7-2009

Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform

Sara J. Rosenbaum
George Washington University

Nancy Lopez
George Washington University

Melanie J. Morris
Simon & Co.

Marsha Simon
Simon & Co.

Policy Brief

Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform

Sara Rosenbaum
Nancy Lopez
Melanie J. Morris[a]
Marsha Simon[a]

July 2009

This work was financed through a contract between the Community Transportation Association of America and The George Washington University. Funds for the project came from the United States Department of Health and Human Service's Community Transportation Assistance Program. The views and conclusions in this paper are those of the authors and do not necessarily reflect those of the Department of Health and Human Services or the Community Transportation Association of America.

[a] Simon & Co., Washington D.C.

Executive Summary

This policy brief examines Medicaid's assurance of medical transportation in the context of medically necessary but non-emergency health care. Reviewing the origins and evolution of the assurance and presenting the results of a 2009 survey of state Medicaid programs, the results of this analysis underscore Medicaid's unique capacity to not only finance medically necessary health care but also the services and supports that enable access to health care by low income persons since Medicaid covers non-emergency medical transportation. This ability to both finance health care and enable its use moves to the forefront as Congress considers whether to assist low income persons in health reform through Medicaid expansions or via subsidies for traditional health insurance, which typically does not provide comparable transportation coverage.

Key Findings

- The assurance of transportation to medically necessary health care is one of several basic program features that set Medicaid apart from traditional concepts of health insurance. In combination, these features embody an approach to health care financing whose aim is to assure not only coverage and payment but also access to medically necessary care.

- Since Medicaid's enactment, medically necessary, non-emergency transportation has been woven into the fabric of the program, first as a basic element of program administration and later as a medical assistance service in its own right.

- While there is considerable variation, virtually all states recognize non-emergency medical transportation as a fundamental aspect of program administration and health care.

- NEMT represents a small portion of overall Medicaid spending, slightly more than $3 billion in FY 2006, yet it constitutes the second largest federal transportation payment system, behind only programs administered by the United States Department of Transportation. Indeed, Medicaid NEMT expenditures represent almost 20 percent of the entire federal transit budget.

- As a result of changes under the 2006 Deficit Reduction Act (DRA), which permit states to replace the existing Medicaid benefits package for children and certain other groups with "benchmark" plans (i.e. limited benefits coverage more like primary insurance plans), nine states have implemented benchmark plans. Of these nine, three states have dropped the transportation benefit, while another has placed limitations on the benefit since the enactment of the benchmark plan option.

- States have increased the use of transportation brokers as a way to provide transportation benefits since the DRA permitted the use of brokerage systems when providing transportation as medical assistance under the State plan. Between 2001 and 2009, the number of states using exchange brokers rose from 29 to 38 (an increase of 31 percent). Brokerage programs may include wheelchair vans, taxis, stretcher cars, transit passes and

tickets, and other transportation methods. Although there is still little evidence about the effects of brokerage services, some research indicates their use may reduce costs and improve access to services.

- To a greater or lesser degree, national health reform proposals pending before Congress provide for coverage of low income persons through enrollment in subsidized health plans offered through health insurance exchanges. Because products offered through an exchange system are expected to more closely mirror insurance products available in a commercial insurance market, it is likely that only emergency transportation will be available for covered populations. The likely exclusion of non-emergency medical transportation within exchange products is an important consideration, particularly to the extent that exchange-subsidies are permitted or designed to substitute for Medicaid eligibility for at least some portion of the low income population.

Introduction

This policy brief examines Medicaid's assurance of medical transportation for medically necessary, but non-emergency health care, also called non-emergency medical transportation (NEMT). The assurance of transportation to medically necessary health care is one of several basic program features that set Medicaid apart from traditional concepts of health insurance. This assurance, having been a basic feature of Medicaid since the programs inception, is now subject to compromise with the passage of certain provisions within the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, leaving those with the most need for health care with limited or non-existent access. The difficulty of having limited or no transportation program within the Medicaid system would be in direct contradiction to a health care financing program whose aim is to assure not only coverage and payment but also access to medically necessary care.

The beneficiaries of Medicaid's approach to health care encompass the nation's most vulnerable populations: low income children, pregnant women, and families living and working in medically underserved urban and rural communities that lack adequate sources of health care; low income and medically impoverished children and adults with serious physical, mental and developmental disabilities; the poor elderly, and special categories of patients (such as low income women diagnosed with cervical and breast cancer) who face health care barriers that transcend affordability alone. In combination with other program elements – reasonable coverage standards and a prohibition against coverage discrimination, protections against more than nominal cost sharing, special early and periodic screening diagnosis and treatment benefits for children, medical case management services, and an option for comprehensive coverage of community-based long term care – Medicaid's transportation assurance, which encompasses both emergency and non-emergency but medically necessary care, sets the program apart from virtually, sets the program apart from virtually all other forms of U.S. health care financing.[1]

Research has shown that transportation problems are one of the most common barriers

[1] Rosenbaum S, Wise P. "Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT," *Health Affairs*, March/April 2007; 26(2): 382-393.; Weil A. There's Something about Medicaid. *Health Affairs*, January/February 2003: 22(1):13-30; Rosenbaum S. Medicaid. *N Engl J Med* 346(8):635-640, February 12, 2002.

faced by low-income populations in accessing timely and necessary medical care.[2] Many low-income people lack the disposable income to have a working automobile or to afford convenient access to public transit in order to get to or from health care appointments. This can be a particular problem for those living in rural areas, where appropriate medical care may be quite distant. In some cases, patients' health problems, such as being disabled, may create special transportation needs. The Medicaid NEMT benefit seeks to fill these gaps by purchasing transportation services, such as taxis, vans and public transit for patients to get to and from their medically necessary medical appointments.

Despite the vital nature of the service, non-emergency medical transportation (NEMT) represents a relatively small program expenditure. NEMT is only used by about 10 percent of the total Medicaid population and represented approximately 1 percent of total Medicaid spending (slightly more than $3 billion in FY 2006, using data from the Kaiser Commission on Medicaid and the Uninsured.[3] Although NEMT represents a small portion of overall Medicaid spending, it constitutes the second largest federal transportation program, behind only programs administered by the United States Department of Transportation. Indeed, Medicaid NEMT expenditures represent almost 20 percent of the entire federal transit budget.[4]

Following an overview of the transportation assurance and its policy evolution, this policy brief examines current state practices and trends in how the assurance is defined and implements and the effect of the Deficit Reduction Act on state NEMT services. The brief concludes with a discussion of the transportation assurance in the context of health reform.

Origins and Policy Evolution

The original statute and implementing guidelines and regulations

Codified at Title XIX of the Social Security Act, Medicaid represents a legal entitlement to "medical assistance" on the part of eligible individuals.[5] While the law accords states considerable discretion over program administration and design,[6] it also establishes a series of requirements that participating states must satisfy and that specify the conditions under which federal funds will be available to assist states pay program-associated costs related to eligibility,

---

[2] See, for example, Rust, G., et al. "Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services" *Arch Intern Med*. 2008 Aug 11;168(15):1705-10; Okoro, CA, et al. Access to Health Care Among Older Adults and Receipt of Preventive Services. Results from the Behavioral Risk Factor Surveillance System, 2002. *Prev Med*. 2005 Mar;40(3):337-43; Peseta, V. et al. "A Descriptive Study of Missed Appointments: Families' Percenptions of Barriers to Care," *Pediatr Health Care*. 1999 Jul-Aug;13(4):178-82.

