

NEMTAC Industry Guidance on the Definition and Scope of Brokers in Non-Emergency Medical Transportation (NEMT)

For Educational and Policy Reference — Not a Regulatory Standard

1. Purpose and Context

This guidance document was developed by NEMTAC to address persistent ambiguity around the term “broker” within the Non-Emergency Medical Transportation (NEMT) industry. The term is used broadly—and often inaccurately—by healthcare organizations, technology vendors, and transportation networks. While “brokerage” has a precise definition under federal laws governing healthcare programs, it has evolved into a colloquial label for various coordination functions across public and private sectors.

This guidance focuses exclusively on brokers operating under federal or state programs funded in whole or in part by the Centers for Medicare & Medicaid Services (CMS) or other HHS agencies—specifically Medicaid, Medicaid Managed Care, Medicare Advantage, and certain Veterans Health Administration (VHA) transportation contracts.

Please note: Private-pay, commercial, and workers’ compensation coordination models are referenced in this guidance *only* to contrast their structure and obligations with federally defined brokerage programs.

The purpose of this guidance is to:

- Clarify how “broker” is defined and authorized within federal healthcare program laws and enabling regulations.
- Explain how the concept of brokerage extends (and does *not* extend) into commercial, private, and regional models.
- Provide a framework for evaluating “broker-like” operations against legal requirements and best practices in safety, compliance, and transparency.

Terminology Note:

This document uses the term “beneficiary” to refer to the individual receiving transportation services. In other settings, this individual may also be referred to as a “member” (health plan), or “rider” (operational context). “Beneficiary” is used here for consistency with policy and regulatory frameworks.

2. The Evolution of the Term “Broker”

2.1 Colloquial Use

In general commerce, a broker is any intermediary connecting a customer to a service provider. In NEMT, this colloquial use may result in defining a platform or network that coordinates rides without assuming regulatory responsibility or financial risk as a “broker.” These entities are *not* brokers under the federal NEMT definition.

2.2 Regulatory Definition under Medicaid

Under Section 1902(a)(70) of the Social Security Act and 42 CFR §440.170, states may establish a Medicaid NEMT Brokerage Program through a State Plan Amendment (SPA). This authorizes a designated entity to arrange transportation for Medicaid beneficiaries who lack other means of travel to covered services.

Key features of the Medicaid broker model include:

- Federal authorization via the Medicaid state plan
- Defined oversight responsibilities for safety, credentialing, appeal rights, and quality
- Conflict-of-interest prohibitions that prevent brokers from also owning and operating vehicles, except in rare, state-approved exceptions
- Recordkeeping, auditing, and program integrity obligations

The defining characteristic of a capital-“B” Broker is authorization under a state or federal funding authority that delegates transportation coordination as part of a covered benefit. The source of funding determines the applicable legal and compliance obligations.

3. Broker Models in Practice

Note: Only the first three Models below operate under CMS authority. The other Models are shown only for contrast.

Model	Who Pays	Regulatory Basis	Accountability / Risk
Medicaid Broker (SPA Authorized)	State Medicaid Agency	42 CFR §440.170; SMD-23-006	Broker under state and CMS oversight
Medicaid MCO Subcontractor	Managed Care Organization	MCO contract + SPA	MCO and Subcontracted Broker
Medicare Advantage Transportation	MA Plan	CMS MA rules	Plan and Vendor
Transit or Human Services Coordinators	Public agencies / Federal Transit Administration (FTA) funds	FTA, state Transportation Disadvantaged (TD) statutes	Transit or Community Transportation Coordinator (CTC)
Hospital / Accountable Care Organizations (ACO) Direct Brokers	Health system or ACO	Private contract and/or HIPAA	Hospital / Vendor
Workers' Compensation / Commercial	Insurer or Third Party Administrator (TPA)	Carrier law / contract	TPA / Broker
Technology Platforms	Subscription / Transaction fee	Contractual, not regulatory	Platform only

4. Legal and Compliance Foundations of the Medicaid Broker Model

The Medicaid NEMT broker model operates under a defined set of federal and state legal authorities. These authorities establish the minimum compliance expectations for any entity functioning as a Medicaid NEMT broker and differentiate CMS-governed brokers from non-regulated transportation coordinators.

4.1 Federal Statutory and Regulatory Authority

Medicaid State Plan Requirements

Medicaid NEMT brokerages exist because states may elect to implement a broker program under their Medicaid State Plan (MSP), as permitted by the Deficit Reduction Act of 2005 and reflected in Social

Security Act §1902(a)(70).

