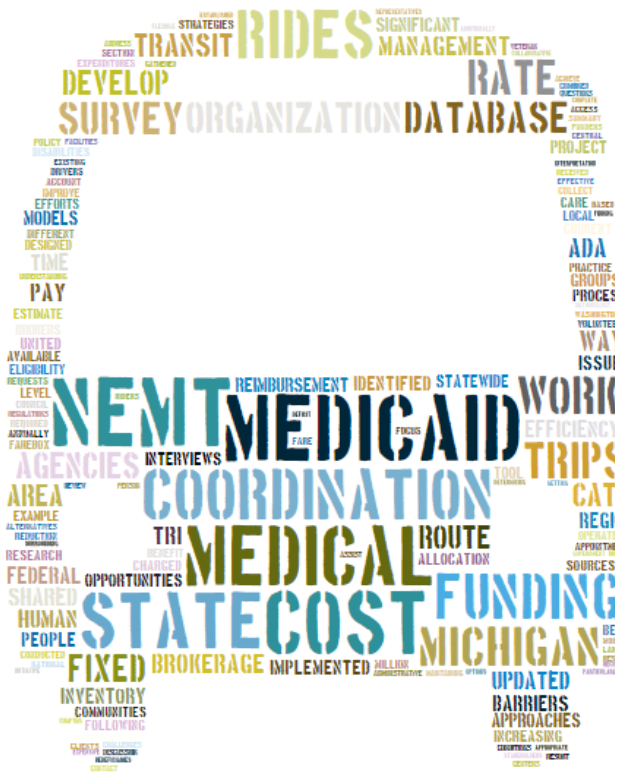
Michigan Livable Communities Demonstration Project

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



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Making Neighborhoods Great Together

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MDOT Michigan Department of Transportation

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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.

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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

1 Project Overview

The Michigan Sense of Place Council, representing numerous state agencies under the direction of Governor Snyder, engaged in a partnership with Smart Growth America to provide technical advisory services to six communities of Michigan pursuing livable communities initiatives. The communities are the City of Marquette, the Southeast Michigan Council of Governments (SEMCOG), ReImagine Washtenaw (Washtenaw County), the Tri-County Regional Planning Commission (TCRPC), the City of Grand Rapids, and the Northwest Michigan Council of Governments (NWMCOG). As part of the Federal Partnership for Sustainable Communities program, the program seeks to coordinate federal funding directed to housing, transportation, and other infrastructure in communities to create more livable places where people can access jobs while reducing pollution and also saving time and money. The assistance provided by Smart Growth America was in two primary areas – community mobility management and strategic transportation demand management (TDM).

Stakeholders in the Tri-County area asked the project team to identify barriers and solutions for improving non-emergency medical transportation (NEMT) in the region. Specifically, they directed the team to focus on research and outreach to develop a better understanding of the most significant federal NEMT funding sources for services being provided in the Lansing Tri-County region. Medicaid is by far the largest and most complex of these funding sources and has been the primary focus of this project. Because of its growing complexity, Medicaid-funded NEMT is also of increasing interest to stakeholders throughout the state and the nation.

To fully explore NEMT challenges and opportunities, the project team researched and conducted outreach to people in the Tri-County region, at the state level and in other states. The team:

- Reviewed a wide range of published information about Medicaid funding for transportation.
- Researched the availability of statewide and region-wide data about the amounts, recipients and uses of this funding in the Tri-County area.
- Interviewed and surveyed human services agencies in the region that are using this funding to provide transportation.
- Interviewed a variety of federal and state agency officials to develop an understanding of how this funding is managed in the region.
- Conducted data analysis to quantify the impact of NEMT
- Researched models from other states

Based on this work, the following chapters present a summary of the key challenges surrounding Medicaid-funded NEMT; tools and techniques that can help address those challenges; local practices in the Tri-County region; strategies and alternatives that were considered for the region; and a recommended implementation plan that could improve availability, efficiency, and cost allocation for NEMT.

2 NEMT Overview and Challenges

Non-emergency medical transportation (NEMT) is a critical link to providing people with quality healthcare. By enabling patients who cannot drive or do not have access to a car to get to appointments, NEMT removes one of the biggest barriers to preventative care, which in turn leads to significant benefits for people's lives and savings in medical care. In the Tri-County region, for example, the project team estimates that every $1 spent on NEMT leads to more than $6 in savings in more effective preventative medical care and extended quality life.[1]

Despite these benefits, regions across the country are facing significant and growing challenges to providing NEMT. The costs associated with NEMT are large and will likely increase substantially over time, and the funding and regulation structures for NEMT are complex and can be difficult for both NEMT providers, human service agencies and clients to navigate.

While many programs fund NEMT at the federal, state and local level, Medicaid-funded NEMT is an increasing focus and concern shared by stakeholders throughout the state of Michigan and the country because Medicaid is by far the largest NEMT funder, and Medicaid policies are increasingly presenting the most complex and difficult challenges facing NEMT coordination efforts.

The following sections provide an overview of three key barriers regions face in providing NEMT:

1. Users find the current NEMT system daunting and inefficient;
2. The demand for NEMT is growing, but the costs of providing the services are high and will likely continue to grow; and
3. Public transit providers are well-positioned to provide high quality NEMT service, but struggle to do so at the rate they are being reimbursed by Medicaid.[2]

A daunting and inefficient system for users

For human service agencies and individual clients the NEMT system is confusing and difficult to use. Arranging NEMT rides is complex and time-consuming, and, as a result, many clients miss appointments. To address these challenges, some human service agencies are providing transportation themselves, but this is often less cost-effective than other options for providing the service.

Individuals or social workers looking for transportation options and organizations offering rides can get lost in the complicated network of federal transportation funding sources and rules. In 2004, the Congressional Office of Management and Budget identified 62 federal programs that

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[1] See Supplement A for calculations and methodology.
[2] Private operators struggle with reimbursement rates in the range of 90% of their costs, but this report focuses on the larger issue of 10% reimbursement when paying only farebox for public demand response.

have transportation funding programs for the human service portion of community transportation. The spaghetti diagram in Figure 2-1 shows these programs. Layered onto the federal funding sources are the state and local governments, the transportation providers, and the supporting social services. Agencies, services, and needs most directly related to NEMT are indicated by the shaded shapes. Supplement B lists the federal programs not part of the Federal Transit Administration (FTA).

Providing a coordinated, efficient NEMT system requires expertise in navigating through this network of often overlapping programs and applying this understanding to the web of community partners and needs. In communities with poor coordination and a lack of expertise and staffing resources to tackle this challenge, the result is typically low funding levels and missed opportunities, with duplicated transportation services in some areas and no service and limited hours in other areas.

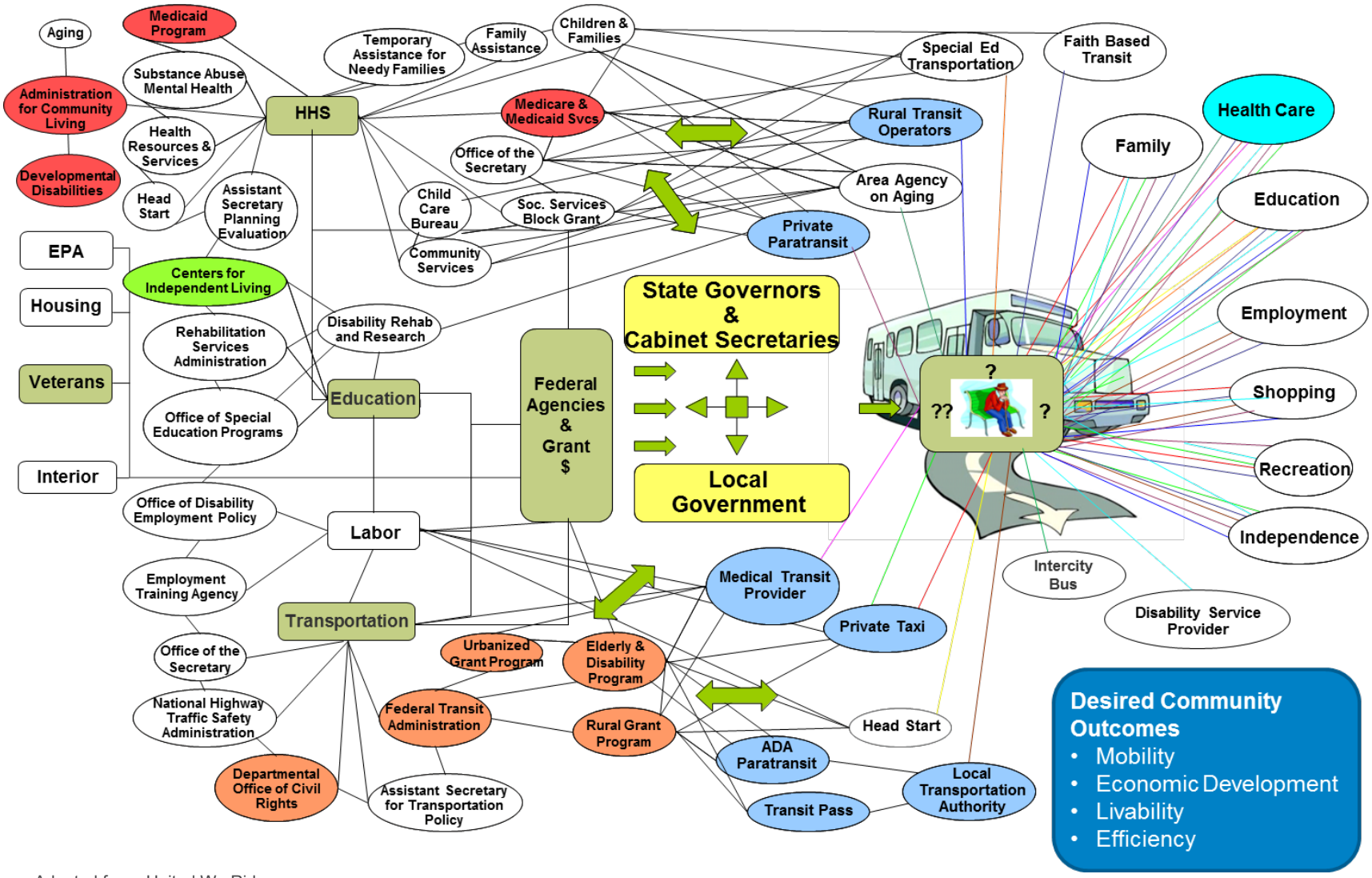
Medicaid funds a significant portion of NEMT rides, and in Lansing and the rest of the nation Medicaid is presenting the most complex and most difficult coordination challenges facing transportation planners, including:

