Michigan Livable Communities
Demonstration Project

Lansing Tri-County Mobility Management & Coordination for Non-Emergency Medical Transportation

Report Supplements

November 2013

Smart Growth America
Making Neighborhoods Great Together

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Many individuals and organizations contributed their time and expertise to the preparation of this report.

Project Leadership

Susan Pigg	Tri-County Regional Planning Commission
Paul Hamilton	Tri-County Regional Planning Commission
Roger Millar	Vice President, Smart Growth America
Rayla Bellis	Associate, Smart Growth America
Geoff Anderson	President, Smart Growth America

Project Stakeholder Group

Debbie Alexander	CATA
Hanadi Ali	STVCC
Karen Batterham	Ingham County Department of Human Services
Rayla Bellis	Smart Growth America
Dawn Benson	Clinton Transit
Sharon Brady	DDS/SSA
Dean H. Brailey	Tri-County Bicycle Association
Jonathan Bromberg	CATA
Gale Capling	Clinton Transit
Paula Clark	Bath Charter Township
Brian Dunn	Central Michigan 2-1-1
Steve Gewirtz	Michigan Public Transportation Association
Michael Hagen	Origami Brain Injury Rehab Center
Ashley Hale	CATA
George Hanby	Developmental Disabilities Council
Crystal Hewitt	DHS
Tekea Jackson	Capital Area Michigan Works!
Kim Johnson	MDOT
Andy Kilpatrick	City of Lansing
Michael Laniewski	Lansing Mason Ambulance Service
Steven Lieby	Tri-County Bicycle Association
John Lindenmayor	League of Michigan Bicyclists
Suzanne Love	CATA LAC
Darlene Mans	MDOT
Lynne Martinez	Capital Community of Bike Share
Beth Mugavero	St. Vincent Catholic Charities
Nick Norcross	Michigan Department of Community Health
Ody Norkin	Indian Trails
Jim Osieczonek	Eatran/Eaton County
Tom Page	Michigan 2-1-1
Rodney Palmer	Mercy Ambulance Service
Steve Palmer	MDOT
Julie Powers	Mid-MEAC
Hary Prawiranata	TCRPC
Joe Pulver	Clinton County Road Commission
John Sabbadin	Lansing Mason Area Ambulance
Bob Scheuerman	City of East Lansing
Ray Severy	Meridian Township
Janine Sinno	Ingham County Health Department
Lia Spaniolo	Power of We Consortium
Howard Spence	Commissioner, Eaton County

Denise Sullivan	STVCC
Donna Webb	EATRAN

Project Team

Lisa Ballard, Principal	Current Transportation Solutions
Ted Lange, Planner	Current Transportation Solutions
Kevin Wright, Planner	Current Transportation Solutions

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Any errors and all interpretations are the responsibility of Smart Growth America. Please direct questions about this report to Roger Millar, PE, AICP, Vice President: rmillar@smartgrowthamerica.org, (406) 544-1963

Table of Contents

Page

Acknowledgements .... Error! Bookmark not defined.

Table of Contents iv

Definitions and Acronyms v

Supplement A: Estimated NEMT Need A-1
- Calculations for NEMT Trips in the Tri-County Region A-1
- Demand increase not yet showing in data A-3
- NEMT Requests and unmet needs in the Tri-County area A-4
- Data sources for further information A-8

Supplement B: Non-FTA Federal Programs B-1

Supplement C: Medicaid C-1
- Medicare and Medicaid C-1
- Medicaid Non-Emergency Transportation Webinar Playback and Documents C-1
- Medicaid Brokerage Final Rule Excerpt C-1

Supplement D: Standard Practice for Calculating the Cost of a Ride D-1

Supplement E: Medicaid Transportation in Other States E-1
- Washington Example E-1
- Oregon Example E-4
- Florida Example E-4
- North Carolina Example E-5
- Pennsylvania Example E-6
- California Examples E-6

Definitions and Acronyms

ACA	Patient Protection and Affordable Care Act of 2010. If a state chooses to participate, the ACA will increases the number of people eligible for Medicaid, which may increase the number of people eligible for Medicaid NEMT.
ACCT	Lawmakers created the Agency Council on Coordinated Transportation (ACCT) during the 1998 Washington State legislative session to coordinate affordable and accessible transportation choices for people with special needs in collaboration with state and local agencies and organizations. The council's Federal Opportunities Workgroup has been working on Medicaid transportation.
ADA	Americans with Disabilities Act of 1990. Landmark federal civil rights legislation that requires public transit systems to make their services fully accessible to persons with disabilities, as well as to underwrite a parallel network of paratransit service for those who are unable to use the regular transit system. In general, paratransit service must be provided within 3/4 of a mile of a bus route or rail station, at the same hours and days, for no more than twice the regular fixed route fare. The ADA further requires that paratransit rides be provided to all eligible riders if requested any time the previous day, within an hour of the requested time.
ADA paratransit eligibility	People who cannot travel to a bus or train, even if it accessible, because of a disability. Eligibility can be situational, such as an inability to access a bus or train because of environmental or architectural barriers not under the control of the transit agency.
CATA	Capital Area Transit Authority serves Lansing and Ingham County with fixed route, Spec-Tran, and curb-to-curb services. Spec-Tran riders must meet ADA paratransit eligibility. Curb-to-curb service in rural areas of the county is open to the general public.
Clinton Transit	Serves Clinton County with demand response and a volunteer program.
CMS	The Centers for Medicare and Medicaid Services, the federal agency that oversees Medicaid in all states.
Curb-to-curb	Demand response service where the rider meets the vehicle at the curb. This is more common than door-to-door service where the driver can assist the rider to the door.
DD Council	Developmental Disabilities Council. The DD Council is a consumer-based program of MDCH. Its Regional Inclusive Community

	Coalitions (RICC) are local groups of grassroots people funded and supported by the DD. Members include people with disabilities, family members, friends, local advocates, community leaders and service providers. RICCs are the self-advocacy part of the DD Council. The DD Council is actively advocating for improved Medicaid transportation in Michigan.
Demand response	Another term for paratransit service, and a more general term than curb-to-curb, door-to-door, or specialized transportation. Sometimes used as an umbrella term to include services not required by ADA, such as services for seniors and general public demand response service in low density areas.
DHS	County Departments of Human Services. County DHS offices are responsible for implementing Medicaid state policies. They assist clients in finding transportation resources
DRA	Deficit Reduction Act of 2005. This legislation and subsequent rule making established the ability for state Medicaid managers to use an NEMT brokerage without the need to apply for a waiver, along with the rules and requirements.
Eatran	Eaton County Transit. Services include demand response, Downtown Lansing Express, and out of county medical trips.
Fixed route	Public transit service provided on a repetitive, fixed-schedule basis along a specific route, with vehicles stopping to pick up passengers at and deliver them to specific locations. This typically is used in reference to local transit service but can be applied to intercity and commuter bus and rail.
FOW	The Federal Opportunities Workgroup, appointed by the ACCT, is charged with identifying relevant federal requirements and barriers that restrict agencies in Washington State from providing more efficient transportation services for people unable to transport themselves.
MDCH	Michigan Department of Community Health. MDCH sets Medicaid program policy at the state level. Several agencies within MDCH also play an important role in administering Medicaid programs
Medicaid	National health program for families and individuals with low income and resources. Medicaid is required to provide access to medical services for those who cannot transport themselves. Medicare, the national health program for seniors, does not have this requirement.
Mobility management	A systems approach to manage transportation resources that involves creating partnerships with transportation providers in a community or region to enhance travel options, and then developing means to effectively communicate those options to the