This option allows states to designate an entity to manage cost-effective, safe, and appropriate transportation arrangements in exchange for modified beneficiary choice of providers..

42 CFR §440.170

Federal regulation requires states to ensure that Medicaid beneficiaries have necessary transportation to covered services. States may fulfill this obligation through a broker model described in their MSPs if they meet certain efficiency and safety requirements.

State Plan Amendment (SPA)

To operate a Medicaid broker program, a state must file a SPA delineating:

- Broker selection process
- Oversight structure
- Delegated responsibilities
- Quality, safety, and program integrity requirements

Because the broker's role is authorized under the MSP, it carries regulatory and compliance obligations that do not apply to private pay or commercial coordination arrangements.

4.2 Structural and Compliance Requirements for Brokers

Conflict-of-Interest and Ownership Restrictions

Federal rules limit a Medicaid broker's ability to provide transportation directly. A broker may not assign trips to vehicles it owns or controls unless the state documents a specific exception—typically when no adequate network exists or can otherwise be developed in a geographic area.

Contracting and Independent Operations

Brokers must contract with transportation providers who are independent contractors / entities. Brokers are responsible for oversight of the independent contractors they use but must avoid exercising control to the extent that it could deem them joint employers of those providers under state regulations. Joint employment is generally determined by labor departments and courts applying a balancing test that depends on such elements as who provides the tools and materials necessary to fulfill the contract, whether the contractor controls their assignments, whether contractors are paid to be available during certain times even if they do not receive trips. Maintaining this separation assures compliance with federal and state laws against self-referral and other program integrity regulations.

Credentialing, Safety, and Quality Monitoring

At a minimum, Medicaid brokers are required to:

- Verify transportation provider credentials
- Maintain vehicle and driver safety standards
- Ensure Americans with Disabilities Act (ADA) compliance
- Oversee incident response practices
- Monitor call center and scheduling performance
- Provide grievance and appeal processes for program beneficiaries

These activities must align with the SPA and the broker's Medicaid contract.

4.3 Program Integrity, Auditing, and Documentation

Medicaid brokers operate under comprehensive program integrity oversight. Requirements often include:

Federal and State Oversight

- Confirmation and documentation of trip eligibility
- Verification that services rendered match billings
- Maintenance of complete records for audit review
- Reporting of suspected fraud, waste, or abuse (FWA)

Audit Readiness Across Multiple Entities

Brokers may be audited by:

- State Medicaid agencies
- CMS (directly or through review of the MSP)
- Managed care plans (for subcontracting arrangements)
- Federal oversight bodies, including the Office of Inspector General (OIG)

Audits may review call center performance, credentialing processes, claims accuracy, quality monitoring, and corrective action management.

Claims Integrity

Brokers must maintain processes that support accurate claims adjudication by ensuring transportation providers understand “clean claim” requirements and have the ability to swiftly and effectively correct rejected submissions. Oversight structures should support transparency in payment decisions and timelines.

4.4 Medicare Advantage and Other Federally Approved Models

Medicare Advantage (MA)

Transportation benefits offered through MA plans are subject to Medicare Advantage regulations rather than Medicaid NEMT rules, but many regulatory requirements are common to both models. Although requirement may resemble Medicaid NEMT brokerage obligations, the regulatory foundations and operational underpinnings of MA and Medicaid / Medicaid managed care may differ. Operational practices may overlap between Medicaid and Medicare Advantage brokerage models; however, regulatory obligations are determined by the governing program and applicable contracts. Note that entities coordinating MA transportation typically function as First-Tier, Downstream, and Related Entities (FDRs) and must comply with MA plan monitoring and reporting requirements.

Veterans Health Administration (VHA)

Some VHA transportation arrangements incorporate elements similar to Medicaid broker oversight—such as credentialing, safety requirements, and monitoring—though they are not governed by 42 CFR §440.170. VHA programs may refer to brokers as “coordinators” depending on contract structure, but

the regulatory obligations may be similar in practice but arise from different statutory and contractual authorities.

Dual-Eligible Populations

For program beneficiaries covered by both Medicare and Medicaid, transportation responsibilities may vary depending on benefit design and state policy. Brokers may need to coordinate across Medicaid NEMT requirements, MA benefit structures, plan-defined operational procedures, and FDR flow-down requirements.

5. Responsibilities of a Medicaid Broker

A Medicaid NEMT broker is responsible for ensuring that transportation services are delivered safely, efficiently, compliantly, cost effectively, appropriately, and in accordance with federal, state, and contractual requirements. These responsibilities extend across operational performance, network management, beneficiary experience, program integrity, and data governance. Collectively, they establish the functional obligations that distinguish a Medicaid NEMT broker from general coordination or dispatch services offered by some healthcare and logistics information technology vendors.

