanced services on a regional basis.

Beginning January 1, 2014, the State of Colorado will expand eligibility for Medicaid benefits to childless adults with incomes at or below 133% of the FPL, the same criteria as set forth in the ACA (annual income up to $14,856 for individuals and $20,123 for couples, based on 2012 FPL). This upcoming expansion will enable the state to cover an additional 160,000 childless adults.

Impact on NEMT. No details regarding NEMT component of the Colorado waiver program were available.

Washington

Approach. The State of Washington received Section 1115 waiver authority to implement the Washington Transitional Bridge Demonstration on January 3, 2011. As a result of this demonstration, approximately 63,300 childless adults were expected to be eligible for Medicaid benefits. The "transition eligible" population includes non-pregnant childless adults ages 19 to 64 with incomes at or below 133% of the FPL who are enrolled in any of the following state-funded programs:

- Basic Health (BH) Program,
- Medical Care Services (MCS) Program, or
- Alcohol and Drug Addiction Treatment and Support Act (ADATSA) Program.

This population includes many individuals with mental or physical impairments and those with alcohol and drug addictions who have been or would have been eligible for state-funded health care coverage prior to the Section 1115 Demonstration.

Those enrolled in the BH program with incomes below 65% of the FPL are eligible for a 50% reduction in cost-sharing. Enrollees in MCS and ADATSA programs have nominal-cost sharing responsibilities. Enrollees of the ADATSA Program participate in a fee-for-services health care delivery system while all other transition eligibles are required to access services through MCOs.

Effective March 1, 2011, two months after receiving the waiver authority, the State of Washington limited eligibility for the BH program to the transition-eligible population and licensed foster parents. At the time of this report, applications were not being accepted and a wait list was in place. The annual average enrollment in the BH and MCS programs has decreased significantly since the beginning of the program. In SFY 2010, the average enrollment in the BH program was 43,000 individuals and is now approximately 30,000. Annual average enrollment in the MCS program in SFY 2010 was 16,000 and is now 9,000. Enrollment in ADATSA has remained fairly steady at approximately 4,000 individuals.

Impact on NEMT. Under this waiver, NEMT services are only available to transition eligibles receiving Medicaid-funded services through MCS and/or ADATSA. NEMT is not provided under the BH program.

According to staff at the Washington Health Care Authority (HCA), about 3% of the total Medicaid population requires NEMT each month, which is supplied by multiple regional brokers. Overall annual costs associated with the delivery of statewide Medicaid-funded NEMT services have decreased by approximately $700,000 since SFY 2010. An important issue to note here is that prior to the issuance of the 2011 Section 1115 waiver, state-funded NEMT was already available to most of the transition-eligible population (with the exception of the BH enrollees); therefore, there would not be an expectation of a significant increased need for this service.

Local public transit services are the primary means of NEMT, with approximately one-third of the trips provided by fixed-route transit. When necessary, medical providers are asked to provide documentation explaining why an individual may not be able to use public transportation. At least 20% of NEMT trips in Washington are made to opiate substitute chemical dependency treatment services, and HCA staff see this number rising with the expanding Medicaid-eligible population. Trips of this nature are also some of the most costly to provide.

Although Washington does not have historical NEMT cost data specific to the transition eligible

population, a significant increase in trip need or cost is not expected as a result of this waiver authority—again because of the previously established eligibility for NEMT for that population.

Beginning January 1, 2014, Washington intends to fully implement its Medicaid expansion to all non-pregnant childless adults between the ages of 19 and 64 with incomes at or below 133% of the FPL, who otherwise meet the eligibility requirements as set forth in the ACA. Up to 250,000 newly eligible individuals are anticipated to enroll in the Medicaid program as a result of the ACA during the first few years NEMT will be an allowable service; and it is likely that the demand for NEMT will increase.

The experience of Washington appears to correspond to that of Connecticut, in that the eligible population that will be covered by Medicaid does not require medical services similar to those of the traditionally eligible population. The newly eligible population in need of NEMT appears to be concentrated in the substance abuse treatment area, with transport to chemical dependency clinics being the top transportation need.

Missouri

Approach. The Section 1115 Demonstration Waiver Authority awarded to the Missouri Department of Social Services (DSS) is more limited and specific than the other Medicaid expansion waivers noted in this section. The "Missouri Gateway to Better Health" demonstration was approved on July 28, 2010, and focuses on preserving and improving the health care delivery system for uninsured adults with family income up to 200% of the FPL in the St. Louis City and St. Louis County region only. This is an innovative partnership between the Missouri DSS and the St. Louis Regional Health Commission and its vendors.

The first two years of the demonstration were focused on redesigning the existing health care delivery system for uninsured adults in the St. Louis region, which went from a direct payment model to a coverage model. The intention of the program is to connect the low-income uninsured population to primary care providers who will coordinate and enhance the delivery of health care services. The Section 1115 Demonstration provided funding to develop the health care system until June 30, 2012.

The "Safety Net Pilot Program" was implemented on July 1, 2012, and provides preventative, primary, specialty, and urgent care to uninsured individuals between the ages of 19 and 64. Participation in the program has grown significantly: In July 2012, 14,900 individuals were enrolled; as of January 2013, enrollment had grown to 19,657.

While the number of uninsured individuals enrolled in the Safety Net Pilot Program has increased, many of them were already receiving health care services from federally qualified health centers in the St. Louis City and County prior to July 1, 2012. These services were funded by statewide Disproportionate Share Hospital (DSH) program cash. The Gateway to Better Health program transitioned the local health care service delivery system from a direct payment model to a health coverage model, which provides enrollees with a defined health coverage benefit package. According to the St. Louis Health Commission, the local health care network is currently providing over 100,000 more visits to primary health care for the adult population than it did 10 years ago.

The demonstration provides two different coverage plans: the "Blue Plan" and the "Silver Plan." The level of health care benefits available to an individual is based upon the population criteria as defined below:

- Blue Plan—Available to uninsured individuals residing in the St. Louis region ages 19 to 64, with family income at or below 133% of the FPL, who are not eligible for state Medicaid plan benefits, and who currently receive health care through one of the primary care providers participating in the demonstration project. This population is eligible for primary care (preventative care, wellness check-ups, dental care, etc.), specialty care (cardiology, oncology, NEMT, etc.), and urgent care services.
- Silver Plan—Uninsured individuals residing in the St. Louis region ages 19 to 64, with family income between 134% and 200% of the FPL, who are not eligible for state Medicaid plan benefits, and who have been referred by any primary care provider under this demonstration. This population is eligible for urgent care and specialty care services only.

