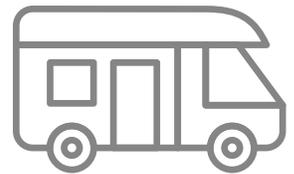
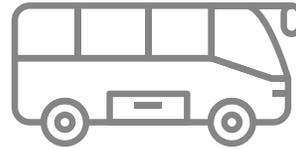
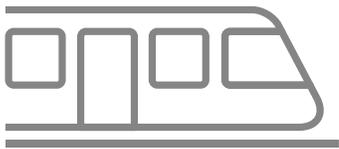


# ISSUE BRIEF

August 2018

## Non-Emergency Medical Transportation:

**PAST, PRESENT, AND FUTURE OF A CRITICAL SERVICE**



### **PART II: CURRENT TRENDS IN NON-EMERGENCY MEDICAL TRANSPORTATION**

#### **About the Authors:**

**The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI)** advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality healthcare and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective healthcare and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

**Lung Cancer Alliance** serves and listens to those living with and at risk for lung cancer to reduce stigma, improve quality of life and increase survival. Lung Cancer Alliance empowers its community by helping people navigate the paths of early detection, diagnosis and treatment. Insights allow Lung Cancer Alliance to improve care, amplify awareness, drive advocacy and lead research with the vision of tripling the number of survivors in the next decade.

## I. Introduction

For roughly 3.6 million Americans, a lack of reliable and affordable transportation acts as a significant barrier to accessing health care.<sup>1</sup> As discussed in **Part I**, Non-Emergency Medical Transportation (NEMT) can fill this gap and, thus, has the potential to improve health outcomes and decrease the costs of care for millions of Americans. However, in administering this benefit, states have faced a variety of challenges that limit access and increase costs for NEMT services. While many states have responded to these challenges by seeking out innovative solutions that would make their programs more efficient and user-friendly, others are instead looking to entirely eliminate this critical benefit for certain populations.

This issue brief, **Part II** in our NEMT series, will discuss current approaches to NEMT delivery, the ongoing challenges associated with these approaches, and the innovative steps that some states are adopting to improve, rather than eliminate, NEMT services.

## II. Trends in NEMT Delivery: Overview of State Medicaid Approaches

States have been required to provide NEMT services to Medicaid participants since the early years of the Medicaid program itself.<sup>2</sup> Like most Medicaid benefits, NEMT was originally administered directly by state Medicaid departments through a fee-for-service model. However, over time states found this model to be costly to administer and susceptible to fraud and abuse.<sup>3</sup> A series of amendments to the Social Security Act and federal regulations have given states increasing flexibility to experiment with how they administer NEMT and to address the challenges arising from the traditional fee-for-service model.<sup>4</sup> Today, many states blend two<sup>5</sup> or more models and take advantage of the flexibility inherent in some of these approaches, such that no two NEMT programs look exactly the same.

**States typically use one or more of the following models to deliver NEMT services:**

1. **Fee-for Service:** Under a fee-for-service model, states remain directly responsible for the delivery of NEMT services. Under this model, states may contract with independent transportation providers (e.g., public transit systems and professional or volunteer drivers) to provide NEMT services at set reimbursement rates.<sup>6</sup> State Medicaid offices are responsible for determining eligibility of transportation providers and beneficiaries as well as for authorizing and arranging trips.<sup>7</sup>



According to an analysis by the Center for Health Care Strategies, as of 2015, **20** states used a fee-for-service model to deliver at least some of their NEMT services.<sup>8</sup> However, administering NEMT directly can be costly and inefficient for state Medicaid departments, and states perceive fee-for-service NEMT programs as vulnerable to fraud and abuse.<sup>9</sup> As a result, many states are moving away from pure fee-for-services models. Of the twenty states using a fee-for-service model as of 2015, nine used a pure fee-for-service model<sup>10</sup> while the remaining eleven used mixed models that combined fee-for-service, brokerage,<sup>11</sup> and/or managed care approaches.<sup>12</sup>

