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Our Final DigitalCT: An Extensive Look at NEMT Brings Us to a Close on a High Note

By Rich Sampson

Through the PDF pages of DigitalCT Magazine – and its printed predecessors, Rural Transportation Reporter, Community Transportation Reporter and Community Transportation, all published by the Community Transportation Association of America – few topics have received the depth and nuance of coverage we’ve afforded to non-emergency medical transportation (NEMT)

And for good reason, for while we’ve produced more articles on rural and specialized transportation providers and issues – logical, given those sectors have been CTAA’s focus since its inception – NEMT requires an entirely unique vocabulary, policy complexity and operational specificity than nearly any other aspect of moving people. A scroll through our archived editions and articles reveals coverage of topics as diverse as wheelchair securement and blood borne pathogens, alongside meaty analysis of Medicaid legal interpretations and capitated rates.

Over time, we’ve devoted entire editions of these publications to NEMT coverage, including July 1997, Summer 2002, Winter 2005, Summer 2006, Fall 2014, and Winter 2016. While the depth of concepts, strategies and trends impacting those providing NEMT service can seem daunting at times, the same fundamental reality spans the years (and the pages): people experience better health care outcomes when they have access to reliable mobility options. Our Editor-in-Chief and CTAA Executive Director notes as much in his extensive overview of NEMT in this edition, which reflects the commitment of CTAA’s members and NEMT providers across the country to do what’s both right and necessary to connect people with the care they need.

That key premise also plays out in the details of issues and challenges impacting today’s NEMT professionals, as CTAA’s Health Care and Transportation Associate Alex King and Communications Specialist Taylor McGinley unpack in-depth and timely topics, such as state Medicaid waivers, NEMT’s return on investment (ROI) and establishing a shared language among the mobility and medical sectors.

At the same time, the innovation and experience of CTAA members rounds out a practical understanding of how NEMT is the work of continual adaptation, flexibility and partnership. CTAA Board of Directors members Barb Cline – sharing her accounts of working with a regional hospital operator – and Dave White, dis-
cussing what his company looks for in NEMT providers as a brokerage, offer their unique perspectives. And although NEMT in the urban space is often considered unresponsive at best and inefficient at worst, Ed Benning of the Flint MTA outlines his agency’s new approach to operating medical trips through its Rides to Wellness program. Finally, Taylor McGinley profiles the business-centered approach of SafeRide and its technology platform.

As the CTAA staff shifts its in-depth content delivery mechanism from DigitalCT’s PDF format to a blog platform on our newly-redesigned www.ctaa.org website, our ongoing attention to what’s new and what works in non-emergency medical transportation will remain unchanged. CT

From the Editor

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The State of NEMT

Non-Emergency Medical Transportation (NEMT): Where It Is, How It’s Changed and Where It’s Headed

By Scott Bogren

The non-emergency medical trip has long been a staple of community and public transportation operations. In fact, from its very inception, the Community Transportation Association of America (CTAA) found itself developing training, research, technical assistance, resources and advocacy directed squarely at ensuring the safe and efficient transport of all Americans to non-emergency medical appointments.


Today, an entirely new set of NEMT opportunities and threats stand squarely before the community and public transit industry — ushering in a new era in non-emergency medical transportation. The role of effective mobility in reducing emergency room visits, ambulance usage and readmissions — to say nothing of the attendant cost savings to the health care industry — is coming into focus. The understanding of the real value of NEMT is seeping out beyond government-funded health care programs like Medicaid, Medicare and the Veterans Administration and into for-profit health care systems. Technology has enabled transportation services to operate fully on-demand, in ways that are both HIPAA and audit trail compliant. And the private sector has stepped fully into the NEMT business in the form of Uber, Lyft and a list of upstart scheduling and analytical technology firms that grows daily and is constantly churning with mergers, acquisitions and bankruptcies. Oh, and the Trump
Administration seems committed to making Medicaid NEMT an optional (and not mandated) benefit.

Yet through it all, the need for a trip to the doctor, has endured.

**Understanding NEMT Today Requires Knowing About NEMT’s Beginning**

Public transportation, throughout its history and evolution, has connected passengers with health care of all types. Hospitals, VA Centers, clinics and health care complexes have long been key trip generators for patients and employees along traditional fixed-route transit service. Further, one of CTAA’s original, founding members, Rochester, N.Y.’s Medical Motor Services, traces its roots back to the 1919 influenza outbreak and the need to connect people, nearly a century ago, with care. So it is factually incorrect to say that non-emergency medical transportation began with the advent of the Medicaid program in 1965. That said, the development of today’s non-emergency models of transportation services, largely demand-response operations, begins with the concurrent advent of federal regulations demanding each state include NEMT in its state Medicaid plan, and the U.S. Department of Transportation launching investment in rural public transportation in the mid-1970s — service that often found older adults, non-emergency medical trips and social service transportation at their heart.

The transportation assurance for Medicaid recipients began to emerge in 1966 in guidance to the states for Medicaid program implementation. In 2009, CTAA’s published a report in conjunction with the Himmelfarb Health Sciences Library at The George Washington University, where authors noted:

“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) and “comparability” (meaning that all eligibility groups be treated comparably in terms of coverage and care requirements; the statutory requirement of efficiency in program administration; the requirement that state programs be administered “in the best interest” of program recipients; the statutory free choice of qualified provider” provisions the use of standards of efficiency and medical necessity in terms of both coverage and payment for medical care; the provision of prompt medical care.”

This language, codified in 42 C.F. R. § 431.53, is the basis for Medicaid NEMT: The general transportation assurance rule provides that a State plan must (a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) Describe the methods that the agency will use to meet this requirement.

A number of court decisions during the 1970s reinforced the validity of Medicaid’s non-emergency transportation benefit, and in many ways these decisions form the firewall that has successfully protected the benefit through today. The most consequential of these decisions was made in Texas in 1974, where a Medicaid-eligible person with a disability brought a class-action against the state for violation of federal regulatory requirements. The court ruled in favor of the plaintiff, stating 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.”

**The Shape of NEMT in ‘80s and ‘90s**

The Medicaid NEMT system that grew out of these regulations and legal decisions was one that was different in every state — 50 state plans included 50 unique ways to assure Medicaid recipients had access to their health care. It was also a system...
where the foundational benefit did not find itself in the Medicaid statutes themselves, a weakness that those opposed to providing access would later exploit.

For the better part of two decades, Medicaid non-emergency medical transportation sailed along in a largely fee-for-service pattern with transit operators and other providers billing trips directly to state Medicaid offices. Mileage reimbursements were also heavily relied upon by many states, creating a transportation network of friends and family members of Medicaid recipients. During this time, the broader notion of coordination and coordinated transit systems — particularly in rural America — began to take a consistent form. Federal Transit Administration funds started to be leveraged by Medicaid contract revenue (a funding source specifically allowed as local match) to build out many a modern community, coordinated transportation operation.

By the mid ‘90s, demand for NEMT began to escalate, partly due to an increasing prevalence of certain medical conditions, but also largely related to the simple growth in the number of Medicaid recipients. The population of the U.S. had effectively doubled since Medicaid’s introduction and though utilization rates for the transportation benefit were still relatively low (typically, 10 percent or lower), simple growth in the number of Americans receiving Medicaid created increased demand. The prevalence of chronic conditions like end stage renal disease (ESRD) and diabetes also began to grow significantly during this time, driving up the demand for transportation.

Two key trends emerged during this timeframe that combined to fundamentally change the provision of Medicaid NEMT moving forward into the 21st Century. First, the specter of fraud and abuse began to drive policy at the Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS). Second, health care delivery, across the US, veered into new outpatient models, dramatically reducing in-patient treatments and escalating demand for transportation to-and-from treatment and therapies.

The Arrival of Brokers

The combination of states’ increased Medicaid spending (due largely to increased enrollees), the perilous condition of many state budgets (Medicaid, though a state-federal partnership, remains the single greatest spending line item in state budgets other than K-12 education), the widespread belief that NEMT was rife with fraud and abuse, and a growing desire on the part of state Medicaid programs to simplify processes created the ideal environment for the introduction of private sector Medicaid NEMT brokers.

Community and public transit operators,

Fraud and Abuse: A Rarity

Let’s talk honestly about fraud and abuse. The phrase conjures images of transit systems fraudulently billing for services never provided, or providing illegal inducements. And though some instances of such illegal behavior have occurred, those instances are far-and-away outliers. Examples of public and/or community transportation operators defrauding the Medicaid program are rarer still, with most instances of such behavior emanating from private sector operators or individuals transporting family members. In one state in which CTTA provided Medicaid NEMT technical assistance, the concept of friends and family NEMT provision had grown an additional “f”, for friends, family and fraud.
used to the fee-for-service model and having rightfully deployed Medicaid NEMT as a vital component in their coordinated systems — coordination that was supported by FTA and several Administrations — quickly understood the threat this new NEMT deliver model represented. But their concerns were often misdirected at the brokers themselves, rather than the state legislatures and state Medicaid departments who were driving the change. Many coordinated rural public transit operations found themselves fighting for a status quo that Medicaid, at both the federal and state levels, was fleeing.

As the broker model picked up steam, along came the Deficit Reduction Act (DRA) of 2006 which codified the practice. In short, the DRA offered two significant, statutory additions to the Medicaid non-emergency transportation language. First, it fully permitted states to establish Medicaid NEMT transportation brokerages; offering states the ability to do so, through the 1915 (b) waiver process, without previous admonitions on comparability, freedom of choice and statewideness. Second, it introduced the concept of limiting the Medicaid transportation benefit through state adoption of “benchmark” plans. Simply put, if the adopted benchmark plan didn’t offer transportation, then the state was not compelled to do so.