- Coordinating between the federal, state, and local levels, as well as across providers and funders, is consistently difficult;
- Policy at the federal and state level can be unclear; and
- All parties lack information sharing and transparency, partly out of concern that sharing information about the use of NEMT funds may raise auditing questions and an even higher level of scrutiny by Medicaid officials.

Increasing needs and significant costs

There are significant needs for NEMT services and demand is increasing due to the nation's aging population. Data and anecdotal information collected from the Tri-County 2-1-1 call center, Clinton County's volunteer driver program, and interviews all indicates a high level of demand in the Tri-County region, including unmet needs for improved and expanded NEMT services as documented in Supplement C.

Providing services to meet this growing need is both costly and complex. Providers of NEMT include a wide range of non-profit and public human service agencies, public transportation providers, and private sector providers ranging from taxi companies to specialized NEMT providers and ambulance operators. Medicaid is required by federal law to provide transportation through the lowest cost feasible option, and to pay what is usual and customary for the service. Table 2-1 illustrates the relative costs typically associated with various non-emergency and emergency medical transportation options, differentiating between the costs that Medicaid covers and the total cost to the provider.



Adapted from: United We Ride

Figure 2-1: Project focus for Lansing Tri-County region – NEMT.

Table 2-1: Relative costs of non-emergency and emergency medical transportation

Relative Cost	Medical transportation option	Costs to Medicaid	Total Cost for Provider
$	• Fixed-route transit service	Farebox - $1.25 per ride for CATA general public Zone 1	$2.37 per ride for average CATA trip
$$	• Mileage vouchers for friends or family • Organized volunteer transportation	$0.33 per mile	$0.608 per mile[3] plus $12-$24 per hour for driver time[4] Volunteer programs have additional administrative costs.
	• Ambulatory paratransit by non-profit organizations • Public paratransit	Farebox[5] - $2.50 per ride for CATA general public Zone 1	$24 per ride for CATA paratransit[6]
	• Ambulatory paratransit by private NEMT company or taxi	$56[7] Florida reimbursement rate	$18-$19[5]
$$$	• Wheelchair paratransit	Farebox[3] - $2.50 for CATA general public Zone 1 $56[5] for private operators	$24 per ride for CATA paratransit[4] $27-$28 for private NEMT[5]
$$$$	• Non-emergency stretcher paratransit	$56[5]	$105[5]
$$$$$	• Emergency ambulance rides	Not analyzed	~$500-$1,000
	• Emergency air transportation	Not analyzed	~$7,500-$8,000

When available and feasible, fixed route transit is usually the lowest cost option, but many clients, such as those with disabilities and those living in low-density areas, require paratransit service[8] because they cannot use or do not have access to fixed-route service. Paratransit service has relatively high costs per trip because rides are typically provided on a per-client basis, making it difficult to achieve any economies of scale in vehicle operation costs as demand for rides increases. This problem is compounded when development patterns require paratransit providers to travel large distances from individual clients' places of residence to

[3] AAA 2013 average cost for owning and operating a sedan driving 15,000 miles annually.
[4] From USDOT 2011 *Guidance on Value of Travel Time in Economic Analysis*: USDOT recommends using 50% of hourly earning rates for personal trips, and 100% for business trips. 2009 recommended hourly earning rate was $23.90.
[5] Public operators and non-profits can negotiate higher reimbursement but no Tri-County providers do this.
[6] CATA does not differentiate cost per ride between wheelchair paratransit and ambulatory paratransit.
[7] Reported 2009 costs for Florida private NEMT operators at wellness09.ctaa.org http://www.youtube.com/watch?v=KKDkzZUEkoo
[8] Demand response, door-to-door, curb-to-curb, dial-a-ride, and specialized transportation are terms used for paratransit service offered by public transportation agencies.

medical facilities. Sharing rides across multiple clients can help reduce costs but can be complicated when clients' rides are covered by different funding sources.

NEMT costs in the Tri-County area: fixed-route vs. paratransit

In a medium- or high-density area, fixed route transit is the cheapest mode, with no significant increase in cost due to increased ridership. For example, in 2011 a fixed route ride on Capital Area Transit Authority (CATA) cost $2.37 (Florida International University, 2013). By comparison, paratransit costs are significantly higher per ride ($24 for CATA), with no economy of scale. While fixed route is capable of taking on more demand (ridership) independent of amount of service, the amount of paratransit miles and hours must increase at approximately the same rate as the number of rides.

The ability for fixed route to carry more rides without increased resources is shown in Figure 2 3. This chart shows that the increase in CATA fixed route ridership since 1995 (221%) is more than twice as high as the increase in the amount of service (91%). By comparison, the increase in ridership on the demand response service (71%) is exactly the same as the increase in the amount of service.

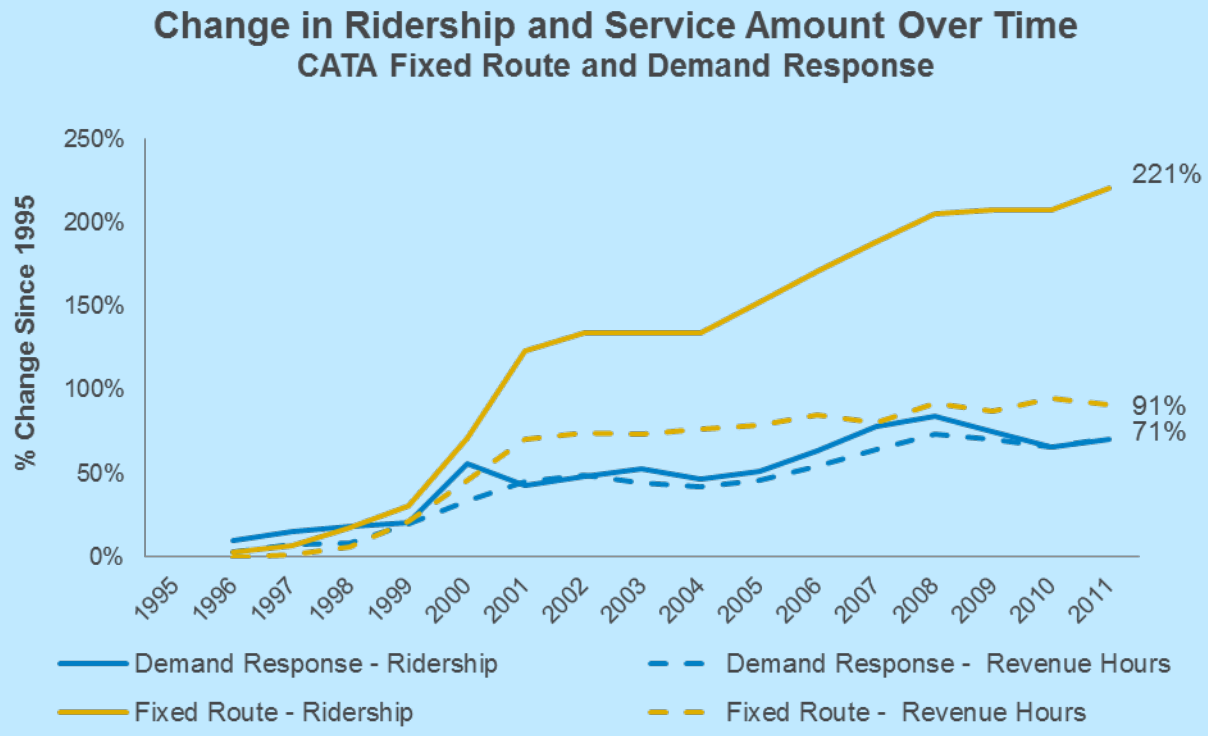


Figure 2-2: CATA demand response trips are increasing over time but not as much as fixed-route.

