NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES MANAGEMENT REPORT
S.L. 2012-142, Section 10.7

REPORT TO THE

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

AND THE

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON TRANSPORTATION

State of North Carolina
Department of Health and Human Services
Division of Medical Assistance

October 2012

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EXECUTIVE SUMMARY

Section 10.7 of SL 2012-142 directed the Department of Health and Human Services, Division of Medical Assistance (DMA), in consultation with the Department of Transportation (DOT), Public Transportation Division, to develop and issue a Request for Proposal (RFP) for the management of nonemergency medical transportation (NEMT) services for Medicaid recipients.

Prior to contracting with a vendor to provide NEMT, the Departments are to report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Transportation. The report is to contain an analysis of nonemergency transportation brokerage services implemented in other states; an assessment of the current coordination of human services transportation within North Carolina and the potential impact of brokerage services on transit system funding and operations; and a cost-benefit analysis of implementing a statewide NEMT brokerage model for Medicaid recipients.

I. GENERAL INFORMATION

Federal regulations require that the state Medicaid programs ensure that recipients have necessary medical transportation to and from covered Medicaid services (42 CFR 431.53). "Necessary" means no other appropriate transportation resources are available to the recipient. In addition, federal rules compel states to operate the Medicaid program efficiently, economically and in a manor that is conducive to quality care (1902(a)(4) and 1902(a)(30) of the Social Security Act). Therefore, states must use the least expensive mode of transportation available that is appropriate for the recipient and transport the recipient to the nearest qualified provider. NEMT is limited to only those services that are covered by Medicaid.

States are given the choice of classifying NEMT expenditures as either an optional medical service expense or as an administrative service. If the optional medical service classification is chosen, uniformity of service, consumer freedom of choice of provider and direct payment of vendors is required. Under an optional medical service, NEMT expenses are matched by the federal government at the federal medical assistance percentage (FMAP) rate.

North Carolina chose the administrative option. Under this option, expenses are matched by the federal government by 50% instead of the higher Federal Medical Assistance Percentage. The administrative service option historically allowed more flexibility because freedom of choice requirement does not apply and it is not necessary to enroll vendors as providers. However, as a result of Section 1902 (kk)(7) of the Social Security Act, passed in March 2011, federal regulations require that all ordering or rendering providers must be enrolled directly with the Medicaid agency.

The Deficit Reduction Act of 2005 (DRA) provided a third option which allows states to limit freedom of choice through a brokerage program while classifying NEMT as an optional medical service (1902(a)(70) to the Social Security Act). This allows states to obtain federal contributions for NEMT at the higher FMAP rate.

In North Carolina, the 100 county departments of social services, acting as the lead coordinating transportation agent for DHHS, are responsible for NEMT. Counties assess the recipients' need for transportation assistance and arrange for transportation to and from providers. NEMT assistance may be provided by volunteers, gas voucher or mileage reimbursement, bus pass, or contracted transportation. Each county enters into contracts with vendors to provide NEMT and, in some cases, to administer it as well. Rates are set by negotiation between counties and vendors.

The Centers for Medicare and Medicaid Services conducted a Compliance Review of NEMT in 2008 and in 2011. On both occasions, DMA was cited for inadequate oversight of the NEMT program. The Compliance Reviews resulted in corrective action plans. A DMA Quality Assurance (QA) audit in 2007 and a 2011 desk review revealed consistent problems, such as:

- Recipients not receiving a Medicaid covered service at the trip destination;
- Individuals not eligible for Medicaid at the time of the trip;
- Recipients not assessed for transportation assistance eligibility;
- Recipients not provided notice that a request for transportation assistance was denied;
- No evidence that the vehicle transporting the recipient was covered by liability insurance.

In order to address both CMS' concerns and the problems uncovered by the DMA QA review, in August of 2011 DMA entered into a collaborative process with stakeholders throughout the State to reform NEMT policy. Stakeholders included county DSS directors, county transportation supervisors, NC DOT, North Carolina Association of County Commissioners (NCACC) and the North Carolina Public Transportation Association (NCPTA) representing transportation providers. The stakeholders group was charged with developing a comprehensive, state-wide corrective action plan. The plan goals were cost and error rate reduction, policy reform and improved communication. This collaboration produced a thorough revision of transportation policy which was published January 1, 2012. The revised policy includes requirements for documentation of trips from request through completion, self-audits of 2% of all trips each month and maintenance of a transportation file containing the above documentation as well as driver/vehicle credentials.

At the recommendation of the Stakeholders group and the North Carolina Department of Transportation Public Transportation Division (NC DOT-PTD), DMA entered into a contract with KFH Group, the firm that performs compliance reviews for the NC DOT, to perform an NEMT compliance review in all 100 counties. KFH completed reviews of 25 counties by August 14, 2012 and is scheduled to have all 100 counties completed by January 2013. These performance reviews measure county compliance with the revised policy.

II. Analysis of Nonemergency Medical Transportation Brokerage Services in Other States

Approximately 40 states currently employ brokers[1] to administer all or part of their NEMT programs. There are significant variations in the brokerage models employed by different states. These models include: a single statewide broker; a regional brokerage program with each region comprised of multiple counties; county level brokerage programs, and programs that have a mixed broker and fee for service system. The brokers can be for profit or not-for-profit entities or governmental agencies.

In preparation for this report, DMA requested the National Association of Medicaid Directors survey its members using a series of questions prepared by DMA (Appendix B). Of the 51 members, 21 states and the District of Columbia responded. DMA also sent questions to the "Medi-tators" group, which reaches all of the state and the District of Columbia Medicaid policy chiefs. In addition, DMA directly contacted six state programs and received extensive information on their NEMT programs. Two out-of-state transportation system representatives added their insights into brokerage systems. Many North Carolina County Directors of Social Services and public transit systems provided information as well. Finally, an internet search was conducted which produced several studies on NEMT brokerage systems.