- 2. Managed Care:** Under a managed care model, states contract with Managed Care Organizations (MCOs) to administer NEMT as well as other services to Medicaid beneficiaries, typically at a capitated rate (i.e., a set rate per-member-per-month).<sup>13</sup> This model of NEMT delivery is relatively new<sup>14</sup> and, as of 2015, was only being used in **four** states.<sup>15</sup> Notably though, 39 states, including D.C., currently contract with MCOs to administer other Medicaid benefits for at least a portion of their Medicaid population.<sup>16</sup> MCO payment structures also have the potential to create incentives to improve care coordination, control costs, and address social determinants of health. These qualities may make MCOs an increasingly popular model for delivery of NEMT services.
- 3. Public Transit:** States with extensive public transportation infrastructure may require beneficiaries to exhaust public transit options before seeking out other forms of NEMT. As of 2015, **four** states used public transit to deliver NEMT services.<sup>17</sup> For example, in Utah, eligible beneficiaries within the service area of the Utah Transit Authority or Cedar Area Transportation Services receive bus passes as part of the state's NEMT program while beneficiaries outside of these areas receive NEMT through a private broker.<sup>18</sup> Making use of existing public transit options can reduce costs and administrative effort. However, this approach also has some notable limitations. For example, many patients may have limited access to public transit, either because of their geographic location<sup>19</sup> or health needs<sup>20</sup> making it difficult for them to take advantage of these types of NEMT services.
- 4. Brokerage Model:** States that use the brokerage model contract with private companies or state agencies to manage NEMT services.<sup>21</sup> Under these arrangements, brokers, rather than state Medicaid agencies, are typically responsible for confirming eligibility of transportation providers and beneficiaries and for authorizing and arranging trips.<sup>22</sup> To use a brokerage model, states and brokers must follow federal rules that require:
  - Competitive bidding in broker selection,
  - Oversight of NEMT services by both the state and broker, and
  - Careful avoidance of conflicts of interest/self-referrals by the broker.<sup>23</sup>

Despite the added burden of meeting these requirements, brokerage remains the most common model of NEMT delivery. As of 2015, **34** states used some variation of a brokerage model.<sup>24</sup> As noted in **Part I** of this series, this popularity may be partially due to the flexibility that states have under the Deficit Reduction Act of 2005 (DRA) to avoid certain Medicaid requirements (e.g., freedom of choice requirements) when establishing a brokerage program.<sup>25</sup> Many states have also switched to the brokerage model because they believe it will allow them to both: (1) better manage costs by paying for NEMT on a capitated (i.e., per-member-per-month) basis and (2) at least partially delegate their responsibilities to monitor NEMT programs for fraud and abuse.<sup>26</sup>

**Transitioning between NEMT Delivery Strategies:** States must take particular care to monitor care delivery when transitioning between NEMT delivery models, as these transitions may leave some patients confused or unable to access necessary services. For example, many states have historically excluded patients with complex medical needs from MCO enrollment and have only recently begun to move these patients into managed care.<sup>27</sup> In one study of Kansas Medicaid patients with disabilities, patients noted that in transitioning to MCO coverage they faced difficulties in accessing transportation services.<sup>28</sup> One participant in the study reported that the NEMT provider hired by the MCO sent an inaccessible car and then caused her injury by incorrectly transferring her between her wheelchair and the vehicle.<sup>29</sup> Other study participants noted issues related to the amount of notice they were required to provide to obtain services, lack of coverage for personal care attendants, and lack of trust when their MCO contracted with new, unfamiliar transportation providers.<sup>30</sup>

### III. Ongoing Challenges in Delivering NEMT

As discussed in **Part I** of this series, NEMT, when efficiently administered, is a cost-effective way to improve health outcomes. However, despite the advances in service delivery described above, states continue to face certain challenges in administering NEMT. These challenges can undermine the benefits of NEMT by impeding patient access to services or creating unnecessary program costs.