	public
MSA	Medical Services Administration. A part of the MDCH, MSA has the primary responsibility for oversight of Michigan's Medicaid program.
NEMT	Non-emergency medical transportation.
OSA	Office of Services to the Aging. OSA is the center point of a statewide network supporting services that benefit the elderly. It is a program of the MDCH.
Paratransit	Flexible passenger transportation that does not follow fixed routes or schedules, including shared taxis and services provided by public transit operators. Within the public transportation profession the term usually refers to transportation service required by ADA for individuals with disabilities who are unable to use fixed-route, public transit systems.
Public paratransit	Terminology used in Medicaid literature to differentiate service provided by public transportation from shared taxis and other private sector or non-profit paratransit services. Service may be open to people who are not ADA eligible, especially in low density areas and for service targeted towards seniors.
Spec-Tran	Specialized transportation, a term used by CATA and many other transit agencies for their ADA-required paratransit service for people who cannot access fixed route due to disability.
TCRPC	Tri-County Regional Planning Commission

Supplement A: Estimated NEMT Need

Calculations for NEMT Trips in the Tri-County Region

Using CATA's average paratransit trip cost and the methodology identified in national literature (Altarum Institute, 2005) we calculated a benefit-to-cost ratio for public demand response NEMT in the Tri County region of 6.11 to 1. For every $0.33 spent on transport the additional medical care made possible by that transportation costs $0.66. Those combined costs of $1 lead to savings in more effective preventative medical care and the value of extended quality life is $6.11.

CATA reported 62,040 one-way paratransit trips to or from the hospital or other medical facility per year[1] (31,020 round trips[2]) at a cost of $1.5 million (Alexander & Brown, 2013). The cost of the additional medical care made possible by this transportation is estimated to be 2.8 million, for a total cost of $4.4 million. The benefit from these trips is estimated to be $27 million. If Clinton Transit and Eaton Transit provide medical transportation at the same per capita rate as CATA, the overall one-way trips to medical facilities provided by Tri-County public paratransit services is102,490 one-way trips. Besides the transportation costs, NEMT is estimated to induce additional medical costs of $4.8 million for people who would otherwise be unable to access medical care. Benefits are estimated at $44.2 million (See Table C-1).

The Washington FOW report conservatively estimated that 10%-30% of the NEMT is provided by public transportation paratransit. Assuming Tri-County is within the same range, there are 340,000 to 1 million NEMT one-way trips in the Tri-County region. At $24 per ride this equates to $8.1 million to $24 million in transportation costs. Since many or most of the rides are provided by unpaid drivers, this estimate includes the in-kind contribution of the volunteers who drive their family, friends, and neighbors to get medical care.

[1] To simplify calculations we assume all rides on paratransit are for the purpose of accessing medical care, and we are ignoring rides via fixed route to access medical care.
[2] Public transportation counts trips on a one-way basis. Medicaid counts per round trip.

Table C-1: Estimated Public Transportation Demand Response Trips, Costs, and Benefits for Three Counties

	Ingham County	Clinton County (Estimated)	Eaton County (Estimated)	Tri County Total
Estimated Number of Trips (2 way)				
Trips Provided for **Chronic** Care	24,468	6,566	9,387	**40,421**
Trips Provided for **Preventive** Care	6,552	1,758	2,514	**10,824**
Induced Demand (0%)	-	-	-	-
Total Trips	31,020	8,325	11,900	**51,245**
Transportation and Medical Costs				
Incremental Transportation Cost	$1,488,968	$399,585	$571,209	**$2,459,761**
Additional Medical Costs for Providing Care	$2,895,548	$777,060	$1,110,811	**$4,783,419**
Total Costs	$4,384,515	$1,176,644	$1,682,020	**$7,243,180**
QALY Adjusted Benefits of Providing NEMT				
Benefits from Treating **Chronic** Conditions	$26,351,812	$7,071,868	$10,109,275	**$43,532,955**
Benefits from Providing **Prevention** Care	$442,969	$118,877	$169,935	**$731,781**
Total Benefits Derived from Providing NEMT	$26,794,781	$7,190,744	$10,279,210	**$44,264,736**
Cost-Effectiveness Ratio of Providing NEMT				**6.11**
Net Cost-Effectiveness of Providing NEMT	**$22,410,265**	**$6,014,100**	**$8,597,190**	**$37,021,556**

Ingham County estimates are based on a count of the number of trips provided by CATA paratransit.
Clinton and Eaton County estimates use CATA rate of NEMT rides, CATA costs, and the appropriate county population.
QALY - Quality Adjusted Life-Year, a measure of enhanced life expectancy used in health economics.

Table C-2: CATA Non-Emergency Medical Transportation[3]

	Spec-Tran	Other Paratransit	Total	Operating Expense @ $24 per ride
Trips to Medical Facilities	**59,020**	**3,020**	**62,040**	**$1,488,960**
Hospitals	4,921	-	4,921	$118,104
Other Medical Facilities	54,099	3,020	57,119	$1,370,856
Total Trips	**319,779**	**117,448**	**437,227**	**$10,493,448**
% Medical Trips	**18%**	**3%**	**14%**	**14%**
Farebox recovery ratio at $2.50 per ride:				10%
Cost of medical trips not covered by farebox:				**$1,333,860**

Under the current way of doing business, Medicaid pays a small portion of NEMT transportation costs. With Medicaid paying only farebox, it pays 10% of the cost of CATA's medical rides. The remainder is paid by FTA, state transportation dollars, and county mill levies that are aimed at transportation, not medical care. For CATA, this leaves $1.3 million per year of unreimbursed costs for transporting people to and from medical appointments on demand response services.

If CATA were to be reimbursed the entire cost of the ride, they could reinvest the funds elsewhere. For example, CATA could operate 2 additional fixed route buses 16 hours per day, 7 days per week[4]. This would benefit people using fixed route service to access medical care, as well as the entire community. Data specific to medical transportation is unavailable for Eatran and Clinton Transit, but we assume the situation is much the same as CATA.

Demand increase not yet showing in data

As the population ages we expect NEMT demand to increase over time, growing faster than the general population. We reviewed CATA ridership trends to find historical evidence of ridership increase yet we found the data inconclusive. Using overall demand response ridership as a proxy for NEMT demand, we see an increase since 1995 of 71%. However, this is much lower than the 221% increase in fixed route ridership in Ingham County[5]. With the limited data we cannot determine if demand response increases are tied to the overall increase in transit ridership, or if aging demographics influence the use.