Without a plan to manage growing transportation costs, NEMT resources will become increasingly strained, posing a significant threat to Medicaid, the organizations who provide NEMT, and the people who need the services. But restricting access to transportation is not the

solution to managing system-wide costs. The cost of providing NEMT transportation, though large, is far less than the cost of medical problems that go untreated because clients lack transportation options to access medical services.

Within the Tri-County area, the team estimated an annual system-wide savings of $37 million from the NEMT trips provided on paratransit through the region's three public transportation systems (Table 2-2). 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 worth $6.11. (See Supplement A for calculations and methodology)

Table 2-2: Estimated Benefits and Costs for NEMT in Tri-County Region

Public paratransit	Benefit-to-cost ratio	6.11 to 1
	Annual benefits from better medical care	Ingham County - $27 million Tri-County - $44.2 million
	Annual NEMT public paratransit costs	Ingham County - $1.5 million Tri-County - $2.5 million
	Induced medical costs from better access to care (annually)	Ingham County - $2.8 million Tri-County - $4.8 million
	Overall annual savings	$37 million

Transportation providers cannot afford to provide Medicaid transportation without higher reimbursement

With a combination of expertise, vehicles, infrastructure, and systems in place, public transportation providers are often best positioned to provide cost effective service to meet NEMT needs. However, the Americans with Disabilities Act (ADA) and the current execution of Medicaid policies in the Tri-County area limit the compensation public transit providers in the region receive for providing NEMT service to the farebox rate for the rides, a small fraction of the actual cost of providing NEMT paratransit. For example, CATA's paratransit service costs $24 per ride on average and farebox covers approximately 10% of that amount.

The discrepancy between the farebox rate and full cost of providing rides is due to the nature of public transportation and ADA regulations. Any public transportation agency that provides fixed route service is required by the ADA to also offer paratransit service for people whose disability prevents them from accessing fixed route service. Required within 3/4 mile of all bus stops, ADA restricts fares to no more than twice the regular fixed route fare.[9] Beyond what is required by the ADA, many public transportation agencies, including all three Tri-County agencies, also provide

[9] 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.

demand response service[10] that is open to the general public as a method of offering public transportation in low-density areas or during hours with low demand.

The result in many cases is that transit providers receive Medicaid reimbursement that is equivalent to the fare charged, but significantly lower than the actual cost of providing the paratransit ride. Federal Medicaid policy includes an allowance for public transit agencies like CATA, Eatran, and Clinton Transit to negotiate a higher reimbursement rate than farebox for public paratransit (see Supplement C for the specific language). Many savvy transit agencies do so, but most including those in the Tri-County area do not. Some previously successful agencies in other parts of the country have recently faced more difficulties negotiating higher reimbursement as state Medicaid budgets tighten and officials turn to tactics such as for-profit brokerages with contractual incentives to minimize payment for service.

Receiving such a low rate of reimbursement puts a strain on public transportation providers' budgets that threatens their ability to continue to provide quality Medicaid NEMT, and they may also be forced to make up the difference by cutting back other service. Tools for reducing ADA paratransit costs are limited since a transit agency must meet or exceed the regulations, so the federal, state, and local public transportation resources that go to Medicaid NEMT tend to be cut from fixed route and rural demand response services that are designed to meet the needs of the general public, but can also provide a cost-effective means of meeting the needs of Medicaid patients when structured to do so.

At the same time Medicaid pays farebox for many public paratransit rides ($2.50 for CATA) Medicaid is paying a negotiated rate closer to the cost of providing the ride ($24 for example) for equivalent service via private taxi companies or other NEMT paratransit services, yet reimbursement rates are still lower than costs. The financial situation is not as severe for the private carriers as for the public operators, but the situation leaves them to report that they too are not reimbursed adequately to cover costs. In order to stay a viable business they are left with few choices. They can make money from other parts of their business, say for emergency transport, and use profits to cover losses on other aspects. They can cut costs, possibly by spending less money on safety and quality of service factors. Within NEMT they can choose to take the trips that make money – those that are for ambulatory patients with little deadhead time – leaving the more time consuming, expensive trips for people in wheelchairs and into low density areas for public operators. Or they can cut the service and get out of the business. Whichever, as a result of low reimbursement rates, riders are set to lose. They will lose service or they will get poor quality service.

[10] This report uses the term "demand response" to differentiate general public paratransit from ADA required paratransit.

Quantified Impact in the Tri-County Region

Under the current way of doing business, 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[11]. 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 E-Tran and Clinton Transit, but we assume the situation is much the same as CATA.

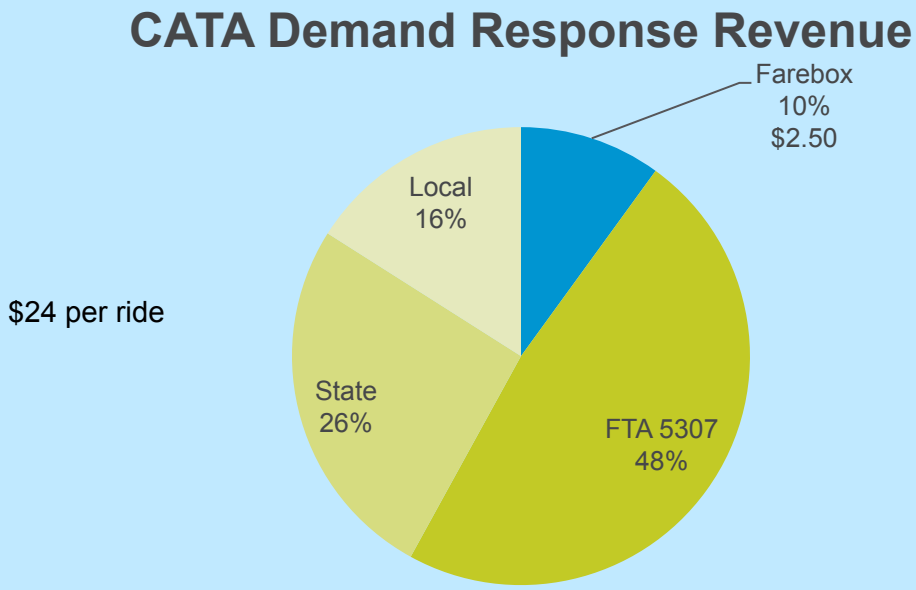


Figure 2-3: Demand response transportation is expensive and farebox only covers 10% of costs

[11] Calculated using NTD 2011 fixed route cost per hour of $112.81, 52 weeks per year, no holidays.

3 State of the Practice in NEMT

Some efforts nationally and in Michigan have been made to address the challenges identified in Chapter 2. In fact, throughout the nation, coordination of and payment for non-emergency medical transportation (NEMT) occurs in a variety of ways and is a central focus of collaborative efforts between transportation providers (public, private, and human service) and the organizations whose stakeholders need transportation. However, while organizations within Michigan and elsewhere offer some successful models for coordinating NEMT, equitable sharing of funds to pay for NEMT services remains a primary point of disagreement between human health and public transit providers.

This chapter provides an overview of the key approaches other states and regions have taken to providing and paying for NEMT and improving access and information for the clients that depend on it. The chapter begins with an overview of **mobility management,** a leading practice in planning and implementing effective coordination for NEMT and other transportation services. The remainder of the chapter outlines specific tools and techniques organized around two key approaches to improving NEMT:

1. Tools for long-term planning and region-wide coordination, and
2. Techniques that make it easier for NEMT clients' ability to find rides on a day-to-day basis.

Leading practices: Mobility Management

Mobility management is a framework for optimizing the value of transportation services through increasing access and reducing complexity. Communities and regions often turn to mobility management to improve coordination of public transportation and human service transportation on a broad scale, but the approach can be equally effective in addressing the specific challenges associated with NEMT by reducing complexity for both clients and providers and improving coordination across providers and between providers, users and NEMT funders.