On December 26, 2012, the State of Missouri sent a letter to CMS announcing its intent to request a three-year extension of the demonstration project, scheduled to expire December 31, 2013. Governor

Jay Nixon announced on November 29, 2012, that he would include the ACA Medicaid expansion in his state budget proposal. If approved, the expansion is expected to provide Medicaid to an additional 300,000 low-income adults statewide.

Impact on NEMT. CMS has given the Missouri DSS authority to limit the availability of transportation for the Safety Net Pilot Program from July 1, 2012 through December 31, 2013. According to the conditions identified in an August 9, 2012 letter, CMS agrees:

> *To the extent necessary, to enable the State to not assure transportation to and from providers for all Demonstration populations (35).*

Missouri, however, did not request that CMS waive the transportation assurance. According to the St. Louis Regional Health Commission, NEMT services are available to all participants in the Gateway to Better Health Demonstration Project (Safety Net Pilot Program) who have no other means of accessing Gateway covered services.

St. Louis ConnectCare is a healthcare network that provides specialty care services to the demonstration participants. This organization also operates a fleet of vehicles to provide NEMT to Gateway-covered services. According to an authorized spokesperson, the increase in the number of individuals covered under the Safety Net Pilot Program has not resulted in a major need for NEMT. The infrastructure that was in place prior to implementation of the Safety Net Pilot Program is sufficient to support the current demand for NEMT and additional resources have not been necessary.

Because of the recent implementation of the pilot program (July 1, 2012) and the limited enrollment area of the demonstration (St. Louis region), it is difficult to draw any major conclusions as to the impact the ACA Medicaid expansion might have had on the need for NEMT services. However, it appears that the existing human services network that was created by the Gateway program is sufficient to meet NEMT demand.

Notable from this demonstration is the fact that CMS waived the transportation assurance for this project. While this waiver authority was not used, it is indicative of how states can use waiver authority to substantially change the methods by which they implement their respective Medicaid programs. This example shows that if a state requested waiver authority of the transportation assurance, CMS could potentially agree to such a provision. Thus, there is no certainty to the transportation assurance.

Minnesota

Approach. The State of Minnesota has long been recognized as an innovator in health care reform and expanded Medicaid eligibility for the uninsured. In July 1995, the state received a Section 1115 waiver for its Prepaid Medical Assistance Plus (PMAP+) program, which provides health care services through a prepaid, capitated managed care delivery system. This demonstration has been renewed and extended many times since 1995. On March 10, 2011, Minnesota received a waiver amendment authority to expand Medicaid eligibility to childless adults ages 21 to 64 with incomes at or below 75% of the FPL. This population had previously received state-funded "General Assistance Medical Care." Approximately 83,000 individuals were expected to be eligible for Medicaid coverage as a result of the 2011 amendment.

On August 1, 2011, the state received a waiver amendment authority to provide a "limited benefit package" to childless adults ages 21 to 64 with incomes above 75% and at or below 250% of the FPL. The "MinnesotaCare Adults Without Children" clients are required to pay monthly premiums for benefits and cost-sharing payments. There is no charge for preventative care services. There is a $10,000 maximum limit on inpatient hospitalizations and a 10% co-pay on inpatient hospital stays with a $1,000 cap.

Impact on NEMT. Perhaps the most noteworthy service exclusion in the "limited benefit package" available to the MinnesotaCare Adults Without Children program clients is the elimination of the NEMT benefit, which is otherwise available to individuals eligible under the state Medicaid plan. Based on the August 2011 Section 1115 amendment, Minnesota is not required to assure transportation to and from medical providers for non-pregnant adults ages 21 to 64 participating in this program. Unless otherwise extended, this demonstration was scheduled to expire December 31, 2013.

Once again, this example demonstrates that flexibility in state management procedures may result in the absence of a transportation assurance associated with some examples of Medicaid program expansion.

District of Columbia

Approach. On March 7, 2002, long before the ACA, the District of Columbia received Section 1115 authority to expand Medicaid coverage to non-pregnant, non-disabled adults, ages 21 to 64, with income between 133% and 200% of the FPL. This was one of the earliest examples of Medicaid expansion later emulated in the ACA.

On June 22, 2010, the District of Columbia received CMS approval to amend its plan in order to provide Medicaid benefits to non-pregnant, non-disabled adults with income at or below 133% of the FPL. This amendment was permitted in accordance with the early option to expand Medicaid as set forth in Section 1902(k)(2) of the ACA. The effective date for the CMS approval was May 1, 2010.

On July 23, 2010, the District of Columbia requested a termination of its previous Section 1115 Demonstration and submitted a new waiver proposal entitled, "District of Columbia 1115 Childless Adults Demonstration." The request was granted and the program was implemented on November 1, 2010, with an expiration date of December 31, 2013.

This program restricts freedom of choice of providers, and waives the requirement to provide medical assistance for three months prior to the date of application. Since this population was already eligible for Medicaid coverage prior to the ACA (based on the 2002 demonstration), it is uncertain whether it will be considered "newly eligible" and thus qualify for the 100% FMAP rate beginning January 1, 2014.

Impact on NEMT. NEMT in the District is managed by Medicare/Medicaid Transportation Management (MTM), which contracts with local public and private transportation providers. MTM provides SmarTrip Fare Cards to eligible NEMT riders to be used for all Metro bus service and rail services. MTM provides funds to the Metro Access EZ Pay System that flow into the accounts of eligible riders based on the number of scheduled medical trips. Travel training services are provided for bus and rail transportation by the Washington Metropolitan Area Transit Authority (WMATA).