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[3] Based on CATA data for May 1, 2012 to April 30, 2013
[4] Calculated using NTD 2011 fixed route cost per hour of $112.81, 52 weeks per year, no holidays.
[5] We didn't assess Clinton and Eaton because the rural National Transit Database has only been in existence for about five years, has some questionable data, and is more difficult to access and query than the urban database.

While fixed route is capable of taking on more demand (ridership) independent of amount of service, the amount of demand response service must increase at approximately the same rate as the number of rides. In other words, you can get more people onto a fixed route, but opportunities for improved efficiency in demand response are fairly limited.

NEMT Requests and unmet needs in the Tri-County area

We have identified three valuable data sources, besides transit data, that can provide insight into needs and resources:

- Central Michigan 2-1-1
- The Michigan Data Warehouse of Medicaid expenditures
- Updates to the earlier transportation inventory and survey.

2-1-1 has been the first resource to provide information for this project.

The Central Michigan Program is a partnership of Capital Area United Way, Eaton County United Way, Lenawee United Way, LifeWays, Livingston County United Way, Resource Genesee, Shiawassee United Way, United Way of Jackson County and United Way of Genesee County. At the state level, the federal Veteran's Transportation Initiative is consolidating the regional 2-1-1 databases into one statewide source of information consistently following the North American standard for indexing and accessing human services resource databases (Information and Referral Federation of Los Angeles County, 2012).

A full-time resource specialist keeps the Central Michigan 2-1-1 database updated. At least annually, each agency in the database receives a complete document of their information for review and corrections. Once Central Michigan 2-1-1 receives the updated information, it is processed within two weeks. The resource specialist also periodically attends community collaborative meetings and is on meeting distribution lists to learn of updates that happen throughout the year. In addition, agencies can request updates or additions to information online as described at http://centralmichigan211.org/agencyupdates.html or via email to 211reports@lifewayscmh.org.[6]

Central Michigan 2-1-1 is able to provide detailed reports relating to transportation requests, unmet requests, and agencies providing transportation-related services. A summary of the data is shown in the following three tables. Table C-1 lists the requests for transportation resources made through 2-1-1. Organizations that provide those resources are shown in Table C-2. Table C-3 shows the number of requests for services for which 2-1-1 was unable to provide a resource.

Information that stands out in this data:

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[6] TCRPC could combine the transportation inventory process with 2-1-1 updates. It would require a simple programming process to ingest AIRS-structured transportation data into the more data-rich transportation inventory database.

- The top request through 2-1-1 is for assistance with bus fare, followed by automotive repair and gas money.
- The top request for assistance that cannot be met is for loosely defined "unmet transportation requests". Assistance with medical appointments transportation ranked third.
- Love INC is, by far, the agency most referred for transportation services, for assistance with bus fare and gas money. This and other agencies in Table 4 are good potential partners in coordination efforts, if they are not currently actively involved.

Table C-3: Central Michigan 2-1-1 Transportation Requests (1/1/2012-4/30/2013)

Referred Service	Service Requests
Clinton	**46**
Bus Fare	10
Automotive Repair	9
Gas Money	8
Automobiles	8
Disability Related Transportation	3
Transportation System Orientation Programs	2
Automobile Payment Assistance	2
Indigent Transportation	2
Transportation Information Clearinghouses/511 Services	1
Medical Appointments Transportation	1
Eaton	**115**
Gas Money	50
Bus Fare	18
Automotive Repair	17
Automobiles	15
Automobile Payment Assistance	9
Transportation System Orientation Programs	3
Mercy Transportation	2
Disability Related Transportation	1
Ingham	**661**
Bus Fare	250
Gas Money	200
Automotive Repair	65
Automobiles	61
Automobile Payment Assistance	35
Medical Appointments Transportation	22
Disability Related Transportation	16
Transportation System Orientation Programs	5
Motor Vehicle Registration	3
Transportation for Endangered People	1
Transportation Information Clearinghouses/511 Services	1
Mercy Transportation	1
Indigent Transportation	1
Grand Total	**822**

Table C-4: Central Michigan 2-1-1 Agencies Referred for Transportation Services (1/1/2012-4/30/2013)

Agency Name by County	Air Fare	Automobiles	Automotive Repair	Bus Fare	Disability Related Transportation	Gas Money	Local Bicycle Transportation	Local Bus Transit Services	Long Distance Bus Fare	Long Distance Bus Services	Medical Appointments Transportation	Transportation for Endangered People	Transportation Information Clearinghouses	Grand Total
Clinton		**8**	**10**	**18**	**3**	**8**				**1**	**1**		**1**	**50**
CHRISTIAN SERVICES/LOVE INC OF GREATER LANSING				9		7								16
MICHIGAN DEPARTMENT OF HUMAN SERVICES			10											10
ADVENT HOUSE MINISTRIES				9										9
CHARITY MOTORS		8												8
CAPITAL AREA TRANSPORTATION AUTHORITY					2									2
MISSION OF HOPE CANCER FUND						1								1
GREYHOUND BUS LINE										1				1
CAPITAL AREA CENTER FOR INDEPENDENT LIVING													1	1
AMERICAN CANCER SOCIETY -- GREAT LAKES DIVISION											1			1
CLINTON AREA TRANSIT SYSTEM					1									1
Eaton		**15**	**19**	**20**	**1**	**50**	**3**	**5**		**1**				**114**
CHRISTIAN SERVICES/LOVE INC OF GREATER LANSING				17		50								67
MICHIGAN DEPARTMENT OF HUMAN SERVICES			17											17
CHARITY MOTORS		15												15
EATON COUNTY TRANSPORTATION AUTHORITY								5						5
GRAND LEDGE EMERGENCY ASSISTANCE PROGRAM			2	2										4
SHARE A BIKE PROGRAM							3							3
CAPITAL AREA TRANSPORTATION AUTHORITY					1									1
ADVENT HOUSE MINISTRIES				1										1
GREYHOUND BUS LINE										1				1
Ingham	**1**	**62**	**76**	**388**	**16**	**207**	**11**	**5**	**1**	**24**	**23**	**1**	**1**	**816**
CHRISTIAN SERVICES/LOVE INC OF GREATER LANSING				222		195								417
ADVENT HOUSE MINISTRIES				153		1								154
MICHIGAN DEPARTMENT OF HUMAN SERVICES			74											74
CHARITY MOTORS		61												61
GREYHOUND BUS LINE										24				24
CAPITAL AREA TRANSPORTATION AUTHORITY					15			4			1			20
PHYSICIANS HEALTH PLAN -- MEDICAID											9			9
SHARE A BIKE PROGRAM							8							8
CHARTER TOWNSHIP OF MERIDIAN				7										7
CENTER FOR FAMILY HEALTH											5			5
STOCKBRIDGE COMMUNITY OUTREACH				2		3								5
AMERICAN CANCER SOCIETY -- GREAT LAKES DIVISION											4			4
MISSION OF HOPE CANCER FUND						4								4
AMERICAN RED CROSS -- MID-MICHIGAN CHAPTER	1			2										3
NATIONAL RUNAWAY SWITCHBOARD				2								1		3
KIDS REPAIR PROGRAM							3							3
MCLAREN HEALTH PLAN -- MEDICAID											2			2
MICHIGAN DEPARTMENT OF MILITARY AND VETERANS AFFAIRS						2								2
SOCIETY OF SAINT VINCENT DEPAUL						2								2
BLUE CROSS COMPLETE -- MEDICAID											1			1
CLINTON AND INGHAM DEPARTMENT OF VETERANS AFFAIRS											1			1
OPERATION HOMEFRONT -- MICHIGAN CHAPTER		1												1
DISABILITY CONNECTIONS, INC.					1									1
CAPITAL AREA CENTER FOR INDEPENDENT LIVING													1	1
LOVE IN THE NAME OF CHRIST OF JACKSON COUNTY									1					1
MICHIGAN DEPARTMENT OF STATE POLICE			1											1
EATON COUNTY TRANSPORTATION AUTHORITY								1						1
GRAND LEDGE EMERGENCY ASSISTANCE PROGRAM			1											1
Grand Total	**1**	**85**	**105**	**426**	**20**	**265**	**14**	**10**	**1**	**26**	**24**	**1**	**2**	**980**