To effectively maximize NEMT options and service coverage while also being efficient and cost-effective, a mobility management system must successfully serve two key functions:

1) A mobility manager must **plan and coordinate region-wide and long term**, by building working partnerships, coalitions and business relationships between multiple transportation service providers, social service providers and other stakeholders.

2) On the short term, **day-to-day level** of serving individual riders and maximizing ridership, they must be effective at creating and managing systems and communication strategies that **help people find rides** and get where they need to go. Mobility management should be focused on both customer needs and cost efficiency so that find-a-ride services are unbiased in pairing customers with the most cost-effective transportation service that fully meets their needs. Based on these two criteria, the most

appropriate ride for a given client may be with public transit, a human service agency, or a private operator.

Combining these two responsibilities, fundamental practices include:

- Ongoing coordination and relationship building between the mobility manager or entity and other stakeholders to achieve positive outcomes.
- Providing access to information for users
- Increasing the role of technology in providing information access
- Coordination at multiple levels including local, state and federal
- Coordination between the worlds of transportation and social services
- Coordination of marketing strategies
- Integration of mobility management efforts into local and regional planning efforts
- Assistance with managing financial and other resource allocations.

Mobility management functions can be assigned to existing staff, or a new position can be completed. In this project we loosely use the term “mobility manager” to apply to anyone carrying out some or all of the mobility management functions, regardless of job title. Mobility management can fall short for one or both of the following two reasons:

1. Qualified staff is hired but have so many responsibilities for operating the local transit system that they have no time for mobility management tasks such as pursuing new funding sources, or building and coordinating coalitions and partnerships.
2. Low salary and low expectations for professional skills result in hiring unqualified personnel.

A quality that communities pursuing effective mobility management efforts all share is that the lead governmental and non-profit agencies have organizational cultures that value cooperation and collaboration and are willing to invest in coordination because they have a shared vision as well as a practical understanding of the benefits that can be achieved.

Tools and Techniques

Within the broad mobility management framework, regions can use a variety of specific and effective tools to fund, coordinate, and improve access to NEMT. As discussed above, these tools fall under two broad categories: long-term planning and coordination, and tactical tools for helping clients find rides day-to-day.

Long-term planning and coordination

Addressing the challenges associated with NEMT requires planning and coordinating region-wide and long-term by building working partnerships between multiple service providers, human service agencies, NEMT funders, clients and other stakeholders. The following table summarizes key techniques.

Table 3-1: Key Tools and approaches for long-term planning and coordination

Approach	Tools and Techniques
Coordination and a collaborative, system-wide approach	• Human Service Coordination Plan- MDOT requires this to access funding from the FTA Senior and Disabled grant program but recommends it for all recipients. Following the MDOT outline, the plan paves the way to coordination between transportation and human service providers while assessing community needs • Develop and update a transportation inventory and assess resources • Integration of mobility management efforts into community development and other types of planning • Facilitate ways for different transportation providers to interact
Identify unmet needs	• Identify and record unmet transportation needs.
Funding Knowledge & Partnership Development	• Develop an in-depth understanding of all relevant funding issues and regulations, and use this knowledge to work with all possible partners to develop creative funding agreements for providing and expanding service.
Other planning	• Help human service agencies build transportation programs to meet needs that cannot be met through public transportation services. Alternative programs may include agency-provided transportation, mileage voucher, gas reimbursement, faith-based transportation, carpool programs, and volunteer driver programs.
Cost allocation and billing	• Develop agreements with social service agencies to fund rides on public transportation. • Track ridership, miles, hours, passenger-miles, costs, revenues • Invoice agencies based on fair share of transportation costs.
Transit system performance	• Track data and assess performance measures. • Collect and process data from an automated vehicle location (AVL) and automated passenger counts (APC) • Use data to allocate costs, help optimize system design, improve customer service, and measure effectiveness.
Marketing	• Coordinated marketing appearance visually linking services • Referencing other service types on websites • Increasing the quality of customer service

Tools for helping clients find rides day-to-day

As described in the previous chapter, the complexity associated with arranging NEMT rides can pose major obstacles for clients traveling to appointments. Local NEMT systems often fall short because the public has a low level of awareness of the services that are available, both fixed route and paratransit. Overcoming these barriers requires creating and managing systems and communication strategies that help clients find rides and get where they need to go.

Table 3-2: Key Tools and approaches for helping clients find rides

Function	Description
Finding available services	• Help for people to find services through printed and electronic transportation guides, 2-1-1 and other one call-one click services, Google Maps and other trip planners, clear and up-to-date maps, and web sites designed to meet the specific needs of a transit rider • Share data that describes services, such as the General Transit Feed Specification (GTFS), for third party applications
Resource directory	• Coordinate with social service agencies to maintain an accurate web-based service directory, designed for easy use by the target riders as well as anyone who will be providing assistance to that target population.
Trip Planning	• Arrange transportation for a customer or a service agency on behalf of its clients. • Take requests for assistance by phone, email, or Internet request. • Transportation may be provided by the public transportation systems, senior transportation programs, volunteer drivers, agency vehicles, gas vouchers, veteran services vans, for hire cars, private intercity shuttles, or taxis. • Transfers between providers may be necessary. • A web-based trip planner supports this function.
Person-centered transportation plans	• Develop individual transportation plans to meet the ongoing needs of the customer.
Travel training	• Work with social service agencies to provide travel training to their clients. This includes in-class training and training transportation ambassadors.
Broker rides	• A ride brokering service books a ride and arranges for payment on any available vehicle when someone calls to request a ride..
Client eligibility (facilitate for mixed region)	• Assist people with establishing eligibility to use paratransit services as required by the Americans with Disabilities Act (ADA).

Cost allocation for NEMT

As discussed in the previous chapter, providing NEMT has significant associated costs, and the question of how these costs are covered (and by whom) is a major topic of discussion nationally and in regions across the country. Cost allocation is a methodology that allows for a fair payment of costs when a service is shared. In the case of NEMT, a cost allocation model is not only important for negotiations with partners such as Medicaid, it is also valuable for payment between public transportation providers, and with human service agencies and large employers.

Developing a cost allocation model requires a budget or statement of operating funds from the service provider, the miles of service, and hours of service for a year. The steps shown in blue in Figure 3-1 are standard practice within the transit industry. The step shown in purple depicts a more detailed allocation to determine fair payment for demand response trips with varying distances and number of passengers travelling between common points. More information about developing a cost allocation model is provided in Supplement D.

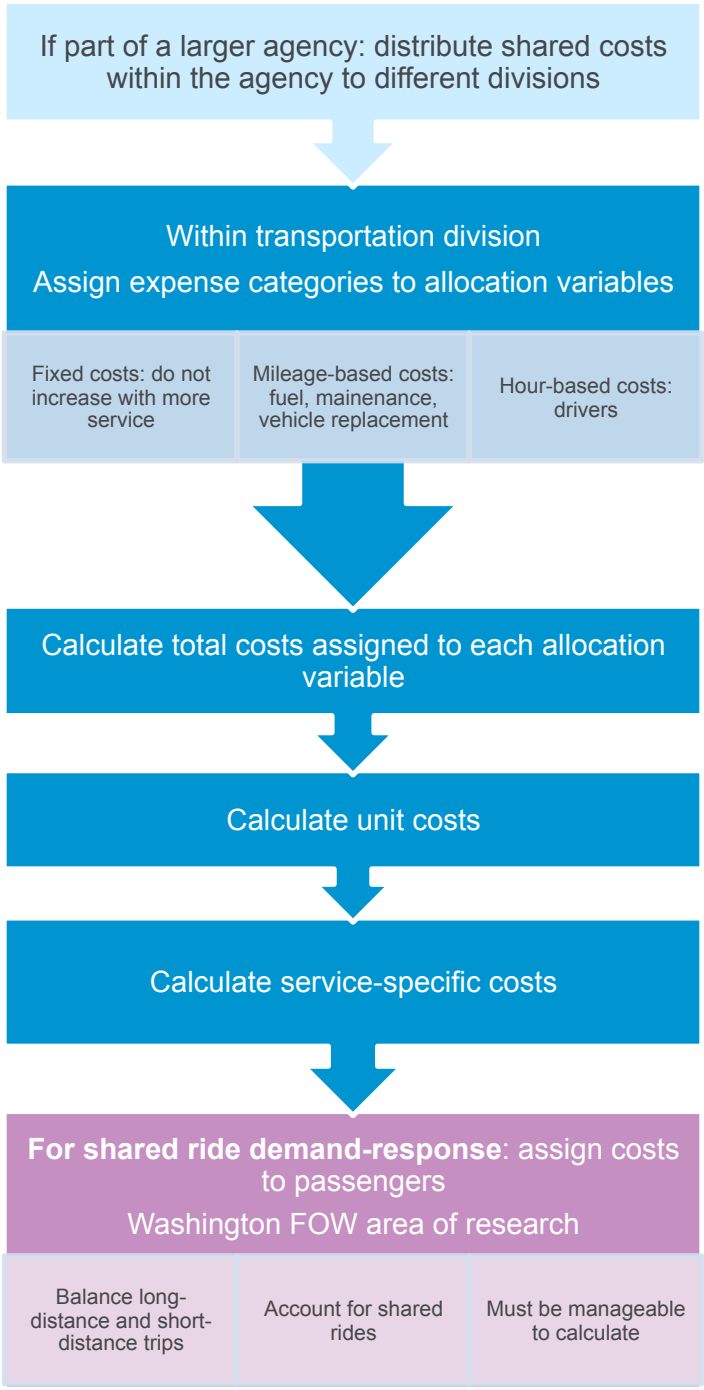


Figure 3-1: Cost allocation methodology for public transportation

Case Study – Washington State

Much of the information included in this report about efforts in other states is derived from a Washington State report (Agency Council on Coordinated Transportation, 2011), and from interviews with ACCT officials and other stakeholders who participated in the Federal

Opportunities Workgroup (FOW) (Chartock, Rural and Coordinated Transportation Administrator, Public Transportation Division of WSDOT, 2013), (Carlson, 2013). The ACCT FOW report is one of the few, relatively current, high quality published sources of information available.

