Washington State Health Care Authority

Report to the Legislature

Non-Emergency Medical Transportation (NEMT)

Overview and gap analysis

Second Substitute Senate Bill 6228; Section 13; Chapter 366; Laws of 2024

December 1, 2024

Table of contents

Executive Summary

Second Substitute Senate Bill 6228 (2024); Section 13; directed the Washington State Health Care Authority (HCA) to:

> Provide a gap analysis of nonemergency transportation benefits provided to medicaid enrollees in Washington, Oregon, and other comparison states selected by the health care authority and provide an analysis of the cost and benefits of available alternatives to the governor and appropriate committees of the Legislature by December 1, 2024.

Key findings

The current not for profit centered community focused regional brokerage model is the best framework through which to administer Non-Emergency Medical Transportation (NEMT) services in Washington State.

- Performance based contracts realized approximately $22 million in cost avoidance over 10 years.
- Billing agreements with five behavioral health facilities for same-day trips.
- Billing agreements with 22 Indigenous nations expanding access to rural communities.
- Broker/Hospital-funded transportation desks in three high-traffic hospitals in Seattle
    - First of its kind in the nation

Comparison states have overly rigid models, confusing administration, lack cost effectiveness, and all three states appeared behind in the use of data to manage their programs.

- Oregon: Regional/managed care organization (MCO) Model is overly complex with 16 different brokers.
- Idaho: Statewide Brokerage Model has high turnover of for-profit brokers resulting in disruption and has a lack of connection to communities.
- Colorado: Regional/In-House Model has a lack of oversight, which resulted in significant audit findings and suspected fraud ring.

The Washington State NEMT (WANEMT) system challenges are directly related to funding. There is no current mechanism in the contracts to ensure administrative costs are aligned with the economy, creating a gradual erosion in service as minimum wage and health care costs increased. COVID-19 further destabilized broker call centers resulting in an increase in complaints, service failures, and a perception of systemic issues.

- Most concerns were directly related to understaffed broker call centers.
- Legislature allocated an additional $7 million per year in new funding during 2024 Legislative session and there has been a substantial improvement in broker call center staffing.

Recommendations

- Add Consumer Price Index (CPI) escalation model to broker contracts through legislative action.
- Continue to expand broker billing agreements with behavioral health facilities.
- Incentivize behavioral health facilities to invest in vehicles including secure transportation.

- Leverage Mobile Crisis Responder (MCR) or Program of Assertive Community Treatment (PACT) programs by establishing billing agreements to ensure reimbursement if a beneficiary requires further treatment and is transported by responders to a treatment center.

Introduction

The Washington State Non-Emergency Medical Transportation (WANEMT) program has been recognized as one of the best programs in the country. States have historically reached out for best practices. The WANEMT program team has met with at least four states over the past three years and has taken a leadership role by managing the nationwide NEMT Listserv in which state NEMT programs ask questions, share best practices, and discuss new guidance from the Centers for Medicare & Medicaid Services (CMS). The WANEMT program has leveraged this resource, in conjunction with frequent outreach from other states, to stay up-to-date on changes in the national NEMT landscape. Some states have replicated Washington State's innovative strategies in gathering utilization data and using it to inform their program management. Others have instituted incentives and performance based contracts after discussions with Washington State.

COVID-19 and static administrative rates created a perfect storm in which transportation brokers could not fully staff call centers causing an increase in complaints, services failures, and a perception of systemic issues when, in fact, brokers did not have the funding to ensure staffing to continue their community outreach. Stakeholder meetings revealed many providers requesting trips didn't understand the role of the WANEMT program and conflated it with public transportation or emergency services.

The purpose of this report is to provide the Legislature a detailed overview of the program in its current state, identify gaps and solutions, discuss funding challenges, introduce a forward looking policy proposal, and provide context through comparison with three other states. **The existing community based, not-for-profit-centered regional brokerage model is the best framework through which to administer NEMT services to the most vulnerable people in our state.**

Current State of WANEMT program

The WANEMT program is administered as a medical match, regional brokerage model in accordance with 42 CFR 440.170(a)(4). NEMT services are included and designated in the Medicaid State Plan as a medical service. This requires a higher level of oversight than if it were identified as an administrative service. Administering a NEMT program as a medical service reduces risk to the Medicaid agency and the state.

WANEMT brokers

HCA contracts with six transportation brokers selected in a competitive request for proposal (RFP) process, in which national firms submitted proposals for consideration. Six regional brokers were selected to serve 13 transportation regions based on historical travel patterns to and from health care catchment areas. Five brokers are nonprofit community organizations and one is an Area Agency on Aging (AAA).

Several brokers provide additional human services to the community through other contracts such as food banks, Meals on Wheels, senior services, the Health Home program, and Community Options Program Entry System (COPES) transportation. Some also hold contracts with the Washington State Department of Transportation (WSDOT) to expand public transit through deviated routes in rural areas, including Americans with Disabilities Act (ADA) transportation.[1] Brokers are community organziations that not only coordinate transportation to medically necessary services for Medicaid beneficiaries, but also act as a central location for human services in their communities.

WANEMT uses a unique payment system in which administrative and service costs are split. The administrative rate is a set negotiated amount that cannot change without legislative action. Service is 100 percent pass through to transportation providers. The broker does not retain any piece of the service cost so there is no incentive to run up costs to increase profitability. In fact, no broker is a for-profit organization so their sole focus is on service. Additionally, WANEMT contracts include incentives for brokers to lower costs and/or increase the percent of low-cost mode trips relative to the total number of trips provided in a quarter. Examples of low-cost mode trips include public transit, mileage reimbursement, gas vouchers, volunteer drivers, train, or commercial bus. Incentives earned must be reinvested into the brokerage.

Public transit

Public transit is often overlooked by state Medicaid agencies. CMS indicated as much in a June 2023 report that, "states rarely use public transit networks for NEMT and should find opportunities to improve operations between NEMT and public transit networks to better coordinate services for beneficiaries."[2]

Washington State has been a national leader in using innovative measures such as the low-cost mode incentive for brokers to improve coordination and work closely with transit agencies in their regions. This innovative policy and brokers' efforts to leverage transit networks resulted in over a third of NEMT trips being performed through public transit between 2013 and 2019. COVID-19 and subsequent driver shortages caused transit agencies to reduce their footprint in communities and transit trips had to be

[1] Deviated routes are routes that expand footprint of a fixed public transit route.

[2] Expanded Report to Congress Non-Emergency Medical Transportation in Medicaid 2018-2021

shifted back to higher cost taxi and commercial vehicles. Only now are transit agencies starting to expand services again.

NEMT rates

Unlike many states in which NEMT services are treated as one-size-fits-all, HCA does not set rates for NEMT services because geography is a major factor in the reasonable cost of transportation. The cost is best determined through negotiaton between the broker and a provider for any given region. Keeping service costs close to the cost of doing business ensures providers operating in rural areas can stay in business.

When states or Medicaid Managed Care Plans consolidate services under one broker and rates are set at the state level, vital resources in rural areas are the first to disappear as small providers are unable to compete and many go out of business. Consolidation reduces competition leading to supply concerns, surging costs, and reduction in quality. The WANEMT program has heard this firsthand from other states, with one state specifically regretting their move to a capitated model for NEMT services.

Innovations

Data and oversight innovations

In 2011, the WANEMT program built a utilization database that is used daily to analyze how the program is performing. This Data Tracking Utilization System (DTUS) was, to WANEMT's knowledge, the first of its kind in the country. It captures over 45 fields of data for each trip. This ensures WANEMT program staff can keep a finger on the pulse of the program. Additionally, brokers provide approximately 20 reports to HCA every month to increase the level of detail and broaden the view program staff have to ensure proper oversight and monitoring to address contract performance, assess gaps, and explore solutions. Washington is a leader in data-driven program management, and this has resulted in one of the most cost-effective programs in the country.

WANEMT data was used to help inform the Substance Use Disorder (SUD) program of where additional methadone dosing sites and mobile units were needed. Areas of need can be identified by analyzing distance travelled and mapping their patterns by medical service. The internal WANEMT dashboard includes several maps that provide visualizations of areas where clients are travelling exceptional distances to access covered services.