State-level Governance and Program Performance Evaluation

Several of the states contacted by DMA emphasized the importance that appropriate transportation software plays in the performance and oversight of a brokerage system.[2] Software and technology can help to manage reservations, scheduling and real-time dispatching. Software can automatically calculate mileage and assign to the closest provider and cut down on staff time. Having provider friendly software is a good selling point to keep smaller vendors involved in the program.[3]

Software can provide data on the number of calls placed, the number of calls abandoned, the average time it takes to answer calls, the average talk time, the number of trips scheduled, the number of trips cancelled, and denials. Software can generate trip summary reports, no-show reports and log and categorize complaints. Brokers can be required to submit monthly encounter data reports. The data provides management staff with information to improve service.[4] In addition the state can require that all call center phone calls be recorded.[5]

The same software packages provide claims management which can track provider reimbursement and issue reports for audit purposes. Billing features can produce reports on performance, utilization and resource management.

Performance bonuses and penalties can be built into contracts. Bonuses saved the state of Washington $300,000 in one quarter at the cost of $23,000 in bonus payments.[6]

Assignment of Geographic Regions

States that have broker systems rely on a variety of factors in determining the number of regions to employ. Factors include geography; the extent existing social service transportation is coordinated, health care catchment areas, the influence of not-for-profit organizations and HMO contracts which include the provision of NEMT.

Some states have only one region with one broker covering the entire state. Others have divided the state into multiple regions. For example, a relatively small state like Arkansas has twelve (12) regions, Washington has thirteen (13) regions, Wisconsin has two (2) and Mississippi has one (1). One or two large regions may mean that call centers will be centralized and less in touch with local geography and medical providers[7]. On the other hand, having a number of regions can lead to coordination problems between brokers.[8]

Factors for North Carolina to consider in determining the number of possible regions in which to divide the state include the state's unique geographical features, areas of expected population growth, Council of Governments areas, the existence of coordinated social service transportation and the extent of coordination among public transit systems.

Quality of Transportation Service Delivery and Recipient Access

South Carolina and Wisconsin have brokered systems and reported that service complaints comprised less than 1% of all trips[9]. Washington recommended avoiding a single broker system because, in their view, single brokers with large call centers have frequent turn over of personnel and poor customer service[10]. Washington felt that it is important for call center workers to be familiar with the region's geography and providers[11]. Each of Washington's eight brokers has its own call center.

Accuracy of Eligibility Determinations

Washington reported that a capitated payment model can result in the broker discouraging usage to eligible recipients[12]. However, Virginia checks encounter data to make sure the broker is not improperly denying tips or eligibility[13]. Wisconsin requires the broker to follow a script created by the state for the purposes of eligibility screening[14]. The Wisconsin policy is supported by requiring the broker to record all calls.

Pricing Models

There are two payment methods for brokered NEMT: 1) capitated payment and 2) fee-for-service. A capitated model may also include a reconciliation process or risk sharing[15]. A fee-for-service structure may also include a cap on administrative costs. Rate structures may also be tiered. For example, Wisconsin has a three tier rate: one rate for the Aged, Blind and Disabled population (frequent users); a second rate for children; and a third for other adults (least frequent users). A tiered rate prevents the state paying from paying a higher rate when population shifts to a lower usage group.[16]

The capitated payment method provides the state with a known cost for the duration of the contract puts the risk of fluctuating costs on the broker and encourages efficiencies and improved coordination. The disadvantage of this payment method is that the broker could have an incentive to cut costs by reducing service and/or lowering fees paid to vendors[17]. In addition, a capitated payment model tends to exclude smaller brokers because of the risk factor[18].

Fee-for-service assures adequate payment to vendors, but puts the risk of increases in usage on the state. States that operate fee-for-service programs "benefit from strong front-end screening processes to ensure appropriate utilization of services and effective review of provider claims to limit opportunities for fraud and abuse."[19]

Contract Structure

There is variation among states in the extent to which NEMT administration is contractually assigned to the broker. Functions that may be contractually assigned to the broker include: establishing a network of vendors and volunteers; making recipients aware of the existence of the NEMT program and how to access it; operating a call center, assessing recipient's need for NEMT; verifying eligibility on date of transport; selecting the least expensive appropriate means of transport; providing transit passes, gas reimbursement or assigning the trip to a vendor; and tracking and reporting utilization, costs and complaints. As a rule, the broker is assigned all of the functions.[20]

Various quality assurance measures can be built into broker contracts. Common provisions include metrics related to client satisfaction, wait-time, on-time performance, incident frequency and vehicle maintenance. Client satisfaction surveys can be employed using criteria to measure on-time performance, vendor "no shows", driver courtesy, trip time, and vehicle condition. Contracts may also allow for periodic unannounced on-site inspections.

Cost of Service

The following is a summary of the cost of NEMT from SFY 2007 – 2012 and projected costs for SFY 2013 – 2015.

SFY	Annual NEMT Recipients	Total $	Federal $	State $	PMPM (Medicaid Eligible Population)	Annual Cost Per NEMT Recipient*
2007	72,787	38,223,180	24,403,125	13,820,056	2.63	43.76
2008	74,639	39,983,557	25,494,777	14,488,780	2.68	44.64
2009	80,153	46,082,200	32,536,068	13,546,133	2.87	47.91
2010	85,147	51,907,228	38,445,330	13,461,898	3.05	50.8
2011	87,926	52,841,556	38,227,265	14,614,292	3	50.08
2012	91,928	54,090,353	35,079,336	19,011,017	2.94	49.03
Total	492,580	283,128,074	194,185,900	88,942,174	2.87	47.9

	Forecasted Expenditures				
SFY	**Total**	**Federal**	**State**	**PMPM**	**Cost Per NEMT Recipient**
2013	**55,678,171**	**36,441,363**	**19,236,808**	**2.90**	**48.28**
2014	**57,312,599**	**37,545,484**	**19,767,116**	**2.85**	**47.53**
2015	**58,995,006**	**38,647,629**	**20,347,378**	**2.81**	**46.80**

Forecasted expenditures for the next three years under the existing North Carolina system

***Note:** PM/PM is based upon Medicaid eligible population. Cost per NEMT recipient is based upon an estimated 6% usage of NEMT services in NC. Of states that have brokered systems and provided PM/PM costs to DMA (Appendix A), the PM/PM costs ranged from $1.02 to $105.00[21]. PM/PM is a variable figure which depends upon the size of a state's Medicaid population and the percentage of that population which utilizes NEMT. Cost per trip is a more accurate comparative metric of system costs. However, North Carolina only began gathering this data in January of 2012 and therefore cannot currently quantify these costs.