The FOW group investigated a wide range of barriers and opportunities related to collaboratively providing transportation services for persons with special transportation needs.. All barriers and opportunities they identified as "high impact" fell under the category of cost sharing and reimbursements. In addition to regulatory barriers, the workgroup also identified a significant technology barrier in that the ability to allocate costs of shared trips on paratransit service was not a feature of any demand response management software available in 2010. Some existing technology has the capability to automate the cost allocation methodology for concurrent or overlapping riders sponsored by different funding sources, but does not have the capability to determine eligibility by funding source.
Washington State came close to a solution as DOT and state Medicaid representatives formulated cost allocation and coordination pilot projects (see Washington State Pilots discussion on page 6-6). Unfortunately, these projects were never implemented, in part due to a lack of clear guidance and participation by the Centers for Medicaid and Medicare Services (CMS) at the federal level.

Additional information from this report, experiences in other states, and our conversations with key stakeholders from Washington may be found in Supplement E.

Shared Ride Allocation

Establishing a system for shared trips on paratransit service has the potential to significantly reduce the costs associated with providing NEMT. However, cost allocation for shared trips is complicated to implement and has not been established in standard practice to date. 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 ride 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.

Brokerages and Other Organizational Structures

Many successful community or coordinated transportation systems serve rural, small urban, and major metropolitan regions around the country. These systems can be categorized into three generalized structures as shown in Table 3-3. Regions can choose different organizational structures for different elements of their mobility management efforts. For example, the provision of trips can be through a brokerage structure, while planning is through a lead agency structure.

Table 3-3: Coordination Structures

Structure	Elements
Lead Agency	In the lead agency model, one local organization is responsible for coordinating transportation services and activities within a defined geographic area. The lead agency may be a private or non-profit organization, social service or related agency, or public entity.
Brokerage	In the brokerage approach, one entity acts as an agent to arrange rides for persons needing transportation among a group of operators that "bid" to provide services. Both the broker and transportation provider receive fees for services, which are rolled into transportation charges per capita, per trip or some unit, and/or per mile. Such charges are paid by individuals or insurance companies directly or via health and social service funding.
Administrative Agency	In the last type, an administrative agency is a public agency or entity (often a transit authority) that has responsibility to coordinate social service or specialized transportation, in addition to its role in providing public transportation.

Throughout the nation, a central issue for NEMT coordination is whether and how to implement brokerages for NEMT services. Brokerage models nationwide fall under three broad categories:

- **Medicaid only brokerage –** A brokerage for Medicaid-funded rides can help minimize Medicaid NEMT costs. However, this approach raises costs for the NEMT transportation system as a whole and undermines mobility management efforts.
- **Non-Medicaid demand-response brokerage** - A brokerage that does not include Medicaid could be configured in a variety of ways and could broker different NEMT needs as well as other demand-response needs such as job access rides. There are models in California and another model is Ride Connection in Oregon.
- **"Holistic" brokerage combining Medicaid NEMT and other demand-response rides -** These brokerages seek efficiencies and fair cost allocation wherever possible, while at the same time staying customer-focused and putting a priority on finding the most appropriate ride for each customer whether it is with a public, private or human service agency transportation provider. Brokerage operators play an active and constructive role in mobility management, handling all types of NEMT and demand-response rides and working with all types of transportation providers. Supplement E summarizes models from five states that demonstrate there are many variations on this model and all of them have the potential to be highly effective.

The most successful coordination models we found from other states are all based on brokerages that take a holistic approach to demand-response services. These brokerages may be operated by public transit agencies, councils of governments, non-profit organizations, or private for-profit companies contracted by government agencies. What they all have in common is that they broker Medicaid NEMT rides as well as other NEMT rides (such as rides funded

through Title III of the Older Americans Act), in addition to a variety of non-NEMT ADA paratransit rides. Moreover, they often play a lead role in mobility management, actively working to achieve efficiency through coordinating and combining different types of rides whenever possible. In some cases they also broker and coordinate rides for job access programs in combination with NEMT and ADA rides. Finally, they have been leaders in developing cost allocation models that reimburse all transportation providers for the full cost of the rides they provide.

In spite of these successful models, public transportation agencies in Michigan and many other states are concerned by and in some cases opposed to the idea of implementing brokerages. This concern stems from the practices of many brokerages that are set up exclusively to broker Medicaid rides. These brokerages generally oppose full cost allocation for public demand-response NEMT services. Public transit services are concerned that significant numbers of Medicaid NEMT rides will be “dumped” on their ADA paratransit services, and because they will only be reimbursed at the farebox rate this will result in significant budget impacts that will force them to cut back fixed route service. Moreover, public transit providers and others are concerned that the narrow focus of these Medicaid brokerages tends to create barriers to coordination.

Case Study – Ride Connection

For the Tri-County Region, the model that we feel may be highly applicable is Ride Connection out of Portland, Oregon. Ride Connection is a non-profit that works with community partners to provide and coordinate transportation options primarily for older adults and people with disabilities. The key to Ride Connection success has been a customer focus, and high quality service. They also work as hard as possible to avoid acting in a silo.

Ride Connection started as a volunteer driving program more than 30 years ago as Tri Met, Portland’s public transportation service, was considering options for managing paratransit. It has now evolved into a quasi-brokerage that connects various human service transportation service providers together.

Among the Ride Connection services worth considering adopting to Tri-Counties is its brokerage system. Within the Oregon Medicaid brokerage system, Ride Connection brokers contracts with the Division of Medical Assistance Programs (DMAP) to provide NEMT to eligible Medicaid clients. Transportation providers are contracted through the brokerage. The brokerage has professional call takers trained specifically to perform the duties of the call center, including verifying eligibility, appointment eligibility, reviewing the client’s ride resources and authorizing appropriate transportation services. The costs of the rides are reconciled through the brokerage service and billing is monitored. The brokerage produces monthly reports of the number of rides, costs, unduplicated clients, "no-shows" and complaints.

4 State and Local Practices and Opportunities

In order to identify barriers and opportunities for improving NEMT services in the Tri-County region, it is important to understand existing conditions locally as well as current NEMT coordination issues at the national and statewide levels. This chapter includes an overview of Medicaid-related NEMT issues nationally and at the state level in Michigan, a summary of organizations that provide or fund transportation in the Tri-County region, and a description of mobility management goals the region has set, and efforts they have achieved.

Medicaid-Funded NEMT in Michigan

Medicaid is a joint program between the states and the federal government to provide medical care for the poor and disabled[12]. It provides funding for NEMT as well as transportation for people with developmental disabilities and some senior transportation services such as programs to prevent seniors from being placed in nursing homes. Nationally, Medicaid transportation expenditures are second only to FTA's transportation funding. The $3 billion spent by Medicaid in FY2006 for non-emergency medical transportation represents a small portion of Medicaid's budget, but almost 20 percent of the entire federal transit budget. (Rosenbaum, Lopez, Jorris, & Simon, 2009)

Medicaid Program Funding Options

Under federal law and Medicaid rules, states can choose between several options for funding their Medicaid programs. States can also delegate this choice to the county or regional level. In Michigan's case the way services are funded locally is worked out between the Michigan Department of Human Services (DHS) and the Michigan Department of Community Health (MDCH, described in greater detail below). The option chosen determines the federal match rate as well as the amount of flexibility allowed in designing the program – such as the use of brokerages.