Summary of State Waiver Demonstration Results

While the state waiver demonstrations provide some insights, they do not provide details concerning the specific number of newly eligible clients who utilize NEMT or the consumption of NEMT services (trips). Nevertheless, lessons learned include:

1. There is an informal consensus that the newly eligible population is more ambulatory than the traditional Medicaid population. Additionally, this population was cited as being capable of using fixed-route services, where available, to a greater extent than the existing Medicaid population.
2. There is a common estimation by the waiver states that about 3% of the newly eligible population requires NEMT transportation. Traditionally, state Medicaid agencies have assumed that approximately 10% of the current Medicaid population requires transportation assistance.
3. While the Medicaid transportation assurance seems to be an accepted matter of law, a state will maintain flexibility under Medicaid expansion to request waivers. These requests can include a waiver of the transportation assurance and CMS appears to be willing to grant such requests (i.e., the Missouri waiver authority).
4. Several states have indicated that the primary NEMT need concerning the newly eligible population is for transporting individuals with chemical dependencies to substance abuse/mental health/treatment facility destinations.

CHAPTER 5 MEDICAID EXPANSION UNDER THE ACA AND CHALLENGES TO THE PUBLIC TRANSIT INDUSTRY

Estimated Newly Enrolled Individuals

The number of potential new enrollees in the Medicaid program is uncertain because regardless of expanded eligibility, enrollment is voluntary and requires individual action. Nevertheless, some experts have attempted to provide a state-by-state assessment of potential enrollees. This synthesis has adopted these estimates and has further segregated the data by states that have indicated participation in the Medicaid expansion (*36, 37*). Overall, it is estimated that just under 16 million individuals will be eligible for Medicaid under the ACA expansion. When non-participating states, those states leaning toward non-participation, and those states that have not taken a position on participation are taken into account, the potential number of new enrollees is estimated to be just under 9 million individuals (Table 5).

Table 5 Estimated newly enrolled Medicaid participants, by Medicaid expansion status of states.

State	Total Population	Current Medicaid Enrollment[1]	Estimated New Medicaid Enrollees		
			Participating States	Non-Participating States	Alternative Plan States
Alabama	4,779,736	1,015,576		351,567	
Alaska	710,231	136,959		42,794	
Arizona	6,412,700	1,783,289	105,428		
Arkansas	2,915,918	778,997			200,690
California	37,253,956	11,168,140	2,008,796		
Colorado	5,029,196	702,239	245,730		
Connecticut	3,574,097	712,350	114,083		
Delaware	897,934	225,458	12,081		
District of Columbia	601,723	175,678	28,900		
Florida	18,801,310	3,421,911	951,622		
Georgia	9,687,653	2,048,362		646,557	
Hawaii	1,360,301	267,002	84,130		
Idaho	1,567,582	251,494		85,883	
Illinois	12,830,632	3,017,131	631,024		
Indiana	6,483,802	1,243,051			297,737
Iowa	3,046,355	574,625			114,691
Kansas	2,853,118	372,522		143,445	
Kentucky	4,339,367	960,776	329,000		
Louisiana	4,533,372	1,312,335		366,318	
Maine	1,328,361	366,735		43,468	
Maryland	5,773,552	960,915	245,996		
Massachusetts	6,547,629	1,568,182	29,921		
Michigan	9,883,640	2,124,018	589,965		
Minnesota	5,303,925	885,311	251,783		
Mississippi	2,967,297	772,166		320,748	
Missouri	5,988,927	1,146,897	307,872		
Montana	989,415	151,422	575,356		
Nebraska	1,826,341	286,887		83,898	
Nevada	2,700,551	290,758	136,563		
New Hampshire	1,316,470	166,363	55,918		
New Jersey	8,791,894	1,231,456	390,490		
New Mexico	2,059,179	637,856	145,024		
New York	19,378,102	5,208,143	305,945		
North Carolina	9,535,483	1,974,287		633,485	
North Dakota	672,591	80,262	28,864		
Ohio	11,536,504	2,427,052	667,376		
Oklahoma	3,751,351	851,674		357,150	
Oregon	3,831,074	643,941	294,600		
Pennsylvania	12,702,379	2,303,775		482,366	
Rhode Island	1,052,567	224,282	41,185		
South Carolina	4,625,364	971,969		344,109	
South Dakota	814,180	142,173		31,317	
Tennessee	6,346,105	1,531,074			330,932
Texas	25,145,561	4,488,188		1798,314	
Utah	2,763,885	294,904		138,918	
Vermont	625,741	199,434	4,484		
Virginia	8,001,024	1,039,298		372,470	

(*continued on next page*)

Table 5 (Continued)

State	Total Population	Current Medicaid Enrollment[1]	Estimated New Medicaid Enrollees: Participating States	Estimated New Medicaid Enrollees: Non-Participating States	Estimated New Medicaid Enrollees: Alternative Plan States
Washington	6,724,540	1,159,333	295,662		
West Virginia	1,852,994	429,578	121,635		
Wisconsin	5,686,986	1,086,801		205,987	
Wyoming	563,626	82,365		29,899	
Total	308,766,221	65,895,394	8,999,433	6,478,693	944,050

NOTES:
[1]Enrollment counts include all ever enrolled, with or without Medicaid services rendered during the fiscal year. Counts are for Federal Fiscal Year 2009 or 2010 (where available), with the exceptions of Massachusetts, Utah, and Wisconsin, which are 2008 enrollment data.
SOURCE: *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL,* July 2014.

The consensus of states with experience in state waiver demonstrations, which indicated approximately 3% of the newly enrolled population will need NEMT, has been applied to these enrollment estimates. Hence, it is estimated that about 270,000 individuals will require NEMT. Traditional estimates would suggest that about 900,000 individuals would require NEMT; however, the eligibility criteria for newly eligible individuals suggest that this group will be less transit dependent than traditional Medicaid populations.

This enumeration methodology is clearly imprecise; however, this situation is not unlike the scenario in the early days of complementary paratransit implementation mandated by the Americans with Disabilities Act (ADA). The ADA provided specific eligibility criteria for complementary paratransit, but there were no known enumeration methods; limited observations were used to suggest that about "2.5 % of the total population is ADA eligible" (Thatcher, Russell and John K. Gaffney, EG&G Dynatrend and Katherine McGuinness & Associates, ADA Paratransit Handbook: Implementing the Complementary Paratransit Service Requirements of the Americans with Disabilities Act of 1990, prepared for the U.S. Department of Transportation, September 1991). In contrast, existing rules of thumb, which assume about 10% of the Medicaid population will require NMET, have been used for this synthesis. Until such time as additional research is conducted, this methodology is the best available for use in identifying the newly eligible Medicaid population requiring NEMT (Table 6).