III. Assessment of the Current Coordination of Human Services Transportation within North Carolina and the Potential Impact of Brokerage Services on Transit System Funding and Operations

NEMT is a component of the coordinated transportation system. The coordinated model was developed as a result of Executive Order # 78 in 1991 (rescinded and replaced by Executive Order 21 in 2002) which established the North Carolina Human Service Transportation Council that provides policy recommendations to the Department of Health and Human Services (DHHS), Department of Transportation (DOT), and other state agencies. The Council is tasked with enhancing the coordination and delivery of

human service transportation services in the safest, most cost-effective, efficient and customer-focused means possible.

Under the coordinated model, transportation services are provided by utilizing an array of funding sources, including the Community Transportation Program (CTP), Rural Operating Assistance Program (ROAP), Elderly and Disabled Transportation Assistance Program (EDTAP) contractual fees for services and rider fares.

A coalition of statewide stakeholders including DSS Directors, the North Carolina Association of County Commissioners (NCACC), North Carolina Public Transportation Association (NCPTA), worked with DMA for nearly a year to improve the current coordinated model. In many regards, the Stakeholders Group served the role of the coordinating council as directed in Executive Order 21. Responding to the audit findings and in support of the coordinated model, new policies and procedures were implemented to effect cost savings measures, reporting improvements, and uniform use of technology throughout the state. Compliance reviews were initiated as part of the Stakeholders Group activities. This included sharing of current data collection technologies that manage reporting of trips, vehicle maintenance, safety plans, training requirements, and drug and alcohol screening currently in place by NCDOT grantees.

According to the federal interagency initiative United We Ride, North Carolina is recognized as having one of the finest coordinated transportation systems in the country.[22]

Potential Impact of NEMT Broker on Coordinated Transportation Model

-- Coordinated System at Risk. For nearly 35 years, the coordinated model of public and human service transportation has served millions throughout the state. Section 10.7 of SL 2012-142 provides only for a management system/broker for the NEMT program and not for the current coordinated systems. The loss of Medicaid participation would result in each agency having to buy its own vehicles, and pay for its own operating expenses, including maintenance, gas, and hiring drivers. In addition, the agencies would be unable to realize the benefit of sharing trips and keeping their overall fully allocated costs down. State funding that currently supports these coordinated systems would diminish and result in rising costs for other agencies, such as those that serve the aging and mentally ill. Further, the use of Elderly and Disabled Transportation Assistance Program (EDTAP) funds would not serve as many passengers since there would be less shared trip costs.

-- Loss of Years of Investments. The long-term investment of dollars, training, resources, and coordination with human service entities are jeopardized if a statewide broker-model is identified as the only option for the delivery of NEMT services in the State. The quality of service, safety and mobility of seniors and the disabled population would also be placed at risk. More state, and possibly county, funds would be needed to maintain human service transportation or less of these citizens will be able to access services because they can no longer afford the higher costs.

-- Fragmentation/Shed Effect. Several area transit systems, NCPTA, NCACC and county commissioners have expressed concern about the impact an NEMT broker will have on the existing coordinated transit system model[23]. Underlying this concern is the belief that a broker will not assign trips to the coordinated transportation providers at numbers equivalent to current usage; and that trip numbers will become more unpredictable leading to a lack of market control. The following is representative of the expressed concerns:

Fragmenting of services by provider (Medicaid) will take a greater number of transportation resources from the system, to move a much smaller group of individuals causing the utilization rate to decline. This decrease in overall efficiency will also result in an overall increase in fees for services to compensate for the loss of clients and efficiency. This fragmentation would also have the same effect on clients from other agencies, causing an increase in contracted rates, doing away with the concept of the shared mile rate and most importantly, demand response clients that will see a decline in service availability if contractual services were eliminated in that particular area..[24]

Many users have transportation services funded by multiple agencies such as an individual that may be a Medicaid recipient, receive services from Senior Services under EDTAP as well as services funded by the HCCBG program. Removing Medicaid clients from this consolidated system would create user confusion, loss of efficiency, and most importantly, deconsolidation of a system that we have spent five years building.[25]

IV. Cost-benefit Analysis of Implementing a Statewide NEMT Brokerage Model for Medicaid Recipients

Advantages of NEMT Broker

- **Improved Oversight of NEMT**
  Currently the 100 counties separately administer NEMT, with each county having contracts with from one to several vendors. Having 100 brokers makes it extremely difficult for the state to ensure that NEMT policy is being applied uniformly and that quality of service is consistently maintained. A brokered system would greatly reduce the contact points between the state and the brokers and therefore allow greater oversight.

  In addition, a broker would be expected to provide the state with monthly encounter data and claims management reports which will allow for greater quality assurance and program integrity monitoring.

- **Reduced Program Costs**
  Some brokers use software which allows them to map which vendor is best suited to transport the Medicaid recipient given the recipient's location. This can reduce the miles travelled by the vendor which will result in shorter trips for and allow the vendor to fit more trips into each day. States that have switched from fee for service to a broker model have experienced savings.[26]

- **Fixed Costs**
  A capitated broker contract would put the risk of increased usage on the broker and provide the state more predictability for its NEMT costs.