**1. Customer Service Challenges:** Some NEMT beneficiaries continue to report issues related to poor customer service and a lack of flexibility on the part of NEMT providers. In particular, beneficiaries have noted the following issues:

- **Scheduling Challenges:** Beneficiaries often must schedule rides significantly in advance of their appointments. Transportation providers may be incapable of adjusting to last-minute changes in pick-up times or locations. They also have difficulty responding to events that cannot be scheduled in advance, such as hospital discharges.<sup>31</sup>
- **Access Challenges:** In some regions—such as rural areas—driver supply issues can limit access to NEMT services. In these regions there are not enough NEMT providers to meet the needs of local beneficiaries.<sup>32</sup>
- **Driver Quality Issues:** Beneficiaries may face long wait times, no-shows,<sup>33</sup> poor driver behavior,<sup>34</sup> or drivers who lack expertise on how to work with patients living with certain conditions.<sup>35</sup>
- **Program Restrictions:** Drivers may not be able to meet patients at their doors or assist them in leaving their homes, thus causing beneficiaries with mobility limitations to miss appointments.<sup>36</sup> Additionally, some beneficiaries require accompaniment to medical appointments. Stakeholders report that, in some cases, states or NEMT providers prohibit such companions from riding with the patient.<sup>37</sup>

**2. Fraud and Abuse:** NEMT programs also continue to struggle to address problems related to fraud and abuse. For example, in Indiana, the owner of an NEMT company was found guilty of Medicaid fraud after billing Indiana’s Medicaid program for over \$1 million for rides that never occurred.<sup>38</sup> Similarly, a New York ambulette company owner was recently sentenced to six months in jail and five years’ probation when he was found guilty of modifying NEMT authorizations to approve ambulette services rather than a lower cost service (taxi rides).<sup>39</sup> Issues like these appear to stem from the following challenges:

- **Data Collection Challenges:** According to CMS, all states require transportation providers to record basic service data including: the beneficiary’s name and Medicaid identifier, pick-up and drop-off locations, the date/time of the NEMT services, and total mileage travelled with the beneficiary in the vehicle (a/k/a “loaded miles”).<sup>40</sup> However, there is no federal requirement that these reports be supported by outside data (e.g., GPS), recorded electronically, or even written in ink rather than pencil.<sup>41</sup> As a result, stakeholders have raised concerns about the quality and accuracy of NEMT data.<sup>42</sup>
- **Oversight Challenges:** Within the bounds of broad federal requirements, states are responsible for designing NEMT oversight systems and ensuring compliance with these systems.<sup>43</sup> However, these oversight systems are often inefficient, lack transparency, and leave NEMT programs susceptible to fraud and waste.<sup>44</sup> For example, a 2016 audit of New Jersey’s NEMT system by the Office of Inspector General (OIG) noted that “[t]he State agency did not adequately oversee its Medicaid NEMT brokerage program to ensure that CMS-approved State Plan provisions were met” and that “only 12 of the 100 claims in [a] random sample complied with contract provisions and State requirements.”<sup>45</sup>

### IV. State Responses to Challenges in Administering NEMT

**Faced with these ongoing challenges and budget pressures, some states are seeking to restrict access to NEMT services.** Specifically, a number of states have sought Section 1115 Demonstration Waivers that would

partially or completely waive the NEMT requirement for particular populations. **Part III** of this series will take a deeper dive into these 1115 Waivers and provide stakeholders with tools and strategies that they can use to respond to similar efforts in their states.

**In contrast, the following section will highlight the ways that many states are instead looking to address these challenges through the use of innovative policies, technologies, and partnerships.** CHLPI and LCA urge policymakers and other stakeholders to explore these options before taking any action to restrict NEMT benefits. By adopting these strategies, states not only have the potential to improve their NEMT systems, but also to reduce unnecessary costs *without* cutting crucial benefits.

**1. Innovative Policy Approaches:** Some states are responding to challenges in NEMT delivery by using state policies and creative contracting to improve program oversight and customer service.