The passage of the DRA gave many states that had yet to move their Medicaid NEMT programs to a brokered model, the impetus to do just that. But more significant change would soon roil the NEMT field with President Obama and Congress passing the Affordable Care Act in 2010, which expanded Medicaid rolls, beginning in 2014, to any individual at 138% of the federal poverty rate and offered states significant federal money to accept the expanded Medicaid population.

Today, 37 states (plus the District of Columbia) have agreed to expand their Medicaid populations. For the best breakdown of how each state currently treats Medicaid NEMT, the Transit Cooperative Research Project’s Project B-44 report offers the following breakdown a little more than a year ago: 19 states have adopted some form of managed care for Medicaid NEMT, while 18 states deploy either statewide or regional brokers.

The non-emergency medical transportation ground shifted even further in December of 2016 when the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) ruled that health care providers (both public and private) could legally, in certain circumstances, contribute or pay for patient transportation. To be clear, these health care providers were under no compulsion to pay for transportation, but the Safe Harbor rule (as it came to be known) allowed that they could choose to without fear of running afoul of conflict of interest rules designed largely for doctors.

CTAA and its members initially viewed this ruling through the prism of private-sector dialysis companies which had consistently pointed to these conflict of interest rules to explain why they were not legally allowed to support the transportation of clients to their clinics. However, the ruling would have a far broader impact with time.

It’s important to recognize the bigger picture that came into focus at this time as a direct result of all of these policy machinations — because it was during this period that today’s NEMT marketplace was forged. The trend lines of growing numbers of Medicaid enrollees, increasingly slim state budgets (don’t forget the dire impact of the recession of the late 2000s), and an emphasis on outpatient and preventative health care models began to converge. And as they converged, new technologies that would greatly impact NEMT in the not too distant future were moving from incubation to infancy to testing.

Enter the Disruptors

In June, 2007, Apple introduced the iphone into what was already a crowded cell phone market. No one used the phrase, “smart phone,” initially, but in a matter of months many came to realize that these
new hand-held devices would fundamentally alter everything from entertainment (music, films, social media) to navigation (GPS) to finance (mobile banking and payments) to, you guessed it, transportation. In little more than a decade, smartphones became ubiquitous and it wasn’t long before the convenience of the devices infiltrated all facets of American life, and business — including health care and transportation.

Initially, technology start-ups like Uber and Lyft, ideas funded entirely by venture capital from Silicon Valley (largely), dubbed themselves ridesharing firms. Not surprisingly, individuals and organizations engaged in actual ridesharing (i.e., two or more people sharing a ride to a location) pushed back vigorously, and eventually they became known as ride-hailing or transportation network companies (TNCs). Regardless what you call them, the TNCs’ arrival was a broadside attack on the taxi transportation model — a model that had long played a role in the delivery of NEMT, particularly in the private sector health care space. Seemingly overnight, an entirely new mode of transportation appeared, one that would eventually find its way to NEMT provision.

The fuel for the TNCs is data. And there are few industries in America that create more data than health care. But it’s what that data is telling the health care industry — specifically, costs — that’s driving the entire health care sector to re-examine transportation delivery models. Always in an effort to lower costs, increase efficiency and improve care.

Whether it’s CMS (Medicare and Medicaid), insurers (i.e United HealthCare, Blue Cross/Blue Shield, etc) or large private-sector hospital groups, that data is telling them they need to reduce hospitalizations, emergency room visits, hospital re-admissions and ambulance trips in order to either maximize profits or control costs — or both. Moreover, the financial burden of a no-show in health care today is one the industry recognizes, and quantifies. Public and private sector health care officials alike measure their no-show rates and comprehend their financial impact — almost always they incur costs in these no-show scenarios without any ability to bill for services rendered. It is not atypical for a no-show to cost a health care provider between $50 to $100, on average. And what’s one of the main reasons for a no-show? Lack of available transportation.

Today we see Uber and (particularly) Lyft entering into relationships with all manner of organizations and businesses in the private-sector health care arena. It’s not hard to see why. The TNCs and their technology offer health care providers a ready-made solution that they often tailor to the marketplace. Concerns with Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance? They develop a HIPAA-compliant platform. Audit trail? The TNC technology makes for a lock-tight trip auditing interface. Accessibility needs? Increasingly, the TNCs are on-boarding fully accessible minivans into their service networks; albeit with longer trip wait times than with their other networks.

Beyond the TNCs and their impact at the provider level, the disruptors are also finding traction at the scheduling and routing stage as both traditional transit vendors and technology start-up companies seek to improve and optimize NEMT through simpler scheduling interfaces designed for health care coordinators and social workers as much as for transportation personnel — always with an eye on lowering costs.

Yet for all its bluster and self-promotion, the disruptors have yet to find a viable business model — or one that at least generates a profit. Uber and Lyft operate deeply in the red each year and are subsidizing each trip they make with investor capital. They re-
main immune to having to meet the Americans with Disabilities Act — a federal law — by insisting they are not transportation companies, but rather technology firms. They resist sharing travel shed data with local transportation planning bodies yet routinely use publicly funded infrastructure from which to base their operations. They have treated public streets as testing tracks for their automated technologies, with sometimes dangerous results. In the NEMT space, the question remains: do you want a family members’ life-sustaining medical trips being provided by a driver for whom the service is (in their own words) a “side hustle?”

The rapid speed of change in the NEMT field, from policy and political to health care delivery to operations and scheduling is escalating. In many ways, the nation’s demographics, more than anything else, are driving this rate of change. Our aging, urbanizing population with a higher prevalence of people with disabilities and a higher incidence of chronic conditions (diabetes, dialysis, etc.) is not going to subside anytime soon. Given these trends, what follows are the key issues facing NEMT providers today.

**Key NEMT Issues Moving Forward**

Service Quality — Community and public transit vehicles undergoing daily and routine inspections and maintenance, are tested at the federal bus testing facility and are part of each agency’s asset management planning. Typical transit operations carry spare vehicles to ensure service consistency and have detailed routine maintenance schedules.

All of these quality attributes are part of the mandate that comes along with an agency accepting even $1 of federal transit funding — as transit operators know all too well. Yet the community and public transit industry has not been able to successfully translate these levels of quality service when competing with the private sector head-to-head for NEMT work. Too often, the only factor in decision making is price.

Compliance with CMS regulations is another important dynamic that must be addressed in the relationship between transportation provider and health care system. Brokers, upon entering the NEMT space, immediately seized upon the importance of program compliance and assured state Medicaid agencies they would meet all compliance factors in their service agreements. Compliance has not always been a strong suit for community and public transportation operators. Compliance is not something that the TNCs have fully tackled.

Additional quality factors like on-time performance, billing, and fraud and abuse mitigation also are key factors in the NEMT quality continuum. To those of us in the public and community transportation industry, it often seems there is a thumb on the scale in the direction of cost alone when it comes to NEMT policy, contracting and decision making. The ability for the NEMT payors — be they public or private — to more fully assess quality and to understand transportation beyond cost will be key to this issue’s resolution.

**NEMT Beyond Medicaid** — As much of this article indicates, the NEMT acronym has long been synonymous with Medicaid recipients and policy. For a generation of public and community transportation professionals, in fact, the two (NEMT and Medicaid) were understood to be one-in-the-same. That historical artifact is changing rapidly for a number of valid reasons.

Today more than ever before, Medicaid is subject to the partisan whims of the acrimo-
The State of NEMT

nious modern political process. The program’s inclusion as a key component in the Obama Administration’s Affordable Care Act (which created the option for expanded Medicaid coverage) put the politicization of Medicaid NEMT on steroids. Issues like NEMT waivers at the state level, work requirements for Medicaid recipients, and the ongoing partisan divide over health care access rightfully give pause to any organization considering committing scarce transportation resources to Medicaid NEMT operations. Further, Medicaid NEMT is a highly competitive business with scant profit margins available to operators.

Adding to these concerns, we also must consider the long-term viability of the Medicaid NEMT benefit itself. As has been covered in this paper, NEMT is not directly in the Medicaid statutes, but rather it is the product of regulations and court orders in the late 1960s and early 1970s. In October, the Trump Administration revealed on a HHS regulatory docket that it plans to introduce a Notice of Proposed Rulemaking (NPRM) in May, 2019, that would allow states the flexibility to choose to cease offering the Medicaid NEMT benefit. Three states — Iowa, Indiana and now Kentucky — have already had Medicaid waivers approved by CMS doing just that. CTAA expects the language in the NPRM to closely resemble language in HR 1394 which was proposed by Rep. Susan Brooks (R-Ind.) during the last Congressional session. The transportation benefit in Medicaid seems destined for a legal fight in the very near future. And, to be sure, a great many states will choose — given the choice — to continue the vital NEMT benefit.

Even Medicare, which has never statutorily paid for anything other than ambulance transportation, is beginning to see the benefits of NEMT — albeit around specific chronic conditions. In the November 30, 2018, Federal Register, CMS announced a one-year extension of the prior authorization pilot program for NEMT for repetitive, scheduled transportation (like dialysis, diabetes and chemotherapy) in Delaware, Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia, and West Virginia and the District of Columbia. The program began in 2014 and CMS is evaluating the program to see if it merits nationwide expansion due to a combination of program savings and improved health care outcomes.

While all of this partisan fighting erupts around the Medicaid NEMT benefit, the private sector health care field (hospital groups, MCOs, insurers, etc.) seem to be moving in exactly the opposite direction. With their prodigious data collection expertise, these health care entities are coming to understand the vital ways in which NEMT can both lower costs and bring real savings by reducing no-shows, emergency room visits, readmissions (in September, CMS announced that 2,599 hospitals across the U.S. are facing readmission penalties) and even ambulance usage. These businesses have crunched the numbers and see transportation as a cost savings, as well as a way to compete for new customers. These private-sector organizations represent a fresh look at NEMT and present emerging opportunities for transportation providers.