- **Improved Access to Care**
  A 2009 study examined the effects of implementing transportation brokerage systems in Georgia and Kentucky and found that there were reductions in hospitalizations by children and ambulatory care sensitive admissions by diabetic adults, suggesting improved health outcomes.[27]

Risks of NEMT Broker

- **Hidden Costs**
  The initial start-up cost as well as the administrative services within the contract may be too high to find economies of scale for programs with a low number of NEMT trips. Transition costs may be extensive and possibly disruptive. In addition, DMA will still be required to manage brokers for quality assurance. This monitoring function may require as much administrative DMA staff time to ensure cost-effective implementation as other types of administration.[28]

- **Reduction in Service**
  Capitated contracts could create an incentive for the broker to deny services to recipients. In addition, capitated contracts could provide brokers the incentive to reduce overhead by paying vendors less. Reduced payments may lead to vendor unwillingness to continue providing NEMT or business failure and cause service disruptions.[29]

  Numerous complaints about clients not being picked up for their trips to essential medical therapies such as dialysis have been consistently reported in states like Wisconsin, Michigan, Florida and under-documented by brokers throughout the country.[30]

- **Reduction in Service Quality**
  Due to the cost cutting incentive, brokers tend to hire small vendors that do not maintain their vehicles properly.[31] Further a centralized call center may be less in touch with local geography and medical providers.[32]

- **Negative Impact on Other Social Service Transportation**
  Reductions in Medicaid participation in coordinated social service transportation systems may lead to higher costs for other social service transportation customers.[33]

- **Woodwork Effect**
  Kansas note that the shift to a broker resulted in a widespread utilization increase due to increased recipient awareness of the availability of NEMT due to broker outreach.[34]

Footnotes

1. An "NEMT broker" is an entity with which the state contracts to provide services ranging from the management of the administrative task of screening transportation requests to the management of the full scope of NEMT services.
2. Bob Knox and Bill Zieser, Virginia Department of Medical Assistance; Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program; Mickey Rendok, Illinois Medicaid program.
3. Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program.
4. Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program.
5. Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program.
6. Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
7. Ibid.
8. Bob Knox and Bill Zieser, Virginia Department of Medical Assistance.
9. South Carolina reports that complaints represent less than 1% of all trips. Wisconsin reports that the brokered system is 99.7% complaint free (counting both substantiated and unsubstantiated complaints).
10. Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
11. Ibid.
12. Ibid.
13. Virginia has one broker covering one region and 6 MCOs covering the other region.
14. Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program.
15. Non-Emergency Medical Transportation Study Report, The Hilltop Institute, 9/26/2008. Nevada incorporated a "risk corridor" into its broker contract. Under this arrangement, if actual costs are more than two percent below expectations, the broker fully refunds all savings above two percent; if the costs exceed expectations by more than five percent, the state pays the broker 50 percent of cost above five percent. Missouri HealthNet NEMT Review Final Report, The Lewin Group, February 25, 2010.
16. Rob Thomas-Implementation Manager and Dave Stepien-Benefit Chief, Wisconsin Medicaid program.
17. Non-Emergency Medical Transportation Study Report, The Hilltop Institute, 9/26/2008; Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
18. Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
19. Non-Emergency Medical Transportation Study Report, The Hilltop Institute, 9/26/2008.

20. Non-Emergency Medical Transportation Study Report, The Hilltop Institute, 9/26/2008.
21. National Association of Medicaid Directors Survey, September 28, 2012; Medicaid Non-Emergency Transportation: Three Case Studies, National Consortium on the Coordination of Human Service Transportation (2002); Iowa Department of Health and Human Services Presentation to the Health and Human Services Appropriations Committee, February 2, 2011; Iowa Medicaid Non-Emergency Medical Transportation System Review and Options for Improvements, University of Iowa Public Policy Center (9-30-2008); Oregon "Brokerage Metrics 2012-09"; Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
22. United We Ride, http://www.unitedweride.gov/1_267_ENG_HTML.htm.
23. David Thompson, Executive Director, Association of County Commissioners, September 21, 2012 Letter to DOT Secretary Eugene Conti; Bjorn Hansen, Project Manager, Centralina Council of Governments, August 15, 2012 Letter to DHHS Secretary Delia and DOT Secretary Conti; Don Adams, Alleghany County Manager, September 18, 2012 Letter to DHHS Secretary Delia; Mandy Stone Health and Human Services Director/Assistant County Manager, Buncombe County, September 14, 2012 Letter to DHHS Secretary Delia; Mike Lovett, Director, Greene County Transportation, Letter to DHHS Secretary Delia; Tony Brown, County Manager, Halifax County, September 20, 2012 Letter to DHHS Secretary Delia; Chris Harper, Lenoir County Transit Director, September 18, 2012 Letter to DHHS Secretary Delia; Onslow United Transit System Letter to DHHS Secretary Delia; Megan Roberts Odell, Director of Transit Services, Aging, Disability & Transit Services of Rockingham County, September 18, 2012 Letter to DHHS Secretary Delia; Scotland County Area Transit System Letter to DHHS Secretary Delia; David Whitson, Assistant County Manager, Henderson County, September 20, 2012 Letter to DHHS Secretary Delia; Rick Hester, Johnston County Manager, Letter to DMA.
24. Megan Roberts Odell, Director of Transit Services, Aging, Disability & Transit Services of Rockingham County September 18, 2012 Letter to DHHS Secretary Delia; Onslow United Transit System Letter to DHHS Secretary Delia.
25. Megan Roberts Odell, Director of Transit Services, Aging, Disability & Transit Services of Rockingham County September 18, 2012 Letter to DHHS Secretary Delia.
26. Medicaid Non-Emergency Transportation: Three Case Studies, National Consortium on the Coordination of Human Service Transportation (2002); Non-Emergency Medical Transportation (NEMT) Brokerage: Regional Set-up Examples, Land of Sky RPO (July 6, 2011).