In addition to operational responsibilities, brokers often function as an intermediary between payers, regulators, and transportation providers. This includes explaining flow-down requirements, compliance expectations, and contractual obligations to providers, particularly those new to regulated programs. Clear communication of the origin and purpose of these requirements supports compliance, reduces friction, and improves program integrity.

5.1 Provider Network Development and Oversight

A broker must build and maintain an adequate transportation provider network that meets:

- State-defined adequacy requirements (capacity, geography, timeliness)
- Safety and credentialing standards, including:
 - Driver background checks
 - Motor vehicle maintenance and records
 - Required training and certifications
 - Insurance coverage verification
- Vehicle standards, including ADA compliance, preventive maintenance, and inspections
- Ongoing provider monitoring, including audits, ride-alongs, or documentation review

The broker must maintain documentation demonstrating that all providers meet network requirements at onboarding and throughout the contracted period.

5.2 Eligibility Verification, Trip Intake, and Scheduling

Brokers must ensure that trips are authorized and scheduled in accordance with Medicaid requirements, including:

- Verification of eligibility for each trip
- Verification of covered services (where applicable)

- Assessment of medically appropriate modes of transport
- Call center or digital intake operations that meet contractual service levels
- Reasonable accommodations for Limited English Proficiency (LEP) beneficiaries and individuals with disabilities

Trip intake functions must be consistently available, documented, and subject to quality monitoring.

5.3 Trip Assignment, Dispatch, and Real-Time Oversight

Brokers are responsible for managing trip distribution in a manner that is:

- Timely
- Equitable across providers
- Transparent in methodology
- Consistent with state regulations and managed care organization (MCO) contract rules

Real-time obligations include:

- Monitoring active trips
- Responding to delays, no-shows, and service disruptions
- Escalating and reporting incidents
- Ensuring adherence to on-time performance standards

Brokers must maintain clear, auditable logs of assignment decisions and operational exceptions.

5.4 Beneficiary Support, Grievances, and Appeals

Brokers must ensure beneficiaries have access to:

- Timely, accurate, and understandable trip information
- Clear instructions for scheduling or rescheduling
- Mechanisms for communicating complaints or concerns
- Human assistance where required by regulation or contract, particularly for grievance and appeal functions where state or federal rules prohibit fully automated adjudication of grievances

Complaint tracking systems must document:

- Nature of issue
- Response time
- Resolution
- Trends analysis and corrective action, where required

5.5 Claims Integrity, Payment Transparency, and Reconciliation

Brokers must maintain processes that:

- Support accurate, timely, and compliant billing
- Establish and communicate a clean-claim definitions

- Allow transportation providers commercially reasonable times and methods to correct defects
- Reconcile trip data with claims submissions
- Prevent payment delays not justified by documentation or eligibility requirements
- Provide accessible reporting that allows providers to understand adjudication decisions

Claims integrity practices must be consistent with state regulations, MCO requirements (where applicable), and federal program integrity policies.

5.6 Reporting, Data Quality, and Performance Measurement

Brokers are responsible for providing timely, accurate data to:

- State Medicaid agencies
- Managed care organizations (MCOs)
- Federal oversight entities (indirectly, via required reporting)
- Law enforcement, where applicable
- Other oversight entities, as applicable

Required reporting typically includes:

- On-time performance
- No-show trends (beneficiary vs. provider)
- Safety incidents and accidents
- Call center metrics
- Network adequacy
- Credentialing status
- Grievance and appeal summaries
- FWA indicators

Brokers must maintain internal systems for:

- Data collection and validation
- Error correction
- Trend analysis
- Documentation of corrective actions

5.7 Program Integrity, Compliance, and Risk Management

Brokers must:

- Maintain a compliance plan consistent with state and federal requirements
- Train staff on applicable Medicaid and MCO rules
- Implement monitoring activities for potential FWA
- Report FWA concerns through required channels
- Maintain appropriate separation of duties and internal controls
- Provide documentation upon request for audits, inquiries, or investigations

Brokers are expected to complete state or MCO program integrity attestations, including compliance with privacy, confidentiality, and security requirements.

5.8 Data Privacy, Security, and Technology Requirements

Brokers must handle protected health information (PHI) in accordance with:

- HIPAA (Health Insurance Portability and Accountability Act)
- State consumer protection and data privacy laws, as applicable
- Contractual data security requirements

This includes:

- Secure data transmission
- Restriction on transmitting trip sheets and other PHI outside approved channels
- Incident-reporting processes for privacy events, incidents, or breaches
- Vendor and system oversight
- Periodic security risk assessments

Where technology platforms are used, brokers remain accountable for data integrity and compliance.