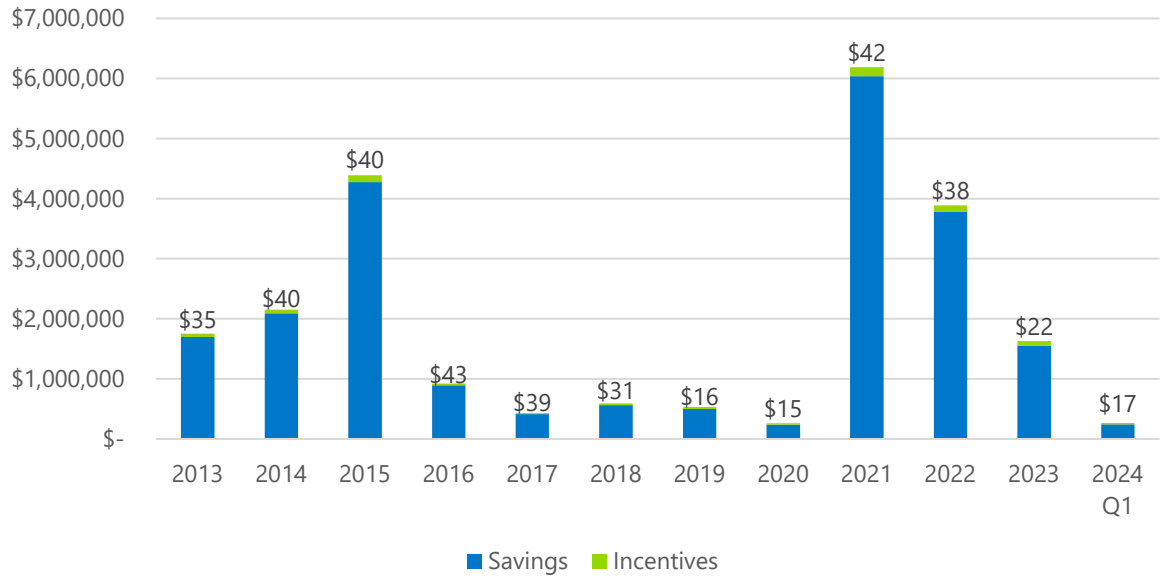
The WANEMT program team is currently building a data model to test managed care network adequacy. This will help improve agency oversight of Medicaid Managed Care Organizations (MCO). Importantly, NEMT data is independent of MCOs and provides a neutral comparison of distance travelled to MCO contract requirements. This will help identify if clients are traveling excessive distances to access medical services offered by the MCOs.

Performance based contracts ensure brokers replicate data driven program management and oversight within their contracts with transportation providers. There are contract requirements for brokers to perform continuous system testing and reviews. This has ensured a proactive approach to identify billing concerns, abuse, or finding efficiencies and cost savings. These contracts, with innovative incentive provisions, have not only ensured compliance and program integrity, but also helped realize substantial cost avoidance.

Since 2013, for every incentive dollar spent each quarter, the state has avoided approximately $32 in cost. This totals over $2 million per year and $22 million over 10 years.

Figure 1 provides a visual of cost avoidance per incentive dollar spent per year. This innovation has garnered the most interest throughout the country.

Figure 1: Cost avoidance to incentive dollar spent



Cost avoidance calculated by comparing average cost per trip and percentage of low cost mode (LCM) to total trips with same quarter as the year before. If there is a cost reduction, total trips are multiplied by the amount saved. If there is an increase in LCM percentage, then the percent difference is multiplied by total trips and difference in cost between LCM average cost per trip with average cost per trip. These two are summed up and a ratio is determined when comparing to incentives paid for that quarter.

Additional innovations in the current WANEMT system

- **Broker transportation desks at three major hospitals in the Seattle area**
  - Jointly funded by the broker and hospital, this ensures clients are connected to transportation and have a place to wait for return trips. They do not have to call the broker as they just go to the desk to request a ride. To our knowledge, this is not happening anywhere else in the country.
  - WANEMT is encouraging other brokers to reach out to hospitals in their regions to expand this innovative strategy into higher-traffic facilities in other parts of the state.
- **Indigenous Nation billing agreements**
  - Leverages Tribal transportation systems of 22 federally recognized Tribes to improve access to clients in rural communities throughout the state. In calendar year 2023, the WANEMT

program reimbursed nations over $2.5 million for trips provided to their members. A majority of the trips were for behavioral health services including substance use disorder (SUD) treatment. Most of the funds used for these trips were eligible for 100 percent federal match.[3]

- **Behavioral health (BH) facility billing agreements**
  - BH facilities with vehicles can enter into agreements with brokers to receive reimbursement for transporting their clients. This expands access to behavioral health services. Five facilities have agreements set up, and four are located in central Washington.
  - These agreements will be key to the hub-and-spoke policy proposal explained in detail following.
- **Pilots**
  - May 2021: Stretcher vehicle pilot in which brokers leveraged private transportation companies offering this specialized mode.
    - At the outset of this pilot, WANEMT realized between $300–$700 savings for each trip transferred from special contracting through the Ambulance Program to the stretcher pilot.
    - The recent increase in rates for non-emergency ambulance services reduced the need for special contracting. The pilot, however, is continuing to expand capacity and further augment the non-emergency ambulance network.
    - The biggest barrier to expansion is the cost of insurance and low or inconsistent trip volume.
  - August 2024: One of our brokers is piloting the use of a transportation network company (TNC) to help with overflow, recovery, and last-minute requested trips in King County.
  - September 2024: One of our NEMT brokers will coordinate with a small transit agency to pilot a human services rate to leverage ADA services as a cost-savings measure for non-ambulatory beneficiaries.[4]

COVID-19: impacts, response, and recovery

COVID-19 was an unprecedented event that required immediate response across all sectors of the economy. Organizations had to immediately build policies and infrastructure around remote work. State administrators balanced regulation with immediately directing resources where they were most needed. Provisions were made to maximize the safety of essential workers that could not work from home, such as providing personal protective equipment (PPE), hazard pay, and other solutions to relieve the pressures on this group. Studies show that the burdens of the early pandemic response fell unevenly upon women, people of color, and according to some census survey reports, immigrants.[5]

---

[3] 100% FMAP for LTSS — Educate Your State | CMS

[4] Human Services Rate means a rate higher than the public ADA rates but reasonably negotiated between the transit agency and transportation broker.

[5] Pandemic's frontline work falls on women, minorities - CBS News

National jobs data for 2023 from the Bureau of Labor Statistics shows people of color are overrepresented in the transportation industry.[6] They account for approximately 60 percent of those working in transit, taxi, and other modes of transportation. While there has not been a comprehensive demographic study of the Washington State transportation industry, the Institute for Immigration Research thoroughly examined the subject in Baltimore, Maryland, and Washington D.C. Their findings aligned with national census data. They found that over a quarter of the workforce were foreign born. When drilling down and excluding all other sectors besides taxi and shuttle drivers, foreign born workers accounted for over 60 percent of the total workforce.[7] Transportation was a key piece in our collective response to the pandemic and drivers were essential, many of which were immigrants and people of color. While there was significant media focus on medical staff, drivers were ensuring transportation disadvantaged clients had access to life-sustaining services at great risk to themselves.

The transportation industry, especially in the private sector, was hit hard due to the competing pressures of a massive loss in revenue due to a sharp reduction in trips and high demand for their services. Many had to reduce the number of drivers and vehicles on the road. A recent study found that workers in the transportation sector were significantly more likely to be unemployed during the pandemic than other essential workers.[8]

Public transit was also significantly impacted by the pandemic. Although overall ridership had been falling for years due to shifting demographics in which higher-income individuals moved to using transportation network companies (TNCs), like Uber and Lyft, and lower-income individuals grew more reliant on public transit, the pandemic hit transit agencies especially hard. They rely heavily on a healthy tax base, and any recessionary reduction cause a ripple effect throughout their system.

During the pandemic, the lower-income population was disproportionately impacted as the overarching public transit mission of moving large numbers of people to and from dense areas of activities were directly at odds with social distancing mandates.[9] University of California, Los Angeles (UCLA) researchers expected public transit to continue to reduce due to lingering concerns about infection and the demographic shift. The study showed that when outside events cause transit agencies to significantly reduce service level, riders do not immediately return, even after service is restored. WANEMT saw this firsthand when transit trips, which accounted for a third of all yearly trips prior to the pandemic, dropped to under 15 percent by 2023. There is, however, an important variable unique to Washington State that is impacting these numbers. Several transit agencies have moved to fare-free models, and the Move Ahead Washington initiative funded by the Climate Commitment Act (CCA) made transit free to all riders 18 and under. If a service is free, that data is not captured by the WANEMT utilization database.