27. Kim, J., Norton, E. C., Stearns, S. C. (Feb. 2009) "Transportation brokerage services and Medicaid beneficiaries' access to care." *Health Services Research* 44(1): 145-61, as quoted in Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends and Implications for Health Reform, George Washington University Department of Health Policy.
28. Linda Wallace, Executive Director, NC Public Transportation Association.
29. Ann Gilbert, Director of the Arkansas Transit Association.
30. Linda Wallace, Executive Director, NC Public Transportation Association.
31. Ann Gilbert, Director of the Arkansas Transit Association.
32. Paul Meury, Medical Transportation Program Manager, Department of Social and Health Services, Washington State.
33. Connie Garber, Transportation Director, York County Community Action Corporation, York County, Maine; David Thompson, Executive Director, Association of County Commissioners, September 21, 2012 Letter to DOT Secretary Eugene Conti; Bjorn Hansen, Project Manager, Centralina Council of Governments, August 15, 2012 Letter to DHHS Secretary Delia and DOT Secretary Conti; Don Adams, Alleghany County Manager, September 18, 2012 Letter to DHHS Secretary Delia; Mandy Stone Health and Human Services Director/Assistant County Manager, Buncombe County, September 14, 2012 Letter to DHHS Secretary Delia; Mike Lovett, Director, Greene County Transportation, Letter to DHHS Secretary Delia; Tony Brown, County Manager, Halifax County, September 20, 2012 Letter to DHHS Secretary Delia; Chris Harper, Lenoir County Transit Director, September 18, 2012 Letter to DHHS Secretary Delia; Onslow United Transit System Letter to DHHS Secretary Delia; Megan Roberts Odell, Director of Transit Services, Aging, Disability & Transit Services of Rockingham County, September 18, 2012 Letter to DHHS Secretary Delia; Scotland County Area Transit System Letter to DHHS Secretary Delia; David Whitson, Assistant County Manager, Henderson County, September 20, 2012 Letter to DHHS Secretary Delia; Rick Hester, Johnston County Manager, Letter to DMA.
34. The Incentive Effects of Organizational Forms: Evidence from Florida's Non-Emergency Medicaid Transportation Programs, Southern Illinois University, July 1, 2007; Missouri HealthNet NEMT Review Final Report, The Lewin Group, February 25, 2010.

APPENDIX A

Information provided in part by the Medi-tators, a List-Serve for State Medicaid eligibility officials.

State	Broker	Date	Regions	No. Brokers	Payment Type	PM/PM	Recommendations
AL	RFP 7/12				Capitated		
AK	Yes				Fee for Service	33.30	
AR	Yes	2002	12	9	Capitated	6.04	
CT	Yes				Capitated		
DC	Yes				Capitated	22.08	
DE	Yes	2002			Capitated	6.04	
GA	Yes	1997	5	2	Capitated		
ID	Yes		1	1		7.04	
IL	mixed				Fee for Service; HMOs Capitated	60.28	Broker IT experience more important than management experience. Fee for service offers state more control; provides better consumer outreach.
ID	yes	2010	1	1	Capitated	7.04	
IA	Yes	2010			Capitated		
KS	Yes	2009	1 + MCOs		Capitated		
KY	Yes			11	Capitated	5.83	
LA	No					20.55	
MI	Yes				Fee for Service		
MT			13	6			
NJ					Capitated	8.86	
NV	Yes	2003	1	1	Capitated	3.3	
OK	Yes	2003	1	1	Capitated	3.73	
OR	Yes	2003	8		fee for service	6.34	
PA					Capitated	80	
SC	Yes	2007	2		Capitated		
SD	No					7.21	
TX	Yes				Capitated		
UT	Yes					1.04	
VA	Mixed	2001	2	7	Capitated	20	The right software can automatically calculate mileage and assign to the closest provider and cut down on staff time. When choosing a broker, determine if they previously have been a provider. Do an internet search to check on brokers.
VT	Yes				Capitated	105	
WA	Yes		13	8	Fee for service; Capitated admin fee	6.5	Avoid Capitated payment model as it leads to broker discouraging usage and squeezing vendors. Avoid single broker system b/c single call center = bad customer service. Single broker gives broker too much power.
WI	Mixed, but going to entirely brokered system	2011	2		Capitated, three tiered rate		Collaborate with the Indian tribes; outreach to stakeholders and advocacy groups; find collaborative efforts.
WV	No						

APPENDIX B

Non-emergency Transportation in Medicaid (2)
October 11, 2012

NAMD fielded this survey on behalf of North Carolina about non-emergency transportation (NEMT) services in Medicaid. For questions or if you would like to add your states' responses to this summary, contact Abby Kahn [abby.kahn@namd-us.org].

NAMD also fielded a survey in June 2012 about NEMT services. You can download the previous survey results from NAMD's states-only website here: http://medicaiddirectors.org/node/436.

Summary

21 states, including Alaska, Arkansas, California, Connecticut, Idaho, Illinois, Kentucky, Louisiana, Michigan, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, Pennsylvania, South Dakota, Texas, Vermont, Virginia, Washington, and West Virginia, and the District of Columbia responded to the survey.

How many NEMT trips were provided in your state during the last fiscal (or contract) year?

0-100,000 trips:

- AK—58,756 (SFY 2012)
- SD—27,791 (SFY 2012)

100,001-1,000,000 trips:

- LA—624,900 (SFY 2011-2012)
- MI—331,415 (Jan - June 2012)
- NE—491,808 (Contract year 1: May 2011 - April 2012)
- NV—599,178 (SFY 2012)
- OK—824,838 actual transports (SFY 2011-2012)
- VT—276,843 (FY 2012)

Over 1,000,000 trips:

- CA—3,039,578 (FY 2011/2012)
- DC—1,266,271 (FY 2011/2012)
- ID—1,197,226 (SFY 2011-2012)
- IL—3,677,810 based on prior approvals issued (FY 2012)
- NJ—5,100,103 (SFY 2012)
- PA—11,468,394 (FY 2010/2011)
- TX—over 10,000,000 one-way trips (FY 2011)
- VA—4,000,000 (FY 2012)
- WA—2,900,000 (2011)

Other:

- KY—Approximately 255,784 per month (2012)

What is your per member per year cost for NEMT?