- **Capitated Payment Models:** Over time many states have moved to a brokerage or MCO model to deliver NEMT services. In these models, the broker or MCO is generally paid on a capitated basis (e.g., per-member-per-month) to deliver NEMT services. As noted in a recent *Health Affairs* blog, these capitated arrangements place much of the financial risk on MCOs and brokers, creating incentives for these organizations to control costs and monitor services for signs of fraud or abuse.<sup>46</sup> Thus, while robust state oversight remains an important part of *any* NEMT program, states can build an additional layer of monitoring into their programs by adopting a capitated approach.
- **Contract Design:** States can also build provisions into their contracts with brokers, MCOs, and transportation providers to address past issues related to data collection and customer services. In a 2016 issue brief, *Justice in Aging* provided an overview of potential innovative contract provisions, including:
  - **Reporting provisions** that require brokers to inform the state of all customer complaints on a regular basis;
  - **Electronic tracking provisions** that require contractors to use real-time GPS trip monitoring to improve data on NEMT services;
  - **Additional training provisions** that require brokers to ensure that drivers are adequately trained to deliver NEMT services;
  - **Scheduling provisions** that require brokers to meet certain benchmarks regarding pick-up and drop-off wait-times; and
  - **Incentive provisions** that tie broker payment to performance on contract requirements.<sup>47</sup>
- **Expanding Driver Networks:** Finally, states can consider adopting creative approaches to expand their pool of NEMT drivers to improve access to NEMT in areas where drivers may be scarce (e.g., rural areas). For example, in a 2016 report, the U.S. Government Accountability Office (GAO) noted that states can expand their driver pools by reimbursing family members or friends of beneficiaries for using personal vehicles to transport beneficiaries to necessary medical services.<sup>48</sup>



**2. Collaboration with Transportation Network Companies (TNCs):** Increasingly, states and health care providers are looking to partner with Transportation Network Companies (TNCs) to improve patient access to care. TNCs, such as Uber or Lyft, are typically characterized by their on-demand ride-hailing capabilities and easy-to-use mobile apps. These capabilities can allow them to alleviate the flexibility and scheduling concerns associated with NEMT services.<sup>49</sup> Additionally, collaboration with TNCs may help to address states' program integrity concerns because these systems result in automatic electronic ride records.<sup>50</sup> A variety of TNCs, or TNC-like models, are currently developing or engaged in partnerships with NEMT programs or individual health care providers across the United States, including:

- **Circulation:** Circulation, a Boston-based startup, has partnered with Uber and Lyft, as well more traditional medical transportation providers, to develop an NEMT system that closely resembles the TNC model.<sup>51</sup> These partnerships have resulted in multiple pilot programs, starting at health care facilities in Boston, Delaware, and Pennsylvania, and spreading to serve over 1,000 facilities across the country.<sup>52</sup> Circulation now serves not only Medicaid patients, but also patients insured by Medicare, dual-eligible, and commercial insurance programs.<sup>53</sup>
- **Veyo:** Veyo, a TNC-like NEMT broker, has also established partnerships with multiple state governments, including Connecticut, Colorado, and others.<sup>54</sup> In total, Veyo now has a presence in eight states—Arizona, California, Colorado, Connecticut, Florida, Michigan, Texas, and Virginia—where it provides services to a variety of Medicaid providers and payers.<sup>55</sup>
- **Logisticare:** Logisticare, the largest private NEMT broker in the country, has recently announced a three-year partnership with Lyft that will provide rides to patients in 276 cities in 31 states and Washington, D.C.<sup>56</sup>

While TNCs have significant potential to increase NEMT access and data quality, they also present certain new challenges. For example, states may have specific credentialing or training requirements for NEMT drivers that may not match up with traditional TNC requirements.<sup>57</sup> Additionally, TNCs such as Uber and Lyft may have limited accessibility options in certain service areas,<sup>58</sup> meaning that states must ensure that there are other accessible options within their NEMT network. Finally, states must carefully monitor the implementation of new TNC collaborations, as major transitions in NEMT delivery can be difficult for both patients and transportation providers. For example, when Veyo initially assumed control over Connecticut's NEMT program, patients complained of long hold times when calling to arrange rides, missing critical appointments, and being stranded when rides never arrived.<sup>59</sup> Given the importance of NEMT services, states must take care in developing TNC collaborations to proactively acknowledge and address these challenges to maximize the benefits of TNCs while protecting patient care.

**3. State Coordinating Councils:** In an attempt to cut down on the overall costs and administrative complexities of NEMT and other state-provided transportation services, some states have tried to coordinate and consolidate services used by similar populations.<sup>60</sup> State coordinating councils—made up of state officials, consumers, and other relevant stakeholders—work to oversee the coordination of these services to ensure that transportation is effective, efficient, and accessible for beneficiaries.<sup>61</sup> The National Conference of State Legislatures (NCSL) has tracked and analyzed these councils over time, and found that as of 2014, 20 states had active state coordinating councils.<sup>62</sup> These councils vary from state to state, taking on different levels of formality.