Table C-5: Central Michigan 2-1-1 Transportation Unmet Services and Needs (1/1/2012-4/30/2013)

Ingham		
39	Automotive Repair	
	27	Client ineligible/target population requirement
	6	Service not available
	5	No immediate resource available
	1	Client ineligible/previously assisted
20	Medical Appointments Transportation	
	11	Service not available
	3	No immediate resource available
	2	Client ineligible/other reason
	1	Client ineligible/outside service area
	1	Client ineligible/target population requirement
	1	Service inaccessible/cost
	1	Service inaccessible/hours
18	Bus Fare	
	8	Service not available
	3	Client ineligible/target population requirement
	3	Client refused referral
	2	No immediate resource available
	1	Client ineligible/previously assisted
	1	Service inaccessible/hours
3	Long Distance Transportation	
	3	Service not available
2	Indigent Transportation	
	2	Service not available
82	Unmet Transportation Requests	
Eaton		
10	Automotive Repair	
	7	Client ineligible/target population requirement
	2	Client ineligible/other reason
	1	Service not available
7	Medical Appointments Transportation	
	6	Service not available
	1	Service inaccessible/other reason
17	Unmet Transportation Requests	
Clinton		
8	Automotive Repair	
	7	Client ineligible/target population requirement
	1	No immediate resource available
4	Bus Fare	
	3	Service not available
	1	Client refused referral
3	Medical Appointments Transportation	
	3	Service not available
1	Indigent Transportation	
	1	Client ineligible/other reason
16	Unmet Transportation Requests	

Data sources for further information

At the time this report was drafted, we were waiting for requested information from the Medicaid Data Warehouse, with inquiry information found here:
http://ihcs.msu.edu/research/medicaid_match_data_warehouse.php

The Michigan Data Warehouse project is a searchable database created to allow the Department of Human Services to track Medicaid claims. This system has saved Medicaid millions of dollars by allowing staff to reduce fraud and track the use of Medicaid throughout the state. The Data Warehouse has been one of Michigan's greatest successes in Medicaid savings. A number of state agencies are successfully using it to track information. This may be the perfect tool to help the project partners understand and track Medicaid transportation expenses over time. MSU's Institute for Healthcare Studies (IHCS) controls research access to the Medicaid portion of the warehouse. While the Data Warehouse may have exactly the information we are looking for, it is not proving easy to access this data. We have obtained the IHCS Request to Obtain Warehouse Data form, which requires signatures from the Michigan Department of Community Health (MDCH) Director, Bureau Director, or Delegated Authority; a Responsible MDCH Sponsor; and a notary. Because we do not need access to any information containing private, personal data we have been in contact with a number of state officials to try to determine whether we can access the data we need without going through the extensive Data Warehouse access process.

Also, this project began developing a process to update the transportation inventory that is largely in paper format from 1991, 2008, and 2009, yet quantitative data is of little use since the scope was limited to eleven Medicaid or Title III recipient organizations, and we received data so far from only four organizations.

Supplement B: Non-FTA Federal Programs

Sixty-two federal programs fund transportation. The following table lists the possible uses for these programs according to United We Ride. Highlighted programs relate most directly to Medicaid NEMT.

Federal Transportation Service Matrix

	Reimbursed Costs (Fares, Gas, Bus Pass, etc.)	Mobility Mgt/ Travel Training/ O and M	Operate Vehicles (Direct or Contract)	Purchase Vehicles (public/nonprofit)
HEALTH AND HUMAN SERVICES				
Administration for Children and Families				
Social Service Block Grant	X		X	X
Child Care and Development Block Grant	X			
Head Start			X	X
Refugee and Entrant Assistant Discretionary Grants				
Refugee and Entrant Asst. State Administered Programs	X			
Refugee and Entrant Targeted Assistance	X			
Refugee and Entrant Asst. Voluntary Agency Programs	X			
State Developmental Disabilities Council and Protection & Advocacy	X	X	X	
Temporary Assist to Needy Families	X			
Community Services Block Grant			X	
Promoting Safe and Stable Families			X	
Administration on Aging				
Grants for Supportive Services and Senior Centers			X	
Programs for American Indian, Alaskan Native and Native Hawaii			X	
Centers for Medicaid and Medicare				
Medicaid	X			
State Health Insurance Program	X			
Home and Community Based Waiver	X	X		
Health Resources and Services Administration				
Community Health Centers	X		X	
Healthy Communities Program	X		X	
HIV Care Formula	X		X	
Maternal and Child Health Block Grant	X			
Rural Health Care Network	X		X	X
Rural Health Care Outreach Program			X	
Healthy Start Initiative			X	
Ryan White Care Act Programs				
Substance Abuse and Mental Health Services Administration				
Community Mental Health Services Block Grant	X	X		
Prevention and Texas Block Grant	X	X		
DEPARTMENT OF EDUCATION				
Voluntary Public School Choice	X	X		
IDEA		X		
Centers for Independent Living		X		

	Reimbursed Costs (Fares, Gas, Bus Pass, etc.)	Mobility Mgt/ Travel Training/ O and M	Operate Vehicles (Direct or Contract)	Purchase Vehicles (public/nonprofit)
Independent Living for Older individuals Who are Blind		X		
Independent Living State Grants		X		
Vocational Rehab Grants		X		
DEPARTMENT OF LABOR				
Bureau of Indian Affairs				
Indian Employment Training and Related Services	X	X		
Indian Employment Services	X	X		
Employment and Training Administration				
Job Corps	X	X		
Migrant and Seasonal Farm Worker	X	X		
Native American Employment and Training	X	X		
Trade Adjustment Assistance for Workers	X	X		
Welfare to Work Grants for Tribes	X	X		
Welfare to Work for States and Locals	X	X		
Work Incentive Grants	X	X		
Workforce Investment Act Adult Services Program		X		
Workforce Investment Act Adult Dislocated Worker Program		X		
Workforce Investment Act Youth Activities		X		
Veterans Programs				
Veterans Employment Program		X		
Homeless Vet Project				
DEPARTMENT OF TRANSPORTATION				
Elderly and Persons with Disability				X
Job Access Reverse Commute (consolidated under MAP-21)			X	X
Non-Urbanized Formula (rural)			X	X
Urbanized Formula				X
New Freedom Program (consolidated under MAP-21)			X	X
Capital Discretionary Program			X	X
HOUSING AND URBAN DEVELOPMENT				
Community Planning and Development				
Community Development Block Grant			X	X
Housing for Ind. w/AIDS	X		X	X
Supportive Housing Programs			X	
Principal and Interest				
Revitalization of Severely Distressed Housing	X			
Veteran Affairs				
Homeless Provider Grants			X	X
Medical Care Benefits	X		X	X
Social Security Administration				
Ticket to Work Program	X			
U.S. Department of Agriculture				
Food stamp and Employment Training Program	X			