Michigan is one of fifteen states that have a Section 1915(b) Managed Care Waiver, which allows the state to provide services through managed care delivery systems or otherwise limit people's choice of transportation providers. Michigan has piloted an NEMT brokerage program that serves Wayne, Oakland and Macomb counties, allowing categorization of brokered transportation as medical assistance resulting in a higher Federal match rate for transportation costs.[13] Both elements affect the provision and payment structure for transportation by incentivizing minimum payment for transportation, with some feeling it shifts costs to public transportation.

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[12] By comparison, Medicare, the federally-operated program for everyone over 62, has no requirements to cover transportation costs.
[13] Authorized under section 6083 of the Deficit Reduction Act of 2005

Michigan Agencies Involved in Administering Medicaid Programs

Stakeholders involved in Medicaid NEMT include the organizations that oversee Medicaid funding, the organizations that provide human services using Medicaid funds, the organizations that provide medical services, the organizations that provide transportation, and the clients. Table 4-1 provides an overview of the government agencies that are responsible for setting policy and implementing Medicaid programs in Michigan.

Table 4-1: Agencies that Administer Medicaid

Level	Program	Description
Federal	The Centers for Medicare and Medicaid Services (CMS)	CMS is the federal agency that oversees Medicaid programs in all states.
State	Michigan Department of Community Health (MDCH)	MDCH sets Medicaid program policy at the state level. Several agencies within MDCH also play an important role in administering Medicaid programs (listed below). Medicaid clients participate in either a fee for service plan, or a managed health service plan. Approximately 2/3 of Medicaid beneficiaries are enrolled in managed care, and stakeholders we interviewed in Michigan stated that Medicaid has recently moved many clients from fee for service plans into managed care plans.
	Medical Services Administration (MSA)	MSA has the primary responsibility for oversight of Michigan's Medicaid program.
	Developmental Disabilities Council (DD)	The DD includes Regional Inclusive Community Coalitions (RICC), 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 groups are likely a good source of information on unmet NEMT needs.
	Office of Services to the Aging (OSA) –	OSA is the center point of a statewide network supporting services that benefit the elderly
Local	County Departments of Human Services (DHS)	County DHS offices are responsible for implementing the state policies. They assist the clients in finding resources and are responsible for the paperwork such as the forms included in Appendix A.

State-level NEMT Coordination Efforts

Within Michigan, the issues surrounding Medicaid-funded NEMT services are receiving increasing attention, resulting in several state level coordination efforts. The Michigan Developmental Disabilities Council (DD Council) has formed a committee focused on "Getting Rides to Medical Appointments". This committee has a broad based membership from other agencies and stakeholders. The DD Council is identifying barriers to consumer access Medicaid services, including getting rides to medical appointments, and has provided a grant to the Michigan Disability Rights Coalition, called the Alliance for Michigan Medicaid Access (AMMA), to explore this and other barriers to Medicaid access. The AMMA grant project works very closely with the DD Council NEMT subgroup by being a member of the Public Policy Committee, Health Issues Work Group (HIWG), and Transportation Work Group (TWG).

In addition, the Michigan Public Transit Authority (MPTA) has hired a new full time transit coordinator position that will be focused on medical transportation. The DD Council and the MPTA have initiated collaboration particularly through TWG meetings. The DHS, MDCH, and MDOT have also participated in some meetings with TWG and transit providers.

Southeast Michigan Brokerage

Michigan currently employs one NEMT broker, LogistiCare Solutions in Wayne, Oakland and Macomb counties. MDCH/MSA feels they have had some success with the broker in southeast Michigan and although their costs have increased so too has utilization. Additionally, the Department of Community Health has received fewer complaints from clients and providers since the employment of LogistiCare. While the possibility exists that Michigan may employ a statewide broker in the future, the prospect of this is not imminent. (Norcross, 2013)

Transportation in the Tri-County region

The Tri-County region's 2008 Coordination Plan indicates that the need for transportation within the region is increasing as the population ages. Greater longevity, a strong desire for independent living, and the looming baby-boom retirement place increasing pressure on the region's transportation systems.

The Tri-County Area also has a strong propensity for transit use. More than 9% of households in Eaton, Ingham, and Clinton Counties were classified as zero-vehicle households by the 2000 census, as compared to the State of Michigan's 1.6%. Over 11 million transit trips were taken on the region's public transit systems in a region with fewer than 460,000 residents.

Three public transportation providers serve the Tri-County region of Ingham, Eaton, and Clinton Counties. Capital Area Transportation Authority (CATA) provides public transportation to Ingham County, while Eaton County Transportation Authority (EATRAN) provides public transportation in Eaton County, and Clinton Transit provides public transportation services in Clinton County. CATA is the FTA-designated lead agency for the region.

The Tri-County area has a variety of other public, private, and non-profit organizations that provide transportation or whose clients need transportation. Information about the providers identified during this project is summarized in the following table.

Table 4-2: Organizations that Provide, Fund or Need Transportation

Organization	Service Area	Fixed	D/R Public	D/R Rural	ADA Paratransit	Client Transport	Transit fare	Mileage	Use Volunteers	Pay for Taxis	Medicaid	Clients need Rides
Capital Area Transit Authority (CATA)	Ingham, Eaton and Clinton Counties	X	X	X	X							
Clinton Transit	Clinton County		X	X	X				X			
Eaton County Transportation Authority	Eaton		X	X								
Dean Transportation	Central/Western Michigan	X										
Amtrak	Ingham County	X										
Greyhound Lines	Ingham County	X										
Indian Trails	Michigan	X										
Capital Transport	Lansing		X	X	X							
Classic Caddy Limousine Service	Michigan		X	X	X							
Lansing Mason Area Ambulance	Ingham, Eaton and Clinton Counties		X	X							X	
Mercy Ambulance	Ingham, Eaton and Clinton Counties		X	X							X	
Ingham County Department of Veteran's Affairs	Ingham County		X	X	X	X						X
Ingham County Department of Human Services (DHS)	Ingham County						X		X	X	X	X
Clinton County Department of Human Services (DHS)	Clinton County						X		X	X	X	X
Eaton County Department of Human Services (DHS)	Eaton County						X		X	X	X	X
Community Mental Health Authority, Clinton-Eaton-Ingham	Ingham, Eaton and Clinton Counties						X	X				X
Gateway Community Services	Ingham, Eaton and Clinton Counties						X					X
Hope Network Lansing Rehabilitation Services	Ingham, Eaton and Clinton Counties											X
Ingham County Health Department	Ingham County						X	X		X		X
Ingham Intermediate School District								X		X	X	X
Moore Living Connections						X	X	X	X		X	X
Tri-County Office on Aging	Ingham, Eaton and Clinton Counties								X			X
St. Vincent Catholic Charities							X	X	X	X		X
Capital Area Michigan Works	Ingham, Eaton and Clinton Counties						X					X
Fresenius Medical Care, Dialysis Services	Eaton											X

Organization	Service Area	Fixed	D/R Public	D/R Rural	ADA Paratransit	Client Transport	Transit fare	Mileage	Use Volunteers	Pay for Taxis	Medicaid	Clients need Rides
Sparrow Hospital	Ingham, Eaton and Clinton Counties					X						X
Sparrow Hospital, Outpatient Dialysis	Ingham, Eaton and Clinton Counties											X
Fresenius Medical Care, Lansing Clinic	Greater Lansing Area											X
Fresenius Medical Care, East Lansing	Ingham, Eaton and Clinton Counties											X
Origami Brain Injury Rehabilitation Center	entire state					X						X
The Pines	Lansing					X						X
Hope Network Lansing Rehabilitation Services	Ingham, Eaton and Clinton Counties					X						
Capital Area Center for Independent Living	Ingham, Eaton, Clinton and Shiawassee Counties											X
Clinton County of Human Services	Clinton County					X						X
CEI-Community Mental Health Transitions-St. Johns	Clinton County					X						X
Cristo Rey Community Center	Lansing					X						X
Delta Retirement Center	Lansing					X						X
Country Creek Adult Foster Care Home	Mason					X						X
Eureka House	Ingham, Eaton, Clinton and Shiawassee Counties					X						X
Grange Senior Citizens						X						X
Independence Village of East Lansing	Lansing					X						X
Tendercare South and West	Lansing					X						X

- Fixed – Operates fixed route bus or van service.
- D/R Public – Operates demand response service open to the general public
- D/R Rural – Operates demand response in non-urbanized areas, open to the general public
- ADA Paratransit – Operates paratransit required by the Americans with Disabilities Act, which could be limited to those who cannot access fixed route.
- Client Transport – Provides or funds transportation for clients of the agency
- Transit fare – Pays for transit fare for clients
- Mileage – Reimburses mileage
- Use Volunteers – Uses volunteers to transport customers
- Pay for Taxis – Pays for taxis for clients
- Medicaid – Uses Medicaid for transportation payment
- Clients need Rides – Serves people who need transportation

Existing Efforts: Addressing NEMT in the Tri-County Region

The Tri-County region has already made significant progress in coordinating transit service across providers, matching riders with appropriate rides and inventorying NEMT and other transportation needs. Some notable achievements in the region include the establishment of a mobility broker position at CATA that fulfills a number of the mobility management functions described in chapter 3 and a highly successful volunteer driver program operated by Clinton Transit. These efforts provide opportunities for the region to build on in addressing specific NEMT challenges moving forward.