- **Formal Councils:** Formal councils may be established by statute, have dedicated funding sources, and spearhead efforts on research, policy change, and more.
  - **Example: The Florida Commission for the Transportation Disadvantaged (CTD)** was established by state statute, is staffed by gubernatorial appointees,<sup>63</sup> and is state-funded.<sup>64</sup> The purpose of the CTD is “to accomplish the coordination of transportation services provided to the transportation disadvantaged.”<sup>65</sup> To do so, the CTD has a number of statutory duties, including establishing statewide objectives for transportation coordination and developing policies and procedures for the coordination of local, state, and federal funding for the transportation disadvantaged.<sup>66</sup> In the past, Florida's state Medicaid agency contracted with the CTD to manage its NEMT program.<sup>67</sup> NEMT is now the responsibility of Florida's Medicaid MCOs, but a representative of the state Medicaid agency continues to participate in the CTD as a non-voting advisor.<sup>68</sup>

- **Informal Councils:** Councils that are more informal often consist of volunteers and may perform assessments and develop strategies, amongst other duties.
  - **Example:** The Washington Agency Council on Coordinated Transportation (ACCT) has established multiple working groups on a variety of issues, and has released a state transportation plan as well as more focused reports.<sup>69</sup> Under its original statutory mandate, the ACCT included representation from both the state Medicaid program and NEMT brokers.<sup>70</sup> However, the ACCT is no longer mandated by statute, is unfunded, and now meets on a volunteer basis.<sup>71</sup>

In many cases, states continue to struggle to truly coordinate Medicaid NEMT with their broader transportation services. This struggle is due in part to cumbersome federal rules (i.e., the prohibition on self-referrals associated with governmental brokers) and to the varied standards and regulations that apply across different publicly funded transportation services.<sup>72</sup> Coordinating councils can create an important space for states agencies and other stakeholders to examine these barriers and potential options for increased coordination. Policymakers should therefore consider creating or leveraging coordinating councils to improve the administration of NEMT services in their state.

## V. Conclusion

NEMT is a vital service for millions of low-income Americans. However, NEMT programs have historically faced challenges related to customer service and fraud and abuse. As discussed in this issue brief, states can proactively address these challenges by adopting a variety of strategies, ranging from creative contracting to innovative partnerships or interagency collaboration. Despite the availability of these strategies, we know that a number of states are still working to restrict, rather than improve their NEMT programs. The next resource in this series will therefore take a closer look at the use of Medicaid Section 1115 Demonstration Waivers to restrict access to NEMT and the ways that stakeholders can get involved in the waiver process to protect transportation benefits.