Therefore, because of the Supreme Court decision's effectively creating an "opt out" strategy, the demographics of the states that have elected to participate, and the eligibility criteria for the expansion of Medicaid that will target low income individuals, the total number of newly eligible Medicaid enrollees is projected to be much lower than the estimates that were predicated on all states participating in the expansion. Moreover, the newly eligible population is less transit dependent than traditional Medicaid enrollees, thus the potential impact on NEMT volumes is further reduced.

While the ACA may not have the impact commonly predicted by some transit industry observers, there are other potential impacts that may be directly or indirectly experienced by public transit operators as a result of ACA implementation, even in states that have opted not to participate in Medicaid expansion. These factors include:

- The move towards coordinated managed care solutions in all areas of the ACA may accelerate efforts to turn over the provision of Medicaid services to MCOs. Within managed care, NEMT may be "carved in" and become a component part and responsibility of the MCO; or be "carved out" and be provided using existing delivery networks.
- The push to contain costs of the Medicaid program may prompt more states to engage or adopt capitated rate structures that may or

Table 6 Estimated number of new enrollees requiring NEMT.

	Participating States in Medicaid Expansion		
		Estimated New Medicaid Enrollees Requiring NEMT	
State	Estimated New Medicaid Enrollees	Low Estimate	High Estimate
Arizona	105,428	3,163	10,543
California	2,008,796	60,264	200,880
Colorado	245,730	7,372	24,573
Connecticut	114,083	3,422	11,408
Delaware	12,081	362	1,208
District of Columbia	28,900	867	2,890
Florida	951,622	28,549	95,162
Hawaii	84,130	2,524	8,413
Illinois	631,024	18,931	63,102
Kentucky	329,000	9,870	32,900
Maryland	245,996	7,380	24,600
Massachusetts	29,921	898	2,992
Michigan	589,965	17,699	58,997
Minnesota	251,783	7,553	25,178
Missouri	307,872	9,236	30,787
Montana	575,356	17,261	57,536
Nevada	136,563	4,097	13,656
New Hampshire	55,918	1,678	5,592
New Jersey	390,490	11,715	39,049
New Mexico	145,024	4,351	14,502
New York	305,945	9,178	30,595
North Dakota	28,864	866	2,886
Ohio	667,376	20,021	66,738
Oregon	294,600	8,838	29,460
Rhode Island	41,185	1,236	4,119
Vermont	4,484	135	448
Washington	295,662	8,870	29,566
West Virginia	121,635	3,649	12,164
Total	**8,999,433**	**269,983**	**899,943**

NOTES:
[1]Enrollment counts include all ever enrolled, with or without Medicaid services rendered during the fiscal year. Counts are for Federal Fiscal Year 2009 or 2010 (where available), with the exceptions of Massachusetts, Utah, and Wisconsin, which are 2008 enrollment data.
SOURCE: *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* and RLS & Associates, Inc. estimates, July 2014.

may not be indicative of the fully allocated cost to delivery NEMT services.

- The paradigm shift of Medicaid's moving away from local service delivery models to regional or statewide delivery models may further expand the use of transportation brokerage management models for NEMT. As public transit systems typically are limited to municipal or county service areas, brokered solutions provide a state with an option to assure statewide coverage in its management of NEMT services.

The potential for increased use of brokerages creates additional challenges for public transportation, including:

- Dual eligibility issues arising from an individual's being eligible for both public transportation and NEMT;

- Rate limitations imposed by Medicaid brokerage rules; and
- Medicaid as the "payer of last resort."

These issues are discussed below.

Other Ancillary Impacts on Public Transportation Systems as a Result of the ACA

Dual Eligibility

Community and specialized transportation providers have long dealt with the issue of dual eligibility–circumstances in which a passenger is eligible under two or more federal programs. This creates the dilemma of how to assign cost sharing responsibility in these situations. Trip purpose restrictions typically provide the only guidance; if the trip is permitted under one program but not another, the transit provider will typically assign costs to the program that permits that trip type. While many programs have such restrictions that may help guide the transit provider, there will remain any number of dual eligibility trips. There is little to no federal guidance on dual eligibility issues and, for the most part, local transit providers have worked with their human service agency counterparts to determine how to assign cost sharing responsibilities.

In the last two decades, this issue has been more problematic with the passage of the ADA. The ADA requires entities that provide fixed-route transportation also provide paratransit services to those individuals who cannot otherwise independently use and navigate the accessible fixed-route system. Moreover, for the first time, a national standard for eligibility for paratransit services was established.

In an oft-cited study, the GAO concluded that 62 different federal programs support passenger transportation (U.S. General Accounting Office, *Transportation-Disadvantaged Populations: Some Coordination Efforts Exist Among Programs Providing Transportation Services, but Obstacles Persist,* Report GAO-03-697, Washington, D.C., June 2003). In a more recent study for the Ohio Department of Transportation, researchers found that 15 programs cited in the GAO study serve disabled populations (*38*). While the definition of an individual with a disability used by these programs may not be consistent with that prescribed in the ADA, it is clear the potential for dual eligibility exists.

These dual eligibility cases create cost sharing issues for the transit provider. Typically, a fee-for-service is negotiated with the sponsoring state or local agency. However, as many transit industry observers have noted—both formally and informally—if a client is eligible under the ADA, the transit system's options for transport may be limited to the complementary paratransit system at the established fare. Indeed, as far back as 1997, TCRP research cited the potential issue of "client dumping," or the shifting of payment responsibility from one organization to another, and the adverse impact on such practice would have on transit systems:

> *As program funds are reduced, client transportation services may be reduced or eliminated. The loss of HHS benefits-related transportation has the potential to fuel public paratransit demand* (Simon, Rosalyn M., *Integrating Americans with Disabilities Act Paratransit Services and Health and Human Services Transportation,* TCRP RRD 10, Transit Cooperative Research Program, April 1997).