[3] Raphael D. Medicaid Transportation: Assuring Access to Health Care: A Primer for States, Health Plans, Providers and Advocates (2001) and recent Medicaid expenditure information available at the Kaiser Family Foundation available at:
http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4.

[4] National Consortium on the Coordination of Human Services Transportation, and Coordinating Council on Access and Mobility, 2003.

[5] Jost TS. *Disentitlement? : The Threats Facing Our Public Health Care Programs and a Right-Based Response*. New York, NY: Oxford University Press, Inc; 2003.

[6] Smith DG, Moore JD. *Medicaid Politics and Policy, 1965-2007*. New Brunswick, NJ: Transaction Publishers; 2008. Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY 1997; 2001-2002 Supplement).

enrollment, coverage, payment, and other activities related to administering their "state plans for medical assistance."[7] As important as Medicaid's rights-creating language is to individuals who depend on the program to finance medical care, the law is equally vital to states, since they, too, are entitled to federal financial participation for costs associated with program administration. Much has been written about Medicaid's vital role in helping states develop and pay for health care for low income and medically vulnerable populations; Medicaid represents the single largest direct federal funds transfer to states, accounting on average for 44 percent of all federal revenues received.[8]

Medicaid's transportation assurance traces its history to provisions of the original Act; the transportation assurance obligation can be found as early as 1966 in the Handbook of Public Assistance (Supplement D), the program's earliest comprehensive federal interpretive guidance.[9] Although the original statute itself did not speak directly to transportation, numerous provisions formed the legal basis for subsequent agency policy – articulated first in guidance and subsequently in regulations – regarding the transportation assurance and the availability of federal financing for medically necessary transportation services: the law's "statewideness" (i.e., that the state's medical assistance plan operate in all parts of the state)[10] and "comparability" (meaning that all eligibility groups be treated comparably in terms of coverage and care)[11] requirements; the statutory requirement of efficiency in program administration;[12] the requirement that state programs be administered "in the best interest" of program recipients;[13] the statutory free choice of qualified provider" provisions[14] the use of standards of efficiency and medical necessity in terms of both coverage and payment for medical care;[15] the provision of

[7] §1902 of Social Security Act[42 U.S.C. § 1396 et seq].

[8] Kaiser Commission on Medicaid and the Uninsured. Medicaid: A Primer. *Key Information on the Nation's Health Program for Low Income People*, January 2009. Available at: http://www.kff.org/medicaid/upload/7334-03.pdf Accessed on May 25, 2009.

[9] Supplement D, issued June 17, 1966, provided at D-5130 as follows: "Criteria for the Administration of the Plan…
2. Criteria to assure high quality of the care and services provided under the plan include the following:…
b. Provision is made for necessary transportation of recipients to and from the suppliers of medical and remedial care and services."

In 1981, the Reagan Administration issued a Statement of Administration Policy formally notifying the public that it no longer intended to rely on *Supplement D* as controlling program guidance. At the same time, many current Medicaid regulations trace their origins to *Supplement D*, and the Supplement continues to offer invaluable and primary insight into the earliest understanding of the policy aims of the original law. Smith DG, Moore JD. *Medicaid Politics and Policy, 1965-2007*. In: Medicaid Implementation. New Brunswick, NJ: Transaction Publishers; 2008:64-72.

[10] 42 U.S.C. §1396a(a)(1).

[11] 42 U.S.C. §1396a(a)(10).

[12] 42 U.S.C. §1396a(a)(4)(A); Kukarni, M. *Fact Sheet: Medicaid Transportation* Services. National Health Law Program. June 2000.

[13] 42 U.S.C. §1396a (a)(19).

[14] 42 U.S.C. §1396a (a)(23). The freedom of choice provisions have been the subject of extensive amendment as Medicaid has adapted to the modern managed care environment, which for both publicly and privately insured persons, utilizes restrictions on provider choice to providers that are in an insurer's network. However, the Medicaid statute, in permitting states to impose such access restrictions, also specifies that care remain accessible. Sec. 1932 [42 U.S.C. 1396u-2] (a)(1)(A) of Social Security Act.

[15] 42 U.S.C. §1396a(a)(30).

"prompt" medical assistance.[16] Beginning in 1981,[17] state Medicaid agencies also became directly obligated to assure that children entitled to early and periodic screening, diagnostic, and treatment benefits (the special pediatric standard of coverage under Medicaid)[18] actually furnish and arrange for the care itself as an express health care access obligation.[19]

Of particular importance may have been the "administrative efficiency" statute, 42 U.S.C. §1396(a)(4)(A), which then (and now) requires that state plans "provide such methods of administration…as are found by the Secretary to be necessary for proper and efficient operation of the plan." This provision has been interpreted by successive Administrations not only as providing the legislative basis for the state transportation assurance,[20] but also as obligating the federal government to assist in the cost of carrying out the assurance as a dimension of both efficiently delivered health care and administrative efficiency. Among the "administrative requirements" that the Secretary has established in regulation is that a State plan "specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers and describe methods that agency will use to meet this requirement."[21] The Secretary's power to interpret and clarify the meaning of the broad and complex statutory terms forms an integral part of the effective administration of the Medicaid program and has been understood as such since the law's enactment.[22]

The general transportation assurance rule provides that a State plan must

(a) Specify that the Medicaid agency will ensure necessary transportation for

---

[16] 42 U.S.C. §1396a(a)(8). In recent years extensive litigation has addressed the question of whether the "prompt assistance" standard reaches only the act of coverage or care itself. As of spring, 2009, the federal circuits are split in their interpretation of the law. See *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004) (stating"medical assistance" means "payment" for various medical services); *WestsideMothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) ("The most reasonable interpretation of § 1396a(a)(8) is that all eligible individuals should have the opportunity to apply for medical assistance, and that such medical assistance, i.e., financial assistance, shall be provided to the individual with reasonable promptness."); *Bruggeman ex rel. Bruggeman v.Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) ("[T]he statutory reference to'assistance' [in the Medicaid Act] appears to have reference to *financial* assistance rather than to actual medical *services* . . . ."); *Okla. Chapter of the Am. Academy of Pediatrics (OKAAP) v. Fogarty*, 472 F.3d 1208, 1214 (10th Cir. 2007) (noting "agree[ment] with the Seventh Circuit's decision in *Bruggeman* that the term 'medical assistance' as employed in [the Reasonable Promptness Provision] refers to financial assistance rather than to actual medical services"; *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006) ("The statutory definition mentions payment for, but not provision of, services; for Circuit holding that "medical assistance" means actual medical services and not payment for such services) see *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (quoting *Sobky v. Smoley*, 855 F.Supp. 1123 at 1147 (E.D. Cal. 1994), that "medical assistance . . . can only mean medical services,"; and *Sabree ex rel.Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004).

[17] Omnibus Budget Reconciliation Act of 1981 (PL 97- 35), United States Statues at Large 9, pp. 37-933 (August 1981).

[18] Rosenbaum S, Wise P. "Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT,"*Health Affairs*, March/April 2007; 26(2): 382-393.

[19] 42 U.S.C. §1396a(a)(43); Rosenbaum and Wise. "Crossing The Medicaid–Private Insurance Divide: The Case Of EPSDT,*supra* n. 15.