The Shape of MaaS — All forms of on-demand transportation — be they Medicaid NEMT, complimentary ADA paratransit or an app-based TNC trip — are beginning to find their place in a broad transportation strategy known as Mobility as a Service (MaaS). Taking attributes from transit coordination tactics and then mobility management and combining them with new technologies and data analytics, MaaS dramatically changes the lens through which trips should be viewed from the perspective of the mode to instead the point of view of the passenger.
MaaS offers great promise for NEMT because it takes a fully networked approach to a trip. In fact, it works best when a variety of transportation services — for example fixed-route operations (bus or rail), bikes, scooters, walking, as well as a spectrum of on-demand mobility — can be deployed to make the most efficient, cost-effective trip happen. Where MaaS offers real promise in the NEMT space is in the long-standing friction between transit’s emphasis on the trip and health care’s focus on the patient. This core discrepancy in viewpoint has often led to tension between transit and health care advocates. MaaS concepts may be the bridge between the two, allowing for the efficiency of transit-style service while maintaining a patient- or passenger-specific approach.

Social Determinants of Health — An individual’s overall health is impacted by so much more than the health care they receive. In fact, the majority of an individual’s health outcomes are due to what happens outside of the health care arena. The other, non-clinical factors form the notion of the social determinants of health (SDOH). Given the growing emphasis on SDOH in the health care sector, moving forward, NEMT operations must become fluent in SDOH.

A brief sweep of the internet quickly reveals that a number of organizations have attempted to quantify these social determinants, from the Centers for Disease Control here in the U.S., to the World Health Organization. The generally accepted five principle social determinants of health are: (1) economic stability; (2) education; (3) social and community context; (4) health and health care; and (5) neighborhood and built environment. What this means, in practice, is that an individual’s education, income, job status, and geography are key determinants in their overall health and well-being.

The Office of Disease Prevention and Health Promotion produces a set of national goals every 10 years (the current goals are called Healthy People 2020) that, among others, dives deep into the underlying factors for each of the aforementioned five key social determinants of health — and it’s in these underlying factors where transportation and mobility, couched as access, is directly addressed.

- Economic Stability — employment, food security, housing instability, and poverty
- Education — early childhood education and development, enrollment in higher education, high school graduation, and language and literacy.
- Social and Community Context — civic participation; discrimination, incarceration, and social cohesion.
- Health and Health Care — access to health care, access to primary care, and health literacy.
- Neighborhood and Built Environment — access to foods that support healthy eating patterns, crime and violence, environmental conditions, and quality of housing.

So within this collection of factors, the key question to ask is how can NEMT (or perhaps more specifically, a targeted application of NEMT) impact these social determinants of health? In many ways, the answer includes widening the scope of NEMT to include employment and education trips, connections to healthy foods, social and human service trips, and the physical safety of mobility options, in addition to direct service to health care services.

Key Opportunities for NEMT

Perhaps the best question to ask of a publication focused on non-emergency medical transportation is, simply: What’s next? CTTA believes that the best way to identify the future for NEMT is to look for the situations where a lack of adequate mobility leads to unsuccessful health care and/or human services outcomes; or, conversely, where the programmatic cost savings of successful health care and/or human services outcomes are so significant that they could be, at the very least partially, applied to improved NEMT (or even MaaS) investment. Using this standard, a number of key opportunities for NEMT come immediately into view.
The State of NEMT

Opioid Addiction Treatment — In statistics released at the end of November by the Center for Disease Control (CDC), 70,000 Americans died from opioid-related overdoses in 2017. For context, that figure doubles the number of Americans that die in traffic accidents each year. Further, the CDC reports that the rate of opioid overdose is higher in rural America (where fewer than one in five Americans lives) than in urban or metropolitan areas.

At the end of October, President Trump signed into law the Substance-Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, which, among others, continues state opioid grants through the Substance Abuse and Mental Health Services Administration. Further, the new law increases the numbers and types of health care providers that can provide medication-assisted treatment (MAT).

Both the opportunity and need for increased levels of NEMT designed to connect patients to opioid treatment programs and services is clear. The disproportionate impact of opioid abuse in rural America, however, makes both the funding and logistical challenges nothing short of severe. Study after study has shown transportation barriers to be among the biggest impediment to success in these treatment programs, with only Medicaid currently available to actually provide resources to pay for transportation to MAT.

Earlier this fall, CTAA offered its assistance to the National Institute on Drug Abuse (NIDA) as it announced a series of funding opportunities focused on a network of researchers collaborating across justice and community-based service settings to transform community-level responses to opioid misuse and opioid use disorder in justice-involved populations. As we noted then: “Transportation is a significant contributor to success or failure in patient outcomes – a key social determinant of health – and such factors are especially relevant where substance use disorder and opioid misuse has become a public health crisis. CTAA and its member represent a network, experience, and skills to support researchers’ work in addressing the opioid crisis. As an organization, CTAA is fully invested in contributing to positive outcomes wherever possible for communities around the country, and the organization would be particularly honored to assist in any efforts to overcome this public health crisis.”

In September, the Federal Transit Administration and U.S. Department of Agriculture hosted a meeting entitled, Opioid Misuse: Increasing Access to Transportation in Rural Communities in Lewisburg, W.V., that further explored the issue.

Clearly, there is a swirl of activity focused on addressing the opioid epidemic — and with an emphasis on the disproportionate impact of the crisis on rural America. And rural transit operators — many of which are highly involved in both the public transit and NEMT services in their communities — want nothing more than to be part of the pilots and demonstrations from which solutions will likely arrive. But the potential service ramifications on these agencies also must be considered.

For many rural public transit operators,
the demand for dialysis transportation (which is, most often, three times a week) has become tough to meet as the number of end stage renal disease patients has grown across the country. CTAA is aware of some such transportation operators that have been forced to cap the number of dialysis patients they’ll accept. With medication-assisted treatment (MAT) being actively supported by the new federal legislation, the service demands of daily suboxone (or similar medication) treatment could be staggering and extremely difficult for a transportation network already straining against capacity constraints to meet. Further, CTAA believes that specialized training for drivers — including, potentially, the use of Narcan to stem the effects of opioid overdose — will be vital in the safe and effective transportation of this population. It seems clear that any attempts to simply place the trip demands associated with opioid treatment programs, particularly MAT, into the currently available NEMT network will fail without increased transportation investment and new approaches to service delivery — like MaaS.

The bottom line is that the opioid epidemic is a health care crisis that is disproportionately striking areas of the country with the least amount of public and community transportation infrastructure and investment. The need for innovative partnerships and technologies in delivering NEMT operations designed to address this health care emergency is clear.

**Drug Courts** — In 2017, the National Criminal Justice Reference Center estimated that more than 3,000 courts now existed across the country with the purpose of striking the proper balance between incarceration and treatment of (typically, non-violent) individuals in the legal system with substance abuse disorders. These courts are designed to develop stringent addiction treatment regimens — including random testing — with the goal of better patient outcomes and providing more cost-effective options for non-violent offenders than going to prison. Not surprisingly, transportation, particularly in rural areas, has become one of the main barriers to successful patient outcomes for those individuals enrolled in those programs.

First and foremost, CTAA believes that substance abuse is a health care diagnosis, regardless the substance. And like other health care diagnoses identified throughout this article, the focus is on how more efficient and cost-effective transportation, as well an innovative treatment program delivery, can create better health care outcomes for patients.

Through its work with the National Center for Mobility Management (NCMM), CTAA is working with a team in rural Michigan to create a transportation service to help participants in the drug court system connect to their multiple required appointments, sometimes as many as 11 appointments a week. The team is partnering with a local nonprofit organization to create a centrally located community hub for drug court participants. This hub not only serves as a central space, but offers supportive activities between appointments including transportation navigation, resume assistance, and GED preparation classes. Given the proximity of the hub to key local destinations, the team is currently considering launching a fleet of free-rent bikes to drug court participants so they could ride to appointments.

Successful drug court participants provide cost savings to both the health care and legal system. As is the case with other emerging NEMT opportunities, fares alone will not come anywhere near paying for these trips, especially when considering the specialized training and on-demand nature of random testing protocols. To become sustainable, a portion of the program savings that successful outcomes create must be re-invested in the transportation network that’s engendered them. Additionally, the demand that drug court-style transportation services create cannot be met, exclusively, by current transportation services in most areas. The MaaS approach with a fully developed network of both fixed-route and on-demand transportation providers and modes will, no doubt, be necessary.

**Rethinking Coordination** — For the better part of the past quarter century,
those of us in the community and public transportation industry have been asked — in myriad ways — to coordinate our services with human service and health care organizations. Sometimes, these coordination efforts have been ruse; austerity measures given a more palatable name. Doing more with less was often how this message was delivered. Other times, coordination implied extending, or even building, transportation services through a multi-platform approach where no single investor could afford an entire operation, but combined investors could.

Yet from the beginning of these coordination efforts, not all transportation investors arrived at the table in good faith. The Federal Transit Administration, through numerous federal programs, across multiple Administrations and with a variety of target audiences in mind has always arrived at the coordination table as a willing funder and partner with its federal agency brethren. The same cannot be said, however, about other federal agencies — which have too often been unwilling to truly commit to coordination, with willingness to merely pay prevailing bus fares for clients or operating under the false assumption that the transit industry is rife with fraud and abuse.