Transit systems are already reporting "client dumping" by HHS agencies. To maintain service delivery levels, some social service agencies are eliminating agency-run client transportation programs, reducing transportation reimbursements, reimbursing only for the public-system passenger fare, or simply referring the client to the public transit system without accompanying transportation funds. This almost always results in increased paratransit demand and in higher costs because many HHS clients are also eligible for ADA paratransit services (*38*).

While arguable that "many HHS clients" are also eligible for ADA paratransit service, there is less doubt regarding clients participating in the programs as noted in Appendix A. These individuals present true dual eligibility issues.

The numbers of dually eligible individuals, while unknown, may be substantial. Medicaid alone reports that the program provides benefits for an estimated 8.8 million non-elderly disabled adults over 18 years of age. While no estimates could be found for other programs, it is likely that additional unduplicated persons are served by these agencies; thus, the total number of persons in this category is not insignificant.

Pursuant to the ADA, transit systems must provide complementary paratransit service to any qualified individual with a disability; there is little a transit system can do when an individual requests paratransit service but to provide that service, even if it is for a

program purpose and could potentially be paid for by the another federal program. This fact, combined with emerging brokered service delivery models being employed by a number of states, presents challenges to public transportation.

Importance to the Transit Industry

While the demographics of the dual eligibility issue has long been recognized by transit agencies, the changes and evolution of emerging service delivery models in the Medicaid program may prove problematic to transit providers. As discussed earlier, there has been substantial migration in type of service delivery models used by states with respect to NEMT. Many states have moved from a locally managed, fee-for-service model to a statewide or regionally managed brokerage model with a single, capitated fee structure. This rate structure, when managed by a private, for-profit brokerage operator, could create the unintended consequence of providing the broker with profit incentives to ensure that all dually-eligible individuals register for paratransit services and utilize those services while paying only the published fare.

While this problem is discussed within the context of complementary paratransit service provision, it is equally applicable to any general public provider of demand response services. For example, many rural transit public providers have a long and successful history of coordinating human services transportation through the provision of services under contract. These agencies have successfully operated rural public transit service while providing stable and dependable human services transportation. Additionally, coordination of services assists in the generation of local match revenues, as 49 U.S.C. § 5311(g)(3)(A), permits these funds to be counted as local match (not revenues that must be deducted from total operating costs to yield net operating costs).

While not subject to the same fare rules as complementary paratransit providers, most rural transit agencies establish public fares that are substantially discounted over the fully allocated cost of service or substantially lower than contract fares. Once again, this scenario gives rise to the potential client dumping as the demand response public fare may be cheaper than the contract fare. Because many state DOTs require a "first-come, first-served" approach in responding to requests for service from the general public, unintended consequences may arise with a the shifting of clients from "sponsored" mode to having clients ride as "unsponsored" passengers (*e.g.*, the general public).

The literature has few quantitative analyses of these scenarios, either in a complementary paratransit or general public demand response situation. In one analysis, the ADA Transit Subcommittee to the City of Madison, WI Transit and Parking Commission, anticipating a statewide move to an NEMT brokerage, determined that 59% of all existing ADA paratransit ridership were program trips, or trips supported by a human service agency. If these passengers only paid the paratransit fare, the net impact to the city would be about $2,523,000 annually (*39*).

Despite the lack of quantitative analysis in the literature, the perception of client dumping remains a concern—real or perceived—by many in the transit industry. This is perception is particularly true with respect to the Medicaid program and there is great apprehension that any expansion of Medicaid through the Affordable Care Act will only exacerbate this problem.

One step all transit agencies could benefit from is an understanding of some key provisions in transit and Medicaid regulations. These provisions include:

- Provision of service under contract in the ADA regulations;
- Medicaid rules on payment allowances by mode in brokerage operations; and
- Medicaid's principle that the program is the "payer of last resort."

ADA Regulations and the Provision of Services Under Contract

ADA regulations (49 CFR part 37.131(c)(4)) permit one exception to the rule that complementary paratransit fares are limited to twice the comparable fixed-route fare. This section of the rule states that a fare higher than that permitted under the regulations is permissible when the transit agency provides services to a social service agency for agency trips.

The rule distinguishes such trips by the fact that they are "guaranteed" to the social service organization, a concept that had more relevance in the early days of ADA implementation. (In the rule, covered entities had five years to fully implement the complementary paratransit provisions. Thus, based on the organization's complementary paratransit plan, it was possible that the transit system would not come into full compliance with the capacity constraints criterion until February 26, 1997.)

Characteristics of guaranteed trips where a negotiated rate can be used include:

- The sponsoring agency makes the reservation;
- The sponsoring agency will pay for the trip; and
- The sponsoring agency will determine which clients will be using the transit service (*39*).

If these conditions are present, the transit system may negotiate a rate for agency sponsored trips. If this agency is a Medicaid agency, then transit providers should be aware of limitations imposed by CMS regulations that impact the negotiated rate.

Contract Rate Limitations Imposed by Medicaid Brokerage Regulations

The ADA regulation does not provide any limitation on the negotiated rate between a transit agency and a social service agency. However, the transit agency must be aware of any limitations of the sponsoring agency. One such limitation exists in the NEMT brokerage rules adopted by CMS in implementing portions of the Deficit Reduction Act (DRA). Prior to this act, a state could not restrict consumer freedom of choice in providers and had to provide NEMT uniformly throughout the state unless the state had applied for and received a waiver of these provisions under Section 1915(b). With passage of the DRA, states were no longer required to obtain a Section 1915(b) waiver in order to provide NEMT as an optional medical service through a competitively contracted broker.

As noted elsewhere in this report, Medicaid has adopted rules that limit the amounts Medicaid will pay for paratransit services to only the rates charged to other state human service agencies for comparable services. While this regulation arguably applies only to circumstances in which a governmental entity is serving as the competitively selected broker, anecdotal evidence suggests that this rule is being applied to all NEMT contracts, regardless of service delivery mode.

Thus, transit agencies should carefully evaluate rate structures in all their existing contracts with human service agencies. Experience has shown that many transit agencies have maintained such contracts at substantially less than fully allocated costs. This may result is little room for rate negotiation with NEMT if a transit agency seeks to provide such services under contract.