$0-100 per member per year: 5 states

- ID—$84.48
- KY—Approximately $70
- NV—$39.60 per year (capitation of $3.30 PMPM * 12 mos.)
- SD— $86.58
- WA— The best current estimate is $6.50/month or $78/year.

$101-$1000: 7 states and DC

- AK—$399.68
- DC—Cost for ID/DD enrollees is approximately $7,500 per member per year. Cost for non-ID/DD waiver enrollees is approximately $265 per member per year.
- IL— $723.40. (Information based on transportation approval data from First Transit Inc, not claims paid by IL Medicaid).
- LA—$246.64
- NJ—$106.31 (This is low in comparison to trips, and it is not a good indicator of costs. Cost per trip is a better indicator.)
- PA—$960
- VA— $240 ($72 million divided by 300,000 members)
- VT—$1259.39 for FY12

Other:

- CA—In 2005, out of an annual budget of $22 billion, less than $100 million (2/5 of 1%) was spent on NEMT.
- OH—Ohio Medicaid handles NEMT under three main administration/payment systems.
- OK—Blended rate (TANF and ABD) is average of $3.73 per member
- WV— Total cost = $22,846,997

How many call centers does your state have for NEMT?

1 call center: 9 states—ID, IL, LA, NE, NJ, OK, PA, SD, and VA

More than 1 call center: 11 states—AK, AR, CA, CT, KY, MI, NV, TX, VT, WA, WV - and DC

- AK—1 prior authorization call center operated by the fiscal agent and 1 travel booking call center operated by broker.
- AR—Each region has a call center, unless a broker's regions are contiguous, so about 6 call centers.
- CA—The state has 2 call centers for all services; one for providers and one for beneficiaries.
- DC—The broker has a local call center during business hours and regional call center for after hours calls.
- MI—Each county office acts as a call center, as does LogistiCare in Oakland, Macomb, and Wayne counties.
- NV—3, but all recipients call the same number. There are additional centers to cover high volume.
- TX— Texas has 4 state-operated call centers and 2 operated by the brokers.
- WA—6 brokerage agencies run call centers, serving the 13 contract regions.
- WV—The state has 3 customer/client service call centers for general inquiry, none are dedicated exclusively to NEMT.

Does your state use a broker for any/all NEMT services?

Yes: 15 states—AK, AR, CT, ID, KY, MI, NJ, NE, NV, OK, PA, TX, VA, VT, WA - and DC

- WA—As defined in our State Plan, the NEMT book of business includes both fee for service and managed care clients.

No: 5 states—CA, IL, LA, SD, and WV

- IL—Note that the information contained in this survey does not include information from the managed care delivery systems. Illinois has three managed care delivery systems: Integrated Care Program (ICP), Primary Care Case Management (PCCM), and Voluntary Managed Care (VMC).
- LA—The Department has contracted with First Transit, Inc. to authorize and schedule NEMT Statewide.

If your state uses a mixed system (part brokered and part not), what other entity or entities provide NEMT?

- LA—The Department also provide NEMT to clients enrolled in the Bayou Health Program as well. Bayou Health is a Managed Care Program. The selected health plans have subcontracted with three (3) dispatch companies to authorize and schedule NEMT.
- MI—County Department of Human Services offices
- PA—Local transit systems and human service agencies
- TX—Texas authorizes all transportation services outside the broker areas. In these areas, regional contracted brokers administer demand response services; the State administers all other services.

If your state is divided into different regions for NEMT brokerage purposes, how are the regions organized?

By geographic considerations: 6 states

- AR—10 regions
- CT—5 regions
- KY—12 regions
- LA—Transportation providers provide NEMT by parish throughout the state.
- MI—3 SE Michigan counties and the rest of the state on a county basis
- VA—7 regions (In the current contract, regions are optional)

By geographic considerations AND health care usage patterns:

- WA—The 39 counties in this state are organized into 13 brokerage regions. Before each procurement, the Washington State Department of Health is contacted to determine if patient movement patterns have changed.

By geographic considerations AND public transit service area:

- TX—2 regions for brokers, 22 other regions
- VT—7 regions

If your state uses a broker system, what pricing model is employed?

Capitated: 11 states—AR, CT, ID, KY, NJ, NV, OK, PA, TX, VA, and VT-and DC

FFS: 4 states—AK, MI, NE, and WA

- WA— The state negotiates with the broker to set a fixed monthly administrative payment amount, while the service cost is a pass through, since the brokers are not allowed to perform any of the trips themselves.

Other:

- NJ—The state will treat the future broker in same manner as MCOs, setting rates by cost annually.

What performance measures have you put into your broker contract?

- AK—USTravel will conduct a quarterly survey of customer satisfaction to a statistically valid sample of Medicaid recipients who utilized travel in the previous quarter. Respondents will indicate at least an 80% satisfaction level with travel plans, response times, phone system use, and agent friendliness.
- AR—On time performance, complaints, and average travel time
- CT—Class A & B sanctions
- DC—Number of complaints per trip leg, pick-up and delivery standards, automated call distribution system, and client satisfaction survey
- ID—Transportation network providers must meet the requirements outlined in the contract; contractor verifies all transportation network providers' claims to authorized trips; pay transportation network providers at least monthly; contractor maintains a call center to assure the daily average hold time for callers does not exceed two minutes; Department may perform random testing of the call center as part of a quality assurance process; and the contractor's Data Tracking and Utilization Information System provides the data required for the reports requested by the Department.
- NE— The broker is held accountable for the ongoing monitoring, evaluation, and actions as necessary for improvement to ensure access for program eligible clients for necessary NET services. The broker is held accountable for the quality of NET services delivered including the appropriateness of NET services. The State's quality assessment and improvement criteria consist of internal monitoring of the broker and reports submitted to the State on multiple aspects of the brokerage services. This includes, but is not limited to the customer call center, complaints, appeals, provider compliance audits, and post payment audits.
- NJ—Note these were recently revised from the contract: call abandonment rate not to exceed 5%; avg monthly speed to answer 45 seconds; percent of calls answered with 2 minutes not to fall below 95%; complaints not to exceed 0.5% of trips; on time performance(not more than 30 minutes late) not to fall below 95%; and provider no show not to exceed 0.04% of unduplicated trips.

