Health Care and Transportation - Spring Policy News Round Up

March 2019

The politics around the Medicaid transportation benefit continue to be complex and most recently we've seen growing attacks on the benefit. This update covers a number of proposed policy proposals around the benefit, and how the benefit as we know it is poised for change. From state legislation focusing on NEMT services, to new demonstration pilots from the Centers for Medicare and Medicaid Innovation (CMMI), the NEMT space is rapidly fluctuating. Below is CTAA's quarterly news roundup of some of the biggest updates and what they might mean for community and public transportation providers:

CTAA EXPO 2019 to Host One-Day Intensive Focused on NEMT

At this year's EXPO in Palm Springs, California, CTAA will be holding a one-day intensive course specifically dedicated to NEMT. The one-day session, **NEMT: Beyond Medicaid,** is specifically designed for NEMT and public transit operators, managers, and advocates alike. This session is a deep dive into the other world of NEMT – one dominated by managed care organizations and private sector health care providers, and one that is growing in investment and importance, facing rapidly changing technology, and increasingly having to address the expectations for on-demand service. This one-day course is for those who are looking to make sense of the ever-growing connection between mobility, transportation, and health care and understand how to grow and create successful partnerships and programs within this space. View the session agenda, and register for expo.

State Legislative Sessions are Targeting the Role of TNCs in Medicaid NEMT

As many are aware, it is the season for state legislative sessions, and this year, an expanded role for TNCs in the Medicaid NEMT space is on the agenda in many state capitols. Over the past few months, CTAA has come across three states that have introduced legislation addressing the role that TNCs could play within Medicaid NEMT.

Just as a reminder, currently TNCs are not a qualified provider under Medicaid NEMT. However, the bills that are being introduced clearly seek to change this. Bills have been introduced in Arkansas, Texas, and Florida. Each bill has focused on creating a way for TNCs to become a

reimbursable provider for Medicaid NEMT services, but they each go about it in vastly different ways.

In **Arkansas**, the introduced bill (HB 1435) targets the ability of Medicaid to provide reimbursement to hospitals and health care facilities for beneficiaries ridesharing fees. This would potentially allow for TNCs to become a reimbursable entity within Medicaid, although the limited language misses many of the nuances, including how TNCs would respond to Medicaid credentialing or standards requirements. So far, this bill has failed to gain traction within the state legislature, and is stalled in the House Committee on Public Health, Welfare, and Labor.

A bill was recently introduced in the **Florida** State Senate, also addressing the connection between TNCs and the provision of NEMT services. Senate Bill 302 would allow for TNCs to directly contract with Medicaid managed care plans, or transportation brokers, for the delivery of NEMT trips. So far, the Agency for Health Care Administration has indicated that the only additional requirement that would be imposed on TNCs, beyond what is already required under by TNC's under Florida status (627.748, F.S.), would be to require that TNC drivers undergo FDLE Level I background screening requirements, as this is required for Medicaid providers. This bill seems to have gained some traction, with the votes in both the Senate Health Policy, and Banking and Rules Committees ending in unanimous approval of the bill. The bill is now currently making its way through the Senate Rules Committee.

With over 120 co-signatories, the legislation introduced in **Texas** (HB 1576) seems to have gained a significant amount of traction. The news from those on the ground is that many co-signatories of this bill may not understand the impact that these changes would have on the larger transportation system, and instead are focused on the promise of a lower cost and more responsive Medicaid NEMT option. However, as transportation providers are aware these lower cost trips that could be picked up by TNCs are typically reserved for ambulatory individuals, or those that are easier to serve. It would still leave the more difficult and expensive trips to the current NEMT providers. The Texas Health and Human Services Commission, which oversees Medicaid, is currently analyzing the bill for the fiscal impact.

The bill focuses on a few aspects of the provision of NEMT, and is suggesting the following changes:

1. Managed Care Organizations (MCOs) can contract directly with TNCs to provide NEMT services,
2. MCOs cannot require TNC drivers to enroll as a Medicaid NEMT provider or require credentials to provide NEMT services, and
3. TNCs are excepted from meeting minimum quality and efficiency measures.