Medicaid as the Payer of Last Resort

While not directly addressing the scenario of a Medicaid agency's purchasing services from another governmental unit, Medicaid embraces the concept of the program's being the payer of last resort. There is little evidence in the literature to suggest this has become a problem for transit operators in dual eligibility situations; however, there remain concerns that billing options for transportation operators that coordinate services may be limited by this provision.

Examples of States that Demonstrate Success in Deploying Brokerage Strategies in Cooperation with Public Transit Services

Understanding Medicaid and CMS rules governing NEMT and brokerage operations is critical to a state's ensuring that NEMT service delivery is effectively coordinated with public transportation in a brokerage service delivery model. Two states have been highlighted to show their respective approaches.

New Jersey

Overview. The New Jersey Department of Human Services (NJDHS) initiated its contract with a single statewide NEMT broker in 2009. The transfer of responsibility for NEMT from 19 county boards of social services to the broker occurred from late 2009 through 2010. The fact that two urban counties (Essex and Hudson) did not provide NEMT provided impetus for the state to consider a brokerage approach to ensuring the efficiency and uniform statewide coverage.

NJDHS consulted with the community transit programs in all 21 counties during deliberations to move to a NEMT brokerage. State officials noted that there was not uniform agreement among existing programs with this approach, but neither was establishment of a statewide brokerage opposed by the existing county providers.

Before the statewide NEMT brokerage was implemented, eight county transportation programs were delivering NEMT services through a network of private taxi and livery services. By the summer of 2010, the last of the social services boards' NEMT programs were assumed by the statewide NEMT brokerage. Five of the County community transit providers entered into agreements to become certified providers in the new network; all but one remain network providers. The remaining three counties elected not to be part of the NEMT brokerage provider network. It is expected that at least 10 additional counties will be joining the provider network by 2014.

Overall, community transit in New Jersey has seen a decrease in NEMT trips since the brokerage was initiated. However, the decrease is due to the fact that two of the three counties that have elected not to participate represent large service areas with a significant amount of NEMT trips.

In New Jersey, the broker's approach to involving public transit has been a success. Of the six million annual trips provided under Medicaid last year, over 800,000 trips (13%) were provided by public transit bus or rail. Although complementary paratransit has not been used for NEMT trips in New Jersey, the use of public transit buses and rail has been a significantly positive financial aspect to the brokerage system.

Access Link provides complementary paratransit for the NJ Transit local fixed-route services statewide, and therefore is the only complementary paratransit operator within New Jersey.

During initial negotiations, the NEMT broker offered Access Link a flat reimbursement rate for providing only the NEMT trips that could be accommodated with pick-ups/drop-offs at locations where Access Link was already scheduled to travel for its general public passengers. Access Link determined that the reimbursement rate was considerably less than the fully allocated cost per trip. Transit officials stated that the broker offered to pay only the incremental or marginal cost associated with new NEMT service. To date, Access Link has been unable to negotiate a more favorable rate and is not in the provider network.

Other providers were offered flat rates per NEMT trip to provide service; this approach dictates that service providers be fully aware of their own cost structure before accepting such trip rates. At least one additional county-based community transportation provider declined to participate as a network provider because the flat rate was too low.

Although the competitively selected broker was reportedly not proactive in reaching out to the transit and community transit sectors in the beginning of the contract, state transit officials indicate that communication has improved between the parties.

NJ Transit's Office of Local Programs has encouraged outreach efforts and open dialogue by facilitating and mediating meetings with the broker's key officials and local county counsels, county controllers, human service agency representatives, and key staff from the local transportation provider. More than 10 such meetings have been held, and NJ Transit considers them successful in improving communication and encouraging proactive communication from the broker.

In summary, the State of New Jersey has experienced a "win-win-win" with its statewide NEMT brokerage. Importantly, participation in the brokerage was seen as a revenue enhancement strategy. In 2008, New Jersey counties received a total of $35 million in Casino Revenue Taxes. In 2014, the Casino Revenue Tax will be reduced to $17 million for the 21 counties. The NEMT brokerage represents alternative revenue to offset some of that loss when local providers are able to work NEMT trips into their existing schedules with marginal or no additional expenses.

The NJDHS/Division of Medical Assistance (DMA) program has realized the benefit of the broker using community transit to lower the costs to the Medicaid program. The DMA realizes that when the broker is able to use community transit, the cost to the Medicaid program is less than the costs would be if a private operator provides the trip. With the DMA perspective of using community transit when appropriate, the NEMT broker can provide service in a more cost effective manner.

NJ Transit continues to work to address negative impacts of the brokerage, such as:

- Certain counties and Access Link have not embraced the brokerage to the degree that would maximize its benefits.
- Counties did not feel that the broker was providing all of the trips that it could have to save money for the Medicaid program.
- NJ Transit would like to involve a broader array of state funding sources included in a brokerage.

While the brokerage was established only as a Medicaid program, the involvement of coordinated systems as providers has helped to improve the overall efficiency of NEMT delivery in the State.

Lessons. NJ Transit officials are generally supportive of the NEMT brokerage concept and have invested considerable efforts and technical assistance to promote coordination between NEMT, the broker, and existing county-based public transit systems.

Early involvement in the planning of a statewide NEMT brokerage was recommended. This strategy suggests that there should be an ongoing dialogue between state Medicaid and transportation officials prior to the implementation of a brokerage. Additionally, the issues of rate setting and

fully allocated costs have limited participation by New Jersey providers, suggesting that information on existing costs of both paratransit and NEMT services should be well documented prior to brokerage establishment.

Oregon

Overview. Like New Jersey, Oregon historically had relied on Oregon Department of Human Services (ODHS) branch offices at the county level to authorize and arrange for NEMT. Providers billed the Division of Medical Assistance Programs (DMAP) directly and DMAP paid providers on a fee-for-service basis.

The concept for creating an NEMT brokerage was initiated by Tri-Met, the regional public transportation provider in Portland, in 1994. The program was viewed as a success and gradually was expanded to include the entire state. DMAP sought waives from CMS under both Section 1915(b) and Section 1115 to implement the program and codified it under the Oregon administrative code.

Under the Oregon brokerage model, DMAP enters into intergovernmental agreements with transit districts and councils of government to provide NEMT brokerage and direct services. The waivers enable DMAP to operate the program without consideration of client freedom of choice in providers.