Frankly, the rationale behind this hesitancy to fully commit to the coordinated transportation model has had merit. Transit’s focus on the trip has always conflicted with health care and human services’ emphasis on the client or patient. The two entities count, serve and evaluate differently. Too often, transit operators were perceived — accurately, in some cases — to be selling a one-size-fits-all approach to potential coordination agencies that was far from what those agencies were seeking to buy. The emergence of a more robust and diverse set of on-demand transportation services, enabled by advances in technology, is the change agent in these coordination dynamics and the impetus for re-thinking coordination.

How so? First, let’s be clear that what used to known as demand-response service has, in reality, morphed into today’s on-demand operations. And the biggest change that goes along with those titles is the leaving behind of the 24- or 48-hour waiting periods that often went along with demand-response service and that was codified with the advent of ADA complimentary paratransit in the early 1990s. The most significant impact that TNCs have had on community and public transportation is how quickly they changed expectation levels on the part of the riding public. On-demand service, today, means right away — the very idea of waiting periods is melting away, particularly in urban environments. The availability of on-demand transportation is a coordination game changer, and it sets the stage for the next great leap forward: the integrated on-demand transportation network or ecosystem.

Smart phones and apps can now bring together a variety of on-demand transportation services into a seamless, coordinated network that seamlessly interfaces with traditional fixed-route transportation operations and that is available at the swipe of a finger. The components of that network are different in every community, but can include TNCs, taxis, ADA complimentary paratransit, NEMT, volunteer drivers, bike and scooter share and social service transportation. The network will handle a first-mile/last-mile leg of a commute as simply as it does a non-emergency medical trip — the only difference being the payor. In this vision of the next generation of coordinated transportation, individuals, human and social services, public (Medicaid/Medicare/VA) and private health care deploy mobility management skills to purchase the more efficient, cost effective service that best suits their needs. This potential model puts together every transportation mode from bikes to cars to small buses to big buses to...
trains and provides trips based on the Mobility as a Service model.

Would the emergence of a coordinated network like the one described above bring new agencies, funders and investors into the mix? Would it provide the best transportation at the lowest price? Would it be flexible enough to meet the wide spectrum of American’s travel needs? CTAA believes it would. But that transition will be neither simple nor quick.

The Crucial Connection

The need for non-emergency medical transportation (NEMT) is not going away. In fact, trends in health care policy, population demographics and budgets virtually ensure NEMT’s prominence today, and even more in the future. The key will be NEMT providers’ and advocates’ ability to articulate the full spectrum of cost savings and enhanced health outcomes that efficient and cost-effective NEMT engenders.

Too often, the term NEMT has been reserved for those serving Medicaid clients. A more expansive definition will be needed moving forward, however; one that encompasses the full continuum of transportation modes, current and emerging technologies and a gamut of investors and payers far beyond what we see today. Updated, adapted versions of transportation concepts like coordination, mobility management and even Mobility as a Service will be tested, iterated and deployed to meet growing demand.

And at the end of all of this, we must return to notion that the fundamental connection to be made is a simple trip to the doctor’s office or health care appointment. Same as it ever was. CT

This vision of conducting a community needs assessment process from South Dakota finds commonality with the work of mobility providers everywhere.
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The Gathering Threat to Medicaid NEMT

By Alex King

Medicaid non-emergency medical transportation (NEMT) is an important component within the public transportation space, particularly for rural providers. The contract revenue from Medicaid NEMT is the largest source of operating funds for many transit systems across the U.S. and a vital source of local match. Additionally, public transportation passengers, both urban and rural, are themselves Medicaid recipients, thus creating both a policy and fiscal link (and both opportunities and tension) between Medicaid NEMT and public transportation services.

The links between public transportation and Medicaid NEMT are critical to understand as the landscape of both types of services continue to evolve and shift. In recent years, both individual states and the current Administration have submitted numerous requests to waive or eliminate the NEMT benefit with varying levels of success. Now, with seemingly few supporters in the top tiers of HHS, CMS, and the Administration, the transportation benefit seems to be facing its biggest threat yet.

Incremental Threats: CMS 1115 Waivers

On the federal level, there is a general movement away from using Medicaid dollars to support NEMT, as high-level officials in the Centers for Medicare and Medicaid Services (CMS) have shown inconsistent levels of support for the transportation benefit. Previously — with Iowa being the most obvious example — the Obama Administration, in an effort to entice more states to accept expanded Medicaid as part of the Affordable Care Act, was willing to trade away the Medicaid NEMT benefit. More recently, the Trump Administration has used waivers to bypass or unravel a number of the Obama Administration’s more expansive health policies, and has granted some states’ requests.

In particular, CMS Administrator Seema Verma (who arrived from Indiana with a predisposition of opposition efficacy of NEMT) has supported waivers of NEMT as a potential reform allowed by law. In a March 2017 letter to state governors, former HHS secretary Tom Price and CMS Administrator Seema Verma encouraged the use of waivers for NEMT services as a cost-cutting measures.

A number of states have taken advantage of the Centers for Medicare & Medicaid Services (CMS) support of the 1115 waiver program to create changes to their Medicaid programs. Section 1115 demonstration waivers specifically allow for state flexibility to implement experimental, pilot, or demonstration projects that differ from federal program rules. These waivers can provide states with considerable flexibility in how they operate their state Medicaid program, beyond what is available under current law.

The movement to limit the transportation benefit, while not widespread, has had varying levels of success in states across the U.S. CMS has approved Section 1115 waivers for three states (Iowa, Indiana, and – very secretly – Kentucky) which have eliminated the NEMT benefit for specific subsections of their Medicaid population. Additionally, five other states (Arizona, Arkansas, Massachusetts, New Mexico, and Pennsylvania) have considered or proposed similar 1115 waivers of NEMT services.

In 2013, Iowa became the first state to receive waiver authority exempting it from providing NEMT to their Medicaid expansion population (adults up to 133 percent of the Federal Poverty Level, FPL)

Indiana’s Section 1115 waiver was first approved in 2015 and waives NEMT for the expanded adult group (up to 133% FPL), and provides exceptions for 19- and 20-year old’s subject to EPSDT (Early and Periodic Screening, Diagnostic and Treatment), pregnant women
and those who are medically frail.

Despite legal challenges, Kentucky’s
Section 1115 waiver was reapproved in late 2018, and includes a waiver of the requirement to provide NEMT for beneficiaries enrolled in the new adult group (up to 133% FPL), with exceptions for beneficiaries who are medically frail, 19- or 20-year-old beneficiaries entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, former foster care youth, survivors of domestic violence, and pregnant women.

Legislative Threats: The Brooks Bill & other legislative proposals

In addition to state-by-state threats to NEMT via CMS waivers, additional legislative efforts to limit or remove pieces of the NEMT Medicaid benefit also have been tested. To date, none of these attempts have been successful; nevertheless, they add to the overall attitude of opposition to the transportation benefit.

In March of 2017, Rep. Susan Brooks (R-IN) in conjunction with Reps Chris Collins (R-NY) and Brett Guthrie (R-KY), introduced H.R. 1394, a bill that would amend title XIX of the Social Security Act to provide states with flexibility with respect to providing coverage for non-emergency transportation under Medicaid. This bill was introduced in the hopes of revoking the federal requirement to provide Medicaid NEMT in an effort to provide states with flexibility. The legislation was referred to the House Committee on Energy and Commerce for consideration, but the effort has since stalled.

Additionally, another Republican proposal in 2017 would have reversed the Affordable Care Act’s Medicaid expansion and in doing so, also reduced federal funding for the NEMT program for this population. This proposal also failed, but other similar individual state efforts via CMS Section 1115 Waivers (see above) still stand.

To clarify, current regulations (CFR §431.53) mandate that a State plan must specify that the Medicaid agency will ensure necessary transportation to and from providers. The concern with both of these threats is that they would ultimately repeal this 50 year old assurance of NEMT for Medicaid Patients.

New Threats from the Administration: The HHS Unified Agenda and the NEMT Advanced Notice of Proposed Rulemaking

Over the past few months, the Medicaid NEMT benefit has come under direct threat from a series of new, and pending, actions by the Administration.

The President’s FY 2019 Budget included a proposal to use regulatory authority to change Medicaid NEMT from a mandatory to an optional benefit. While the congressional budget seems unlikely to include this proposal (due to the lack of support for the 2017 Brooks Bill), the Administration was able to find another avenue through which to move this idea into action.

On October 17th the Administration announced its semiannual forecast of the rules that the Department of Health and Human Services (HHS) will be churning out over the next year. The lengthy list includes issues that are top of mind for the department and the administration is expected to move forward with many of these priorities in the coming months. This year’s announcement included revealing a potential rule that would re-examine non-emergency medical transportation (NEMT) coverage requirements for states under Medicaid.

While very little is known about the content of the proposed rule (which is speculated to be released in May 2019), the overwhelming consensus is that it will revisit NEMT benefit requirements for beneficiaries with no other means of accessing medical services. Reportedly, the goal of the proposed rule aligns with the Administration’s goal to provide states with greater flexibility as part of the administration’s reform initiatives. This also matches the goal of the Brooks Bill proposed back in 2017.

Potential Impacts

Despite the lack of information, many have continued to speculate on the avenue the proposed rule may take in re-examining the
The Gathering Threat to Medicaid NEMT

NEMT benefit. One potential change being discussed is that the rule could possibly allow states to make changes to their NEMT program through a State Plan Amendment versus a Waiver, which would be an easier and less time intensive process. Taken at face value, the wording of the announcement does not appear to be focused on any one specific Medicaid population or set of eligibility categories, and any high risk or particularly vulnerable populations have not been identified at this time as being potentially exempt from any changes.

Given the framing of providing states with greater flexibility, it can be assumed that if made optional, not all states will choose to revisit or change the NEMT benefit. Each State Medicaid program operates individually under the federal rules. Therefore, if this proposed rule does fall under the idea of state flexibility, the changes to Medicaid NEMT may not be as sweeping as potentially feared.