With so many moving parts, competing pressures, and the vital ongoing need for transportation disadvantaged clients, many NEMT programs throughout the country found themselves severely restricted by their rigid systems. The WANEMT program, however, worked in partnership with brokers,

---

[6] **Bureau of Labor Statistics: Household Data Annual Averages**
[7] **Institute for Immigration Research | Essential Workers: Transportation ... (gmu.edu)**
[8] Transportation Research Interdisciplinary Perspectives: **The impacts of the COVID-19 pandemic on transportation employment: A comparative analysis**
[9] **Transportation and COVID-19 - UCLA Institute of Transportation Studies**

leveraged their connection to communities, and used the built-in flexibilities of the existing system to decisively respond. While many states struggled to expedite service-cost rate changes through their legislature, WANEMT immediately implemented a time-limited COVID fee of $10 per trip to ensure transportation service providers stayed in business. This ensured the WANEMT transportation network remained healthier compared to other states. Additionally, the WANEMT program approved special rates for transportation providers to transport COVID-positive clients, while many states tried to use an overleveraged ambulance system. Washington State was recognized as a leader in using the community-based brokerage system to coordinate a strong response to the pandemic. Several states requested meetings to discuss best practices, however, many were bound by rigid programs and could not implement suggested best practices.

As vaccination numbers started to rise, trips gradually began to increase. Brokers were initially able to respond to the growing demand, however, they were quickly overwhelmed. By mid to late 2020, clients began to endure long hold times as brokers struggled to adequately staff their call centers.

Another lingering factor during the recovery was a statewide driver shortage. This was true in all sectors of the transportation system. Public transit could not expand service and in some instances had to restrict service by dropping routes due to the lack of drivers. As public transit agencies pulled back their footprint, the WANEMT system was inevitably left as a backstop for transportation disadvantaged clients. This increased pressure on an already fraying system that was dealing with the same driver shortage.

In 2024, we are finally seeing recovery in all sectors. Broker call centers are gradually getting ahead of demand and transportation providers report hiring has improved. Public transit has not yet rebounded but service is starting to return.

Administrative funding: issues and gaps

Administrative payments cannot change without legislative approval. There have been three increases since 2013, the most recent went into effect July 1, 2024. This is being used to stabilize broker call centers after COVID-19, as severe gaps in service were direclty connected to broker call center hiring struggles.

Several brokers began running deficits with one in particular nearing a two million dollar deficit due to the unprecedented fallout from the pandemic. The WANEMT program and HCA were fortunate the brokers are not-for-profit organizations and service-based. Any for-profit organization would have likely ended the contract early the moment they found it unprofitable as happened in Idaho and Wisconsin.[10] [11]

COVID-19 aside, the static administrative rates have been a long-time concern of the WANEMT program. Static rates do not respond to state and local policies around minimum wage or other costs associated with personnel such as health insurance. A consumer price index (CPI) escalation solution was suggested by WANEMT in 2019 and again in 2024, but both were not moved forward.[12] Without a mechanism that

---

[10] **Veyo NEMT Broker Contract | Pantonium** – Veyo Terminates State NEMT Contract Early

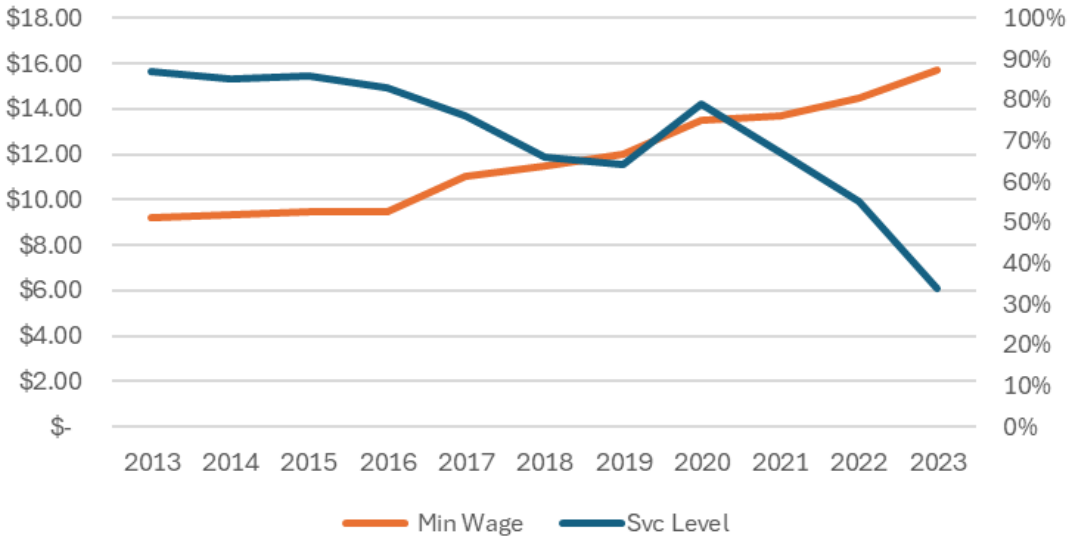
[11] **LogistiCare leaving Wisconsin after all (jsonline.com)** – LogistiCare (now ModivCare) ended NEMT contract with Wisconsin early causing state officials to scramble.

[12] **CPI Escalation Solution:** WANEMT takes average CPI from the year prior as reported by the Bureau of Labor Statistics as baseline and at the end of the biennium compares it to determine the amount of admin increase. Increases to admin shall not exceed five percent.

allows the program to adjust contract administrative rates to account for inflation every two years, WANEMT will inevitably fall into an ongoing cycle of service erosion immediately following any rate increase.

This phenomenon of service erosion over time is illustrated in the following table showing an inverse correlation of broker service level to minimum wage. There is a clear tipping point in 2020.

Figure 2: Call centers service level compared to minimum wage, 2013–2023



Service level means the percentage of calls answered within five minutes.

A majority of WANEMT service gaps, which will be outlined in the following section, are direclty related to call center staffing concerns. An understaffed call center cannot efficiently serve clients. A cycle of churn, wage compression, and burnout causes loss of WANEMT program knowledge and increased mistakes. This can result in clients receiving inadequate service or experience missed rides and appointments.

We expect substantial improvement with the investment approved by the Legislature during the 2024 legislative session. Stabilized call centers will improve services thorughout the entire system. Brokers will have staffing to be more responsive to complaints or concerns. Leadership will have the time to focus on building efficiencies, identify new technology or applications that will improve client experience, and be more involved in commuity meetings to educate stakeholders about the WANEMT service.

Over the past few years, WANEMT took part in several Family Youth System Partner Round Table (FYSPRT) meetings and found a majority of concerns raised by the group were due to misunderstandings about what the WANEMT system is and how it works. Many in those meetings confused NEMT with public transit which, unlike NEMT, has restrictions based on transportation districts. There was a clear failure in communication between stakeholders and brokers that can be immediately improved when brokers are at the table. With call centers adequately staffed, brokers can attend and even host community meetings.

Gaps identified within existing system

As outlined above, COVID-19 destabilized broker call centers, but the service erosion existed prior to the pandemic. Stagnant administrative payments resulted in several brokers running deficits or cutting staff to

avoid running deficits. When there is not adequate staffing in call centers, gaps in service and oversight begin to emerge.

Destabilized broker call centers

Brokers were not immune to the volatility that impacted the employment market throughout the economy during and in the aftermath of the pandemic. Eventually COVID-19 challenges were replaced by inflation and general economic concerns. Some highly trained broker call center customer service representatives decided to move to less stressful jobs where the pay was the same or more than what the brokerage could offer. Static administrative payments to brokers made it impossible to compete in the volatile job market. This created a "brain drain" effect and initiated a cycle of churn within call centers leading to longer hold times and more mistakes. A lack of attention to detail and poor training can result in clients being stranded at the doctor's office, drivers dispatched to the wrong addresses, and clients unable to get through to the call center if their ride has gone awry.

The WANEMT program found that failures due to call center staffing accounted for a vast majority of complaints received in stakeholder meetings, through brokers, or directly to WANEMT program staff. This created a perception of gaps in the brokerage model when, in fact, it was due to administrative funding not being at appropriate levels for brokers to adequately staff their call centers.

Client/provider education

During the FYSPRT meetings, WANEMT program staff found that many of the concerns voiced by members were based on a lack of understanding of the program. Additionally, it appeared many concerns raised at the meetings were never escalated to brokers at the time of the event which means if there was a concern about driver behavior or vehicle safety, the broker was not aware and could not immediately investigate. One of the brokers' key roles is authorizing and deauthorizing drivers and/or vehicles if an issue arises. It is imperative that any concerns regarding driver behavior or vehicle safety are immediately escalated to the broker, especially if they are related to a minor.

Another typical point of confusion is the belief that brokers cannot take clients out of their county. It is routine for WANEMT clients to travel across county lines, especially in rural areas. There are, however, restrictions and boundaries for public transit. These could be by city limit, county, or transportation district. If a client has medical justification to travel out of their local community and it is outside of the transit service area, brokers will know the client is not a good candidate for public transit and consider other modes such as mileage reimbursement, gas vouchers, or coordinate the trip with one of their subcontracted transportation providers.