5.9 Oversight of Automation and Algorithmic Decision-Making

If brokers use automation or artificial intelligence (AI) for trip assignment, messaging, or beneficiary interaction, they must ensure:

- Transparency of underlying functionality and logic
- Documentation of rules and parameters
- Ability to override or correct system decisions
- Monitoring for unintended bias or systemic errors
- Human review for grievances, appeals, and other high-risk decisions

Emerging state and federal oversight trends indicate that automated decision-making in eligibility, service authorization, or beneficiary communication may become subject to expanded scrutiny.

6. Universal Principles Across All Broker Models

Although only Medicaid NEMT brokers operate under the statutory and regulatory requirements described in Sections 4 and 5, there are core principles that apply across all models performing transportation coordination functions, regardless of payer type, funding source, or operational structure. These principles form a universal baseline for responsible transportation coordination in healthcare and human services programs.

6.1 Transparency

Clear communication of trip assignment processes, rate structures, performance expectations, and reporting obligations.

6.2 Accountability

Documented procedures for monitoring provider performance, addressing complaints, and correcting operational errors.

6.3 Accessibility and Equity

Commitment to providing transportation that accommodates individuals with disabilities, linguistic needs, rural access limitations, and social vulnerability considerations.

6.4 Safety and Quality

Adherence to safety expectations, vehicle standards, driver competency requirements, and consistent quality monitoring.

6.5 Data Security and Privacy

Protection of PHI and personally identifiable information through secure data systems, confidentiality protocols, and responsible vendor management.

6.6 Integrity and Conflicts Avoidance

Avoidance of practices that create conflicts of interest, unfair competitive advantages, or inappropriate steering of services.

6.7 Human Oversight

Ensuring that automated, algorithmic, or digital systems do not replace required human judgment, especially for complaints, appeals, safety issues, or medically sensitive decisions.

6.8 Beneficiary-Centered Experience

Respectful, timely, and effective support for beneficiaries throughout the transportation process. These principles are not regulatory requirements for non-Medicaid models but reflect commonly accepted expectations across healthcare delivery and public service settings.

7. Implications for the Wider Healthcare Ecosystem

The distinctions outlined in this guidance have direct implications for states, managed care plans, healthcare organizations, transit agencies, technology vendors, and transportation providers. Understanding these distinctions helps ensure compliance, fosters transparency, and supports the appropriate deployment of transportation coordination models across different funding and service environments.

7.1 Transportation Providers

Providers should understand whether they are contracting with a:

- Medicaid-authorized broker
- Medicare Advantage coordination vendor
- Commercial or private-pay aggregator
- Technology platform

This distinction affects credentialing, claims processing, audit exposure, and contractual rights. Providers should request documentation of the broker's regulatory status and understand the regulatory and contractual obligations that flow down to them.

7.2 Hospitals, Health Systems, and ACOs

Organizations coordinating transportation through discharge planning, care management, or population health programs should avoid using the term “*broker*” unless the entity is authorized under a Medicaid or MA program.

These organizations may adopt best practices from Sections 5 and 6 but are not bound by the regulatory framework in Section 4.

7.3 State Medicaid Agencies and Managed Care Plans

This guidance can support:

- Vendor evaluation
- Contract development
- Request for Proposal (RFP) design
- Oversight structures
- Clarification of what constitutes a compliant Medicaid broker

It also helps distinguish between administrative vendors, technology platforms, and true brokers.

7.4 Transit Agencies and Regional Governments

Many transit agencies operate mobility management or coordinated transportation programs that may resemble brokerage functions. While these are not Medicaid brokers unless authorized under the MSP, the universal principles in Section 6 provide a framework for ensuring consistency in safety, quality, and equity across multimodal transportation environments.

7.5 Medicare Advantage Plans and Vendors

MA plans coordinating transportation should ensure that vendors comply with FDR requirements, MA program rules, and plan-level monitoring expectations.

MA vendors may adopt Medicaid-like operational practices but should not represent themselves as Medicaid brokers unless they operate under a MSP authority.

7.6 Technology Platforms and Software Providers

Technology companies offering dispatch, routing, optimization, or network-management tools should avoid presenting themselves as brokers unless they meet the qualifications outlined in Section 4. Platforms may play a critical role in supporting coordination functions but are distinct from entities authorized as Medicaid brokers.

7.7 Workers’ Compensation and Commercial Payers

These models operate under contractual and carrier-specific requirements that differ from Medicaid or MA structures.