Source: United We Ride 2007c

Supplement C: Medicaid

Medicare and Medicaid

Medicare covers everyone over 62 and operates across the country. Medicaid covers the poor and disabled. The federal government pays a percentage-based factors such as poverty rate and unemployment, typically around 54%.

The Medical Services Administration (MSA) was set up under the general fund; now it's a medical model. Michigan has a B-3 waiver that allows bundling of services. Able-bodied poor were moved to an HMO model. In 2000, those with substance abuse, mental health, and development disabled were also moved to an HMO model.

Medicaid Non-Emergency Transportation Webinar Playback and Documents

(Community Transportation Association of America, 2010)

Valerie Miller
Medical Transportation Specialist
800.891.0590 x713
202.294.2212

The complete audio and visual playback of the CTAA Medicaid Webinar Parts I and II is available on the CTAA website.

- Medicaid Non-Emergency Transportation Part I Playback
- Medicaid Non-Emergency Transportation Webinar Part II Playback

Medicaid Brokerage Final Rule Excerpt

The next two pages show the discussion regarding public paratransit reimbursement.

Federal Register. (2008, December 19). Vol. 73 No. 245 p. 77254. *Medicaid Program: State Option to Establish Non-Emergency Medical Transportation Program. Final Rule.*

funding would not be available to match the part of any future State expenditures funded by the SAFETEA–LU grant because federal statutes authorizing the SAFETEA–LU grant program do not expressly authorize use of SAFETEA–LU funds for matching other federal funds.

Comment: Many commenters felt that if the proposed rule were implemented it would interfere with a State's ability to develop coordinated transportation services. Some commenters suggested that there needs to be a special section of the regulation that deals with coordinated transit services, that States that have rural regional transit agencies need to conceptualize an efficient mechanism to bring Medicaid into coordinated service, and that NEMT brokerages for coordinated rural regional systems should be allowed to reside with the rural regional transit system providing the regional transit agency can show that the total cost to Medicaid is significantly reduced by parallel coordinated service contracts with other human services agencies. One commenter said that human service transportation would be reduced if Medicaid were to be taken out of the coordination mix. One State transportation agency objected to any requirement that the brokerage function be devoted exclusively to Medicaid funded transportation. Another State Transportation Department suggested that CMS add language to the final rule that includes as a criterion for selecting the broker consideration of the benefits of a coordinated transportation system.

Response: The statute did not specifically address coordinated transportation. Coordination of transportation services is a positive goal and we encourage States to develop coordinated transportation systems in order to promote efficiency and cost-effectiveness. However, it should be noted that Medicaid funds may only be used for Medicaid services provided to eligible beneficiaries. When administering the Medicaid NEMT program, States must comply with all applicable Medicaid policies and rules regardless of whether the Medicaid rules interfere with their ability to coordinate their transportation efforts.

Comment: Many commenters disagreed with the requirement for governmental brokers to document with respect to the individual's specific transportation needs that the government provider is the most appropriate and lowest cost alternative, and that the Medicaid program is paying no more than the rate charged to the general public. The commenters said that the documentation requirement will result in additional and costly recording-keeping. One commenter objected to any requirement that a governmental broker using other governmental entities as transportation providers document that the transportation is the least costly and most appropriate for each beneficiary because it precludes government social service agencies from being used by the broker to provide transportation.

Response: We do not believe that this documentation requirement will result in significantly more record-keeping. Medicaid laws and regulations, as well as CMS guidance, have always required that there be documentation of medical services that are provided to beneficiaries and that they be made available to CMS upon request. In general, documentation should include verification of eligibility, verification that the service was provided on the date claimed and information about the cost of services. When NEMT is provided as a medical service there should be documentation, not only that the specific ride was provided, but that a Medicaid reimbursable service other than the transportation itself was actually provided on the dates when transportation was claimed. We do not agree that the documentation required when a governmental broker refers to another government entity would prohibit government social service agencies from being used as transportation providers. Given the nature of the client populations served by many of the social service agencies, governmental brokers should not find it difficult to document that the social service agency is the most appropriate and least costly provider of transportation for their client(s).

For the purposes of the final rule, the additional documentation required for the NEMT brokerage would not be significant and should be relatively simple. An annual comparison of the fees paid by Medicaid under the brokerage program for fixed route transportation to the fees charged to the general public for fixed route transportation, and a comparison of the fees paid by Medicaid for public paratransit services to the fees charged to other agencies for comparable public paratransit services, should be all that is necessary.

Comment: Many of the commenters disagreed with the proposed requirement that Medicaid pay no more than the rate charged to the general public for the same type of ride when a governmental broker is a provider of transportation or refers to or subcontracts with another governmental transportation provider. Commenters expressed concern that the actual cost of providing public transportation, particularly publicly provided paratransit rides (that is, door-to-door or curb-to-curb services usually provided to those who are disabled) to the Medicaid population far exceeds the fees charged to the general public because public transit services are subsidized by Federal, State, and local funds, which allows the fares paid by the general public to be set lower than the actual cost of providing the ride. The commenters maintain that prohibiting Medicaid from being charged its fully allocated cost will shift the financial burden of public transit and paratransit trips to State and local entities that fund public transportation. Therefore, the public fare, particularly for paratransit rides, should not be used as a measure to set Medicaid's payment. Medicaid should be charged the fully allocated costs for paratransit rides consistent with this provision and Medicaid's responsibility to assure NEMT.

Many commenters pointed out the fact that the Americans with Disability Act (ADA) requires that States provide disabled members of the public with comparable paratransit services wherever public fixed-route services are offered, and the amount that can be charged to disabled members of the public for comparable public paratransit services may not exceed twice the amount charged to the public for similar fixed-route services. However, these guidelines also say that agencies which purchase publicly-provided paratransit trips for their disabled clients may pay more than the rate charged to disabled individuals receiving a comparable paratransit ride.

Response: In general, States have established rules prohibiting Medicaid from paying more for a covered service than what other third-party payers (for example, health insurers) are charged for the same service. In the case of publicly-provided transportation on fixed routes, while there are other third-party payers (for example, State Human Service agencies) that often cover and reimburse these trips for their clients, we have been informed that such third-parties or agencies generally pay the same amount as the public is charged for these rides. Therefore, we are prohibited from paying more than the public is charged for public transportation on a fixed-route trip.