However, it does not matter if your state has already waived the benefit, is considering waiving it, or has no intention of waiving it, this potential proposed rule should be of interest to all transportation providers.

In addition to the potential elimination of benefits, there are also many potential unintended consequences on transportation services as a whole. As mentioned above, Medicaid NEMT is an influential figure within public transportation. Changes to the Medicaid NEMT benefit will impact funding streams for transportation, impact ridership, and create new and unknown challenges to transit providers, particularly rural public operators who have grown to depend on the investment.

Many specialized and public transit systems simply do not have the capacity or funding to take on the additional demand that would occur if the NEMT benefit were eliminated. In addition, contract revenues used for FTA match dollars could diminish or disappear, threatening rural public transit’s ability to meet the match requirements thus creating a wider range of impacts on transit services and community mobility.

If the benefit becomes optional on the federal level, some of these links could change on the federal level as well – therefore threatening the current structure even in states that choose not to change their NEMT benefit.

It is critical to note that at this point in time, the comments above, and any others you hear, are merely speculations until further information is released by CMS.

Looking Ahead

No matter which, if any, of the above dangers come to fruition, public transportation should be alarmed. The threat to Medicaid NEMT is no longer gathering; it is here. As transit providers, and community members, we need to consider the impact that Medicaid NEMT has not only on our services, but on our community members, and on our wider network of public services.

We must work together with our partners and other key stakeholders who are reliant on NEMT to create a unified response strategy across groups. From public transportation providers, NEMT brokers, health care insurers, hospitals, to patient advocacy groups, we all need to illustrate the value of non-emergency medical transportation in the hopes of fighting these threats.

CTAA is currently tracking developments around the proposed rule and other existing and potential threats closely and is preparing a response and advocacy strategy. We are working with a number of key stakeholders in this arena including Brokers, Insurers, and other organizations who have members or constituents reliant on NEMT services, to create a unified response strategy across groups. As our strategy takes shape, and more information emerges, we will be sure to share any relevant updates on our website.
The perfect compliment to Digital CT is our bi-weekly E-Newsletter, CT Fast Mail. Delivering the latest news on transit policy from the nation’s capitol, developments from across the country, research and analysis publications and information on resources and technical assistance from the Community Transportation Association and other partners, CT Fast Mail is the most direct location for the most relevant news and updates in the industry.

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Cross-sector collaboration is central to solving the complex problems transportation providers face. However, each sector is unique and has its own way of approaching problems, which can create barriers to successful partnerships.

While the activities of health care and transportation clearly overlap, there is often relatively little discussion or collaboration between them. This limited conversation between sectors creates inefficiencies in services, decreased access to care, poorer health outcomes for patients, and a general tension and frustration. One such barrier to building productive partnerships likely includes the unique jargon that forms in any specialized industry which can feel overwhelming or intimidating to outsiders.

In order to better address complex health and mobility problems, health care and transportation must work together to create a shared language, and cross-sector understanding of key terms and ideas is critical to making such an effort succeed. A shared language can mean the difference between a successful partnership which creates new and innovative ideas, or a failed one that yields few results.

Below are a few key questions that can help transportation professionals gain a better understanding of health care terminology and how it impacts the services that get clients to their appointments. In each, we offer both analysis of the question and a useful transit tip.

What is a Community Health Needs Assessment (CHNA)?

Passed as a part of the Patient Protection and Affordable Care Act (ACA), tax-exempt hospitals must complete a Community Health Needs Assessment every three years and adopt an implementation strategy to meet needs identified in the assessment. The goal of a CHNA is to improve the health of communities by ensuring that hospitals have critical information needed to accurately provide services and care that meets the needs of their local population. These assessments also provide an opportunity to improve coordination of hospital benefits with other services and initiatives to improve community health, well-being, and equity in access to health care services.

Transit Tips: Community stakeholders, including transportation providers, should see CHNAs as a chance to engage with their local hospital in the process of prioritizing community needs. Transportation providers can leverage the CHNA process to identify and create new partnerships to improve health care transportation and overall mobility in communities. A recent study of hospital CHNA’s found that 14 percent of hospitals identified transportation as a priority need as a result of their community research; however, only 8 percent of hospitals decided to act on that finding and include transportation as a part of their implementation plan.

Why does health care rely on capitated rates?

The current U.S. health care environment has been experiencing a shift over the past decade towards value-based care, including a change in reimbursement and payment models. Value-based models largely use a capitated payment model, where providers
are paid a prospective cap, or per-member per-month (PMPM) payment to provide the care for individuals enrolled in a health plan. The goal of this type of payment model is to encourage providers to consider best practices, value, and preventative health when addressing payment needs. Providers are incentivized to provide the right care at the right time to their patients, so that they can profit from any net realized savings below the assigned payment per patient. Additionally, the capitation model is recognized as more stable and financially certain, as it offers a monthly financial guarantee, whether patients seek care or not.

**Transit Tips:** It is fairly common for NEMT payment to be offered as a capitated rate. In states that use managed care organizations (MCOs) or a brokerage model for NEMT, the state will pay the MCO or broker a PMPM rate based on the number of Medicaid enrollees and assumptions about NEMT need. While there are benefits to having the transportation costs be both known and fixed, research has shown that capitated rates can discourage high-quality transportation. Pre-determined rates can vary dramatically from actual transportation costs, and when the rates cannot cover the costs, both services and quality will be cut to cover the losses. In particular, the recent impact of the opioid epidemic on transportation need has exponentially increased trip rates for Medicaid populations needing treatment. A capitated rate has little chance in adequately covering the trip need for individuals traveling for treatment seven or more times a week, particularly when the PMPM capitated rate was likely determined before the scope and impact of the opioid crisis was realized.

Transportation providers need to work with health care to help them understand why the capitation model does not always effectively promote quality care in the same way for transportation as it does in health care systems. Quality and effective transportation may end up increasing instead of decreasing use of transportation services — thus capitated rates create a disincentive to have high quality transportation as high transportation use limits potential profitability.

**What is HIPAA and does it apply to transportation?**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a series of national standards that health care organizations must have in place in order to safeguard the privacy and security of protected health information. In 2003, HIPAA established uniform privacy protections over patients’ health information (PHI). PHI is any demographic or individually identifiable information that can be used to identify a specific patient including names, addresses, emails, telephone numbers, full facial photos, etc.

**Transit Tips:** Public transportation agencies maintain some medical information about their clients; however, only those organizations that provide health care and bill for services electronically must comply with the HIPAA law, which means at this time, very few transit systems fall within this category.

Currently, there is no concrete guidance available on how transportation, particularly non-emergency medical transportation, relates to the HIPAA privacy rule. Even the U.S. Department of Health and Human Services (HHS) website does not disclose any guidance, advice, opinion, or decision regarding whether or not transit agencies need to comply with HIPAA.

Based on current practice and available research, to be subject to HIPAA, a transit agency would have to be HIPAA’s definition of a business associate and have a business associate agreement (BAA) with a covered entity that authorizes the creation, sharing, maintenance or transit of PHI on behalf of the covered entity. Current practice leaves a major exception to the idea that HIPAA does not apply to transit, NEMT brokers are required to sign BAAs as a part of their contracts with state Medicaid offices, thus requiring them to comply with HIPAA.

However, as technology evolves and what is considered patient health information expands, transportation providers are
beginning to become more aware of which HIPAA rules may apply to them and consider if and how they need to begin working towards becoming HIPAA compliant.

What is the Lewin Report and why is it important?

Indiana’s Section 1115 waiver to expand their Medicaid program was first approved in 2015, and included a waiver for NEMT services for expansion adults (Note: Medicaid expansion adult group includes beneficiaries with income from 101-138 percent of the Federal Poverty Level, and provides exceptions for 19- and 20-year old’s subject to EPSDT [Early and Periodic Screening, Diagnostic and Treatment], pregnant women and those who are medically frail – ed). As a part of the terms and conditions of this waiver, Indiana was required to conduct an independent evaluation of the NEMT benefit to ‘allow the state and CMS to consider the impact of the State’s NEMT policies on access to care.” The state hired The Lewin Group to conduct the evaluation. The resulting report evaluating the experience of the Indiana Medicaid beneficiaries included in the NEMT waiver, has since become famous in NEMT circles and is frequently referred to simply as “The Lewin Report.”

This report has become fuel for those who support eliminating the NEMT benefit, due to the implications of its content on the lack of impact that the NEMT benefit has on missed appointments due to transportation barriers. However, despite the use of this report as support against the benefit, both CMS and the Lewin Group expressed concern about the limited scope of the research conducted and the lack of comparability of the information researched.

Transit Tips: Largely, CTAA believes that the Lewin Report is not nearly as devastating to the NEMT benefit as some may want us to believe. Even with the limited scope of members surveyed for the research, utilization of services and percentage of missed appointments due to transportation were in line with the percentages seen in other states across the country. In addition, the report actually illustrates the value of NEMT by recording the decision of some managed care providers in Indiana to provide private coverage of the NEMT benefit for the population no longer covered by Medicaid. The Lewin Report, while frequently used to support the elimination of the NEMT benefit, when read between the lines, actually does just the opposite.

What is a Section 1115 Waiver?

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. These waivers can provide states with considerable flexibility in how they operate their state Medicaid program, beyond what is available under current program rules and federal law. The purpose of these demonstrations is to demonstrate and evaluate state-specific policy approaches that improve the integrity and effectiveness of the Medicaid program for low-income beneficiaries.

Transit Tips: There has been significant variation in the length of time it takes to get final approval of a Section 1115 waiver. However, every waiver must go through both a 30-day public comment period at both the state and federal level. Public transportation and community partners should take advantage of these opportunities and use them to submit concerns when applicable and necessary.