[20] See 42 C. F. R. §431.53, which directly cites §1396a(a)(4)

[21] (42 C.F.R. §431.53). The assurance was originally codified in 1969 at 45 CFR 249.10 [Federal Register Vol. 34, No. 120 Part 249]. and was subsequently moved in a program-wide recodification in 1978 43 FR 45175 (Sept. 29, 1978, effective Oct. 1, 1978).

[22] *King v. Smith*, 392 U.S. 309 (1968), 88 S. Ct. 2128; 20 L.Ed.2d 1118.

> recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement. (§1902(a)(4) of the Social Security Act)[23]

Beyond the general transportation assurance rule, the Medicaid EPSDT benefit[24] and its associated state plan administration requirements[25] have been interpreted by the Secretary as establishing their own independent regulatory transportation obligations. Thus transportation must be offered "prior to each due date of a child's periodic [EPSDT] examination"[26] and in connection with access to necessary diagnostic and treatment services.[27]

That states' transportation assurance obligation transcends emergency medical transportation (i.e., transportation in a medical emergency using vehicles or means of transport offering emergency transport capabilities) is not in question. The obligation to assure all medically necessary transportation is a clear aspect of states' general Medicaid responsibilities as well as their administrative responsibilities in administering EPSDT benefits for children, as interpreted by the Secretary. Furthermore, the earliest transportation assurance rules underscore the broad understanding on the part of then the United States Department of Health, Education, and Welfare (HEW), the successor agency to the Department of Health and Human Services, regarding the scope of the assurance and the extent to which federal funding would be available to states to meet this assurance.

In promulgating early Medicaid regulations,[28] HEW further clarified that the state transportation assurance could be interpreted and administered either as an administrative undertaking or as an aspect of medical assistance itself:[29]

> *Services and Payment in Medical Assistance Programs.* Amount Duration and Scope of Medical Assistance. . . .§249.10 Amount, Duration, and scope of medical assistance. (a) State plan requirements. A State plan for medical assistance under title XIX of the Social Security Act must:… (4) Specify the amount and/or duration of each item of medical and remedial care and services that will be provided . . . Effective July 1, 1970, specify that there will be provision for assuring necessary transportation or recipients to and from providers of services and describe the methods that will be used.[…]
> "(b)(15) *Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.* This term includes the following items . . . (i) Transportation, including expenses for transportation and other

[23] 42 C.F.R. §431.53.
[24] 42 U.S.C. §1396d(a) and 42 U.S.C. §1396d(r).
[25] 42 U.S.C. §1396a(a)(43).
[26] 42 C.F.R. 441.62(a). See also Health Care Financing Administration, U.S. Dep't of Health & Human Services, State Medicaid Manual §§ 5121, 5150. See also DHHS, Centers for Medicare and Medicaid Services, State Medicaid Directors Letter #06-009 from Dennis Smith (March 31, 2006). Available at: http://www.cms.hhs.gov/smdl/downloads/SMD06008.pdf
[27] 42 C.F.R. §441.56(c) and 441.62.
[28] 34 Fed. Reg. 9787 (June 24, 1969).
[29] HEW, *Medical Assistance Manual, Part 6. General Program Administration* §6-20-00: Transportation of Recipients, §6-20-20 Implementation of Regulation, §6-20-20(E) Federal Financial Participation; HCFA – AT-78-51, May 30, 1978.

> related travel expenses, necessary to securing medical examinations and/or treatment when determined by the agency to be necessary to the individual case.

A decade later, in 1978, HEW issued further interpretive guidance related to federal Medicaid transportation policy, clarifying the basis for the assurance as well as the choice on the part of states in administering their plans and claiming federal financial participation. States could chose to do so either as an administrative activity or as a form of medical assistance (which in turn could result in federal contributions at a higher rate than would be the case were transportation to be paid at the normal federal 50 percent federal contribution rate for most forms of program administration:

> 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. One of these administrative requirements (42 C.F.R. 449.10 (a)(5)(ii) stipulates that the State Title XIX plan . . . assure necessary transportation of recipients to and from providers of services, and a description of the methods to be used. . . . [T]he Medicaid program has, from the beginning (1966), encouraged States to arrange for transportation for recipients to and from necessary medical care. The regulation in 42 C.F.R. 449.10(a)(5)(ii) . . . requires that a State plan under title XIX of the Social Security Act must "specify that there will be provision for assuring necessary transportation of recipients to and from providers of services, and describe the methods used." This requirement is based on the provisions in the Act and Federal regulations requiring that medical assistance be: 1) available in all political subdivisions of the State; 2) provided with reasonable promptness to all eligible individuals; 3) furnished in the same amount, duration, and scope to all individuals in a group; 4) provided in a manner consistent with the best interests of the recipient; 5) available to eligible recipients from qualified providers of their choice; and 6) provided in accordance with methods of administration found necessary by the Secretary for proper and efficient operation of the State plan. This requirement is also based on the recognition, from past program operation experience, that unless needy individuals can actually get to and from providers of services, the entire goal of a State Medicaid program is inhibited at the start." (HCFA – AT-78-51, May 30, 1978)
>
> D. Transportation as an Optional Medical Service. Section 1905(a)(17) of the Social Security Act gives the Secretary authority to specify medical care and services not otherwise listed in the Act, and recognized under state law. Transportation has been and continues to be included under this authority, and is defined by Federal regulations (HEW, 1978)[30]

The transportation assurance rule is now codified at 42 C.F. R. § 431.53; and the special transportation obligations applicable to children entitled to early and periodic screening diagnosis and treatment benefits is found at 42 U.S.C. §431.62. It is also important to note that although the Secretary of Health and Human Services has broad authority under §1115 of the

[30] HEW, *Medical Assistance Manual, Part 6. General Program Administration* §6-20-10 Legal Background and Authority; §6-20-20. Implementation of Regulation; HCFA – AT-78-51, May 30, 1978.

Social Security Act[31] to waive state plan requirements, certain other statutory requirements, and implementing regulations to permit states to pursue research and demonstration activities that promote the Act's objectives,[32] no §1115 demonstration involves the complete waiver of the transportation assurance although as discussed in the following section, a number of demonstrations have experimented with approaches to non-emergency transportation financing and delivery.

Current federal guidelines related to the transportation assurance as it relates to non-emergency transportation provide as follows:

> A State plan must—
>
> - Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers;[33] and
>
> - Describe the methods that the agency will use to meet this requirement[34];
>
> - Provision of transportation is also a federal requirement under states' implementation of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) in Medicaid for individuals eligible for EPSDT services[35]
>
> - Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) that necessary transportation and scheduling assistance under EPSDT services is available upon request;[36]
>
> - States can choose to either treat transportation costs as an administrative cost or as medical service and are required to identify in their state plan how they intend to treat the costs[37]

In addition, as discussed at greater length below, states that furnish transportation as a medical assistance service now have the discretion to waive freedom of choice and utilize transportation brokers as a state plan option and without waivers. Federal guidance issued in the wake of the 2006 Deficit Reduction Act of 2005 legislation creating this new state plan option provides as follows:

---

[31] Lambrew J., op cit. and Mann C. "The New Medicaid and CHIP Waiver Initiatives," The Kaiser Commission on Medicaid and the Uninsured, February 2002; Department of Health and Human Services: Centers for Medicare and Medicaid Services website. *Research and Demonstration Projects-Section 1115.* Available at: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp. Accessed May 25, 2009.

[32] Smith DG, Moore JD. *Medicaid Politics and Policy, 1965-2007*. New Brunswick, NJ: Transaction Publishers; 2008; See also Kaiser, *Research and Demonstration Projects-Section 1115 supra* n. 28.