In the case of publicly-provided paratransit services and rides, based on the comments received and the information provided, we believe that it is appropriate and consistent with current practice for Medicaid to pay

over

more than the rate charged to disabled individuals for a comparable ride. Based on principles of accounting and financing found in OMB Circular A–87 and section 1902(a)(30) of the Act and 45 CFR 92.36, pertaining to procurements, we believe that Medicaid, through its NEMT program with government brokers, can pay a fare for publicly provided paratransit trips that represents reasonable costs and which is no more than the fare paid for similar paratransit trips by other State Human Services agencies. Therefore, in this final rule we have modified the regulations text at § 440.170(a)(4)(ii)(B)(4)(iii) to require the governmental broker to document that Medicaid is paying for public fixed-route transportation at a rate that is no more than the rate charged to the general public, and no more than the rate charged to other State human services agencies for public paratransit services.

The commenters appear to be concerned about potential limitations on Medicaid payment for public transportation services. The final rule as revised is consistent with current practice and when the State awards a brokerage contract to a governmental transportation broker that is itself a provider of transportation or who refers or subcontracts with another government entity this should not have a significant effect on Medicaid payments to transportation providers. We could have precluded governmental brokers from providing transportation or referring beneficiaries to governmentally-operated transportation altogether. Instead, we provided for safeguards to ensure that governmental brokers operate as independently as non-governmental brokers. We believe that these safeguards will ensure that such transportation will be cost-effective and that the transportation referral will be based on the best interests of the beneficiary, while at the same time meeting the mandate to provide transportation that is the least costly appropriate mode.

Comment: Several commenters disagreed with the requirements of the proposed rule and felt that States were best equipped to design their own systems to prevent the kind of abusive practices and conflicts of interest that might arise when a broker is involved in direct service delivery. These commenters believed that States should be permitted to decide how to institute proper controls that would eliminate any conflicts of interest. A number of commenters said that regional transportation systems and public transportation systems operating as the NEMT broker have the best opportunity and means to coordinate transportation for the benefit of the public. One commenter believed that the State's Department of Transportation and not the Health and Human Services Medicaid program should coordinate Medicaid transportation.

Response: States have broad flexibility to construct an array of NEMT programs that meet each State's diverse needs in terms of geography, transportation infrastructure, and targeted populations, and this final rule preserves this flexibility. However, Medicaid NEMT programs have long been identified by State and Federal Inspector General Reports (for example, HHS, OEI–04095–00 140) as having a high potential for fraud and abuse. As a means of reducing the risk of fraudulent and abusive practices that result in unnecessary or inappropriate use of Medicaid transportation and the loss of millions of Medicaid dollars, the statute specifies that certain provisions be included in the contract between the State and the NEMT broker. The statute also directs us to establish prohibitions on broker referrals and conflict of interest. As a result we have implemented the contract requirements and the prohibitions as provided for in statute.

Comment: One commenter stated that the proposed rule prohibited non-profit transportation providers from being paid more than a governmental broker.

Response: We assume the commenter intended to speak about how the proposed rule prohibited non-profit brokers from being paid more than a governmental broker and therefore believe the commenter misunderstood how the proposed rule distinguishes between two types of brokers, governmental and non-governmental. There is no restriction on a non-profit broker that is not a governmental entity from negotiating rates with public transportation providers.

Comment: Several commenters said the language requiring the contract with a governmental broker to "provide for payment that does not exceed actual costs calculated as a distinct unit, excluding personnel or other costs shared with or allocated from parent or related entities," is ambiguous and can be read two ways, either to include or exclude these costs in the final analysis. Several commenters opposed requiring the public entity broker to be a distinct governmental unit. One commenter expressed the need for further clarification of the requirement that a public broker be a distinct governmental unit and was concerned that the brokerage function would be required to be devoted to only Medicaid-funded transportation, which is directly contrary to the policies established under EO 13330. Another commenter believed that this language was too restrictive and would potentially limit the number of entities that would be eligible to bid.

Response: We agree that this sentence is confusing. Therefore, we have amended this final rule by making it clear, at § 440.170(a)(4)(ii)(B)(4)(i), that if the government broker wishes to be excepted from the self-referral prohibition, the government broker's contract with the State Medicaid agency must specify that the government broker will not charge the Medicaid agency for any personnel or other costs that are shared with, or allocated from, parent or related governmental entities. We expect the governmental broker to maintain an accounting system as though it were a distinct unit, such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program. Costs that are shared with or allocated from other governmental entities will not be paid by Medicaid.

Comment: One commenter said that the proposed rule does not make allowances for currently existing models that meet the financial, oversight, and contracting requirements of the proposed rule. Another commenter wrote that the proposed rule failed to consider any best practices already in place.

Response: States with existing NEMT brokerage models that do not meet all of the requirements of the DRA and this final rule have other options available, such as obtaining 1915(b) waiver authority or providing NEMT as an administrative expense. The 1915(b) waiver authority process does not prohibit the broker from self-referring nor does it require that the broker be selected through competitive bidding. Providing NEMT as an administrative expense provides States with the greatest flexibility in designing their program.

Comment: One commenter noted that the proposed rule did not mandate provision of bus passes or other fare media for those Medicaid recipients who are able to use public transportation, while another commenter contended that bus passes were not addressed at all in the proposed rule. One commenter suggested that if a Medicaid trip were directed by a broker to a bus, a transit provider should be reimbursed by Medicaid for the cost of a monthly bus pass whether the cost is higher or lower

Supplement D: Standard Practice for Calculating the Cost of a Ride

Standard practice for calculating the cost of a ride requires developing a cost allocation model. This requires a budget or statement of operating funds, the miles of service, and hours of service for a year.

As an example, the cost allocation model for a transit agency we recently worked with is summarized by the following equation from the costs and associated categories in the agency's budget.

2012 Operating Cost =	**1.45**	**(**	**$34.90**	**x**	**# of Hours in Service**	**+**	**$0.87**	**x # of Miles in Service)**

The cost of providing transportation could vary between different organizations if one organization has higher overhead or driver salary costs than another. Such cost variations could result from differences in overall organizational efficiency. Any other significant difference would likely result from accounting practices that do not capture the full cost of the ride. Generally, staffing costs and overhead are more significant factors than fuel costs.

The cost allocation model shown above follows a standard transportation cost allocation models and includes only operating costs. Values for the cost model are calculated as follows:

$$Fixed\ Cost\ Factor = 1 + \frac{Fixed\ Costs}{Hour\ Costs + Mile\ Costs} = 1 + \frac{\$301{,}683}{\$471{,}225 + \$203{,}580} = 1.45$$

$$Average\ Unit\ Cost = \frac{Hour\ Costs}{Vehicle\ Hours} = \frac{\$471{,}225}{13{,}504\ hr} = \frac{\$34.90}{hr}$$

$$Average\ Mile\ Costs = \frac{Mile\ Costs}{Vehicle\ Miles} = \frac{\$203{,}580}{232{,}764\ mi} = \frac{\$0.87}{mi}$$

The average cost per hour of service is $72.31. The average cost per mile of service is $4.20.