## Endnotes

- <sup>1</sup> Richard Wallace et al., *Access to Health Care and Nonemergency Medical Transportation: Two Missing Links*, 1924 Transportation Research Record: J. Transportation Research Board 76, 79 (2005) (finding that roughly 3.6 million Americans miss at least one medical trip in a year due to lack of transportation)
- <sup>2</sup> Sara Rosenbaum et al., *Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform*, The George Washington University School of Public Health and Health Services, 4 (2009).
- <sup>3</sup> Suzie Edrington & Jessica Bullock, *Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination: Review and Summary of Relevant Literature*, Texas A&M Transportation Institute, 7-8 (2014). *Id.* at 8-12; see also 42 C.F.R. § 440.170(a)(4).
- <sup>4</sup> As of 2015, 15 states used a mixed model approach. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>5</sup> Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 3 (2017).
- <sup>6</sup> *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*, Transportation Research Board of the National Academies, 25 (2014).
- <sup>7</sup> Alaska, Alabama, Colorado, Florida, Indiana, Louisiana, Maryland, Michigan, Minnesota, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Tennessee, Texas, and Wyoming. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>8</sup> See Michael Adelberg & Marsha Simon, *Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?*, Health Affairs Blog (Sept. 20, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170920.062063/full/> (last visited July 20, 2018); Suzie Edrington & Jessica Bullock, *Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination: Review and Summary of Relevant Literature*, Texas A&M Transportation Institute, 7-8 (2014).
- <sup>9</sup> Alaska, Alabama, Indiana, Louisiana, Minnesota, New Hampshire, North Carolina, Ohio, and Wyoming. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>10</sup> Colorado, Maryland, Michigan, New York, North Dakota, Pennsylvania, Tennessee, and Texas. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>11</sup> Florida, New Mexico, and Oregon. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>12</sup> *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*, Transportation Research Board of the National Academies, 25 (2014).
- <sup>13</sup> *Impact of the Affordable Care Act on Non-Emergency Medical Transportation (NEMT): Assessment for Transit Agencies*, Transportation Research Board of the National Academies, 25 (2014).
- <sup>14</sup> Arizona, Florida, New Mexico, and Oregon. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017). Only one state—Florida—does not use this model in combination with a fee-for-service model. *Id.*
- <sup>15</sup> Arizona, California, Colorado, Delaware, D.C., Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin. *Medicaid MCO Enrollment*, Kaiser Family Foundation (2017), <https://www.kff.org/other/state-indicator/medicaid-enrollment-by-mco/?currentTimeframe=0&sortModel=%7B%22colld%22:%22State%22,%22sort%22:%22asc%22%7D>.
- <sup>16</sup> California, Rhode Island, South Dakota, and Vermont. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>17</sup> See *Utah Medicaid Provider Manual: Medical Transportation*, Division of Medicaid and Health Financing, 2 (July 2017), available at <https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Medical%20Transportation/Transportation.pdf>; *Non-Emergency Transportation*, Utah Department of Health: Medicaid, <https://medicaid.utah.gov/non-emergency-transportation> (last visited July 20, 2018).
- <sup>18</sup> See, e.g., *Rural Communities: Expanding Horizons*, American Public Transit Association, 3 (2012), available at <http://www.apta.com/resources/reportsandpublications/Documents/Rural-Communities-APTA-White-Paper.pdf>.
- <sup>19</sup> See, e.g., Jill L. Bezyak et al., *Public Transportation: An Investigation of Barriers for People with Disabilities*, 28(1) J. Disability Policy Studies 52, 52–53, 56–57 (2017).
- <sup>20</sup> Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community*, National Conference of State Legislatures (Jan. 2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.

- <sup>22</sup> Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community*, National Conference of State Legislatures (Jan. 2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.
- <sup>23</sup> 42 C.F.R. § 440.170(a)(4)(i).
- <sup>24</sup> Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 2 (2017).
- <sup>25</sup> See Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6083 (2006); 42 C.F.R. § 440.170(a)(4).
- <sup>26</sup> Suzie Edrington & Jessica Bullock, *Examining the Effects of Separate Non-Emergency Medical Transportation (NEMT) Brokerages on Transportation Coordination: Review and Summary of Relevant Literature*, Texas A&M Transportation Institute, 8 (2014).
- <sup>27</sup> See, e.g., Jean P. Hall et al., *Medicaid Managed Care: Issues for Beneficiaries with Disabilities*, 8 Disability & Health J. 130, 130–31 (2015).
- <sup>28</sup> Jean P. Hall et al., *Medicaid Managed Care: Issues for Beneficiaries with Disabilities*, 8 Disability & Health J. 130, 132 (2015).
- <sup>29</sup> Jean P. Hall et al., *Medicaid Managed Care: Issues for Beneficiaries with Disabilities*, 8 Disability & Health J. 130, 132 (2015).
- <sup>30</sup> Jean P. Hall et al., *Medicaid Managed Care: Issues for Beneficiaries with Disabilities*, 8 Disability & Health J. 130, 132-33 (2015).
- <sup>31</sup> See, e.g., Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 4 (2017).
- <sup>32</sup> *Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States*, U.S. Government Accountability Office, 21 (2016).
- <sup>33</sup> See, e.g., Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 4 (2017); Fay Gordon, *Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults*, Justice in Aging, 5-6 (Oct. 2016); *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 7 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.
- <sup>34</sup> See *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 7 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.
- <sup>35</sup> See, e.g., Jean P. Hall et al., *Medicaid Managed Care: Issues for Beneficiaries with Disabilities*, 8 Disability & Health J. 130, 132 (2015).
- <sup>36</sup> Center for Health Law and Policy Innovation of Harvard Law School & Lung Cancer Alliance, *Challenges and Innovations in Non-Emergency Medical Transportation: A Webinar and Facilitated Discussion* (Mar. 5, 2018) (comments from facilitated discussion).
- <sup>37</sup> Center for Health Law and Policy Innovation of Harvard Law School & Lung Cancer Alliance, *Challenges and Innovations in Non-Emergency Medical Transportation: A Webinar and Facilitated Discussion* (Mar. 5, 2018) (comments from facilitated discussion).
- <sup>38</sup> *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 9 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.
- <sup>39</sup> *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 9 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.
- <sup>40</sup> *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 11 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>.
- <sup>41</sup> See *Medicaid Non-Emergency Medical Transportation Booklet for Providers*, Centers for Medicare and Medicaid Services, 11 (2016), available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf>; Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 5 (2017).
- <sup>42</sup> See, e.g., Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 5 (2017).
- <sup>43</sup> *Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States*, U.S. Government Accountability Office, 11 (2016).
- <sup>44</sup> See *Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States*, U.S. Government Accountability Office, 16–20 (2016); Fay Gordon, *Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults*, Justice in Aging, 5-10 (Oct. 2016).
- <sup>45</sup> *New Jersey Did Not Adequately Oversee Its Medicaid Nonemergency Medical Transportation Brokerage Program*, Department of Health and Human Services: Office of Inspector General, ii–iii (2016), available at <https://oig.hhs.gov/oas/reports/>