[33] 42 CFR §431.53(a) (Sec. 1902(a)(4) of the Social Security Act).

[34] 42 CFR §431.53(b) (Sec. 1902(a)(4) of the Social Security Act).

[35] 42 USC §1396d(r) requires states to cover certain services to correct, or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid state plan.

[36] 42 CFR §441.56 and §441.62.

[37] 42 CFR §440.170.

- States are not required to obtain a §1915(b) waiver to use a NEMT brokerage program when transportation reimbursed as a medical assistance.[38] However, the transportation regulations provided:
    - Must be cost-efficient
    - Must use competitive procurement process to select broker
    - Must perform regular auditing and oversight of brokerage program for quality
    - Brokerage contract must:
        - provide that broker has oversight procedures
        - Transport personnel are licensed, qualified, competent & courteous
        - Broker will comply with requirements related to prohibitions on referrals[39]

Judicial Interpretation of the transportation assurance (1974-2006)

At several points over more than 30 years, the courts have examined the transportation assurance as part of litigation brought by private individuals to enforce federal requirements and federal rights. Two distinct legal theories support private enforcement actions seeking judicial intervention aimed at requiring state agency officials to comply with federal Medicaid program requirements. The first theory, grounded in the Supremacy Clause of the United States Constitution, holds that conditions of federal funding under Spending Clause statutes such as Medicaid are enforceable by individuals, with federal courts acting under general federal question jurisdiction and individual enforcement as an implied right of action.[40] The second theory – which, until narrowed by the United States Supreme Court in recent years,[41] offered the more popular approach because of the availability of attorneys fees as well as broader forms of relief – holds that federal Medicaid law creates rights that can be privately enforced under 42 U.S.C. §1983, a post-Civil War statute that for nearly 150 years has given individuals the right to sue states to protect federally secured rights. Although in recent years the United States Supreme Court has placed important new limits on §1983 actions, the use of Civil Rights Act laws as a Medicaid enforcement mechanism remains a central judicial avenue.

Positive Cases

In *Smith v. Vowell,*[42] the first case to test the enforceability of the transportation

[38] Deficit Reduction Act of 2005 (Pub. L 109-171) §6083 amending §1902(a) of Social Security Act by adding new section 1902(a)(70).
[39] Centers for Medicare and Medicaid Services. See letter from Dennis Smith to State Medicaid Directors dated March 31, 2006. Available at: http://www.cms.hhs.gov/smdl/downloads/SMD06009.pdf. Accessed on May 29, 2009.
[40] *Indep. Living Ctr. of S. Cal. Inc v. Shewry*, 543 F.3d 1050 (9th Cir 2008); *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006); *Planned Parenthood of Houston v. Sanchez*, 403 F.3d 324 (5th Cir. 2005), *Local Union No. 12004*, 377 F.3d 64 (1st Cir 2004); *Burgio & Campofelice*, 107 F.3d 1000 (2nd Cr 1997); *Quest v. City of Santa Fe*, 380 F.3d 1258 (10th Cir. 2004); Bobroff R. Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes. *Loy. J. Pub. Int. L.* Fall, 2008; 10(27):27-83.
[41] *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283; 122 S. Ct. 2268; 153 L. Ed. 2d 309 (2002).
[42] *Smith v. Vowell*, 379 F. Supp. 139 (W.D.Tex. 1974).

assurance, a federal district court ruled in favor of the plaintiff in 1974. In *Smith*, the Texas Dept of Public Welfare refused to provide plaintiff with transportation to a physician. Plaintiff, a disabled Medicaid recipient, brought class action under 42 U.S.C. §1983 seeking injunctive and declaratory relief against the defendants for violation of federal regulatory requirements. A question of first impression, the issue on which the case turned was whether federal regulations could be enforced. Finding the regulations both unequivocal and within the power of the Secretary to promulgate, the court discussed the history of federal concern about medical transportation, as well as the extent to which transportation was essential to the proper administration of Medicaid. The court concluded that the transportation rule rested squarely in the power of the Secretary to determine that transportation was necessary to efficient program administration. The court noted that under federal policy, the choice of means by which to carry out the obligation was a matter of state discretion, but that the assurance of non-emergency transportation represented a mandatory duty. Because the regulation was promulgated with the full authority of the Secretary, it could be enforced as if it were part of the statute itself.

A similar result was reached in *Blue v. Craig,*[43] which involved a class action suit for declaratory and injunctive relief against the state of North Carolina. Plaintiffs alleged a violation of rights in the state's failure to provide them either with transportation or payment for the cost of transportation in connection with medically necessary care. In upholding plaintiffs' right to proceed against the state for violation of their federally secured rights, the court of appeals in effect acknowledged the presence and importance of the transportation obligation.

Fant v. Stumbo[44] involved a challenge to a state regulating limiting available transportation to four trips per month. Citing the regulatory requirements promulgated by HHS, the court concluded that a four-trip- per-month limitation was invalid as an arbitrary limit on the amount of coverage and unrelated to legitimate medical necessity considerations. The following year, California's courts held in *Bingham v. Obledo*,[45] that California's efforts to limit transportation only to specific groups of beneficiaries constituted a violation of federal law, as well.

Daniels v. Tennessee Dept. of Health and Environment,[46] similarly involved the scrutiny of the legal sufficiency of a transportation plan. Unlike *Smith v Vowell*, in which the state provided no transportation whatsoever, these later transportation cases involved judicial scrutiny of the sufficiency of a state's transportation plan in relation to federal regulations and manuals. In these cases, as in *Smith*, the legitimacy of the federal regulations as a reasonable interpretation of the statute was reinforced, and the legitimacy of the regulatory standards was further extended in *Daniels* to the federal Medical Assistance Manual, a set of interpretive policies that further amplifies on the meaning of the rules. As a result, it was appropriate, in the court's view, to review a state Medicaid plan not merely for the existence of any transportation assurance but rather for an assurance that is sufficient in its description to address the key elements identified in federal standards. That is, state Medicaid plans must address transportation, not merely generally, but via a description of the manner in which the assurance would be carried out, and

[43] *Blue v. Craig,* 505 F.2d 830 (4th Cir 1974).
[44] *Fant v. Stumbo, 552* F.Supp 617 (W.D.Ky.1982).
[45] *Bingham v. Obledo,* 195 Cal.Rptr.142 (1983).
[46] *Daniels v. Tennessee Dept. of Health and Environment* ,1985 U.S.Dist.LEXIS 12145 (1985).

the methods that would be used. At the same time, the court in *Daniels* concluded that a system of paid volunteers was sufficient to satisfy the transportation assurance and that the state in turn could deny access to a paid volunteer system if the beneficiary had access to a serviceable motor vehicle, public transportation, or transportation from friends.

Other cases that have found a right to enforce the transportation assurance include *Morgan v. Cohen*,[47] *Boatman v. Hammons*,[48] *Conti and Rivera v. Ferguson*,[49] and *Dajour v. City of New York*. [50] *Conti* involved an express rejection of the notion that non-emergency transportation services could be limited to non-ambulatory persons, while *Dajour* involved claims brought by homeless children with asthma pursuant to the state's EPSDT transportation obligations.