Discharge planning

Same-day, urgent, and no-notice trips are some of the most difficult for brokers to coordinate. It is standard practice across the country for NEMT systems to require clients and providers to give at least two business days' notice (many require three days' notice) when coordinating a non-emergency medical transportation trip. NEMT programs are non-emergency by definition and not designed or funded to be emergency services or an on-demand service.

TNCs, like Uber and Lyft, could help in urban areas but state administrators must balance this with the fact that TNC drivers are not vetted or trained, are rarely available in rural areas, and may leave a client stranded if they appear to be unstable. Brokers have reported facilities informing them of TNC drivers

showing up only to refuse transport after seeing the client. Nonetheless, WANEMT sees potential in using TNCs in a very limited way and has authorized a broker to pilot TNC use for overflow and recovery trips for eligible clients in King County beginning in August 2024.

Brokers do have after-hour transportation providers for discharges, but resources are very limited. In researching cases in which facilities routinely request short-notice trips, it has become apparent that transportation is not considered in the early stages of discharge planning. If the medical or behavioral health facility brought the broker into the conversation earlier, the broker can better plan for the client's transportation and there is less possibility of a service failure.

The WANEMT team has requested brokers attend local FYSPRT meetings to be available and educate clients and providers about the program. These meetings are also an opportunity for brokers to identify barriers or concerns specific to the regions they serve. As brokers continue to staff up, they will be able to do more community outreach.

Specialty modes of transportation

Some clients require a higher level of service such as needing to travel in a prone/supine position or in a secure fashion to ensure the client's and driver's safety during transport. Some states, such as Oregon, offer these modes within their NEMT program where the private market grew organically along with all other NEMT modes of transportation. The market in Washington State, however, was stifled and controlled due to concerns from the ambulance industry about loss in revenue and potentially weakening the state emergency system as a whole if non-ambulance vehicles were used for specialty modes.[13]

Stretchers

In 2005, the Washington State Legislature amended the term "stretcher" to exclude personal devices that reclined to a flat position.[14] This was necessary because any stretcher trip was required to be provided by an ambulance regulated under RCW 18.73.180. By excluding personal mobility devices in the definition, the Legislature opened the door for non-ambulance vehicles to perform trips even if the client's personal mobility device was in a flat position.

Within a year, it was determined there were still significant barriers to clients with disabilities in accessing services because many clients who required prone/supine transportation and did not need medical assistance while being transported had personal devices that couldn't be secured in a vehicle. This led to House Bill 1837 which was passed during the 2007 legislative session. It provided an exception to the prohibition on using non-ambulance vehicles for clients who could not be properly secured in the vehicle. It required written authorization for the non-ambulance personnel to transfer the client from their personal mobility device to a stretcher for transport. Additionally, the bill required the Washington State Department of Health (DOH) to develop guidelines regarding when non-ambulance vehicles can be used and methods of properly securing and transferring individuals to a stretcher.

[13] HB1837-2007 Washington State Legislative Session: Summary of Bill and Testimony
[14] HB1237-2005 Washington State Legislative Session: Bill amending definition of "stretcher"

This did not, however, increase non-ambulance stretcher transportation utilization. The main factor was the extremely low Medicaid rates for ambulance transportation. There was no room for a specialty mode at a decreased cost between non-emergency ambulance and non-ambulance stretcher transportation.

It wasn't until 2019 when WANEMT was taking part in a transportation workgroup regarding the extremely low ambulance rates, that HCA learned we were entering into high-cost special contracts with ambulance providers because the ambulance industry was refusing to accept non-emergency ambulance trips due to the low rates. This helped WANEMT reframe how a proposed stretcher mode could be established. With the knowledge that the agency was already paying significantly more than the posted fee-for-service (FFS) rate through special contracting, WANEMT directed brokers to approach transportation providers with stretcher capability to negotiate a non-ambulance rate.

This created an opportunity to leverage the brokerage system. A WANEMT stretcher pilot was started in May 2021 and proved to be extremely cost effective and efficient. It was determined that for each trip diverted to the WANEMT stretcher pilot, HCA saved hundreds of dollars. While still very limited, the pilot continues to ensure clients can access vital medical appointments.[15]

Gaps that remain with both the WANEMT stretcher pilot and non-emergency ambulance are high frequency subscription requests such as clients accessing dialysis. There are not enough non-ambulance transportation resources and an ambulance's priority is to respond to emergencies making them an inconsistent option for non-emergency ambulance services. Barriers to expansion of the WANEMT stretcher pilot are the high cost of insurance and the lack of consistent trips. There are not enough trips for providers to justify substantial investment in specialized vehicles that would require at least two drivers to staff.

Secured

In Washington State, secured transportation has historically been provided by ambulance providers and peace officers. As indicated in the Behavioral Health Involuntary Transport Report from 2022, House Bill 1310 limited the situations when law enforcement could use force and included personal liability for officers involved in detaining individuals. This may have caused reduced law enforcement's interest in assisting ambulance providers with mental health transports further reducing capacity.[16]

A secured transportation mode did not evolve organically within the NEMT space in Washington as it did in Oregon for many of the same reasons listed above. The ambulance industry was very concerned about loss in revenue if specialized modes were moved to non-ambulance vehicles.

Now that there is interest and little pushback from the industry in establishing a non-ambulance secured transportation solution, it is incumbent on DOH and the Washington State Department of Licensing (DOL), in collaboration with WSDOT and HCA to establish guidelines regarding certifications, licensure, and vehicle standards and classifications. Additionally, a competitive private market must be set up to ensure costs are controlled. There is currently no established market, and the specialized training required for drivers to assist clients in crisis would exclude almost every current driver authorized by brokers to

[15] The special contracts were discontinued after the Legislature approved a significant increase in ambulance rates in 2023.

[16] **Health Care Authority Report to the Legislature: Behavioral Health Involuntary Transport**

provide WANEMT services. A possible solution is to augment the WANEMT system with a hub-and-spoke model where behavioral health providers transport their own patients and receive reimbursement through the WANEMT brokerage system.

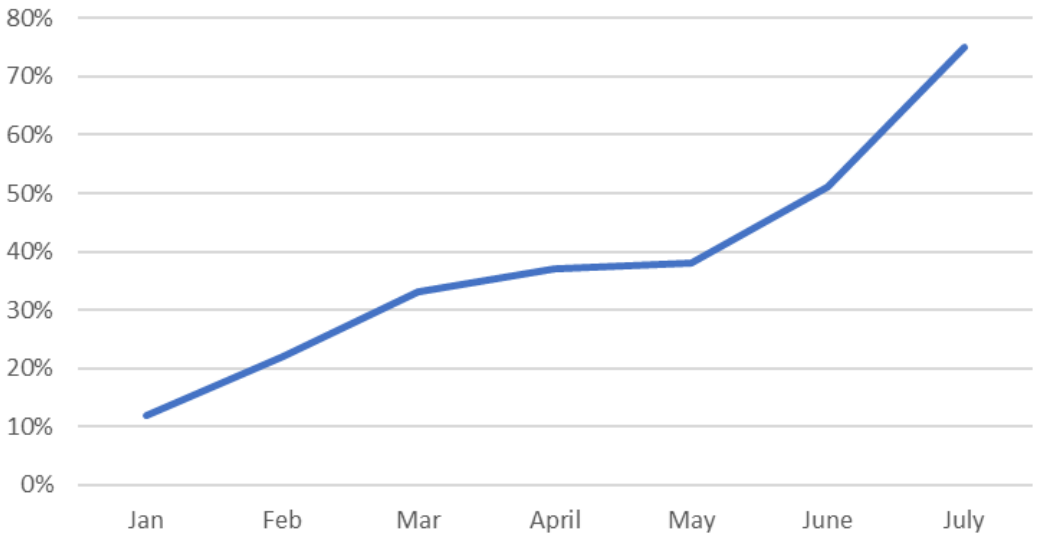
Administrative rate increase, July 2024

The Legislature approved increasing the broker administrative rate, allocating an additional seven million dollars per year to the WANEMT budget to stabilize call centers after COVID-19 destabilized and disrupted the system. Although we are only months into the increased rates, the WANEMT program has seen astounding improvements.

One broker made the decision to adjust their pay scale in January 2024. They adjusted pay based on market research and the cost of living in their regions. It was determined that a 28 percent increase to the starting wage was necessary. As of July 2024, their service level has improved 625 percent in seven months. They are still training new staff, and we expect continued improvement.

The following graph shows their improvement month over month.