- NV—Monthly statistical reporting; customer satisfaction surveys; monitor and report on ride destination (i.e. must be to and from a medical transportation); Network adequacy (enough drivers and vehicles); responsible for all subcontractor actions; annual vehicle inspections; statewide access to transportation, even in rural and frontier areas; must use least expensive form of transportation; all riders must be assessed for ability to use public transportation, including paratransit; transportation must be provided to the closest appropriate medical provider.
- PA—Blocked call rate (busy signal): <1%; average speed of answer: <30 sec; call abandonment: <5%; late trips (pick up outside 15 minutes from scheduled pick up time): <10%; missed trips (trip not completed due to provider failure): <1%; one-hour rule for medical appointments (% of trips where client is dropped off more than 1 hour early or picked up more than 1 hour late as it relates to a healthcare service appointment): <10%; on-time service for medical appointments: >90%; availability of curb-to-curb services; % of valid complaints: <1% per month; total customer rating: >85%; consumer satisfaction rating for children: >85%; consumer satisfaction rating for clients with LEP: >85%; timely submission of reports; adherence to provider/driver/vehicle compliance regulations; 90.0% of accurate invoices must be adjudicated within thirty (30) days of receipt; 100.0 % of accurate invoices must be adjudicated within forty-five (45) days of receipt; and 100.0 % of all invoices must be adjudicated within ninety (90) days of receipt.
- VA—Call center statistics; <1% complaints (including on-time complaints); 100% of vehicles inspected 2x annually; and 100% of clean claims paid in 30 days.
- VT—Customer service considerations, direct service provisions, and reporting requirements.
- WA—The performance measures were implemented January 2011. The first is a penalty if the broker does not answer 80% of calls within 3 minutes. The second is a bonus to their monthly administrative payment, if the service cost per trip does down, when compared to the previous year. Since the administrative cost is 15% and service is 85%, the state realized an 8-fold benefit from this payment.

If your state uses a broker system, what is your customer complaint-to-trip ratio for the past fiscal year?

Less than 1/1000 (0.1%): 4 states

- AK—1 complaint was reported (SFY 12)
- ID—1 complaint for every 1,469 trips =0.07% (total trips = 1,294,330) (SFY 12)
- KY—Approximately 4/255,784 per month = 0.002% (2012)
- WA—Less than 0.01% (2011)

Greater than 1/1000 (0.1%): 7 states and DC

- DC—0.2% (calendar year 2011)
- MI—939/331,415 = 0.2% (Jan - June, 2012)
- NE—2.6/1000 = 0.3%(SFY 2012)
- NJ—less than 0.5% (SFY 2012)
- NV—899 complaints : 599,178 trips = complaint ratio of 1:667 = 0.15% (SFY 12)
- OK—98.8% complaint-free (overall), 99.7% complaint-free (minus no-shows) = 1.2-1.3% (SFY 12)
- VA—1/100 = 1% (SFY 2012)
- VT—1/750 = 0.13% (FY 2012)

If your state uses a broker, what on-time performance standard is in the contract?

- AK—For all on-line booking requests received prior to 11:59am, USTravel will fulfill 95% of the requests by 7:00pm on the day of receipt. For online booking requests received on or after 12:00pm, USTravel will fulfill 95% of the requests by 12:00pm the following day. USTravel will maintain an after-hour system whereby 100% of emergent calls (recipients that are candidates for organ transplant and have been notified that an organ is available) are responded to within 20 minutes.
- AR—15 minutes
- CT—Provide the Department network performance data including a list of and an examination of delays and missed pick-ups with the causes of such and report to the Department
- DC—Transportation provider shall wait 15 minutes beyond pick up time; must arrive with 30 minutes from time of notification by recipient or facility; and, in multiple-load situations, ensure that no recipient is forced to remain in the vehicle more than 60 minutes longer than the average travel time for that recipient's direct transport from point of pick-up to destination.
- ID—Trips are scheduled to ensure participants are in transportation providers' vehicles no longer than twice the amount of time of the normal average commute from participants' pickup and delivery locations. Trips are scheduled and dispatched to ensure the average waiting time for previously scheduled pickups does not exceed 15 minutes.
- NE—NET providers must ensure that the average waiting time for a scheduled pick-up time going to an appointment should not exceed 15 minutes prior to the scheduled pick up time; however, the client does not have to board the vehicle prior to scheduled pick up time. The average waiting time for a scheduled return trip, after an appointment, shall not exceed 30 minutes. Will-Call trips are not held to the same standards listed above. Exceptions to the above times may be made for trips with pick-up or destinations outside the client's local area, or verified scheduled consecutive trips.

- NJ—5% of trips arrive no more than 30 minutes late, although the goal is no more than 15 minutes late. (Note: There are significant issues with reporting and recording lateness. The state recommends an automated system used on each vehicle to check riders on and off for both legs. That is the only way to obtain reliable information).
- NV—Trips shall be scheduled and dispatched to ensure that the average waiting time for pickup or delivery does not exceed 15 minutes, and at least 90% of all pick-ups must be within 15 minutes of the scheduled pick-up time, measured on a monthly basis.
- OK—OHCA SoonerRide Manager is responsible for monitoring the Broker. Monitoring techniques include, but are not limited to, telephone contact, audits of the Broker's records and customer service satisfaction surveys.
- PA—>90%
- TX—The brokers negotiate on-time performance standards with the subcontractors.
- VA—"Late" is more than 15 minutes after the scheduled pick up time. Provider late & provider no-show account for about 80% of complaints.
- WA—There are a variety of on-time standards in the contract, such as: Average waiting time for pick-up may not exceed 15 minutes. For shared rides the client may not remain on the vehicle for more than 45 minutes longer than the average travel time for that trip.