While Section 1115 waivers are the main avenue for states to request waiver authority for the NEMT benefit, the waivers can be wide ranging in scope and do not necessarily have to include any changes to NEMT or transportation whatsoever. Some 1115 waivers may even work to expand NEMT or create innovation demonstration pilots expanding services focused on social determinants of health such as transportation.

Additionally, Section 1115 waivers have recently become a vehicle for the creation of work requirements for Medicaid beneficiaries, which at times have impacts on transportation. The Kentucky HEALTH program which created work requirements...
A Transit-Health Care Shared Language Guide

for Medicaid Beneficiaries ties the required 80 hours of work, job training or searching, or community service per month directly to the provision of key benefits such as dental, vision, and NEMT. On the opposite side of the spectrum, Ohio currently has a pending 1115 waiver that includes a request for federal match dollars to provide supportive services including transportation for individuals working to meet the work and community engagement requirements. Ohio specifically identifies and calls out transportation as a critical supportive service for beneficiaries who are working to meet the employment and community engagement requirements. To date, Ohio is the only state to submit an 1115 waiver including work requirement that is also requesting a federal match to provide supportive services such as transportation to help beneficiaries meet the work requirement.

How is the shift to Managed Care impacting NEMT?

More than 55 million Medicaid beneficiaries are enrolled in Managed Care across the U.S., making Managed Care the current dominant health care delivery system. The managed care delivery system was created to manage cost and utilization while improving quality by delivering health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs). An MCO is a health care provider or a group or organization of medical service providers who offers managed health care plans. Given their focus on managing costs and improving care, it makes sense that MCOs use value-based capitated payments to incentivize providers to provide efficient, effective, and higher quality care.

Transit Tips: A majority of states using the MCO model have shifted to delivering NEMT through either NEMT focused brokers or MCOs who then subcontract with NEMT brokers. Capitated PMPM payments are used by either the broker or the MCO to manage the NEMT benefit. The push towards managed care delivery systems has directly impacted the use of capitated payment within the Medicaid NEMT space. Additionally, it is important to note that there have been some instances, such as in Indiana, of MCOs choosing to provide NEMT services either in addition to or in replace of state covered NEMT benefits under Medicaid.

Why should transit care about co-pays?

A co-payment, or co-pay, is a common form of cost-sharing under many health insurance plans. Beneficiaries pay a fixed amount established by an insurance plan for sharing the cost of a certain health service. Specific rules regarding health insurance co-payments vary based on the policy and provider. The cost-sharing system between providers and beneficiaries is a critical selling point for each plan.

Transit Tip: Among the many places that discussions between transportation and health care providers break down, the subject of fares often tops the list. Health care advocates, particularly in the federally-funded Medicaid program, typically are willing only to pay the same fare the public pays for a trip. Transit professionals, understanding the true nature of farebox recovery and how much additional investment goes into every trip provided, balk at the notion of merely charging a fare.

Next time you find yourself in this conundrum, bring up the health care systems’ use of co-pays. Simply put, just as fares don’t pay for all that goes into a transit trip, neither do co-pays cover the entirety of a doctors’ visit, to say nothing of a surgical procedure. Co-pays are an entry charge into the health care system. Fares serve the same function in transit.

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The worlds of health care and finance are consistently dominated with buzzwords like big data, information governance or datafication, making it difficult to break through those language barriers and communicate strategically with other sectors. As health care continues to expand its support for social determinants of health, it calls our attention to the fact that health care will need to work with new sectors, such as housing and transportation. In the previous article, we’ve established that in order to successfully work with these other sectors, it has become increasingly important for a cross-sectional shared language; one that allows all sectors to discuss how they overlap and impact the others. Without understanding the value that other sectors can provide, potential discussions, or even partnerships will be stalled. To develop this by thinking about value, let’s look at what impacts everyone - costs and return on investments (ROI).

Recent trends show health care providers moving towards value-based payment models; increasing the quality of care while decreasing costs. The goal is to provide better care, prevent readmissions, and improve overall patient outcomes, all without taking a hit to their bottom line. A focus on preventative care, and ensuring patients maintain regular and consistent care is critical to reducing costs related to avoidable readmissions or emergency care. Because of this, ROI for health care typically tends to be straightforward and determined on whether or not the health care system sees overall cost-savings.

A consistent problem in the health care industry is appointment no-shows. Appointment no-shows can result in an average daily loss to the health care system of $725 and cost the overall health care industry an estimated $150 billion a year. Not only do these no-shows hurt health care providers and insurance companies, but also the patient. No-shows lead to increased medical costs, poor patient care, potential health complications and increased emergency room visits. Health care providers are increasingly looking at the issue of no-shows and how they affect overall ROI.

As mentioned above, health care has recognized that there are multiple factors that impact person’s ability to make it to their medical appointment, such as: a lack of transportation, employment, child care, chronic conditions or memory issues. A lack of safe, reliable transportation alone accounts for an estimated 3.6 million no-shows annually. If transportation-disadvantaged populations had improved access to health care, no-shows would decrease, reducing national health care costs and offsetting the minimal increase in transportation costs. By examining how transportation can create ROIs for the health care industry, we can strengthen transit’s role as a critical player in the health care industry and make
Data Typically Used in ROI Studies

Historically, it has been difficult to study and provide a standard for data in addressing transportation and health care. Metrics across sectors typically misalign or don’t make sense in different contexts. However, the transportation industry is getting better at providing figures that prove their value; certainly more than just ridership numbers.

There are several factors that should be considered when determining how a lack of access to transportation can impact the health care industry. A first step is to identify:

1. The population that doesn’t have access to safe, reliable transportation;
2. Typical characteristics of that population;
3. Medical conditions that population may have and the subsequent impact on the trip needed; and
4. Potential consequences of missing an appointment.

The Transportation Research Board studied general characteristics found amongst populations that routinely miss appointments. On average, the populations that tend to miss medical appointments are female, poorer, older, have less education and are more likely to be a part of a minority group. These populations also generally tend to have multiple medical conditions, however if treated in a preventative manner, can be manageable. Additionally, the conditions listed to the right were among the most common by those who have particularly high tendencies to miss care.

Typical Critical Medical Conditions Found in Populations That Generally Miss Care Appointments

<table>
<thead>
<tr>
<th>Arthritis</th>
<th>Diabetes</th>
<th>Renal disease</th>
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<tbody>
<tr>
<td>Asthma</td>
<td>Heart disease</td>
<td>Screening for high cholesterol levels</td>
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<tr>
<td>Cancer Treatment and Screening</td>
<td>Medical allergies</td>
<td>Screening for high blood pressure &amp; hypertension</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Obstetrical Care</td>
<td>Vision problems</td>
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<tr>
<td>Dental Problems</td>
<td>Pain or aching joints</td>
<td>Poor circulation</td>
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<td>Depression and mental health</td>
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* Information from the Transportation Research Board
Costs to the health care system are determined by a variety of factors including the examination of readmission rates, cost by appointments and potential revenue lost by year due to missed appointments, which all vary by provider. In total, as noted earlier, the collective impact of no-shows can cost the entire health care industry an estimated $150 billion a year.

Social Determinants of Health, Patient Care and Transportation

Examining the social determinants of health has become a critical piece in understanding why people are unable to make their scheduled health care appointments. A number of studies have been produced that highlight the multitude of factors that impact a patient’s decision to go, or not go, to their appointment from transportation, to the cost of co-pays, mistrust of doctors, to simply feeling too sick to make the trip. The following studies dive into the social determinants of health, and the potential impacts of resolving transportation barriers to care.

Recently, Lyft and Hitch Health (a technology company specializing in integrating health records with ride hailing platforms) released findings of a year-long pilot program conducted at a health clinic in Minneapolis, where Hitch Health’s automated short message service (text) technology offered Lyft trips to patients needing a ride. At this specific clinic, the cost to the hospital of a no-show was averaging $100 for each scheduled, but unattended visit. The pilot program found the cost of paying for non-emergency medical transportation (NEMT) services to be less than $15 each way. At the pilot program’s conclusion, the transportation services had reduced no-shows by 27 percent and increased revenue at the clinic by an estimated $270,000, producing an ROI of 297 percent.

“We are looking forward to reaching even more people across the country with Hitch Health to ensure transportation is no longer a barrier to accessing health care,” says Gyre Renwick, vice president of Lyft Business.

A study produced by HealthConnections, a program from WellCare Health Plans, found that in a given year, patients who had their social service needs met could reduce spending by the health care industry by 11 percent. The study team focused on how to address the social factors contributing to a person’s inability to go to a medical appointment. They did this by looking at two groups: those who had their social service needs met and those who did not. Those who had just one of their social needs met experienced a seven percent reduction in total care costs compared to those who had none of their needs met. This shows how even a limited intervention can be helpful in reducing total health costs, while also improving the life of the patient.

“Effective healthcare delivery may require interventions from a broad array of community-based organizations that act beyond the scope of the medical care provider,” notes HealthConnections’ study.

The State of Florida offers many programs for the transportation disadvantaged, which primarily focus on getting people to medical appointments, employment, education, nutrition and other critical life-necessities. In order to see what the effects would be if just one of these barriers were solved for this population, the Florida State University’s (FSU) College of Business conducted an ROI study into each of these categories. Specifically related to medical trips, they sought to understand if preventative medical care would help keep low income, elderly and disabled Florida residents out of the hospitals and nursing homes, while also improving the mobility and health of the patients. By doing so, they wanted to calculate the return generated by funds invested into these programs by the state of Florida. The study found that if one percent of the NEMT trips funded resulted in the avoidance of an emergency room visit, the ROI for the state is 1108 percent, or about $11.08 for each dollar the state invests in this program.