When the hours and miles for a special service are estimated, these numbers can be plugged into the formula to estimate cost, which in turn can be used to negotiate contracts.

In addition to allowing an agency to know the true cost of the services provided, a fully allocated cost model also allows equal comparison of costs between varying types of service, such as a commuter service that covers a longer distance at a higher average

speed, and an in-town route that travels at a lower average speed with more stops. When combined with ridership, this establishes a baseline for developing a fair contract for service, or multi-agency fare structure.

The cost of providing transportation could vary between different organizations if one organization has higher overhead or driver salary costs than another. Such cost variations could result from differences in overall organizational efficiency. Any other significant difference would likely result from accounting practices that do not capture the full cost of the ride. Generally, staffing costs per hour and overhead are more significant factors than fuel efficiency.

Shared Ride Allocation

Cost allocation for shared ride demand response is not yet established in standard practice. Whenever two or more customers are being transported in a vehicle at the same time and those customers are sponsored by different funding sources, each sponsoring organization is obligated to ensure that it only pays for its share of the service and that it is not subsidizing the transportation of the other riders. This requirement starts at the federal level, according to 42 CFR Part 440.170.

Many recognize that a shared seat allocation, which can be based on time or miles, is an equitable cost allocation methodology. This also happens to be the most complicated methodology to implement and automate, and a major subject of research for the Washington Federal Opportunities Workgroup.

Supplement E: Medicaid Transportation in Other States

The following is a summary of the status of coordination between public transportation and Medicaid transportation in other states. The examples from other states are primarily derived from (Agency Council on Coordinated Transportation, 2011) supplemented by interviews with key Washington stakeholders (Chartock, Rural and Coordinated Transportation Administrator, Public Transportation Division of WSDOT, 2013), (Carlson, 2013). They illustrate different models for a holistic approach to -managing NEMT services. However, the interview subjects reported increasing challenges working with state-level people with Medicaid in Washington, and the outlook for success has diminished significantly since these examples were documented in 2010.

Washington Example

Funding Option

The state has opted to fund NEMT transportation statewide using the Deficit Reduction Act option.

Cost Allocation

For NEMT trips, brokers pay transportation provider's based on a pre-negotiated rate, which may include mileage, time, a flat fee, or other factors. The costs are allocated equitably to the clients' specific medical program account codes. There are currently over 90 program account codes that are used to allocate costs for NEMT trips.

When arranging for shared trips, each funder is invoiced for their rider's portion of the trip. These trip costs may include reduced shared ride rates that transportation providers include in their negotiated rates.

Coordination – Brokerages Operated by Non-Profit Organizations (12 of 13 regions) or Brokerage Operated by Council of Government (1 region)

By design, the Washington State transportation brokerage system is a mechanism to share trips among various funders. They arrange for the lowest cost, most appropriate method of transportation, which can include public transit bus passes, gas vouchers, client and volunteer mileage reimbursement, taxi, cabulance, ferry, commercial bus, and air.

Since 1989, Washington's NEMT services have been managed by transportation brokers for the state's 13 transportation service regions. Washington's Department of Social and Health Services contracts with the transportation brokers, which are selected through a competitive procurement process.

In addition to brokering NEMT trips for Medicaid eligible clients, NEMT brokers also can and do contract with other programs to arrange for transportation, such as seniors, veterans, students, and employment transportation. When appropriate, these trips can be shared and costs allocated by trip, miles, service hours and/or a combination of all methods.

NEMT brokers or their providers who arrange trips for multiple programs typically assign grouped or shared ride trips only if the assigned group or shared ride trip is more cost effective to the funding source than it would be in comparison to providing separate individual trips, or when it is not possible to provide separate trips.

We interviewed the Director and another management level staff member at People for People – a non-profit organization that operates one of Washington's regional brokerages out of Yakima. As a model for a holistic approach to brokering, People for People stands out for a number of reasons:

- Their brokerage is operated out of the regional 2-1-1 call center to fully integrate coordination of these two important services.
- A number of years ago, they developed software for brokering Medicaid NEMT because nothing else that was available met eligibility requirements. Since developing the software, they have continued to refine and improve it, and have also shared it with others around the state.
- In addition to operating the brokerage, for the last 12 years the organization has provided facilitation and leadership for a consortium of human services providers created to plan and implement regional coordination. They have been successful at getting agencies to consolidate rides and coordinate scheduling (times and days) of appointments and other activities. The consortium includes the office on aging, tribal transit, the vocational rehab department, hospitals, sheltered workshops, Head Start, school districts, and public transportation providers.
  Most of People for People's funding is from state and federal transportation dollars and the contract for operating the brokerage is a key part of their funding structure.

Recent Updates from the Council Administrator

Don Chartock | ACCT Administrator; Rural and Coordinated Transportation Administrator | Washington State Department of Transportation | 360-705-7928 | chartod@wsdot.wa.gov

The state of Washington has been particularly successful at achieving well-coordinated, cost-efficient NEMT services, but in spite of this success they report increasing service reductions and unmet needs due to changes in Medicaid policies. In an interview, the Intercity and Rural Specialist at the Washington DOT Agency Council on Coordinated Transportation stated that dropping reimbursement rates combined with increased paperwork due to greatly increased federal oversight requirements are resulting in significant service cuts by both non-profit and government operated NEMT providers. These impacts are particularly acute in rural area but are starting to affect suburban areas as well. Increasingly, instead of providing door to door service to medical facilities, the NEMT providers are transferring riders to fixed routes. While fixed routes offer much higher cost efficiency and should be used as the preferred alternative whenever possible, when fixed routes become the only alternative, a significant percentage of riders who are unable to use fixed route buses are left with no transportation options.

In the two years since the FOW Final Report was published in February 2011, the federal Centers for Medicare and Medicaid Services (CMS) have been reluctant to provide written direction and backing, leaving state Medicaid officials unwilling to participate with the ACCT. As a result, the

three proposed pilot projects have not been initiated. ACCT is now working through their Congressional delegation to try to get policy clarification and collaboration from CMS.

Chartock reported that the increasing difficulty of working with Medicaid is also impacting the states and regions that were presented as positive examples in the 2011 FOW report. Even in 2010 when the report was being developed, most regions around the country that were successfully sharing rides and allocating costs were generally unwilling to discuss the details of their models out of concern that these details would raise concerns with Medicaid officials, resulting in Medicaid pulling out of their coordinated NEMT systems. As a result, it was difficult to gather even the summary information included in the FOW report. Since then Oregon, Florida and Pennsylvania – all of which are featured examples in the report – have been pulling back on their ride sharing and cost allocation approaches.

In the meantime, ACCT has been focusing on researching and quantifying the problem with riders who qualify for both Medicaid and ADA paratransit service, where the farebox rate is limited to no more than twice that on fixed route public transportation.