region2/21401001.pdf.

- <sup>46</sup> Michael Adelberg & Marsha Simon, *Non-Emergency Medical Transportation: Will Reshaping Medicaid Sacrifice An Important Benefit?*, Health Affairs Blog (Sept. 20, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170920.062063/full/> (last visited July 20, 2018).
- <sup>47</sup> Fay Gordon, *Medicaid Non-Emergency Medical Transportation: An Overlooked Lifeline for Older Adults*, Justice in Aging, 6-8 (Oct. 2016).
- <sup>48</sup> *Non-Emergency Medical Transportation: Updated Medicaid Guidance Could Help States*, U.S. Government Accountability Office, 21 (2016).
- <sup>49</sup> Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 6 (2017).
- <sup>50</sup> Adam Ganuza & Rachel Davis, *Disruptive Innovation in Medicaid Non-Emergency Transportation*, Center for Health Care Strategies, Inc., 6 (2017).
- <sup>51</sup> Wyatt Cmar, *How a Boston-Based Startup Is Changing Non-Emergency Medical Transportation*, Statescoop, Oct. 9, 2017, <https://statescoop.com/how-a-boston-based-startup-is-changing-non-emergency-medical-transportation>; Allison Proffitt, *Circulation, Lyft Announce Medical Transportation Partnership*, Clinical Informatics News, Dec. 5, 2017, [http://www.clinicalinformaticsnews.com/2017/12/05/circulation-lyft-announce-medical-transportation-partnership.aspx?mkt\\_tok=eyJpIjoiWWVjMVI6VXpaROU0Tm9uZS9kZDZlMjE2eEs0YkJKJmZlR096QlwwQl-h6SGhmUVFIWEMifQ%3D%3D](http://www.clinicalinformaticsnews.com/2017/12/05/circulation-lyft-announce-medical-transportation-partnership.aspx?mkt_tok=eyJpIjoiWWVjMVI6VXpaROU0Tm9uZS9kZDZlMjE2eEs0YkJKJmZlR096QlwwQl-h6SGhmUVFIWEMifQ%3D%3D).
- <sup>52</sup> *Circulation Expands into 700 Health Facilities across 25 States*, Business Wire, Apr. 20, 2017, <https://www.businesswire.com/news/home/20170420005514/en/Circulation-Expands-700-Health-Facilities-25-States>; Allison Proffitt, *Circulation, Lyft Announce Medical Transportation Partnership*, Clinical Informatics News, Dec. 5, 2017, [http://www.clinicalinformaticsnews.com/2017/12/05/circulation-lyft-announce-medical-transportation-partnership.aspx?mkt\\_tok=eyJpIjoiWWVjMVI6VXpaROU0Tm9uZS9kZDZlMjE2eEs0YkJKJmZlR096QlwwQl-h6SGhmUVFIWEMifQ%3D%3D](http://www.clinicalinformaticsnews.com/2017/12/05/circulation-lyft-announce-medical-transportation-partnership.aspx?mkt_tok=eyJpIjoiWWVjMVI6VXpaROU0Tm9uZS9kZDZlMjE2eEs0YkJKJmZlR096QlwwQl-h6SGhmUVFIWEMifQ%3D%3D).
- <sup>53</sup> *Circulation Expands into 700 Health Facilities across 25 States*, Business Wire, Apr. 20, 2017, <https://www.businesswire.com/news/home/20170420005514/en/Circulation-Expands-700-Health-Facilities-25-States>.
- <sup>54</sup> See, e.g., *Non-Emergent Medical Transportation (NEMT)*, Colorado Department of Health Care Policy & Financing, <https://www.colorado.gov/pacific/hcpf/non-emergent-medical-transportation> (last visited July 22, 2018); *Non-Emergency Medical Transportation (NEMT)*, Connecticut State Department of Social Services, <http://portal.ct.gov/dss/Health-And-Home-Care/Non-Emergency-Medical-Transportation> (last visited July 22, 2018).
- <sup>55</sup> *Veyo: The Next Generation of Patient Transportation Has Arrived*, Veyo, <https://veyo.com/> (last visited July 22, 2018).
- <sup>56</sup> Press Release, *LogistiCare & Lyft, LogistiCare And Lyft Announce Nationwide Partnership* (Feb. 7, 2017), available at <https://www.prnewswire.com/news-releases/logisticare-and-lyft-announce-nationwide-partnership-300403514.html>.
- <sup>57</sup> David E. Williams, *Bringing On-Demand Rideshare to Medical Transport. Interview with Veyo's CEO*, Health Business Group Blog, <https://healthbusinessgroup.com/blog/2017/03/09/bringing-on-demand-rideshare-to-medical-transport-interview-with-veyos-ceo/> (last visited July 22, 2018).
- <sup>58</sup> See *Accessibility at Uber*, Uber, <https://accessibility.uber.com/> (last visited July 22, 2018); *Accessible Vehicle Dispatch*, Lyft, <https://help.lyft.com/hc/en-us/articles/115013081668-Accessible-vehicle-dispatch> (last visited July 22, 2018).
- <sup>59</sup> Mackenzie Rigg, *New Transportation Contractor for Medicaid Patients Off to Rocky Start*, The CT Mirror, Jan. 12, 2018, <https://ctmirror.org/2018/01/12/new-transportation-contractor-for-medicaid-patients-off-to-bumpy-start/>.
- <sup>60</sup> Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Health Community*, National Conference of State Legislatures (Jan. 2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.
- <sup>61</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 5-6 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf).
- <sup>62</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 7 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf).
- <sup>63</sup> Fla. Stat. § 427.012.
- <sup>64</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 22-23 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf).
- <sup>65</sup> Fla. Stat. § 427.013.
- <sup>66</sup> Fla. Stat. § 427.013.