Planning Efforts

Two significant planning efforts have been completed in recent years – the 2008 Regional Coordinated Public Transportation and Human Services Transportation Plan (Coordination Plan), and a 2009 study conducted by the Power of We Consortium (PWC) Transportation Ad-Hoc Committee that included a survey of both human service agencies and clients. PWC is a community collaborative organization with a membership that includes local government agencies, human service agencies, elected officials, non-profit organizations and faith-based organizations.

These two documents provide the best windows on existing conditions and the community's plans for moving forward. Communications with TCRPC and other stakeholders indicate that the state of NEMT in the region has remained relatively unchanged since these two planning documents were approved, and most planning and coordination efforts have focused on the three public providers. Some conversations have occurred with human service agencies, but a broad-based NEMT coordination effort has not yet been planned or launched.

Both documents include a number of important recommendations relevant to NEMT in the region, as described below.

Mobility Manager Position (Coordination Plan – Leadership Strategy #3)

A mobility management position, described as a "Mobility Broker" has been created as part of CATA's Clean Commute Options program[14]. The position is largely focused on the tactical find-a-ride functions of mobility management, including:

- Being the central point of contact for consumers who need information and services and the providers who operate the services;
- Having a primary role for assisting the public with trips across county boundaries requiring more than one public transportation system
- Development and maintenance of website and electronic systems to assist the public with trip planning; and
- Marketing efforts.

For the last one-and-a-half years, the Mobility Broker has been providing outreach to human service agencies as well as helping individuals navigate the many available options for finding

[14] http://powerofwe.org/wp-content/uploads/2010/08/Microsoft-Word-Mobility-Broker-short-description.pdf

rides. The idea of having a mobility manager responsible for data collection and planning activities has not been implemented, but individuals currently in leadership positions have been taking on many data collection and planning functions.

Data Collection and Coordination Plan Updates (Coordination Plan Data Collection and Planning Strategies #1,2 & 3)

The Coordination Plan includes recommendations for periodic Coordination Plan updates, data collection to document the successes and benefits of coordination efforts, and a more unified data collection system for the three public transportation providers. The 2008 Coordination Plan and the PWC study both collected a large amount of valuable data about human service providers. While TCRPC has not yet updated the 2008 Coordination Plan, the 2009 PWC study asked agencies to report transportation costs and client needs.

Making connections across county boundaries (Coordination Plan – Customer Service Strategy #1, Transportation Services Strategies #6 & 7)

The Coordination Plan includes a number of recommendations to improve service across county boundaries. These recommendations include an improved fare structure, intercounty transfer policies; development of transfer boarding centers at county lines; and providing a demand response general public paratransit overlay service. These recommendations all clearly identify issues with crossing county boundaries as a significant barrier to improved NEMT service and public transportation service generally. The importance of this issue was also identified in the client survey responses included in the PWC study, which indicated that in 2009 transfers were a disincentive to using public transportation for trips across county lines.

Pooling Resources (Coordination Plan – Funding Strategies #1 & 3)

The Coordination Plan includes recommendations for sharing trips, reducing the duplication of transportation services and increasing the usage of the region's transportation vehicles; and for joint procurement of fuel, vehicles and other equipment. The PWC study includes a very similar recommendation. These objectives are currently a high priority for the region's planning and public transportation providers. While some conversations with human service providers have occurred, the region has had limited success in achieving these objectives.

Automatic Vehicle Location (AVL) and/or dispatching software (Coordination Plan –Customer Service Strategy #2)

The Coordination Plan recommends exploring the possibility of utilizing AVL and/or dispatching software that will allow all providers in the Tri-County Region to share trip information and to allow for a quick and easy trip making process for consumers.

All three public service providers have dispatching software and AVL or are in the process of getting software and AVL. Because of the varying needs and software costs they chose to purchase different software packages. Moving forward, this means the different software systems will need to communicate with each other in order to share data. This is completely in line with the accepted architecture used by Intelligent Transportation Systems (ITS) systems engineers, as long as the differing data structures "use a common language".

Volunteer Driver Programs – A Tri-County Region Best Practice

Volunteer driver programs are used to connect NEMT beneficiaries with critical resources and have a large flexibility to meet the needs of the diverse community they serve. Clinton County's volunteer driver program, written up as a best practice while it operated under the FTA New Freedoms grant program, has functioned as a reliable, sustainable and flexible model to meet a range of NEMT needs.

Clinton Area Transit System's volunteer program, managed by Gale Caplin, was founded under the New Freedom Program to provide flexibility to seniors and people with disabilities that required several stops during an outing or had difficulty transferring at the county line. The program has grown conservatively, but has been highly effective at using volunteer support to provide reliable service and leverage a variety of funding sources. Since starting operations on June 1, 2011, demand has risen from serving 7 people per month in the first month to 200 people per month in the current month, an increase equivalent to 20-30% per quarter. A complete write up can be found in (Use of Volunteers in the New Freedom Program: Clinton Transit). This document includes samples of agreements, volunteer driver applications, training instructions, and policies and procedures.

Clinton Transit's program is successful for a number of reasons:

Extensive volunteer screening

Gale puts each prospective volunteer through a rigorous screening process that weeds out those who are on the fence about their commitment to the program. Volunteers are also screened for personality to ensure they will provide quality service to beneficiaries. Screening volunteers ensures commitment, and ensures a high quality network of support.

Active volunteer engagement

Once a volunteer has made it through the screening process Gale takes steps to keep them, including regular communication and holding monthly and annual gatherings to thank all volunteer drivers.

Creative fundraising

Money may not come dependably from grants, but the show must go on. Volunteer driver programs are often short on cash. Gale has organized jewelry sales as a strategy to successfully pay for program expenses.

Strong leadership and volunteer organization

Motivating and managing volunteers while coordinating with health and human service and transportation agencies to ensure an effective program requires a motivated and committed leader.

Measured program growth

Growing too quickly can lead to demands the program cannot meet during early stages of development. Demand for new flexible service will most likely be high. Avoid excessive advertising and publicity that could lead to scrambling staff and burned out volunteers.

Coordinated support system of social service agencies

With greater coordination comes the capacity for resource and idea sharing. Gale Capling's program has succeeded in part due to the support of a network of social service experts.

5 Strategies and Alternatives

The project team identified a variety of strategies for addressing NEMT challenges in the Tri-County region through discussion with local stakeholders. This section provides an overview of the full set of discussed alternatives. Strategies deemed a high priority by the project stakeholders were then developed further into recommendations for the region, as discussed in the following chapter.

Because the challenges of Medicaid-funded NEMT exist throughout the nation, many promising approaches have been developed to overcome them. One of the greatest challenges we encountered when assessing potential solutions was that Medicaid NEMT policies vary greatly from state to state and in some cases even from county to county. This can pose a barrier to applying lessons learned elsewhere to the Tri-County region, but may also mean that stakeholders in the region will not encounter some of the same barriers that have confronted stakeholders in other states.

Following are the top priority actions we identified for improving NEMT cost efficiency and service in the Lansing Tri-County area. Overall, these strategies require a collaborative, system-wide approach to reducing costs and meeting needs. The only way to achieve cost efficiency for the system as a whole while without reducing access to medical care is to take a nuanced, creative, collaborative approach.

Strategies

1. **Match riders to the most appropriate and cost-effective transportation options**
   Build Medicaid transportation policies to make it easy for clients to use fixed route whenever possible. Develop a holistic brokerage to reduce system-wide costs while helping clients find rides.

2. **Reimburse public transportation providers for the full cost of Medicaid-funded paratransit rides**
   This would ease the financial burden on public transit agencies and pave the path towards efficiency through shared paratransit rides among more human service programs. It also allows public transit to invest in fixed route service that could provide NEMT at significantly lower per-ride cost.

3. **Enhance clients' experiences finding services and planning trips**

4. **Collect the data necessary to document NEMT needs and coordinate services**

Implementation Steps

For each strategy mentioned above, a series of implementation steps were determined based on the needs of the Tri-County region.