Negative Cases

The leading case to have rejected non-emergency medical transportation as an enforceable right is *Harris v. James*, 127 F.3d 993 (11th Cir. 1997), In *Harris*, the state of Alabama's medical transportation plan was challenged for its sufficiency. A trial court granted summary judgment in favor of the plaintiffs and based on the clear discrepancy between the federal regulation and the state's plan. The state appealed. In reversing the lower court, the United States Court of Appeals for the Eleventh Circuit ruled that federal regulations alone cannot create enforceable rights under §1983 and that while transportation may have been implied under the statute (the court did a review of all of the provisions giving rise to the regulatory transportation assurance), there was no clear statutory right to transportation. The court noted that while earlier Supreme Court rulings held that a valid regulation can create a federal right enforceable under § 1983,[51] it would adopt the view expressed by the dissent in a later United States Supreme Court case[52] which concluded that "an administrative regulation … cannot create an enforceable § 1983 interest not already implicit in the enforcing statute." Under this reasoning, although a state Medicaid agency may have an obligation to assure transportation, only the Secretary of Health and Human Services can enforce it. (The Eleventh Circuit did not consider the question of whether the Supremacy Clause offered an alternative theory of enforceability, since such a claim was not raised by the plaintiffs).

Following in *Harris'* wake is the most recent decision in *Avila v. Smith.*[53] At issue was plaintiff's claim that Defendants had wrongfully denied her Medicaid funding for travel to medical appointments outside of Vermont. Defendants move to dismiss the complaint, arguing that the assurance created no enforceable rights and was merely a regulatory obligation to be enforced by the Secretary. Agreeing with the reasoning of *Harris*, the trial court found the assurance privately non-enforceable under §1983. The court noted that while the Second Federal Judicial Circuit (in which Vermont is located) has not conclusively ruled on the matter, "[m]ost

[47] *Morgan v. Cohen*, 665 F.Supp 1164 (E.D.Pa 1987).
[48] *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998).
[49] *Conti and Rivera v. Ferguson*, 2001 R.I. Super. LEXIS 72 (2001).
[50] *Dajour v. City of New York* , 2001 U.S. Dist. LEXIS 15661(S.D.N.Y. 2001).
[51] *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582, 638; 103 S. Ct. 3221, 3251; 77 L. Ed. 2d 866 (1983).
[52] *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 107 S. Ct. 766, 93 L. Ed. 2d 781 (1987).
[53] 2006 WL 1519420 (D. Vt.).

circuits have held that regulations do not, by themselves, create federal rights, and that such rights must be at least implicitly recognized "in the regulation's enforcing statute."[54]

At the same time that some courts have ruled the transportation assurance a non-enforceable right, other courts have held that federal requirements can be enforced through the Constitution's Supremacy Clause.[55] This means that even though transportation may not be enforceable as a federal right, the federal obligation created by the transportation assurance rules may be considered enforceable in other judicial settings.

The Deficit Reduction Act of 2006

Paradoxically, the very issue that acted as a barrier to individual enforcement – the absence of an explicit reference to states' transportation obligation in regulation – was removed in 2006 by legislative amendments contained in the Deficit Reduction Act of 2005 (DRA),[56] which was aimed at giving states additional flexibility in how the assurance could be carried out. As yet, there has as of yet been no transportation litigation in the wake of this amendment; but the very problem noted by the *Harris* court in a judicial enforcement context, that is, the absence of statutory evidence of Congressional intent, appears to have been rectified by the amendments.[57] Whether the amendments are evidence of a federal right enforceable under §1983 or instead of a federal obligation enforceable under Supremacy Clause litigation, remains to be seen.

The DRA contained two amendments of relevance to the state transportation assurance. First, the Act amended the Medicaid statute to permit states to establish non-emergency transportation brokerage programs to help ensure transportation services; implementing regulations were published in 2008.[58] This allowed states "to establish a non-emergency medical transportation brokerage program without regard to statutory requirements for comparability, statewideness, and freedom of choice."[59] NEMT may be provided under contract with brokerage entities that are selected through competitive bidding process, have oversight procedures to monitor access, complaints, and quality, are subject to regular auditing, and require separation of brokerage and transportation provider in most circumstances.[60]

Second, the DRA amended the Medicaid statute to permit states greater flexibility in defining covered benefits for certain Medicaid-eligible populations, including the use of "benchmark" benefit plans. Benchmark plans include: the Federal Employees Health Benefits

---

[54] Ibid. at p.10 citing *King v. Town of Hempstead*, 161 F.3d 112, 115 (2d Cir. 1998) and *Rodriguez v. City of New York*, 197 F.3d 611, 617 (2d Cir. 1999).
[55] See, e.g., *Independent Living Center v. Shewry*, 543 F.3d 1050 (9th Cir 2008); The United States Supreme Court appears to be in accord with this Supremacy Clause theory of enforcement, although the High Court has not yet ruled directly on whether the Supremacy Clause covers beneficiary claims. See, e.g., *Pharmaceutical Research and Manufacturers of America v. Walsh*, 538 U.S. 644; 123 S. Ct. 1855; 155 L. Ed. 2d 889 (2003).
[56] Pub. L. 109-171 (109th Cong., 2d sess.)
[57] Kukarni, M. *Fact Sheet: Medicaid Transportation Services.* National Health Law Program. February 2008.
[58] 73 FR 77519 (December 19, 2008) adding §1902(a)(70) to Social Security Act; 42 C.F.R. 440.170(a)(4), effective January 20, 2009.
[59] Ibid at 77520.
[60] Ibid.

Program (FEHBP) Blue Cross/Blue Shield preferred provider organization (PPO); a state's employee coverage plan; the health maintenance organization (HMO) with the largest number of non-Medicaid enrollees in a state; or any other plan approved by the secretary of the U.S. Department of Health and Human Services (HHS). Final regulations published by the Bush Administration in December, 2008, interpreted this "benefit flexibility" provision to include state authority to eliminate the transportation assurance for affected populations, as state employees do not receive a transportation benefit as part of their health insurance coverage.[61] In defending this interpretation of the Act (which contained no specific reference to transportation in defining the scope of state flexibility, even as the same Act amended the statute to specifically reference transportation, as noted), the Administration stated as follows:

> . . . [O]ffering benchmark or benchmark-equivalent benefit packages without regard to the assurance of transportation is consistent with the benchmark options that Congress specified. . . . Since section 1937 of the Act gives States the flexibility to provide benefits that are similar to commercial packages, it would appear inconsistent with that flexibility to require the States to provide NEMT that the selected benchmark package do not offer. We disagree that benchmark and/or benchmark equivalent plan options undermine the intent of the Medicaid program and create major barriers to access appropriate care. The benchmark and benchmark-equivalent plan options provide unprecedented flexibilities to States in an effort to create benefit packages that appropriately meet the needs of their Medicaid populations. In order to provide States with maximum flexibility, the rule provides that States can offer benchmark or benchmark equivalent coverage without regard to the assurance of transportation, which will align these plans with today's health care environment. . . .[62]

The Administration's explanation did not discuss the provisions of §1937 insofar as such provisions specifically retained the EPSDT benefit as additional coverage for children or the fact that implementing EPSDT regulations (still in force) include transportation services.

Table 1 identifies the nine states (Idaho, Kansas, Kentucky, Missouri, South Carolina, Virginia, Washington, West Virginia, and Wisconsin) that have approved state plan amendments for a benchmark plan. Of these nine States, three (South Carolina, Missouri and Wisconsin), do not provide NEMT services to beneficiaries enrolled in benchmark programs and West Virginia has placed a limit of five round trips per year on the benefit. It is important to recognize that Section 1937 of the Act continues to provide protections for children and exempt individuals. Children should continue to have access to NEMT as an EPSDT benefit. Exempt individuals will have an informed choice to determine whether enrollment in an alternative benefit package is advantageous, and may take into account the availability of NEMT in making that election.