Figure 3: Broker service level



Service level means the percentage of calls answered within five minutes.

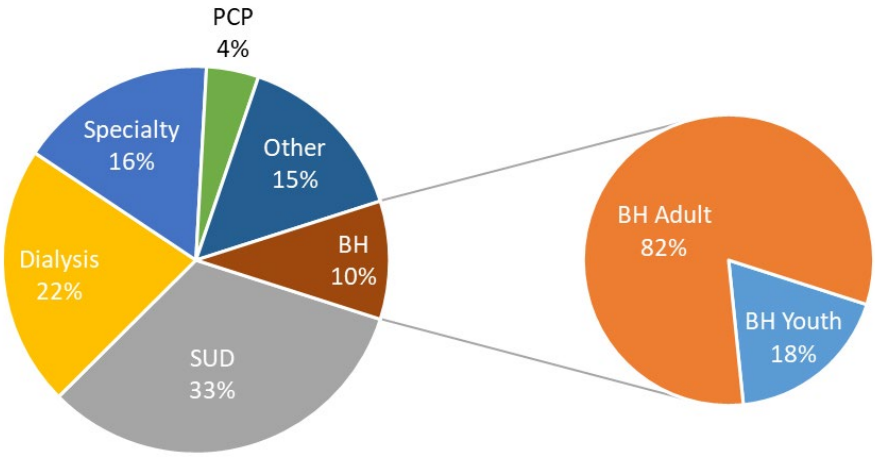
WANEMT is seeing incremental improvement among the rest of the brokers after they initiated their pay increases to coincide with the increased administrative payment starting July 1, 2024, and will continue tracking results with an expectation of vastly improved service levels over the course of the coming year. Improved customer service center service level frees brokers to expand their community outreach and reconnect with medical providers in their regions including behavioral health providers.

Behavioral health and WANEMT

Prior to the pandemic, transportation to covered behavioral health services, including substance use disorder (SUD), accounted for almost 60 percent of WANEMT trips, with half being done by public transit. It dropped to about 43 percent in 2023 with transit trips dropping to about 29 percent. The two most likely factors are telehealth expansion and the recent trend of some public transit agencies going fare free.

Transportation for youth 18 years of age and younger has hovered around 18 percent of all behavioral health trips excluding SUD.[17] These numbers may be even more skewed as the Move Ahead Washington initiative made transit free for youth 18 and under in most jurisdictions.[18] With no associated cost, those trips are not captured by the WANEMT database.

Figure 4: NEMT trips by medical service, CY 2023



Youth (18 years and under) accounted for 18 percent of behavioral health trips (excluding SUD) in 2023.

Transportation to behavioral health services are routine and the vast majority are performed without incident. Recent call center struggles have been the main factor in service failures. However, as mentioned in the previous section, increases to the administrative rate will help brokers increase and improve staffing with expected improvement over the next year.

The following section will provide an outline of challenges and highlight the need for behavioral health provider education regarding the WANEMT program. It will also provide an explanation of existing resources available to behavioral health providers, evaluate the feasibility of a peer-led, trauma-informed transportation mode, and conclude with a policy proposal.

[17] Transportation for youth 18 and under to SUD is limited. About 0.3% of all SUD trips and 1.2% of clients traveling to SUD are 18 and under.

[18] Youth can ride transit for free in most of Washington | WSDOT

Challenges and provider education

The biggest issue (outside of service failures associated with destabilized call centers) are short and no-notice cross-state trips. These are the most challenging trips for brokers to coordinate. Many behavioral health providers treat them like emergencies and expect an immediate response. This is an unrealistic expectation of a non-emergency program. There are not enough transportation providers available in the state to meet this type of demand 24/7. Additionally, cross-state trips tie up limited transportation resources causing adverse downstream effects. HCA and the state must focus on building up local behavioral health services so beneficiaries don't have to travel unreasonable distances to access vital medical services, such as residential treatment.

When a client requires transportation, it is important for discharge planners to bring brokers into the process as soon as possible. This ensures they are able to coordinate the trip by the expected discharge date. Additionally, discharge planners must keep direct communication with brokers to update them of any changes. Many short-notice trips result in no-shows because the client and/or facility find another way to transport the client. When they fail to notify the broker of a change in plan, the transportation provider experiences a no-show and cannot be paid. This creates waste and diverts vital resources from serving other transportation-disadvantaged clients.

As brokers begin to stabilize and staff up, they will have the capacity to perform more outreach in the community to educate medical and behavioral health providers in their regions. Providers must, however, reciprocate and improve their internal processes and communication efforts with brokers to create lasting improvements to the system. Transportation is part of a client's continuum of care and it is the responsibility of medical and behavioral health providers to ensure their transportation of disadvantaged clients are connected to services available through their benefit service package. This means integrating transportation into the discharge plan from the beginning, bringing the broker into the discussion as soon as possible, and maintaining frequent communication until the client is safe and their needs are met.

There have been reports of behavioral health facilities initiating discharge trips without ensuring the client has a place to stay on the other side. When brokers contact the facility to inform them the transportation provider will return the client because the receiving location is refusing to accept them, they refuse the return and on at least one occasion instructed the broker to just, "drop them off on a corner." That is an unsafe suggestion and if there is nowhere for the client to go, brokers instruct providers to drop them at the safest possible place, which is usually the local emergency department (ED). Unfortunately, this exacerbates the problem of psychiatric boarding in EDs but without an adequate discharge plan, there is no other safe option. HCA must have resources in place to improve oversight of behavioral health agencies and/or managed care plans to ensure clients are receiving adequate care including robust discharge plans that position them for a successful journey through the behavioral health system.

Existing resources

In 2020, the WANEMT program team provided guidance to brokers encouraging them to work with behavioral health providers by developing billing agreements for reimbursement if there is a NEMT system failure or a request that cannot be accommodated by the system, such as short- and no-notice, long-distance, or after-hours trips.

These billing agreements provide a mechanism for behavioral health providers to seek reimbursement through brokers for trips they have paid for or performed with their own vehicles. Reimbursement can

range from Greyhound and/or Amtrak tickets to mileage reimbursement if the behavioral health facility uses their own vehicle. Additionally, if the behavioral health facility has a separate contract with a transportation provider, the broker could consider reimbursing the facility if the system failed, and the behavioral health provider had to coordinate and pay for the trip themselves.

There are currently five behavioral health facilities in the state that have billing agreements with a broker. Four agreements are for facilities located in central Washington and one in eastern Washington. Brokers routinely offer this option to facilities reporting difficulty with the WANEMT system, or if they are aware the facility owns vehicles.

Evaluation of peer-led, trauma-informed transportation

NEMT programs across the country are required to ensure safe and secure transportation. This entails proper securement of clients in wheelchairs and ensuring all clients wear seatbelts. NEMT programs leverage private and public transportation systems in which there are no trauma-informed care standards. Currently there are no states who offer this higher-level mode of transportation.

The WANEMT team recently met with three states to discuss models and asked if they have a peer-led, trauma-informed transportation mode. None reported having this type of mode and shared that there was no known market within their state providing such a specialized level of transportation. They reported the focus of their NEMT program is safe and professional transportation which does not include an added level of trauma-informed care. Additionally, the WANEMT team sent a question regarding trauma-informed transportation to the national NEMT Listserv, and no state reported this type of mode existed in their system.

Although there is no known market offering this level of service, the WANEMT team is considering requiring trauma-informed care training for drivers providing NEMT services. This, however, does not make them specialists in trauma-informed care, just as drivers completing cardiopulmonary resuscitation (CPR) training does not make them certified emergency medical technicians (EMTs).

As with any other specialized transportation mode, there may not be enough trip volume to sustain companies offering this higher level of service. A way to move towards this more specialized level of care would be to implement the following policy proposal that leverages behavioral health facilities and their deep understanding and experience with peer-led, trauma-informed care.

Policy proposal: hub-and-spoke model to augment existing system

With the lack of a private market and the limitations of driver training, WANEMT has determined the best way to integrate peer-led, trauma-informed transportation into the WANEMT system is by leveraging the existing billing agreement mechanism. Behavioral health facilities already have a peer-led, trauma-informed framework for the services they offer and could apply it to a limited, internal regional transportation system sustained by reimbursement through the WANEMT brokerage model.

There should be a phased roll out of this proposal. The first phase is already underway and requires brokers to perform outreach to behavioral health facilities, educate them on the program, and offer to set up billing agreements so there is a mechanism for the facility to be reimbursed if they have paid for commercial transportation or used their vehicles to transport clients to Medicaid-covered services. The

second phase should be initiated only if necessary as it would require the agency to use its purchasing power to incentivize select facilities to invest in vehicles and staffing.