Public brokers are responsible for arranging and paying individual contractors; in this program, DMAP is not required to adhere to the prohibition against broker self-referral, although some brokers never have served as transportation providers. DMAP pays the brokers a contracted rate per ride; the broker then negotiates rates with the service providers.

The brokerage provides more than 1.5 million rides annually at an overall cost of about $40.9 million per year. The average cost of an NEMT trip was reported to be $26.31.

DMAP outlines its NEMT business model as follows:

- Same contract agreement for all brokerages;
- Neutral public agency to manage regional services;
- Cost savings through lowest cost, most appropriate trip assignments;
- Ability to monitor overall system;
- Track costs and services regionally and statewide;
- Increased accuracy of client information;
- Customer service issues tracked and corrected through training and accountability;
- Consistent policies across entire state;
- Consistent billing practices across the state;
- Transportation provider monitoring (driver background and driving record checks, vehicle inspections, insurance and training);
- Timely payments to transportation providers;
- Statewide driver trainer for broker drivers; and
- Ability to implement new programs that increase client access, reduce costs and provide improved accountability.

After years of successful publicly operated regional brokerages, Oregon is about to embark on a new managed care delivery model. In this model, the MCO will have the authority to determine whether or not to use the existing network of brokers or to provide its own transportation.

While DMAP has been proactive in touting the benefits of its regional brokerage model, the MCO will be contractually bound to utilize these services. Thus, substantial changes may occur in the state; these changes will gradually be implemented beginning January 1, 2013.

Lessons. As shown in this report, there are multiple brokerage service delivery options that a state can elect to implement if it chooses this model. In this case, DMAP elected to replicate a successful demonstration model developed by a public transit provider, Tri-Met, and extended the model statewide, embracing and incorporating public transportation providers.

As noted earlier in this chapter, wholesale changes in the methods that states will use to deliver Medicaid services, such as coordinated, managed care systems, will affect NEMT/public transportation service coordination. As is evidenced by the Oregon example, states may not require managed care providers to use existing NEMT delivery networks. While DMAP actively touts the cost effectiveness of its brokerage program, these providers will be free to re-design NEMT services. It is likely that similar changes will be seen in other states. Thus, transit providers will need to develop relationships with a whole new class of businesses—managed care providers—if coordinated delivery of NEMT services is to be maintained.

CHAPTER 6 CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Summary

Analysis of any potential impact of the Affordable Care Act on public transportation is hindered by events that have transpired since passage—in particular, a U.S. Supreme Court decision that created a scenario whereby states could reject Medicaid expansion.

Historically, Medicaid has been the largest funding source among all human service agency transportation programs. States have continually been working to evolve their service delivery models to ensure that the "transportation assurance" has been met. Four basic models are currently in use: brokerages; fee-for-service models; managed care models; and mixed models that incorporate two or all of these approaches. The level of public transit coordination with these service delivery models ranges from full coordination to none.

The impacts of the ACA will be mitigated by the Supreme Court's decision to permit states to "opt out" of the law's Medicaid expansion provisions. In those states that elect to not participate, it is anticipated that there will be little impact on existing NEMT services. Moreover, the demographics of the states that have elected not to participate include the majority of projected newly eligible Medicaid participants; less than half of the original estimates made by CMS actually reside in states that will expand.

There are no known demand estimation tools that model the travel behavior of the newly eligible Medicaid population. A review of the literature indicates only a single work that has addressed transit demand estimation among human service transportation programs (*40*). Yet this demographic-based approach uses trip-making rates from traditionally eligible Medicaid clients, not the population that would become Medicaid eligible under the ACA.

A number of states have used waiver authority prior to 2012 to implement expansion of their Medicaid programs, including coverage of populations that are slated for inclusion in the ACA's Medicaid expansion. Experience from these states suggests:

1. There is consensus that the newly eligible population is more ambulatory than the traditional Medicaid population. Additionally, this population was cited as being capable of using fixed-route services, where available, to a greater extent than the existing Medicaid population.
2. There is general agreement by the waiver states that about 3% of the newly eligible population requires NEMT transportation. Traditionally, state Medicaid agencies have assumed that approximately 10% of the current Medicaid population requires transportation assistance.
3. While the Medicaid transportation assurance seems to be an accepted matter of law, a state will maintain flexibility under Medicaid expansion to request waivers, including waivers of the transportation assurance. The Centers for Medicare and Medicaid Services (CMS) appears to be willing to grant such requests (*i.e.*, the Missouri experience).
4. Several states have indicated that the primary NEMT need for the newly eligible population appears to be for individuals with chemical dependencies to substance abuse, mental health and/or treatment facilities.

Expansion in Medicaid in the participating states is estimated to generate 6.16 million newly eligible individuals. Based on the experience gleaned from waiver demonstration states documented in this synthesis, the newly eligible population is not as transit dependent as the traditional Medicaid population. Thus, it is projected that about 185,000 to 616,000 individuals in the newly eligible category will require NEMT. To meet this need, it is estimated that NEMT spending will need to increase by about $100 million per year (for the low estimate range).

While the impacts on direct service delivery are projected to be modest, other institutional changes in the way states will be encouraged to use coordinated care approaches in the Medicaid program may result in infrastructure changes at the state and local level that will impact existing NEMT delivery models. As seen in Oregon, a move to adopt managed care approaches in the Medicaid program as a whole may work to undermine the success regional brokerage model.

Additionally, transportation providers must be aware of the intense pressure from all quarters to reduce costs in the Medicaid program, including transportation. Increased use of capitated rate structures may be on the horizon. Additionally, transportation providers that are existing NEMT service

providers will be challenged to seek out lower cost means of delivery mobility.

Transportation providers should monitor state Medicaid plans, particularly with respect to any requested NEMT waivers. Based on the long legal history, many industry observers have concluded that the transportation assurance represents an irrevocable right to transportation. However, Medicaid clients could lose mobility if a state requests a waiver from NEMT in ACA implementation. Evidence suggests that CMS is willing to grant such waivers.