Overall, this bill appears to create an environment for TNCs to provide NEMT services while being exempted from standards that all other NEMT providers are required to meet. Not only does this create an unlevel playing field, but by allowing these entities to bypass industry accepted service standards, it places the safety, quality, and care of Medicaid patients at risk.

A trend is becoming clear across the three state bills mentioned above – an idea that NEMT should be different, and in these cases include and potentially highly leverage TNCs. In recent years the push towards more on-demand services, and the changing expectations of transit, have created increasing burdens and complaints on NEMT services, which still require 48 hours' notice to book a trip in most states. These bills are showing that NEMT services may be in need of a change, a shift in the provision of services to better fit the changing mindset of how transportation should work. However, caution needs to be taken around waiving standards, compliance requirements, or quality assurance just for quicker access. Medicaid beneficiaries who require transportation assistance are a unique population, and must be treated with the level of service they deserve.

Transportation officials should be wary of these bills as they undermine the services, standards, and quality that public transportation and NEMT providers are required to provide for each and every ride. TNCs should be asked to rise up to the required standards of service, rather than be exempt from them.

Presidential Budget Seeks to Establish Medicaid NEMT As Optional

CTAA has been closely tracking the gathering threats against the Medicaid non-emergency medical transportation (NEMT) benefit. From the Centers of Medicare and Medicaid Services (CMS) and Department of Health and Human Services (HHS) Joint Letter to the nation's Governors in March 2017 to the Fall 2019 HHS Unified Agenda, there have been a number of documents released by the current Administration that include language directly looking to limit or eliminate the NEMT benefit.

Building on those documents, this month President Trump release his FY2020 Presidential Budget, and similarly to last year's, the HHS Budget in Brief includes language specifically targeting the NEMT benefit:

> **Make Medicaid Non-Emergency Medical Transportation Optional**
> "Under current regulations, states must provide Non-Emergency Medical Transportation (NEMT) to all Medicaid beneficiaries. States have requested additional flexibility from this requirement due to challenges containing NEMT costs and addressing program integrity concerns. The Budget commits to using regulatory authority to change the provision of this benefit from mandatory to optional to provide greater flexibility to states. [No budget impact]"

This language is largely similar to the language included in the FY2019 and FY2018 President's Budget, and it aligns with the previous and existing efforts to support states who are interested in waiving the NEMT benefit. As mentioned in the previous health and transportation policy update, there is also a potential proposed rule on the horizon that is expected to reexamine non-emergency medical transportation (NEMT) coverage requirements for states under Medicaid. The talk on the ground is that this rule will likely come out later this spring, potentially in May.

These continued threats are concerning for transportation providers who provide this benefit and community members who use this benefit. In addition to the potential elimination of benefits, there are also many potential unintended consequences on transportation services as a whole. CTAA will continue tracking policy developments around the NEMT benefit and we are currently working with a number of key stakeholders in this arena to develop and implement an advocacy and policy strategy. Interested in knowing more? Check out our recent NEMT one-pager.

HHS Launches Innovative Payment Model With New Treatment and Transport Options to More Appropriately and Effectively Meet Beneficiaries' Emergency Needs

In February, CMMI unveiled a new, five-year, voluntary, payment model for emergency ambulance services that will allow for specific experimental changes to emergency triage, treatment, and transportation following a 911 call. The model seeks to engage health care providers across the care continuum to more appropriately and effectively meet beneficiaries' needs. This new delivery model is called the Emergency Triage, Treat and Transport (ET3) model. The general gist is that CMS will now offer to pay participating ambulance teams for other services beyond just transporting a Medicare patient to a hospital. More specifically the model will:

1. Make it possible for participating ambulance suppliers and providers to partner with qualified health care practitioners to deliver treatment:
    a. In place (either on-the-scene or through telehealth),
    b. and with alternative destination sites (such as primary care doctors' offices or urgent-care clinics).
2. Encourage development of medical triage lines for low-acuity 911 calls in regions where participating ambulance suppliers and providers operate.