Strategies for phase two could include incentivizing behavioral health facilities to build up their mobile crisis responder units and/or leverage the Program of Assertive Community Treatment (PACT) program to include last-minute transfers, discharges, or even a secured transportation mode.[19] [20] This would be possible only if DOH and DOL created credentialling and licensure for secured transportation.[21] Expanding these programs could attract drivers with a background in counseling and kickstart a sector, and eventually a market, that can plug into the brokerage system and augment existing services.

Paying for the second phase of this proposal can be done through several mechanisms such as an enhanced MCO per member per month (PMPM) rate or a state-funded payment to help certain facilities build up their programs and invest in vehicles and staffing. Behavioral health facilities could apply for a capital grant through the WSDOT consolidated grant program as a first step.[22] Once vehicles are purchased and drivers staffed, they could enter into agreements with the transportation broker operating in their county.

Grants are available to organizations that have identified a community need for transportation in rural areas. A limited hub-and-spoke model in which behavioral health facilities are selected by the agency based on need, revenue, volume of services, or geography could be set up and plugged into the WANEMT system through a series of billing agreements based on a negotiated rate for the transportation service the behavioral health facility provides. Rates should be aligned with typical costs of NEMT in the region and the service could act as a stopgap if the WANEMT program cannot accommodate through normal procedures. Once set up, it could become a more efficient way for facilities to serve patients and enhance their continuum of care.

Billing agreements are already in place in central and eastern Washington. WANEMT has seen this model succeed with tribes. A majority of federally recognized tribes in Washington State use a form of these special billing agreements to receive reimbursement for trips they provide to members. Billing agreements augment the WANEMT system and expand access to rural areas of the state.

WANEMT encourages brokers to expand their outreach to behavioral health facilities. When they become aware a facility has vehicles or is paying for transportation outside the WANEMT program, they suggest setting up a billing agreement. As more behavioral health facilities enter into billing agreements with brokers, the agency can determine if there are still gaps that would require a more robust agency response and initiate phase two of the policy as outlined above.

[19] **Mobile Crisis Response Program Guide**
[20] **Program of Assertive Community Treatment (PACT)**
[21] **Behavioral Health Involuntary Transport**
[22] **Washington State Department of Transportation Consolidated Grant Program**

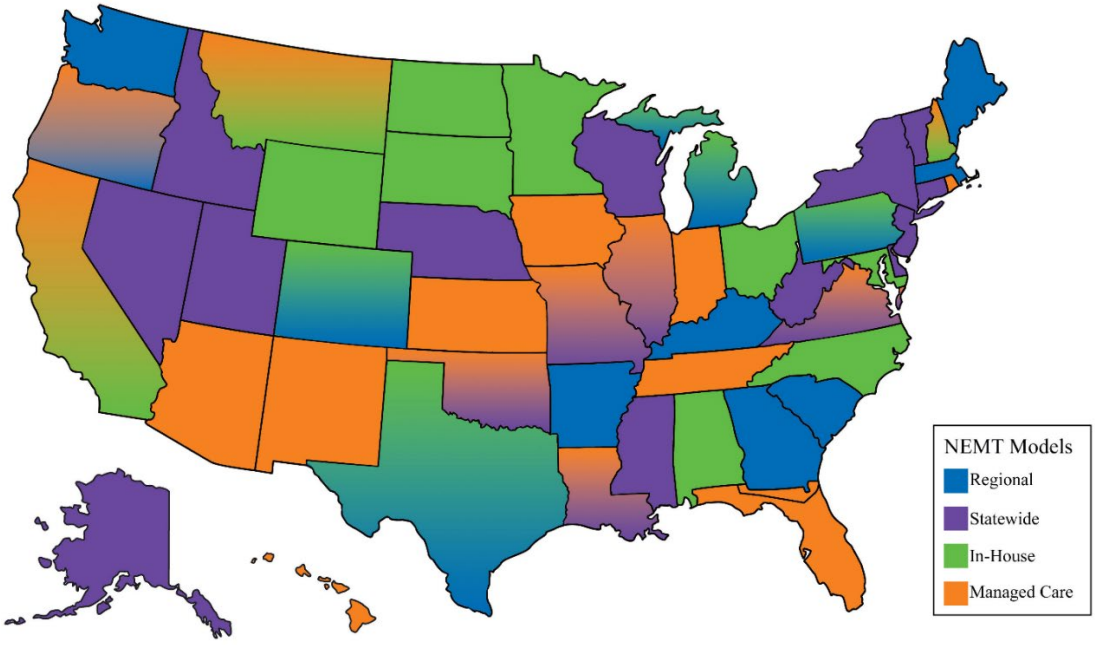
National landscape

CMS allows states wide flexibility on how they administer their NEMT benefit and what services are covered (provided the service is restricted to beneficiaries who have no other transportation resources available to them). Some states interpret this to mean that if a client owns a vehicle, they are not eligible for NEMT while others, like Washington, acknowledge costs associated with driving and allow mileage reimbursement or fuel vouchers.

The models through which states provide NEMT vary widely and are specific to their existing transportation systems, making comparisons of states' NEMT programs difficult. Additionally, state Medicaid programs are very different and the NEMT system supporting those services are tailored specifically to each state's needs. There are, however, similarities. The most common is all NEMT programs leverage existing public and private transportation resources within the state, they are offered as a last option for clients who have no other way to access covered services, and they are non-emergency which requires clients and medical providers to provide at least two or three days' notice. There is provision for urgent trips, but it is limited by available resources and priority is given to clients with a documented medical need.

Figure 5 shows the wide variety of NEMT models used throughout the country. The four main models are Regional Brokerage, Statewide Brokerage, In-House, and Managed Care. Some states have a mix of models which are represented by gradiants on the map. Mixed models are likely a reflection of states transitioning to a different model while others are mixed by design.

Figure 5: NEMT models used throughout U.S.



Snapshot of NEMT models nationwide. Info has been taken from several sources including direct outreach from states, the Transit Cooperative Research Project (TCRP) Project B-44: Researching Effects of Brokerage Systems on Coordination (WANEMT was a panel member on that project), and Health Management Associates' report on Medicaid's Non-Emergency Medical Transportation Benefit from 2021.

Regional Brokerage (Washington model): States with regional brokerages generally have community-based brokers, many of which are non-profit organziations. Call centers tend to be located in the regions they serve and brokers have deep knowledge of travel patterns, available medical services, and the transportation system within the regions they serve. Brokerages within this model tend to be long-standing and stable.

Statewide Brokerage: These are dominated by large for-profit brokerages holding contracts in multiple states with out-of-state and (possibly) out-of-country call centers. States with statewide brokerages tend to have more disruption than a regional brokerage model. There have been instances of companies pulling out of the state in the middle of contracts because profits did not meet expectations or service degraded to an unsustainable level.

In-House: The oldest model in the country in which states run the system in house. This model usually operates from the bottom up. Counties certify transportation providers and book trips. The providers then bill the state directly for transportation. This type of model will likely disappear over time as oversight and monitoring are administratively burdensome and the decentralized nature of the service makes it very difficult to oversee. There have been some high cost audit findings in states without a broker acting as a gate keeper. Settlements with the federal government usually require states move to a brokerage model.

Managed Care: Newest model in which states delegate all NEMT services to MCOs and include NEMT services in their capitated rate. This is the least administratively burdensome model to the state, however, by delegating services the state loses connection to the services and becomes entirely reliant on data provided by the MCOs. Additionally, MCOs are free to administer the NEMT program however they wish, which can create a confusing consortium of multiple brokers being managed by mulitple MCOs. Several brokers could be operating in the same geographic location and competing for valuable transportation resources. With multiple MCOs doing different things, the state could have 10 or 15 brokers operating in overlapping geographic areas causing confusion for beneficiaries.

State surveys

WANEMT runs the nationwide NEMT Listserv and over the years has posed questions to other states regarding:

- Behavioral health services
- Peer-led, trauma-informed transportation
- Response to COVID-19
- Other topics

From the states that responded, many indicate they struggle with same-day and no-notice trips and they reiterated that their state's NEMT program is focused on safe, secure, and timely transportation. None of the states who responded reported familiarity with trauma-informed transportation.