Does your state have a cap on administrative costs built into your contract?

Yes: 4 states

- KY—cap is $440,000
- NV—cap is 20%
- VA—Bidders included an admin cost in their proposal. Currently, it is about 18%.
- WA—The administrative rate is negotiated and paid at a fixed amount per month. If the trip count changes more than 10% for 3 consecutive months then a rate negotiation may be requested.

Has the ratio of trips to eligible members increased, decreased or remained the same since going to a broker system?

Increased: 9 states—CT, ID, MI, NJ, NV, OK, PA, VA, and VT—and DC

- NJ—The state recently moved all managed care trips to the broker, and this has led to a significant increase in the trip to client ratio.
- VA—Increase is largely due to growth in the number of people in our ID Waiver and Elderly/Disabled Waiver, plus recession-related growth in the FFS population.
- VT—Both membership and trips have increased over the years since the state went to a brokerage system.

Decreased: NE—Broker ensured benefit administered in compliance with federal and state regulations.

Remained the same: 2 states—AK and KY

- KY—The brokerage system has been in place for approximately 12 years in Kentucky.

Other:

- LA—The State does not have a brokerage system; however, the fee for service trips have somewhat decreased due to the implementation of the Bayou Health Program.
- WA—The broker system has been in place for 23 years.

Who is responsible for assessing recipients' need for NEMT services? If broker performs assessments, what oversight does state exercise over the process?

Broker: 14 states and DC

- AR—Brokers, however beneficiaries can call and complain to an independent organization, and beneficiaries can appeal through the State agency.
- CT—The nurse employed by the broker is responsible for assessing recipients' need for NEMT[i].

- DC—The transportation broker provides level of need assessments, and the District provides oversight through monthly reporting and on-site audits[ii].
- ID—The broker utilizes Federal & State rule as well as policies and procedures that have been approved by the State when assessing recipients' needs. The broker also meets with the Medicaid Medical director at least once a week[iii].
- IL—Broker (First Transit, Inc.)
- KY—NEMT trips are compared to recipient utilization of medical services, and the Department ensures NEMT trips occur on the same day as medical service[iv].
- LA—The Transportation Dispatch Office assesses the need for recipient's receiving NEMT services. The State provides oversight when recipients are not able to receive transportation through the call center in normal situations[v].
- MI— Broker (LogistiCare Solutions)[vi]
- NE—The broker must verify that the program eligible client meets a needs test to determine appropriateness for NET services. This is required in the form of a "database script" that is approved by the State[vii].
- NJ—The Broker uses medical necessity forms and clients complain if they are wrongfully denied a trip or a level of service[viii].
- TX—The broker performs the assessments. The State provides oversight through complaints and on-going quality monitoring[ix].

- VA—The state monitors denials of service. Members get the denial orally at the time of the call, then in writing within 5 days. The written denial states the right to appeal to an impartial state hearing officer in the state Appeals Division[x].
- VT—Assessments for trips within 30 miles are completed by the brokers, while all out of state and longer distance in-state trips are assessed by the state.
- WA—If unhappy with broker decisions the client may ask for an administrative hearing. Of, the client may call the 1-800 number of their Medicaid card and talk with state staff[xi].

State: 3 states

- PA—The state reviews monthly and quarterly data regarding utilization based on the reporting of transportation modes. The state anaylzes shifts between the least costly and most costly mode of transportation.
- SD—State Medicaid Agency
- WV—Local office eligibility staff

Other:

- AK—The fiscal agent prior authorization call center is responsible for determining medical necessity, not the broker.
- CA—The provider assesses a beneficiary's need for NEMT services based on medical necessity.
- NV—All medical appointments must be accepted. The broker assesses for least costly mode of transport. The state audits the broker for compliance[xii].

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[i] Connecticut: http://www.ct.gov/dss/cwp/view.asp?a=2345&q=304920&dssNav=.
[ii] District of Columbia: http://app.ocp.dc.gov/RUI/information/scf/online_pdf/DCHC-2007-E-0010_1.pdf.
[iii] Idaho: No link available - RFP can be emailed.
[iv] Kentucky: http://www.lrc.ky.gov/kar/603/007/080.htm. Additional information can be provided by emailing lisa.lee@ky.gov.
[v] Louisiana: http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1734.
[vi] Michigan: Last contract: http://www.michigan.gov/documents/buymichiganfirst/1300036_335374_7.pdf.
[vii] Nebraska: RFP no longer available on line but can be provided upon request.
[viii] New Jersey: http://www.state.nj.us/treasury/purchase/noa/contracts/t2503_08-x-20091.shtml. Please note that the next version will be very different.
[ix] Texas: http://www.hhsc.state.tx.us/contract/529110004/rfp.shtml.
[x] Virginia: No longer on website. Request a copy from robert.knox@dmas.virginia.gov.
[xi] Washington: http://hrsa.dshs.wa.gov/Transportation/index.html. This link has substantial information about the Washington State Medical Transportation Program, including the latest procurement document with information pertaining to many of the questions in this survey.
[xii] Nevada: http://purchasing.state.nv.us. Please note that any RFP posted on this website does not include RFP amendments. Interested parties should contact Nevada State Purchasing at: MAIN PURCHASING OFFICE - 515 E. Musser St, Suite 300, Carson City, NV 89701, (775) 684-0170, fax (775) 684-0188, nvpurch@admin.nv.gov.