Suggestions for Future Research

Despite representing a significant funding source of human service agency transportation, there is a scarcity of data concerning a range of NEMT characteristics, including:

- Number of Medicaid eligible individuals who require NEMT, by Medicaid population and/or program segment;
- Method of NEMT service delivery (*e.g.*, mileage reimbursement, volunteer, bus pass for fixed-route, community transportation, etc.);
- Efforts to model NEMT trip-making, enabling state agencies to better estimate the costs of program and waiver decisions; and
- Impacts of NEMT from mode selection in broker managed programs.

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Appendix A GAO summary of programs with potential dual eligibility with ADA complementary paratransit programs.

No.	Agency	Department/Branch	Program	Popular Title of Authorizing Legislation	U.S. Code Provisions Authorizing Funds for Transportation
1	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Assistance for Education of All Children with Disabilities	Individuals with Disabilities Education Act Disabilities	20 U.S.C. § 1401(a)(22), 1411(a)(1)
2	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Centers for Independent Living	Workforce Investment Act of 1998	29 U.S.C. § 796f-4(b)(3) and 705(18)(xi)
3	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Independent Living Services for Older Individuals Who Are Blind	Workforce Investment Act of 1998	29 U.S.C. § 796k(e)(5)
4	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Independent Living State Grants	Workforce Investment Act of 1998	29 U.S.C.§§ 796e-2(1) and 705(18)(xi)
5	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Supported Employment Services for Individuals with Most Significant Disabilities	Workforce Investment Act of 1998	29 U.S.C. §§ 795g and 705(36)
6	DOE	Department of Education, Office of Special Education and Rehabilitative Services	Vocational Rehabilitation Grants	Rehabilitation Act of 1973, as amended	29 U.S.C. § 723(a)(8)
7	HHS	Department of Health and Human Services, Administration for Children and Families	Developmental Disabilities Projects of National Significance	Developmental Disabilities Assistance and Bill of Rights Act of 2000	42 U.S.C. § 15002, 15081(2)(D)

Typical Uses as Reported by Program Officials	Types of Trips as Reported by Program Officials	Target Population as Defined by Program Officials	Fiscal Year 2001 Federal Spending on Transportation
Purchase and operate vehicles, contract for service	To access educational services	Children with disabilities	No actual data or estimate available from the federal agency
Referral, assistance, and training in the use of public transportation	To access program services	Persons with a significant disability	No actual data or estimate available from the federal agency
Referral, assistance, and training in the use of public transportation	To access program services, for general trips	Persons aged 55 or older who have significant visual impairment	No actual data or estimate available from the federal agency
Referral, assistance, and training in the use of public transportation	To access program services, employment opportunities	Persons with a significant disability	No actual data or estimate available from the federal agency
Transit subsidies for public and private transportation (e.g., bus, taxi, and paratransit), training in the use of public transportation	To access employment placements, employment services, and vocational rehabilitation services	Persons with most significant disabilities	No actual data or estimate available from the federal agency
Transit subsidies for public and private transportation (e.g., bus, taxi, and paratransit), training in the use of public transportation	To access employment placements, employment services, and vocational rehabilitation services	Persons with physical or mental impairments	$50,700,000 (estimate)
Transportation information, feasibility studies, planning	General trips	Persons with developmental disabilities	No actual data or estimate available from the federal agency

(*continued on next page*)

Appendix A (Continued)

No.	Agency	Department/Branch	Program	Popular Title of Authorizing Legislation	U.S. Code Provisions Authorizing Funds for Transportation
8	HHS	Department of Health and Human Services, Administration for Children and Families	State Councils on Developmental Disabilities and Protection and Advocacy Systems	Developmental Disabilities Assistance and Bill of Rights Act of 2000	42 U.S.C. §15002, 15025
9	HHS	Department of Health and Human Services, Centers for Medicare & Medicaid Services	Medicaid	Social Security Act, as amended	42 U.S.C. § 1396a, 1396n(e)(1)(A)
10	HHS	Department of Health and Human Services, Substance Abuse and Mental Health Services Administration	Community Mental Health Services Block Grant	ADAMHA Reorganization Act, as amended	42 U.S.C. § 300x-1(b)(1)
11	DOL	Department of Labor, Employment and Training Administration	Work Incentive Grants	Workforce Investment Act of 1998, as amended	29 U.S.C. § 2801(46), 2864(d)(2)
12	DOL	Department of Labor, Employment Standards Administration	Black Lung Benefits Program	Black Lung Benefits Reform Act of 1977	30 U.S.C. § 923
13	DVA	Department of Veterans Affairs, Veterans Health Administration	Automobiles and Adaptive Equipment for Certain Disabled Veterans and Members of the Armed Forces	Disabled Veterans and Servicemen's Automobile Assistance Act of 1970	38 U.S.C. § 3902
14	DVA	Department of Veterans Affairs, Veterans Health Administration	Veterans Medical Care Benefits	Veterans' Benefits Improvements Act of 1994	38 U.S.C. § 111

SOURCE: U.S. General Accounting Office, *Transportation-Disadvantaged Populations: Some Coordination Efforts Exist Among Programs Providing Transportation Services, but Obstacles Persist,* GAO-03-697, Washington, D.C. (June 2003).

Typical Uses as Reported by Program Officials	Types of Trips as Reported by Program Officials	Target Population as Defined by Program Officials	Fiscal Year 2001 Federal Spending on Transportation
State Councils provide small grants and contracts to local organizations to establish transportation projects or collaborate in improving transportation for people with disabilities; Protection and Advocacy Systems ensure that people with disabilities have access to public transportation as required by law	All or general trips	Persons with developmental disabilities and family members	$786,605 (partial outlay)
Bus tokens, subway passes, brokerage services	To access health care	Recipients are generally low income persons, children, and persons with disabilities, but states determine specific eligibility	$976,200,000
Any transportation related use	To access program services	Adults with mental illness and children with emotional disturbance	No actual data or estimate available from the federal agency
Encourage collaboration with transportation providers	To access one-stop services	Persons with disabilities who are eligible for employment and training services	No actual data or estimate available from the federal agency
Mileage reimbursement, transit fares, taxi vouchers	To access health services	Disabled coal miners	No actual data or estimate available from the federal agency
Purchase of personal vehicles, modifications of vehicles	General trips	Veterans and service members with disabilities	$33,639,000
Mileage reimbursement, contract for service	Trips to access health care services	Veterans with disabilities or low incomes	$126,594,591

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