For the purpose of this report, WANEMT selected three states representative of the different models for a more in depth discussion. We chose the following states based on proximity and previous interactions:

- Oregon: Mixed Managed Care and Regional Model
- Idaho: Statewide Broker Model
- Colorado: Mixed Regional and In-House Model

Oregon: Mixed Managed Care and Regional Model

Figure 6: Details of Oregon's NEMT model

OREGON						
YEAR	STATE	OPERATING AUTHORITY	MODEL	TYPE OF EXPENSE		PAYMENT STRUCTURE
2023	OR	State Plan 1915(b) Waiver	Mix Regional and Managed Care	Medical		Mix Fee-For-Service and Capitation
Total NEMT Eligibles	TOTAL COST	Admin (if not capitated)	SVC (if not capitated)	TOTAL TRIPS	UNIQUE CLIENTS	PERCENTAGE OF UTILIZATION
1.5M	$111M	N/A	N/A	1.76M	80K	5.6%
COST/TRIP		COST/CLIENT		PM/PM		
$63.08		$1,380		$6.17		

Since 2014, the Oregon Health Authority (OHA) has administered their NEMT system by delegating oversight to the Medicaid managed care plans, also known as coordinated care organizations (CCO) for over 80 percent of their Medicaid beneficiaries. They retained the previous regional brokerage model for remaining members residing in more rural parts of the state.

This resulted in 23 separate contracts. Fifteen contracts that included the NEMT benefit were awarded to CCOs, and eight NEMT services-only contracts were awarded to brokers for the remaining FFS clients and rural areas. There are currently 16 separate transportation brokers operating within the state. Some serve geographically overlapping service areas. This is common when states delegate NEMT to managed care as they do not control who the organization chooses to partner with unless there is a compliance issue. Clients may experience confusion as their broker is connected to their managed care plan and not their geographical location. A client switching managed care plans would need to call a different broker for the same NEMT services. There is also the risk of brokers competing over limited transportation resources that can result in access issues and increasing costs.

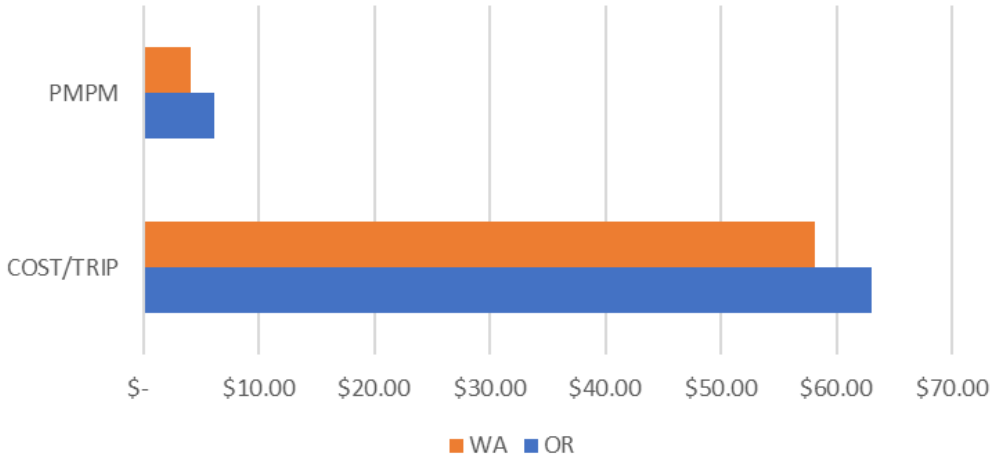
The Oregon NEMT system offers the usual transportation modes such as taxi, wheelchair, volunteer drivers, mileage reimbursement, and public transit. These are drawn from regional transit authorities and the private transportation sector. Oregon NEMT also has a long history of offering stretcher and secured transportation through their NEMT system. This is different from Washington State where, in the early 2000s, the ambulance industry was a vocal opponent to including non-ambulance stretcher or secured services into the WANEMT system.

In our discussions with Oregon, it appears they are not as connected to the services on the ground as we are in Washington State. This is a natural consequence when states delegate oversight to MCOs. Their focus appears to be on policy and reactive management as opposed to proactive management through data analysis and direct monitoring of brokers. They do receive monthly data from CCOs and the regional brokerages serving FFS clients, however it is not centralized or neutral, making data-driven program management very difficult.

There have been anecdotal reports from brokers serving border areas who contract with providers that also contract with a broker in Oregon that the Oregon model is confusing and frustrating for some smaller transportation providers. Rates are very low and do not reflect the actual costs of transportation. Consolidation of the market by bigger providers has pushed vital rural providers out. Additionally, OHA rules are interpreted differently by different organizations. When there are 16 organizations providing the

same service, and CCOs interpreting minimum requirements differently, there is a lot of room for misinterpretation and confusion.

Figure 7: Comparison of Washington and Oregon PMPM and cost per trip in 2023



Washington State NEMT is not capitated but the program calculates the PMPM to compare with states that have chosen a capitated model. While it isn't a perfect comparison, it provides a general view of where the WANEMT program stands.

Idaho: Statewide Model

Figure 8: Details of Idaho's NEMT model

IDAHO						
YEAR	STATE	OPERATING AUTHORITY	MODEL	TYPE OF EXPENSE		PAYMENT STRUCTURE
2023	ID	1902(a)(70) State Plan	Statewide Broker	Medical		PMPM
Total NEMT Eligibles	TOTAL COST	Admin (if not capitated)	SVC (if not capitated)	TOTAL TRIPS	UNIQUE CLIENTS	PERCENTAGE OF UTILIZATION
346K	$45.63M	N/A	N/A	1.86M	69K	5.2%
COST/TRIP		COST/CLIENT		PM/PM		
$37.10		$2,521		$10.16		

The Idaho Department of Health and Welfare (IDHW) has used a brokerage model since 2010. The transition was initiated to realize costs savings through higher federal financial participation as outlined in the Deficit Reduction Act of 2005. Many states switched for similar reasons including the higher level of oversight that comes with a brokerage model.

In 2016, IDHW contracted with a new provider, Veyo, that combined traditional NEMT brokering with a TNC component using ride-hailing software like Uber or Lyft in which independent driver providers (IDP) augmented the network. While seeming to be an innovation, it led to network issues due to disruption in the transportation system which led to widespread service failures. By September 2018, Veyo terminated their contract early while IDHW worked to improve their NEMT service through enhanced monitoring. IDHW had to initiate an emergency procurement and MTM, a national broker contracting with over 30 states, won the contract. In 2022, MTM acquired Veyo capping a concerning trend of consolidation in the for-profit brokerage space.

IDHW reports similar struggles with short- and no-notice trips, rising insurance costs for transportation providers, and difficulty with broker/facility coordination. MTM does not have an office in Idaho as the current contract waived that requirement and the state was seeing some concerns regarding limited understanding or connection to the local community. MTM implemented regional liaisons and IDHW officials report improvement on this front.

IDHW expressed interest in the regional model due to its flexibility and connectedness to the local community, however, the legislature in their state has mandated a statewide broker. This is an example of rigid rules that can cause inefficiencies especially during difficult periods such as the pandemic. Another innovation Idaho is very interested in is replicating Washington State incentives for increasing the use of low-cost transportation modes, such as public transit and mileage reimbursement. Their system's rigidity, however, makes this type of innovation impossible without legislative action.

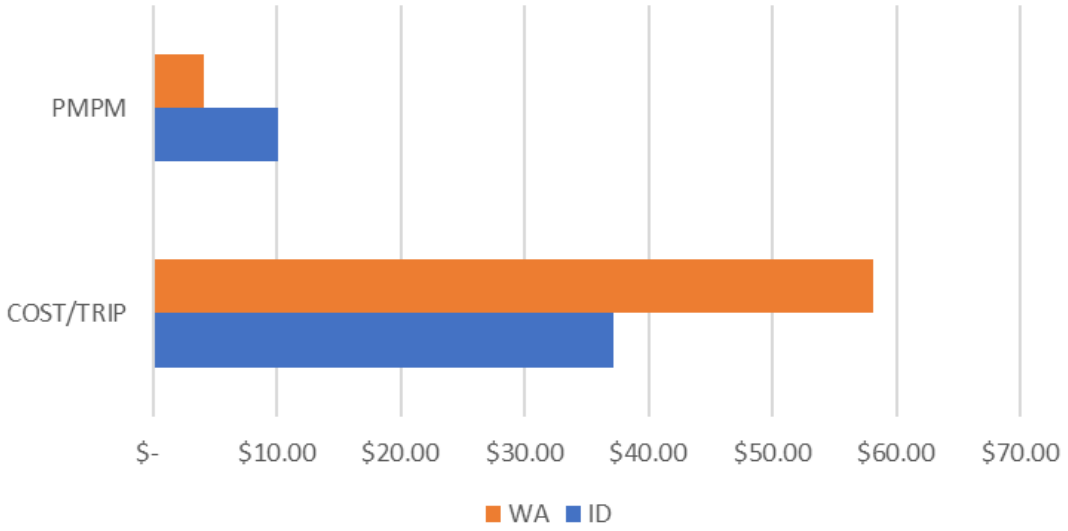
IDHW reports vast improvement of services when compared to Veyo, however, transportation providers have shared concerns regarding the brokerage system. Idaho has not been able to substantiate these concerns.