[61] 73 Fed. Reg. 73694 (December 3, 2008) adding §1937 to Social Security Act.
[62] Ibid at 73715.

Table 1: State Medicaid Benchmark Plans, 2009.

State with benchmark plan	NEMT Included	Limitations
Idaho	Yes	
Kansas	Yes	
Kentucky	Yes	
Missouri	No	
South Carolina	No	
Virginia	Yes	
Washington	Yes	
West Virginia	Yes	Limited to five round trips per year
Wisconsin	No	

Source: Information obtained through Centers for Medicare and Medicaid Services (73 Fed Reg. 73700, December 3, 2008) and 2009 Survey of Medicaid Directors by George Washington University and Simon & Co.

The DRA benefit flexibility rules are in flux. On April 2, 2009, the Obama Administration extended the original effective date for these regulations (February 2, 2009) until December 31, 2009 to permit additional comments on the rules, including the regulation reclassifying transportation as an optional service.[63] Furthermore, the Children's Health Insurance Program Reauthorization Act of 2009[64] amended the Medicaid benefit flexibility statute to significantly narrow state authority in the design of benchmark plans, [65] although the impact of this narrowed authority on states' ability to exclude NEMT is a matter that will require CMS interpretation. For this reason, it now appears that the 2008 rule will now require significant revision; at the present time there is no regulation in effect that would, in the absence of a §1115 demonstration waiver, authorize any state to depart from its transportation assurance obligation for any covered population.

Further research is needed to assess the impacts of the DRA changes. The adoption of benchmark benefit plans that exclude NEMT suggest some beneficiaries may have greater problems securing transportation for medical care. Even if these changes are reversed by future regulatory or statutory changes, the changes provide an important opportunity to understand the effects of having or losing transportation benefits in Medicaid.

Current State Practices Related to Non-Emergency Medical Transportation

The literature on Medicaid NEMT literature is quite sparse. The most recent comprehensive state survey to determine how states are administering NEMT was done in 2003,[66] and most studies have been carried out by companies serving as transportation brokers themselves or associations representing transportation providers. The small amount of scholarly

[63] American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), H.R. 1, 111th Cong. (2009).
[64] Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111-3), H.R. 2, 111th Cong. (2009).
[65] *See* CHIPRA n.57, § 611(a) and §611(a)(3).
[66] Stefl G, Newsom S. *Medicaid non-emergency transportation: National survey 2002-2003.* National Consortium on the Coordination of Human Services Transportation. (2003).

research that does exist tends to show that NEMT is a utilized and necessary benefit. Below we present a summary of current state Medicaid agency NEMT practices based on a review of current literature and data we collected through a survey described below.

Study Methods

Information on the non-emergency medical transportation requirements was collected by conducting a textual review of federal Medicaid regulations through hard copy and internet review of the Code of Federal Regulations[67], the Federal Register[68], the State Medicaid Manual through CCH Internet Research[69], and State Medicaid Director Letter #06-009[70]. With regard to collecting information on each state's individual non-emergency medical transportation requirement, a survey using the internet website Survey Monkey[71] was created by George Washington University along with Simon & Co. and sent via internet to each of the 50 state Medicaid directors. The survey was in questionnaire format and contained questions regarding the state's Medicaid program and in particular the state's non-emergency medical transportation benefit. Questions included, but were not limited to, requests about the state's non-emergency medical transportation utilization methods, populations served, transportation methods used, limitation on NEMT services, effects of the Deficit Reduction Act on NEMT practices and how NEMT is financed within that state's program.

Information obtained from this survey was used specifically for Tables 2 and 3. Table 2 delineates the results of the 2009 survey answers regarding use of the NEMT brokerage option and compares the results to brokerage usage for those same states pre-DRA amendments. Table 3 shows the results from the 2009 survey which questioned the twenty-two states not using a broker in 2001 as to whether they have implemented a brokerage program since of the passage of the DRA, and whether it was due to the passage of the DRA and subsequent regulations no longer requiring a waiver to use a broker. Table 4 shows coverage of and limitations to the NEMT services of each state from 2006 according to the Kaiser Family Foundation.

Key Findings

Federal financing of NEMT

As discussed in the previous section, transportation services can be paid as either an administrative or medical assistance service. When furnished as an administrative service, states can avoid obligations that attach to Medicaid when the service to be financed is classified as "medical assistance," such as free choice of provider provisions, the application of certain medical assistance payment standards, and other matters. On the other hand, as an administrative service, the transportation assurance is paid at a 50 percent federal financial

[67] http://www.gpoaccess.gov/cfr/index.html
[68] http://www.gpoaccess.gov/fr/index.html
[69] http://hr.cch.com/primesrc/bin/highwire.dll?ult=p&tpl=hrilogin.tpl&eg=h13&
[70] Department of Health and Human Services, Centers for Medicare and Medicaid Services. State Medicaid Directors Letters from Dennis Smith Nos. #06-009 and #06-008, March 31, 2006. Available at: http://www.cms.hhs.gov/smdl/downloads/SMD06009.pdf
[71] http://www.surveymonkey.com/

participation rate, which can be considerably lower than states' Federal financial rate for medical assistance services, which range from 50 percent to 76 percent.[72] NEMT has been the subject of state §1115 demonstrations, as well. Table 2 shows state approaches to transportation financing as of 2003.

Table 2: Non-emergency transportation as a medical assistance or as state plan administration expenditure under Medicaid, 2003.

STATE	Medical Assistance or Administrative Expenditure
Alabama	Administrative
Alaska	Medical Service
Arizona	Medical Service
Arkansas	Medical Service
California	Medical Service
Colorado	Medical Service
Connecticut	Administrative
Delaware	Administrative
District of Columbia	Medical Service
Florida	Medical Service
Georgia	Medical Service
Hawaii	Medical Service
Idaho	Medical Service
Illinois	Medical Service
Indiana	Medical Service
Iowa	Both
Kansas	Medical Service
Kentucky	Medical Service
Louisiana	Medical Service
Maine	Medical Service
Maryland	Administrative
Massachusetts	Administrative
Michigan	Both
Minnesota	Both
Mississippi	Medical Service
Missouri	Medical Service
Montana	Both
Nebraska	Medical Service
Nevada	Medical Service
New Hampshire	Administrative
New Jersey	Both
New Mexico	Both
New York	Both
North Carolina	Both
North Dakota	Medical Service
Ohio	Both
Oklahoma	Administrative

[72] The American Recovery and Reinvestment Act (ARRA) provides a temporary FMAP increase from October 1, 2008 through December 31, 2010.

STATE	Medical Assistance or Administrative Expenditure
Oregon	Administrative
Pennsylvania	Administrative
Rhode Island	Both
South Carolina	Medical Service
South Dakota	Medical Service
Tennessee	Medical Service
Texas	Medical Service
Utah	Both
Vermont	Administrative
Virginia	Administrative
Washington	Administrative
West Virginia	Medical Service
Wisconsin	Both
Wyoming	Administrative

Source: National Consortium on the Coordination of Human Services Transportation. *Medicaid Non-Emergency Transportation: National Survey 2002-2003,* December 2003.