Perspective from a Non-Profit Broker

Madelyn Carlson | Chief Executive Officer | People for People | Central Washington |
(509) 248-6726 | mcarlson@pfp.org | http://www.pfp.org/pfp/pfp/AboutUs.aspx

People for People is a non-profit 501(c)3 organization committed to serving people in Washington State since 1965. The organization provides transportation services for the general public and special needs population, employment and training services, and 2-1-1 Information Referral Services. They also broker Medicaid and transportation services.”

Brokerage

Medicaid has been changing in Washington. As a broker, monitoring responsibilities have become a “nightmare” with extensive scrutiny required. As part of brokering she purchases tokens/passes on public transportation for Medicaid clients. The brokerage is operated through the 211 call center.

Coordination

For 12 years People for People provides facilitation and leadership for regional coordination for a consortium of human services providers. They have been successful at getting agencies to consolidate rides and coordinate scheduling (times and days) of appointments and other activities. They have been able to get stakeholders to coordinate without having to extensive number crunching by conducting a fairly simple analysis showing that they would get more passengers on fewer trips. However, they serve very rural areas with long trips, so the benefits are fairly obvious because of the significant mileage involved. Carlson feels that as resources have become more limited over the 12 years, motivation for coordination has increased. The consortium of providers includes: office on aging, tribal transit, vocational rehab dept., hospitals, sheltered workshops, head start, school districts, and public transportation providers.

Medicaid Compensation

In the areas where People for People provides transportation they are able to bill Medicaid for the full cost of the trips they provide because they are a non-profit. Carlson recently participated in the Federal Opportunities Working Group. Unfortunately, because of challenges described by (Chartock, Rural and Coordinated Transportation Administrator, Public Transportation Division of WSDOT, 2013) she reported that public providers are now restricted from charging Medicaid more than their customary rates (i.e. farebox) because of new state policy.

Oregon Example

The state Medicaid NEMT transportation program in Oregon is administered by the Department of Medical Assistance Program, within the Department of Human Services (DHS). The state has opted to fund NEMT transportation statewide as a medical service with a 1915 (b) waiver. Through intergovernmental agreements, eight transportation brokers arrange for NEMT statewide. Five of the brokers are public transit agencies and three are council of governments.

Funding Option

The state has opted to fund NEMT transportation statewide as a medical service with a 1915 (b) waiver.

Cost Allocation

DHS negotiates a single average cost per trip with each broker, which includes both direct services and administrative and overhead costs. Brokers reimburse the provider for the actual cost of providing the trip, which may be more or less than the negotiated rate. At the end of the year, the accounts are reconciled.

Coordination – Local Transit Agency

In Lane County, Lane Transit is both the ADA service provider and the Medicaid NEMT broker. All customers call the same number into the same call center to arrange for their ADA and/or NEMT trip. The coordinated transportation center, known as RideSource, integrates ADA and Medicaid trips. In 2009, they developed a cost-sharing methodology to distribute direct service and administrative/overhead costs to the sponsoring agencies. The approach has recently been approved by Oregon DHS.

http://www.ltd.org/search/showresult.html?versionthread=a2ee93a82001a789610a752bb8a82282

Florida Example

Funding Option

The state has opted to fund NEMT transportation statewide as a medical service with a 1915 (b) waiver.

Cost Allocation

The state Medicaid NEMT transportation program in Florida is administered by the Transportation Disadvantaged Commission (TD) per an interagency MOU between the TD commission and the agency responsible for Medicaid NEMT services.

The TD commission's statewide cost allocation method/model is based on grant accounting principles used in the TD Program. The method is built upon three years of both historical and projected budget data, and provides fully allocated rates with local ability to adjust rates in mid-period.

Coordination – Local Transit Agency

In Orlando and three surrounding counties, Lynx transit agency is the region's Community Transportation Coordinator and retains a contractor to operate its coordinated paratransit services. In this system, Medicaid NEMT trips are shared with ADA trips, as well as other agency-funded trips. The rates charged to Medicaid and the other funding agencies are based on the TD's statewide cost allocation and rate methodology.

North Carolina Example

Funding Option

The state has opted to fund NEMT transportation in some regions as an administrative service, and in some regions as a medical service with a 1915 (b) waiver.

Cost Allocation

The statewide cost allocation method/model is based on grant accounting principles used for the CTPs, and is built upon historical data (from an analysis of service) and projected budget data. This end product is a fully allocated per trip rate for demand responsive service, noting that the locals have the ability to adjust the rate based on subsidy considerations.

Coordination – Local Transit Agency

In North Carolina, the local county-based Medicaid offices are directed to utilize the predominantly county-based Community Transportation Program (CTP) for NEMT needs, per Executive Order and interagency MOU.

The Winston Salem Transit Authority (WSTA) provides countywide fixed route and paratransit service in a large urbanized area (Forsyth County, NC – 330,000 pop; 410 sq. mi). The paratransit service includes ADA paratransit, Medicaid NEMT, and senior transportation funded by Title III-B.

The paratransit service is operated by WSTA, augmented by overflow taxi vendors. The paratransit service is completely integrated: ADA paratransit, Medicaid trips and senior trips are shared when it is lowest cost and most appropriate. Client eligibility is determined by Forsythe County Department of Social Services (DSS), which is electronically submitted to WSTA. Rates are annually negotiated between the City (Winston-Salem) and Forsythe County DSS. Per trip rates are based on fully allocated cost of paratransit service, using the statewide model.

Pennsylvania Example

Funding Option

The state has opted to fund its NEMT transportation as an administrative service.

Cost Allocation

For all but three high volume programs, agency sponsors are charged the zone-to-zone fare, which is based on fully-allocated historic costs of the brokerage as a whole. In the case of three high volume sponsors (including Medicaid), a statistically relevant number of trips are selected and costed out. This process considers the degree to which trip is or isn't shared, the time in which those trips are shared, and the carriers' hourly rate. These costs are then averaged to calculate an average cost per trip for each of the three sponsoring agencies. This cost, plus their share of the fixed administrative cost, becomes the rate for the ensuing 6 months, when the process is repeated.

Coordination – Private broker sponsored by public transportation provider

ACCESS is sponsored by Port Authority of Allegheny County and is operated by ACCESS Transportation Systems, Inc., a subsidiary of Veolia Transportation:
http://www.veoliatransportation.com/index

Pittsburg ACCESS is a brokerage that manages Americans with Disabilities Act (ADA) paratransit service and a senior shared-ride program, on behalf of the Port Authority of Allegheny County (the local transit provider). ACCESS has entered into sponsorship agreements with over 120 different human service agencies, including the State's Medical Assistance Transportation Program – the NEMT service.

ACCESS Transportation Systems and Port Authority of Allegheny County, Pennsylvania receive a 2005 United We Ride Leadership Award featured on the United We Ride website:
http://www.unitedweride.gov/1_865_ENG_HTML.htm

California Examples

Some brokerages do not broker Medicaid rides at all. Two examples are Wheels, which is the public transportation system in the Livermore Amador Valley and brokers ADA services to private operators; and FACT, which operates in San Diego and brokers Above and Beyond senior services.