According to the FSU study, “based on these figures, it seems fair to conclude that the estimated benefits of transportation disadvantaged programs far outweigh their
costs. It must be restated that these ROI figures are generated using highly conservative assumptions. Realistically, the actual ROI would probably be much greater, and more accurate, if they considered the number of clients who actually avoid hospitals, nursing homes, and assisted living facilities by utilizing these transportation disadvantaged programs.”

The Medical Transportation Access Coalition (MTAC) was organized to advocate for the benefits of NEMT to elected officials (CTAA is an allied partner to MATC – ed). Originally founded by NEMT brokers, the coalition has worked hard to educate patients, health providers and plans, and policymakers on the necessity of access to transportation. MTAC has recently released a study where they examined the ROI of NEMT by looking at Medicaid claims data and surveying NEMT users. They focused on three specific chronic medical conditions and treatments: dialysis for kidney disease, wound care for diabetes patients and treatment for substance use disorders. The study found that:

- 58 percent of nearly 1,000 beneficiaries surveyed reported that without NEMT, they wouldn’t be able to go to their medical appointment;
- The total ROI of NEMT for all three conditions and treatments per 30,000 members per month is more than $40 million.

Not only was this study critical in quantifying the importance of NEMT, it helps shape the way transit providers talk to the broader public by offering ROI figures in relation to Medicaid costs. It also further solidifies the reality that NEMT benefits pay for themselves as part of a managed care strategy for people with certain chronic conditions.

Applications in Reality – the NCMM Experience

CTAA has been fortunate to be a leader of the National Center of Mobility Management (NCMM), a Federal Transit Administration (FTA)-funded technical assistance center focused improving transportation options for all Americans. NCMM’s primary activities support mobility management professionals, FTA grantees, and partners in adopting proven, sustainable, and replicable strategies that achieve its mission. The team works to:

- Provide assistance to communities through dissemination of promising practices, a monthly e-newsletter, and customized technical assistance;
- Deliver in-person and web-based trainings, including webinars;
- Network with mobility management practitioners through several communica-

Data produced by MTAC demonstrates that increased access to care reduces costs for the health care sector.
tion forums; and

- Align and support the goals and activities of the Federal Coordinating Council on Access and Mobility (CCAM) and the Federal Transit Administration.

The Center also provides grant opportunities; more recently the Health Care Access Design Challenge 2017. The Health Care Access Design Challenge 2017 was a funding opportunity to assist communities in addressing health care access issues. The goals of the projects were to 1) support communities in designing ready-to-launch health care transportation solutions that improve access, and 2) disseminate results of the communities’ work to facilitate the implementation of solutions in part or in whole by other communities.

The 2017 Design Challenge was comprised of teams from seven states, each working to improve access in one of the following categories: 1) access to behavioral health, 2) treatment for chronic diseases, 3) ongoing treatment for post-hospitalization recovery and avoidance of re-hospitalization, and 4) treatment for acute/immediate care.

A team located in Rockingham County, Virginia, led by Valley Program for Aging Services, worked to improve access to ongoing treatment for post-hospitalization recovery and avoidance of re-hospitalization. Their team found that the local patients most desired dignity of choice in regards to the level of support needed in accessing care. To address this, the team designed a set of solutions that patients could choose from: a transportation buddy system, a transportation options informational card and a transportation navigator. When interviewed at the completion of their project, Pam Collins, Care Coordinator at Sentara East Rockingham Health Center, said how their primary care facility was going to see reduced long-term costs thanks to these transportation solutions.

“This solution is a win-win for everyone: the patients, the provider, and the health care facility,” says Collins. “It reduces readmission to the hospital. The patient gets to their health care appointment. They have their hospital follow-up. Medically, it’s wonderful for them. For the provider, their slot is filled. When a patient misses their appointment and doesn’t get into their provider for more than seven days, there is a greater chance of readmission to the hospital.”

While the NCMM grant was focused on the planning phase, the Rockingham team will be able to continue their work via a significant grant from a local hospital that will allow them to implement a limited launch for their solution.

Each team not only created valuable solutions for their community, but also ensured that ideas for the solutions created tied directly back to the needs of their most vulnerable populations. These solutions work towards not only improving the quality of life for community members, but enhancing
economic development for their community, and promoting healthy living for all.

**Benefits that Far Outweigh the Costs**

Measuring the benefits of providing transportation is far more difficult than measuring its costs. Nonetheless, the studies mentioned have succeeded in developing accurate estimates. These studies have shown that interventions that include transportation to increase attendance at appointments often reported positive results, including fewer missed appointments, reduced length of stay, and fewer emergency room visits.

While these studies prove optimistic, we can never prove total causation between transportation and health outcomes, just correlation. Social determinants of health are incredibly variable and include a host of other social factors; proving that there can never just be a simple cause and effect between a social service and improved health. However, these studies demonstrate how tipping the needle towards improving a social service can impact the health and well-being of people in a positive way.

“These results reinforce the need for policies that encourage organizations to accept financial responsibility for addressing social determinants of health through nonmedical interventions,” summarizes the HealthConnections study.

Financial executives, health care practitioners, and transit leaders are learning to speak the same language, but there is still work to be done. We need to continue to work towards ways to communicate effectively across sectors and truly demonstrate the ROI transit can bring to health care. Those who typically miss medical appointments due to transportation barriers will potentially make their medical conditions worse, battle with costly medical care, will continue to harm them as well as those who are working to help them.

Today, it is more important than ever to conduct further research and develop strong partnerships across sectors. We as an industry need to reach out to the health care industry and demonstrate how valuable transportation really is for reducing their costs and improving the lives of their patients. At a time when health care is looking to reduce costs as much as possible, we need to make sure transportation programs aren’t the ones on the cutting block. CT
CTAA’s Small Urban Network is working to improve federal transit legislation and policy for smaller cities. If you represent a transit operation in a small-urban community, please contact Rich Sampson at sampson@ctaa.org and be sure to get on our SUN mailing list. We’ll be hosting our next SUN Conference August 2019. Stay tuned for further details...

ConneCTAA: A Listserv for CTAA’s Small Urban Members

Our members are CTAA’s greatest asset. For that reason, we’re proud to introduce a new tool for CTAA members to share questions, discussion, examples and resources directly with each other: ConneCTAA.

ConneCTAA is an email-based electronic listserv - available only to CTAA small-urban transit members. Because you’ve told us you need a forum to speak candidly and openly among yourselves to share your questions, frustrations and solutions with your peers, no vendors or government officials – at any level – will have access to this group, even if they’re CTAA members.

Please share your questions, challenges and ideas with your peers by emailing sun.ctaa@gmail.com. That’s all there is to it, just like any other email you might send.
As we focus on new innovations and approaches to non-emergency medical transportation (NEMT) in this edition of DigitalCT, we turn to a number of CTAA members to share their experiences in adapting to the changing needs in connecting people with health care. We start off with a look at how a large, multi-county rural transit provider – Prairie Hills Transit (PHT) in western South Dakota – has partnered with a regional hospital company – Regional Health, which operates facilities in Spearfish, Rapid City, Custer, Sturgis and Deadwood – to directly serve their patients. Barb Cline is Executive Director of PHT and CTAA’s Upper Midwest Regional Director – ed.

As a rural transportation provider, we know partnerships are the key to survival. Regional Health is an integrated health care system in South Dakota with a mission to “make a difference. Every day.” The company was aware of our reputation for safety, reliable vehicles and training because nursing homes owned and operated by them had been our customers for years. We came to an agreement that solidified our role in hospital discharge service. At the present time, we do not bill Medicaid for any of these trips, although I’m sure a high percentage qualify. Each year, we carry over 2,350 patients for Regional Health.

Six years ago, Regional Health’s Vice President of Innovation and Operations scheduled a meeting to talk about discharge transportation from their largest hospital in Rapid City, the largest city in western South Dakota. Explaining the circumstances of patients being discharged and the difficulties many of the individuals faced in returning to their homes impressed upon us the seriousness of the request. He said he was aware of the health-care utilization of PHT throughout the region and had only heard good things about us. He explained that while Regional Health knew health care, he was confident that we knew transportation and were very good at it. We were the kind of company he wanted to work with.

For over 20 years, we worked contractually with area nursing homes owned by Regional Health. Hospital patients being discharged had often come in by ambulance and had no way to get home. Also, they often would not have clothing appropriate for weather conditions as they were discharged. One of our PHT board members – who uses a wheelchair herself – pulled together area community groups to provide blankets, hats, and booties to stock on each bus. In fact, the same board member gave her coat to a patient being discharged.

Interested in the partnership, I explained that I didn’t have funding to buy a vehicle and they readily agreed to purchase a bus for us to operate. We entered into an agreement to provide transportation for a daily fee during specific hours and an hourly fee outside those hours. Prairie Hills Transit works with Regional Health to coordinate non-emergency medical transportation trips, especially for patients being discharged from facilities.

Just recently, we retired that bus and they again purchased two accessible vans for us to operate for them. Honesty and integrity – along with open communication – have served us both well as our partnership has evolved and matured. CT
NEMT In Action: As a Broker, What We’re Looking for in an NEMT Provider

By Dave White, CCTM, and Jana Hunkler, CCTM

As a transportation management firm, or brokerage, Coordinated Transportation Solutions, Inc. has developed professional commercial transportation networks in multiple states. We understand that our providers are ultimately the face of the program, at least for the patient, and arriving on-time, every time, safely and with a professional driver is the goal of any NEMT program. Our business model, to partner with our provider networks, supports our overall goals of creating transportation solutions that work and offering exemplary customer service. That being said, our expectations from each provider are exacting, as patient safety is our overriding concern. Prior to contracting, we perform both a desk audit and a site visit where we review driver records, policies & procedures and vehicles and their maintenance records.