This guidance can help commercial payers adopt best practices from Section 6, but they are not subject to Medicaid's regulatory framework.

8. Path Forward for NEMTAC and the Industry

This guidance is intended to serve as a foundational reference for understanding the structure, responsibilities, and regulatory context of NEMTAC brokerage models within healthcare and human services programs that offer transportation benefits. Building on this foundation, NEMTAC will continue developing additional resources and standards to support state agencies, managed care plans, transportation providers, technology vendors, and other stakeholders.

8.1 Development of a Medicaid Broker Standard

Following publication of this guidance, NEMTAC's next priority is the creation of a Medicaid Broker Standard.

This standard will:

- Define the minimum compliance expectations for entities operating under MSP authority
- Expand on the operational and program integrity elements introduced in Sections 4 and 5
- Provide a consistent reference for states and MCOs issuing RFPs
- Offer clarity for organizations seeking to enter or expand within Medicaid brokerages

The Medicaid Broker Standard will undergo NEMTAC's standard development process and review and multi-stakeholder input before approval.

8.2 Consideration of Stakeholder-Specific Resources

Following publication of this guidance and evaluation of industry needs, NEMTAC may consider whether additional stakeholder-specific educational resources would be beneficial. Any such materials would draw from the principles outlined in this document and be developed subject to advisory committee input and prioritization.

8.3 Support for States and Managed Care Organizations

NEMTAC will continue developing tools to help states and plans evaluate vendor proposals and monitor broker performance, including:

- RFP language recommendations
- Oversight and monitoring templates
- Network adequacy evaluation tools
- Audit support checklists
- Key performance indicator (KPI) frameworks

This work will align with evolving CMS guidance, including expectations derived from SMD-23-006.

8.4 Integration With Other NEMTAC Standards and Committees

The insights and distinctions established in this guidance will inform work being conducted across other NEMTAC advisory committees, including:

- Provider Standards (NEMTAC 3001) updates
- Claims and documentation guidance
- Vehicle and equipment safety standards
- Insurance and risk management guidance
- Transit and urban mobility integration efforts

NEMTAC advisory committees will assist by ensuring that each standard or resource is aligned with the appropriate regulatory framework.

8.5 Continuing Education and Industry Outreach

NEMTAC will support dissemination of this guidance through:

- Webinars and training sessions
- Conference presentations
- Publication in NEMT Today and other industry forums
- Direct communication with states, plans, health systems, and providers

These efforts will promote consistent understanding of NEMT brokerage roles and requirements.

8.6 Future Revisions and Industry Feedback

This guidance is intended to be a living resource.

NEMTAC will periodically review and update the document to reflect:

- Changes in CMS or HHS policy
- Emerging trends in automation and AI governance
- State or regional innovations
- Input from stakeholders
- Evaluations from Compliance & Regulatory Advisory Committee and other advisory committees

9. References

Federal Statutes and Regulations

- Social Security Act §1902(a)(70) – Authority for Medicaid NEMT brokerage
- Social Security Act §1902(a)(4) – State plan requirements for program administration
- 42 CFR §440.170 – Non-Emergency Medical Transportation (NEMT)
- 42 CFR §431.53 – Assurance of transportation
- Deficit Reduction Act of 2005, §6083 – Authorization of NEMT brokerage model
- 42 CFR §422 – Medicare Advantage program regulations

CMS Guidance

- CMS State Medicaid Director Letter (SMD) 23-006: *Medicaid Transportation Coverage Guidance*
- Medicaid State Plan Amendment (SPA) Process and Instructions (CMS)
- Medicare Managed Care Manual, Chapter 21 – Compliance Program Guidelines (FDR requirements)
- CMS Medicare Advantage Oversight and Monitoring Guidance
- CMS Medicaid Program Integrity Guide

Office of Inspector General (OIG)

- OIG Work Plan – Items related to transportation, program integrity, and managed care oversight
- OIG Compliance Program Guidance for Health Care Entities

Civil Rights, Accessibility, and Safety Standards

- Americans with Disabilities Act (ADA), Titles II & III
- U.S. DOT ADA Regulations (49 CFR Parts 37 and 38) – Transportation accessibility standards

Privacy and Security

- HIPAA Privacy Rule (45 CFR Part 160 and Subparts A & E of Part 164)
- HIPAA Security Rule (45 CFR Part 160 and Subparts A & C of Part 164)

Additional Supporting Guidance

- State Medicaid Manuals and contract language relevant to NEMT brokerage
- State-level NEMT policies and oversight guidance (varies by state)
- Industry best-practice materials developed through NEMTAC committees and external stakeholders