Use of NEMT Brokerage Systems

As previously discussed, the DRA authorized the use of brokerage systems whose purpose is to permit states to limit free choice of providers for NEMT as a medical assistance benefit (paid at the higher federal contribution rate) as a state plan option and without seeking special federal waiver approval under §1915 of the Social Security Act, which provides "freedom of choice" demonstrations.[73]

Under a brokerage program, the State contracts with one or more transportation brokers to manage the NEMT services for beneficiaries who need transportation to or from medical providers. Typically the transportation brokers provide an alternative to directly contracting with transportation providers on a fee-for service basis. The brokers can be either a profit or not-for-profit company that contracts directly with local transportation providers such as a taxi service, van service or even provides fares on public transit such as buses or subways. The brokers seek to establish a network of NEMT providers. It is customary for brokers to manage the entire NEMT program from receiving the trip requests, to assigning trips to providers and scheduling the trips.[74]

Reimbursement methodologies used by states for NEMT services vary but can be generalized as "the least expensive appropriate and available mode of transport" [75] States may utilize volunteers, who are usually paid mileage rates. They may also directly reimburse beneficiaries for the cost of prior approved long distance travel and accommodation. The states often rely on public carriers such as buses, for which beneficiaries are typically given tokens. They may pay taxi companies or other commercial transport firms on a mileage or trip basis. Some states contract with transportation brokers to coordinate and pay for all necessary

[73] 42 U.S.C. §1396a(a)(70); For a general discussion of the Medicaid freedom of choice waiver program see CCH, MED-REG, MED-GUIDE ¶21,011.55, 42 CFR §431.55, Waiver of other Medicaid Requirements.
[74] Information provided from LogistiCare, a NEMT brokerage company to Simon & Co.
[75] Kaiser Family Foundation website. Available at: http://www.kff.org/medicaid/benefits/sv_foot.jsp#21.

transportation with a co-payment to the broker. If necessary, a state may pay for long distance transport via a commercial airline, railway or bus company (Ibid.).

To establish a NEMT brokerage program for providing transportation as medical assistance, a State must submit a State plan amendment (SPA) that elects this option and assures that applicable requirements related to cost effectiveness, competitive procurement, oversight and quality are being met (DHHS March 31 2006 letter). NEMT brokerage programs must be cost effective and states must select NEMT brokers through a competitive procurement process in order to comply with the DRA. The Congressional Budget Office scored the brokerage provision in the DRA of a savings 55 million dollars over five years, assuring that transportation is a means for states to restrain Medicaid costs. [76]

Most states cover NEMT to enable Medicaid beneficiaries to obtain covered medical services from both local providers and from tertiary care centers at some distance from their homes. Several of the states assure appropriate utilization through prior approval processes or may set limits on the number of trips allowed per month or with local community agencies or vendors to coordinate the services.

Recent literature argues that the shift to transportation brokerage services has improved access to care among Medicaid beneficiaries and decreased expenditures. For example, a recent study by University of South Carolina researchers examines the effects of implementing transportation brokerage systems in Georgia and Kentucky and found that this increased access to care and reduced transportation expenses. Moreover, there were reductions in hospitalizations by children and ambulatory care sensitive admissions by diabetic adults, suggesting improved health outcomes.[77]

Another forthcoming article examining the incentive structure of Florida's NEMT program finds that a broker supplies more effort on both quality assurance and cost reduction but less effort on screening trip eligibility as its share of transit services increases. The article further asserts that because of the compensation structure, the number of Medicaid beneficiaries using services and the number of claims per user increase as the broker's share of transit services increases. The article concludes that for a given number of claims, cost per claim decreases as the brokers share of transit services increases.[78]

[76] The Congressional Budget Office Cost Estimate on S. 1932 Deficit Reduction Act of 2005 Conference agreement, as amended and passed by the Senate on December 21, 2005. January 27,2006

[77] 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.

[78] Dai, C., Denslow, D., Dewey, J. (2007). The incentive effects of organizational forms: Evidence from Florida's non-emergency Medicaid transportation programs. Manuscript submitted for publication.

Table 3: State Medicaid Agency Use of NEMT Brokerage Programs Before and After the DRA Brokerage Amendments, 2001 and 2009.

STATE	Use of Brokers in 2001	Use of Brokers in 2009
Alabama	No	No
Alaska	No	Yes
Arizona	No	No
Arkansas	Yes	Yes
California	No	No
Colorado	No	Yes
Connecticut	Yes	Yes
Delaware	Yes	Yes
District of Columbia	No	Yes
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	No	No
Idaho	Yes	Yes
Illinois	No	Yes
Indiana	Yes	Yes
Iowa	No	No
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	Yes	Yes
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	Yes	Yes
Minnesota	No	Yes
Mississippi	Yes	Yes
Missouri	Yes	Yes
Montana	Yes	Yes
Nebraska	No	No
Nevada	No	Yes
New Hampshire	No	No
New Jersey	No	Yes
New Mexico	Yes	Yes
New York	Yes	Yes
North Carolina	No	Yes
North Dakota	No	No
Ohio	No	No
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	Yes
Rhode Island	Yes	Yes
South Carolina	Yes	Yes
South Dakota	No	No
Tennessee	Yes	Yes
Texas	No	No
Utah	Yes	Yes
Vermont	Yes	Yes
Virginia	Yes	Yes

STATE	Use of Brokers in 2001	Use of Brokers in 2009
Washington	Yes	Yes
West Virginia	No	--
Wisconsin	No	No
Wyoming	No	Yes
Total States Using Brokerage	29	38

Source: Survey Medicaid Non-emergency Medical Transportation: National Survey 2002-2003, Community Transportation Association of America: 2001; 2009 survey conducted by MJ Simon and Associates and the George Washington University.

Table 3 shows that the number of states using a transportation broker has increased by 9 since 2001. Officials in Minnesota, New Jersey, Nebraska and Wyoming specifically cited the DRA in our interviews as influencing their decision to use of broker. North Carolina now uses a broker system, however, they specifically noted that the DRA and the lack of waiver did not influence their decision to use a broker. Texas does not yet have a broker system, but officials indicated that they will reconsider the issue in 18 months and plan to take the DRA into consideration in whether or not they will be using a broker. Thus the enactment of the brokerage option resulted in a 31 percent increase in use of the option. This indicates that making it simpler for states to implement a brokerage option, by filing a state plan amendment rather than requiring approval of a waiver, increased the usuage of the brokerage option in Medicaid.

Current state practices on non-emergency medical transportation

Table 4 summarizes information on current state coverage standards as of 2006 for NEMT and limitations for various populations, including categorically needy beneficiaries and those who are medically needy (i.e. who typically spend down to Medicaid eligibility levels by incurring costs for medical assistance). While Table 4 provides only limited insight into current practice, it is fair to conclude from the table that all states have NEMT programs in place, that some limitations are present in the form of trip limits, prior authorization, or cost sharing.

Table 4: State NEMT Practices: Coverage and Limitations, 2006.