- <sup>67</sup> See Nicholas J. Farber and Jaime Rall, *Human Service Transportation Coordination State Profile: Florida*, National Conference of State Legislatures, 4 (2010), available at <http://www.ncsl.org/documents/transportation/FL-HSTCprofile.pdf>.
- <sup>68</sup> See *2017 Annual Performance Report*, Florida Commission for the Transportation Disadvantaged (Jan. 2018), available at <http://www.fdot.gov/ctd/docs/AORAPRDocs/FinalApprovedAOR2016-20171052018.pdf>.
- <sup>69</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 63-64 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf); *Welcome*, Agency Council on Coordinated Transportation, <http://www.wsdot.wa.gov/acct/> (last visited July 23, 2018).
- <sup>70</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 63 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf).
- <sup>71</sup> Jaime Rall and Amelia Myers, *State Human Service and Transportation Coordinating Councils: An Overview and State Profiles*, National Conference of State Legislatures, 63-64 (2014), available at [http://www.ncsl.org/Portals/1/Documents/transportation/SCC\\_transportation\\_final02.pdf](http://www.ncsl.org/Portals/1/Documents/transportation/SCC_transportation_final02.pdf).
- <sup>72</sup> Amelia Myers, *Non-Emergency Medical Transportation: A Vital Lifeline for a Health Community*, National Conference of State Legislatures (Jan. 2015), <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.



CENTER *for* HEALTH LAW  
*and* POLICY INNOVATION  
HARVARD LAW SCHOOL