The existing model of care results in most Medicare patients waiting to go to the emergency room for care, which creates huge costs to the system. By opening the destination list to a number of other key healthcare destinations, the new CMMI model acknowledges the fact that the current covered Medicare destination list may not adequately cover the continuum of care needed by beneficiaries. Currently, Medicare only pays for ambulances to emergency care, dialysis centers, nursing homes, or rehab centers.

By allowing treatment in place, or ambulance trips to alternative destinations, CMMI hopes that it will cut down on costs related to emergency department usage, while also more appropriately and effectively meeting beneficiaries needs. However, if the goal of this model is to fit within a value-based health care system, that prioritizes the right care, the right price, in the right setting, from the right provider, it is missing a key problem with the Medicare benefits system – the limited transportation benefit.

Currently ambulances are the only qualified and reimbursable transportation provider under Medicare benefits. This means even individuals who are ambulatory or may not need an

ambulance are required to use (this more expensive) transportation option. Not only does this create additional cost burdens to the Medicare program, it limits Medicare's ability to right-size care to each patient. Not all patients will need an ambulance for care, and the current Medicare benefit structure means, many patients may end up calling 911 for non-emergencies simply to get transportation assistance.

The CMMI ET3 delivery model, while definitely a step in the right direction, leaves room for further opportunities. The conversation should expand to consider non-ambulance transportation services, and how they could play a role in improving the Medicare Care Continuum across emergency and non-emergency care. However, this model could offer opportunities that could surprise us. Perhaps an ambulance company could partner with a primary care or urgent care clinic to test better ways to transport Medicare beneficiaries that don't require an ambulance or an ER, but who can't access health services otherwise.

While the potential for this model is exciting, it is critical to remember that until further information on the ET3 model is released, the above ideas are merely speculative.

FTA 2019 Small Business Innovation Research Solicitation on Cost Allocation Technology for NEMT

FTA is encouraging small businesses to submit project proposals for the FY 2019 Small Business Innovation Research (SBIR) Solicitation. The chosen research topic is Cost Allocation Technology for Non-Emergency Medical Transportation.

The SBIR program encourages domestic small businesses to engage in federal research that has the potential for commercialization. Through a competitive awards-based program, SBIR enables small businesses to explore their explore their technological potential and provides the incentive to profit from its commercialization.

Find more about the SBIR Solicitation from the below links:

- FY 2019 Small Business Innovation Research (SBIR) Solicitation
- U.S. DOT's SBIR program
- Suggest a topic
- SBIR FAQs

Social Impact Partnership to Pay for Results Act (SIPPRA): A New Way for States to Access Federal Funding for Social Determinants of Health Interventions

In early February, the U.S. Department of the Treasury announced a new funding opportunity for state and local governments looking to invest in social determinants of health (SDOH). The funding opportunity, known as the Social Impact Partnerships to Pay for Results Act (SIPPRA), comes from a little-known provision in the Bipartisan Budget Act of 2018. So far, more than $66 million has been appropriated and allocated to finance outcomes-based payments for "social impact partnership projects."

The Social Impact Partnership to Pay for Results Act (SIPPRA) was signed into law on February 9, 2018 and is intended to improve the effectiveness of certain social services. SIPPRA allows the Treasury to pay state or local government for outcomes, and is intentionally divorced from established government programs like Medicaid – instead it is focused on overarching goals. SIPPRA explicitly targets social services related to 21 categories of outcomes.

Find more about SIPPRA from the below links:

- SIPPRA Legislation
- Notice of Funding Availability 2/22/2019
- Center for Health Care Strategies Blog Post covering SIPPRA and the framing around the funding announcement

Looking Ahead

CTAA will continue to watch the trends outlined above, and share more information and updates as these stories and policies progress. If you have information about specific health and transportation policy updates happening in your state, please be sure to share it with us.

Contact CTAA's Health Care and Transportation Associate, Alex King at king@ctaa.org or 202-340-5284 with any updates, information, or questions.

Interesting NEMT Links

- When staying healthy depends on whether you can get a ride
- Medicare Advantage Beneficiaries Will See a Jump in New Supplemental Benefit Offerings in 2019
- Uber and Lyft are Officially Part of the Health Care System, But at What Cost?
- Dialysis Transportation: Intersection of Transportation and Healthcare