STATE	POPULATIONS COVERED	LIMITATIONS
Alabama	Categorically Needy	2 trips per month
Alaska	Categorically Needy	Prior Approval Required
Arizona	Categorically Needy & Medically Needy	Prior Approval Required
Arkansas	Categorically Needy & Medically Needy	No Restrictions
California	Categorically Needy & Medically Needy	Prior Approval Required
Colorado	Categorically Needy	No Restrictions
Connecticut	Categorically Needy & Medically Needy	Prior Approval Required

STATE	POPULATIONS COVERED	LIMITATIONS
Delaware	Categorically Needy	$1 Copay per trip
District of Columbia	Categorically Needy & Medically Needy	Prior Approval Required for medi-van transport
Florida	Categorically Needy & Medically Needy	Prior Approval Required, $1 Copay per trip, and limited to beneficiaries unable to arrange for medically necessary transportation through any other means
Georgia	Categorically Needy & Medically Needy	$1 copay per trip
Hawaii	Categorically Needy & Medically Needy	No Restrictions
Idaho	Categorically Needy	Prior Approval Required
Illinois	Categorically Needy & Medically Needy	Prior Approval Required for all transports other than nursing facility residents
Indiana	Categorically Needy	$.50-2 copay per trip, depending on payment, priori approval required for transports great than 50 miles, and limited to 20 one way trips less than 50 miles per year
Iowa	Categorically Needy & Medically Needy	Benefits for beneficiaries with disabilities and residing outside of metropolitan areas only
Kansas	Categorically Needy & Medically Needy	Prior approval required on specified modes of travel
Kentucky	Varies by plan	Prior approval required
Louisiana	Categorically Needy & Medically Needy	Prior approval required
Maine	Categorically Needy & Medically Needy	Prior approval required on transportation of nursing facility residents
Maryland	Categorically Needy & Medically Needy	Prior approval required on anything other than public transportation
Massachusetts	Categorically Needy & Medically Needy	No Restrictions
Michigan	Categorically Needy & Medically Needy	No Restrictions
Minnesota	Varies by plan	No Restrictions
Mississippi	Categorically Needy	Prior approval required
Missouri	Categorically Needy & Medically Needy	$3 copayment required
Montana	Varies by plan	Prior approval required
Nebraska	Categorically Needy & Medically Needy	Prior approval required
Nevada	Categorically Needy	Prior approval required
New Hampshire	Categorically Needy & Medically Needy	Prior approval required
New Jersey	Categorically Needy & Medically Needy	Prior approval required
New Mexico	Categorically Needy	Transportation to pharmacy for prescription pick-up not covered

STATE	POPULATIONS COVERED	LIMITATIONS
New York	Categorically Needy & Medically Needy	Prior approval required
North Carolina	Categorically Needy & Medically Needy	No Restrictions
North Dakota	Categorically Needy & Medically Needy	No Restrictions
Ohio	Categorically Needy	No Restrictions
Oklahoma	Categorically Needy	No Restrictions
Oregon	A - See state-specific	Prior approval required
Pennsylvania	Categorically Needy & Medically Needy	.$50-$3 per service, depending on payment
Rhode Island	Categorically Needy & Medically Needy	Prior approval required
South Carolina	Categorically Needy	No Restrictions
South Dakota	Categorically Needy	No Restrictions
Tennessee	Varies by plan	No Restrictions
Texas	Categorically Needy & Medically Needy	Prior approval required on specified sources
Utah	Varies by plan	No Restrictions
Vermont	Varies by plan	No Restrictions
Virginia	Categorically Needy & Medically Needy	Prior approval required
Washington	Categorically Needy & Medically Needy	Prior approval required
West Virginia	Categorically Needy & Medically Needy	Prior approval required
Wisconsin	Categorically Needy & Medically Needy	$1 copay per trip in specialized medical vehicle, prior authorization required on long trips
Wyoming	Categorically Needy	No Restrictions

Source: Kaiser Family Foundation website. Available at: http://medicaidbenefits.kff.org/service.jsp?gr=off&nt=on&so=0&tg=0&yr=3&cat=3&sv=21.

Discussion

Since Medicaid's enactment, medically necessary, non-emergency transportation has been woven into the fabric of the program, first as a basic element of program administration and later as a medical assistance service in its own right. Along with certain other aspects of Medicaid, such as eligibility requirements that embrace individuals who bear the major burden of illness, coverage of long term care, and unique and comprehensive coverage rules for children, transportation is one of the dimensions of Medicaid that set it apart from traditional health insurance.

Today, Medicaid's non-emergency transportation assurance represents one of the nation's largest publicly supported transportation undertakings. In the intervening years, federal policy has sought to incentivize transportation through federal funding enhancements (e.g., allowing transportation to be claimed as a medical assistance benefit), innovation in financing and delivery through the §1115 demonstration process, and streamlined federal requirements that

provide states with greater autonomy to design non-emergency transportation systems that are efficient and appropriate to the beneficiary population. The most recent of these efforts, legislative enactment of transportation brokerage systems, further solidifies the Medicaid transportation obligation by, for the first time, codifying transportation in statute.

The findings in this policy analysis also reveal that while there is considerable variation, virtually all states recognize non-emergency medical transportation as a fundamental aspect of program administration. These findings, as well as the formal recognition given to transportation in 2006, suggest transportation's essential role as a matter of both policy and practice in Medicaid. Thus, in revising the Medicaid benchmark purchasing regulations in light of the 2009 CHIPRA amendments clarifying and narrowing the benchmark option, it would seem logical that non-emergency medically necessary transportation be preserved as an assurance for all populations. Indeed, efforts to clarify the continuing application of the non-emergency medical transportation requirements were underway in Congress at the time of CHIPRA's enactment.[79] The narrowed CHIPRA language appears consistent with these efforts to clarify that added flexibility in the design of health insurance coverage does not extend to the discretion to eliminate what HHS and the courts have recognized for nearly 45 years, namely, the fundamental importance of assistance in transportation to program quality and efficiency.

The transportation assurance, along with the legislative reforms enacted in 2006, suggest important and ongoing oversight and research activities as well. Understanding which types of brokerage systems result in both efficient use of resources as well as stable and reliable systems of non-emergency transportation for different types of patients is key. Key issues include the patient population and health conditions involved, geographic setting, availability of transportation alternatives to organized systems, and the types of transportation business arrangements developed. It is also important to understand the issues that may arise as states implement and oversee brokerage arrangements, in the areas of quality, cost, and the ability of the system to integrate with a state's broader Medicaid improvement aims and goals.

Finally, the history of the Medicaid non-emergency transportation assurance underscores Medicaid's significant and distinctive role in financing health care, in ways not reached by more traditional health insurance. For low income persons, the lack of non-emergency transportation can pose a major barrier to care.

Congress is now deliberating, as part of national health reform, whether to offer coverage subsidies for low-income people through Medicaid expansions or through subsidized enrollment into traditional insurance under health insurance exchanges and could create changes that will eventually shift some current Medicaid enrollees into private coverage. Since private insurance does not generally cover non-emergency transportation, this could cause some to lose coverage for benefits, such as NEMT, that are covered in Medicaid, but not private insurance. This could make it more difficult for some low-income people to get transportation for medical appointments, unless they can find voluntary sources of assistance. While the details of Congressional plans are still uncertain, this could cause some people to miss or delay medically necessary care that their insurance would cover, because of the transportation barriers.

[79] H.R. 4355, 110th Cong. (2007); Children's Health and Medicare Protection Act of 2007H.R.3162, 110th Cong. (2007).

Medicaid's ability to pay not only for care but for the services and supports that enable health care is a critical factor to be considered. Because improving the quality and preventive orientation in health care as well as health care efficiencies represent high level considerations in reform, the question of whether to expand through Medicaid or a subsidized insurance exchange becomes one of important matter for long-term consideration. For low income persons insured through an exchange, an important area of future research will be the impact of non-emergency transportation on health care access and quality.