WANEMT was surprised to hear that using Uber and Lyft has not been as successful as IDHW wished when allowing them into the NEMT system. TNC trips account for about three percent of their trips but have had a 50 percent no-show rate. This was very surprising to hear and something WANEMT will keep in mind while evaluating our own TNC pilot in King County.

WANEMT also asked IDHW officials about trauma-informed transportation, and they reported there is no such thing in their state. They agreed that some form of trauma-informed training for drivers could be helpful but expecting drivers to provide trauma-informed care or higher-level services can be problematic. In their NEMT program, clients are unlikely to have the same driver and if they were to start prioritizing this, it could cause significant inefficiencies in their system. This aligns with what WANEMT has heard from states responding to questions posed to the national Listserv.

Although it is impossible to provide an apples-to-apples comparison, the following graph provides a comparison of PMPM and cost per trip between Washington and Idaho. It is important to note that although Washington State is not a capitated system, WANEMT calculates the PMPM to compare with states that are capitated. Additionally, there is a big difference between minimum wage in Idaho and Washington. In 2023 minimum wage in Idaho matched the federal rate of $7.25 while Washington State was more than double that at $15.74 per hour. This means service industry jobs such as transportation have a higher cost of doing business in Washington than in Idaho and rates must reflect this for companies to stay in business.

Figure 9: Comparison of Washington and Idaho PMPM and cost per trip in 2023



Washington State NEMT is not capitated but the program calculates the PMPM to compare with states that have chosen a capitated model. While it isn't a perfect comparison, it provides a general view of where the WANEMT program stands.

Colorado: Mixed Regional and In-House Model

Figure 10: Details of Colorado's NEMT model

COLORADO						
YEAR **2023**	STATE **CO**	OPERATING AUTHORITY **1902(a)(70) State Plan Amendment**	MODEL **Mix Regional and In-House**	TYPE OF EXPENSE **Medical**		PAYMENT STRUCTURE **Mix Fee-For-Service Admin: Negotiated**
Total NEMT Eligibles **1.814M**		TOTAL COST **$126M**	Admin (if not capitated) **N/A**	SVC (if not capitated) **N/A**	TOTAL TRIPS **961K**	UNIQUE CLIENTS **61K**	PERCENTAGE OF UTILIZATION **3.4%**
COST/TRIP **$128.52**			COST/CLIENT **$2,066**		PM/PM **$5.79**		

The Colorado Department of Health Care Policy & Financing (HCPF) currently administers their NEMT program as a mixed model. The populous counties are covered by a for-profit regional broker and the rest of the state is administered through their county health departments. Transportation providers operating outside the brokerage system submit claims to the state directly.

A performance audit report published by the state auditor in 2021 found providers within the broker's region were illegitimately bypassing the broker and billing the state directly. State systems did not have guardrails in place to reject those claims. The report recommended the state improve their use of data in their oversight. Additionally, it recommends improved reporting of client complaints and accidents/incidents. State officials reported they are planning to transition the model to a statewide broker.

In 2024, an investigation into a suspected multimillion-dollar fraud ring resulted in a moratorium on any new and pending provider enrollments. Officials reported they are accelerating the transition and will be

sending out an RFP request in late October with a proposed statewide broker contract starting July 1, 2025. Colorado offered to share their RFP documents with WANEMT for feedback as they recognize the success of the Washington State system.

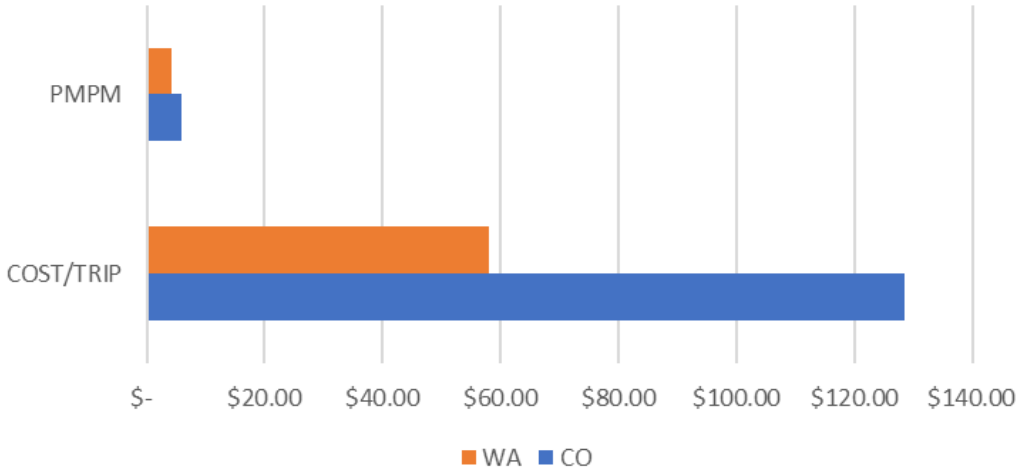
NEMT services offered in Colorado span the normal modes of transportation offered by states throughout the country, however, public transit is not leveraged as much as they would like. Officials cited improved coordination of transportation resources in the community as another reason for their transition to a statewide model. Additionally, they expressed interested in the low-cost mode incentive developed by the WANEMT team.

Similar to Washington State, Colorado is cautious when it comes to using TNCs for Medicaid trips. They report meeting several times with Uber and Lyft. Both companies were resistant to following state statutes regarding insurance and background checks. Colorado requested WANEMT share findings after completion of the limited TNC pilot in King County.

When discussing challenges with transportation to behavioral health services, state officials shared an interesting program that operates outside of their NEMT system. It is called the Secured Behavioral Health Transportation program and is a little over a year old. It operates as a subset of Colorado's emergency transportation system and works mostly with ambulance companies. The WANEMT team will reach out to the individual running the program to learn more.

While there is some turmoil within the Colorado system, state officials expect a statewide broker will finally stabilize the service and ensure proper oversight is in place. There are currently only two people running the program, but it is expected the team will expand in the coming years.

Figure 11: Comparison of Washington and Colorado PMPM and cost per trip in 2023



Washington State NEMT is not capitated but the program calculates the PMPM to compare with states that have chosen a capitated model. While it isn't a perfect comparison, it provides a general view of where the WANEMT program stands.

Conclusion

The WANEMT program is a recognized leader and one of the most cost-effective and innovative programs in the country. The existing community-based, not-for-profit centered regional brokerage model is the best framework to administer NEMT services in Washington State. The strength of the model lies in the brokers' role as hubs for human services within the regions they serve. They work collaboratively with public transit, medical and behavioral health facilities, social services agencies, and Tribes to ensure clients have access to vital medical services. Innovative performance-based contracts leveraging incentives have avoided approximately $22 million in costs over the past 10 years.

Although it is an effective model, funding has not kept up with inflation. Prior to the pandemic the program struggled with service erosion. Administrative increases did not keep up with rising costs associated with minimum wage and health insurance. Some brokers had to cut staff to avoid falling into deficit while others started running a deficit anyway. When the pandemic hit, broker call centers were further destabilized as they lost even more staff and struggled to hire replacements. This resulted in a significant increase in complaints and service failures. Brokers could no longer be innovative and proactive as they were constantly putting out fires. Many facilities including behavioral health facilities were finding it hard to reach brokers or were not aware of the system because brokers did not have the staffing for community outreach.

Much-needed legislative investment arrived July 1, and brokers were finally able to start staffing up. One broker could afford to be proactive and increased call center pay by almost 30 percent in January. They have seen improvement in service level exceeding 600 percent. WANEMT expects similarly dramatic improvements with other brokers in the coming months. While this funding will go a long way to stabilizing the brokerage system, the NEMT program still needs a mechanism within broker contracts that keeps the administrative payment in line with the economy. The WANEMT team developed a consumer price index (CPI) escalation model to end the cycle of service erosion and keep the NEMT program funded effectively. Implementation of the CPI model will require legislative action.

An adequately funded NEMT program will ensure continued improvement and innovation. The model has the flexibility to respond to new services such as Apple Health Expansion (AHE) or Health Related Social Needs (HRSN) services. Brokers will have the staffing to expand their billing agreements with behavioral health facilities. These agreements are an important first step in implementing the hub and spoke proposal to augment the system. Consistent funding levels aligned with the economy through CPI escalation will help the program build upon and expand successes such as co-funded transportation desks in hospitals, investment in new technology, and continued coordination with medical and behavioral health providers to ensure Washington State remains a national leader in the NEMT space.