Drivers or vehicles that do not meet our standards are removed from service. We employ corrective action plans (CAP) with providers if their performance begins to trend downward, up to and including removal from our network.

I (Dave) founded Coordinated Transportation Solutions, Inc. (CTS) more than 20 years ago as a 501(c)(3) transportation management firm, because I knew there was a better way to connect patients to health care. The CTS mission of service to vulnerable populations is accomplished through partnerships, not just with government agencies and health plans, but with our extensive network of providers. We have grown from a 3-person organization working for one health plan to more than 150 employees, coordinating millions of trips in multiple states as a result of this partnership approach.

The business must be in good standing, with drivers that are properly licensed, trained, drug tested, and able to perform monthly background checks. All vehicles must be clean, scent and smoke-free, in good mechanical condition, with all applicable licensure, and meet state, federal, and manufacturer’s safety standards. Accessible vehicles must comply with ADA regulations.

We support our providers with a dynamic provider relations team, not only at our Connecticut headquarters, but with local staff, on the ground, everywhere we operate. These field representatives not only credential and monitor each provider, they offer their industry and business expertise to the network which strengthens our partnerships and ultimately elevates service levels. We value our relationships with our provider network and strive to maintain open lines of communication so that expectations and programmatic regulations are understood by all providers. We also hold annual provider meetings in each region to provide trainings and a forum to discuss their concerns and suggestions for program-wide improvement.

The best partnerships are built with those transportation providers that understand how truly important our work is to supporting positive health outcomes for the fragile riders we transport, and that are respectful, professional able to be flexible to meet the unique needs of those riders. An overview of our provider requirements can be found on the CTS website.

Dave White is the Founder and President of Coordinated Transportation Solutions, Inc., while Jana Hunkler serves as its Vice President of Business Development.
In 2015, the Mass Transportation Authority held community listening sessions with local healthcare providers for the purpose of determining what the unmet needs were related to individuals aging in place, living longer, and the need for more medical services. Out of this process I determined that there may be an opportunity to partner with some of the agencies to address these concerns regarding gaps in services; especially surrounding medical transportation.

Based on the information that I received, it was important to develop a model for early delivery of services and I recognized the need for new special on-demand medical services that would go beyond the traditional transit model of fixed route service and/or para-transit. Therefore, it was incumbent that we provide services that were flexible, reduced barriers and impediments and would provide for a better quality of life for the residents of our community, especially those needing access to medical services.

As the CEO of the Mass Transportation Authority, it was incumbent upon me to develop a team within our organization capable of rolling out a program that would meet all of the aforementioned concerns. We then established the Rides to Wellness program and in 2016 we determined that an even higher level of service was needed – providing same day service within 30-minutes of the received request. In addition, this included special consideration for families, young children, babies in car seats and a full service that provided rides to doctor appointments, prescriptions, and shopping.

The same day service model that was developed has grown tremendously over the last two years and the Rides to Wellness program today transports between 8,000 – 9,000 passengers per month and soon, we will be adding on a new portion of the program that will provide same day services for veterans on an expanded service model for those needing to travel within the region, as well as to adjoining areas such as Ann Arbor, Saginaw and Detroit, MI.

As a transportation provider operating in today’s environment we must find more efficient, more effective on-demand services that better address the needs of residents throughout our communities.

Ed Benning is the General Manager and CEO of the Mass Transportation Authority (MTA), a CTAA Small Urban Network (SUN) member in Flint, Mich.
Within the last ten years, key trends have emerged from the health care industry: namely, the industry’s shift away from a reimbursement model to a value based care model and the increase of populations that require access to health care. A value-based care model stresses the importance of payments based on a quality basis and is being heavily encouraged by the Centers of Medicare and Medicaid Services. This helps to ensure that the entire life of a patient is managed and that people receive quality care.

Simultaneously, those in the baby boomer generation are aging, putting increased stress on health care providers. Coupled with a continued rise in life expectancy, more and more people need access to care for longer.

As these trends began developing and continued to grow, a group of innovative entrepreneurs saw an opportunity to ensure that patients were getting the care they needed, while ultimately lowering long-term health care costs.

SafeRide, one of many software platforms used by NEMT and care providers, was founded by Robbins Schrader, Ben Salter and Whit Schrader in 2015 and partners with care provider networks, health plans, NEMT providers and Lyft.

“Our founders seized a moment to improve patient outcomes by improving access to transportation,” explained Ghermayn Baker, Marketing Manager at SafeRide.

SafeRide’s partnership with NEMT providers allows for high-quality door-to-door service. SafeRide relies on their network of NEMT providers, who are appropriately trained and have the required vehicle types, to provide this additional level of patient assistance. The partnership with Lyft has enabled SafeRide to provide patients with increased access to care, by providing curb-to-curb service. Lyft drivers are not trained to assist patients with door-to-door service, however they are able to offer non-emergency trips to patients who don’t require additional assistance.
Combating Costly No-Shows

More than three million Americans miss or delay appointments annually due to a lack of access to transportation. This saddles health care providers with high costs and lost time. For example, if a dialysis patient misses their appointment, hospital readmission costs dramatically increase for that patient and the care provider. To combat this issues, SafeRide reports they developed a software that helps patients get to their appointments in a timely manner, while avoiding costly no-shows.

The SafeRide platform allows the NEMT dispatchers and care providers to view the same software on their desktop. The care provider schedules the patient’s next appointment, which the NEMT dispatcher is alerted to through the software, and then assigns the ride to a specific driver. The ride then gets pushed to the driver’s mobile app, where they can see the ride in real-time and receive GPS updates. Alternatively, rides can also be assigned to Lyft drivers if that is the most appropriate service level (i.e. curb-to-curb). Lyft drivers receive a notification that the trip is from SafeRide and alerts them that the rider may require extra assistance.

“SafeRide gives us access to all patient movement in real-time; we find this to be very helpful for our teams, our aides and patient’s families,”SafeRide health care partner Optimal Aging says about their relationship.

This process allows the patient to get the right ride at the right time, whether it be previously-scheduled or offered on-demand. SafeRide reports that this experience has become easy to use for all participants and sources the best ride for the patient based on their needs.

“Wapato Shores Accessible Transportation strives to stay at the leading edge of technology available in the marketplace and have been impressed with the responsiveness of SafeRide’s Development Team,” says Fred Voelkel, Human Resources, Training, and Recruiting Manager at Wapato Shores Accessible Transportation. “They have been responsive to our needs and have even gone to the incredible length of sending their entire team to Portland, Oregon to meet with our managers, dispatchers and schedulers, and our drivers to improve the product to better meet the needs of our industry.”

Delivering Meaningful Results

Thanks to SafeRide’s software, the company has found that their partnered health care providers have seen a 50 percent decrease in appointment no-shows. They’ve also been able to increase the number of on-time appointments, as well as streamlining the patient experience.

Not only have there been increased benefits for health care providers, but there have
NEMT in Action: SafeRide’s Responsive Approach

Click here to shift to MapView

This is your full day’s timeline

Each bar/box in this represents a Ride. Color of the box will represent the ride status.

We have the same Driver’s tray at the bottom of this view to give more information about the ride.

Click here to Log out of the SafeRide App.

Click here to switch the ride

Each bar/box has the patient’s name written on top of it.

Click on any of the box to open up it’s details on the tray.
also been additional benefits for NEMT providers. SafeRide can provide transportation providers with a consistent level of demand, leading to increased revenue. SafeRide’s software also optimizes routes, making better use of their time on the road and producing more efficient service.

SafeRide can support NEMT providers by sourcing patient trips after they’ve established the demand through the health care providers. When SafeRide partners with a care provider in a specific region, they receive the following data:

• Patient and ride volume
• Trends in patient transportation, whether they organize transportation in house or use a tax service
• Types of vehicles needed
• Typical hours

Using this information, a care profile is created, allowing SafeRide to determine what transportation options are needed. SafeRide seeks out NEMT providers that can fulfill specific requirements, such as HIPPA compliancy, training standards, and the capacity to meet ride volume.

NEMT providers set their own trip costs and from there, SafeRide passes that cost directly to the care providers with no markups. By doing so, they are providing market rates directly to care providers at cost and seek to make a more efficient marketplace.

Connecting More People to Care

The ease of integration between SafeRide’s care provider network and NEMT providers has worked efficiently to reduce no-shows, provide reliable medical transportation and improve the patient experience – the kind of performance-based model the health care industry is seeking.

Through increased partnerships with NEMT providers, SafeRide has built a robust network, that offers a consistent stream of demand, increased efficiency and ultimately connects more people to care.

“SafeRide has transformed our ability to care for the elderly and at-risk,” says Marika Rausa, Director for Providence Optimal Aging.

If you are an NEMT agency looking for technology that will best assist your operation, CTAA works closely with many software providers. We would be happy to provide feedback on what could work best for you. CT

CTAA’s Keys to NEMT Success Online Training

The world of non-emergency medical transportation (NEMT) is rapidly changing - so fast, in fact, that any organization providing NEMT services today needs some help. Wouldn’t it be great to have a recognized NEMT expert - someone who’s been an NEMT operator and has experience working directly with insurance companies, brokerages and state Medicaid agencies - at your disposal to help you understand exactly how the changing environment will impact your operation, and how to take advantage of new opportunities?

Interested in Joining a Keys to NEMT Success Session?

Contact Instructor Rex Knowlton at knowlton@ctaa.org

Course Fees: $175 for CTAA members, $250 for non-members.
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Community Transportation Magazine is the voice of the Community Transportation Association, a national association dedicated to making mobility alternatives available to all Americans. The Association’s Board of Directors provides national leadership and direction for the Association. The Board relies on the special expertise of its State and Tribal Delegate Council to assist in their important efforts.

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