Implementation Step	Timeline
Priority 1: Match riders to the most appropriate and cost-effective transportation options *Champions: CATA, Clinton Transit, E-Tran, Michigan Public Transit Association, Department of Human Services, MDOT, DD Council*	
Use fixed route bus service whenever possible	Year 1
Enable and encourage shared paratransit rides	Year 1
Support volunteer driver programs	Year 1
Pursue NEMT coordination strategies that do not require a brokerage	Year 1
Build a "holistic" brokerage for all types of NEMT and human service transportation needs	Year 2
Priority 2: Reimburse public transportation for the full cost of providing NEMT paratransit rides *Champions: CATA, Clinton Transit, E-Tran, Michigan Public Transit Association, Department of Human Services, MDOT, DD Council, Ingham County DHS*	
Determine the most suitable cost allocation approaches to address the Medicaid NEMT funding gap	Year 1
Negotiate cost agreements with one or more human service agencies	Year 1
Engage in state level discussions and policy-making	Year 1
Design and implement a pilot project	Years 2
Priority 3: Enhance clients' experiences finding services and planning trips *Champions: CATA, TCRPC, Central Michigan 2-1-1*	
Expand the scope of the Mobility Broker program to provide information about all transportation providers	Year 1
Expand marketing of Mobility Broker program to include human service transportation	Year 2
Collaborate with 2-1-1 and human service agencies to provide one-call one-click NEMT information	Ongoing
Continue to "unravel the spaghetti" of NEMT funding programs	Ongoing
Priority 4: Manage data to document NEMT needs and coordinate services *Champions: CATA, TCRPC, Central Michigan 2-1-1, DD Council*	
Coordinate with 2-1-1	Year 1
Explore data available from the Michigan Data Warehouse	Year 1
Build and maintain regional data inventory	Ongoing

6 Recommendations and Implementation

This chapter presents recommendations focused on the highest priority issues identified through our research, outreach and stakeholder discussion. The complex funding streams, numerous providers, and significant inefficiencies, if addressed, offer an opportunity that could help reduce the costs of providing NEMT and improve the user experience. Michigan Medicaid officials who have been contacted as part of this project have been responsive and have expressed willingness to participate in stakeholder discussions. If the stakeholders in the Lansing Tri-County area continue to work together to build broad-based partnerships and take action on these issues, they have potential to implement creative solutions that can serve as a model for other regions in Michigan and nationwide.

1. Match clients to the most cost-effective and appropriate transportation options

The Tri-County region can both reduce the overall costs of providing NEMT service and improve the experience for users by working to match clients to the most cost-efficient options that meet clients' particular needs. Overall, cost efficiency will be maximized by coordinating all NEMT and other demand-response services to combine rides whenever possible, and using fixed-route bus service whenever possible. Riders who need NEMT services range from low-income individuals with no disabilities to people with disabilities who are accompanied by a caretaker and need curb-to-curb transportation in a wheelchair compatible vehicle. Knowing when fixed route service is appropriate requires an understanding of client needs, as well as the regulations governing the funding source that is paying for the ride.

Throughout the nation, many states and regions are matching clients to rides by implementing a variety of brokerage models. Michigan is exploring brokerages as an option and the Tri-County region should be proactive in exploring whether a brokerage model could meet the Lansing area's needs. At the same time, a number of approaches could be implemented with or without a brokerage. The following recommendations address the most promising strategies for both brokerage and non-brokerage scenarios.

Use fixed route bus service whenever possible

NEMT riders should be encouraged to use fixed route transit whenever possible, since the marginal cost of an additional ride on fixed route transit is negligible. To maximize the use of fixed route buses, managers and policy makers must make it as easy as possible for individuals and human service agencies to use this option. The following actions can help achieve this goal.

Make it easy for human service agencies to provide bus passes

During this project, human service personnel reported that it has become increasingly difficult to provide clients with fixed route bus passes because of Medicaid policies designed to ensure that

Medicaid money is only spent on NEMT transportation. Each trip is paid for individually and clients are required to get trips approved as much as five days in advance.

In contrast, providing a client with a round-trip, one-week or even one-month bus pass would be a far more cost-efficient use of funds in many cases, as well as far more beneficial and less onerous for the client. To change these policies, the Tri-County partners will need to document costs and benefits, participate in state-level discussions, and potentially design a pilot project.

Provide Travel Training

For many first-time riders such as seniors, using fixed route transit can be confusing and intimidating. Providing travel training is a proven approach used by many communities around the nation. Through partnerships between CATA and human service agencies, one or more travel training programs could be developed for specific target populations.

Facilitate transfers and modify routes as necessary

The three public transit agencies should continue to work to coordinate dispatching and schedules to make inter-county transfers efficient. They should also continue to collaborate to make transfer locations as convenient, welcoming and comfortable as possible.

Using high quality data about NEMT needs and destinations, collected through the actions under section 4 below, CATA may be able to identify opportunities to modify their routes and schedules to improve access to important NEMT destinations.

Enable and encourage shared paratransit rides

Combining paratransit rides for clients with similar trip origins and destinations can help reduce the costs of providing NEMT service in the Tri-County region, but can be complicated when clients' rides are covered by different funding sources. A key step to enabling shared paratransit rides on a broad scale, therefore, is to determine an approach to allocating costs across multiple funding sources.

Determine an approach to cost-allocation for shared rides

Whether NEMT service is demand response, fixed route, public, or private; sharing rides between clients sponsored by different funding streams will require a method to fairly share costs. Efficient and fair cost allocation requires knowledge of the funding and transportation policy environment and clear coordination and communication at all levels between transportation providers, human service providers, funding agencies and policy makers. A sample cost allocation formula is provided in Supplement D.

Manage appointment times and locations to facilitate shared rides

Human service organizations can work with clients to coordinate appointment times and locations to facilitate shared or overlapping paratransit rides.

Support volunteer driver programs

Volunteer driver programs are a cost effective approach to meeting NEMT needs and have the added benefit of providing flexibility to meet the diverse needs of different populations. While volunteer driver programs should not be relied on as the region's primary source of NEMT service, such programs can serve an important role in filling gaps in service.

Gale Capling with the Clinton Area Transit System has developed a model volunteer driver program providing cost effective service that is also highly effective at meeting client needs by combining NEMT trips with other stops such as grocery shopping. We recommend expanding or replicating this program to serve the entire region.

Pursue NEMT coordination strategies that do not require a brokerage

Nationwide many public agencies and non-profit organizations play leadership roles in providing highly effective regional NEMT coordination. This coordination work can be effective whether or not it is done in conjunction with a brokerage. Overall, the common element in many successful regional NEMT coordination efforts is that one organization steps up to take the lead. It will be important for the Tri-County partners to identify an organization to play the lead role in regional coordination efforts.

An example of coordination leadership included in Supplement E is People for People in Washington State. For the last 12 years, this non-profit organization has provided facilitation and coordination leadership for a consortium of human services providers in a rural region of the state. This consortium includes the Office on Aging, the Vocational Rehab Department, hospitals, sheltered workshops for adults with disabilities, Head Start, school districts, public transportation providers, and tribal transit. Their focus is on consolidating rides and coordinating schedules to achieve cost efficiency by getting more passengers on fewer trips. A critical element underlying the success of this model is that the consortium is not a short term working group but rather a coalition of key stakeholders committed to working together over the long term. In the Tri-County region the Power of We Consortium (PWC) may be the best starting point for a similar long-term coordination effort.

In addition to broad based coordination efforts, coordination between the Tri-County transit agencies has significant potential to improve NEMT services. For example, to serve some populations, the most cost effective approach may for the three public providers to share resources to provide direct inter-county service that eliminates transfers.

Build a “holistic” brokerage for all types of NEMT and human service transportation needs

The project team has concluded that a “holistic” brokerage model (described in greater detail in Chapter 3) focused on finding the most cost efficient and appropriate ride for each client whether it is with a public, private or human service agency transportation provider offers the best option for meeting the Tri-County region’s NEMT challenges. A brokerage using this model could be operated by a transit or other government agency; MPTA; a non-profit organization; or even a private for-profit contractor as in the Pennsylvania example in Supplement E. If possible, we recommend following the example of People for People in Washington State and co-locating the brokerage with the regional 2-1-1 call center.

It appears that the future viability of this model will depend on decisions regarding Medicaid at the state and federal level. If stakeholders at the community and regional level become engaged in the decision-making process they could potentially have significant influence on the outcome of these policies. Specifically, stakeholders should advocate that any MDCH-contracted brokerages and reimbursement policies do not sacrifice quality nor shift costs

2. Reimburse public transportation for the full cost of providing NEMT paratransit rides

As discussed in the previous chapters, public demand-response services are the most appropriate option for meeting a significant percentage of NEMT needs. However, most public transit systems will be unable to afford to provide these services sustainably unless Medicaid reimbursements pay the all or most of the full cost of these rides. Medicaid typically reimburses private providers and human service agencies for an amount close to the full cost of paratransit rides[15]. Doing the same for public transit agencies would have two primary benefits:

1) It would allow public transit agencies to provide quality paratransit service to meet increasing NEMT demands.
2) It would enable public transit agencies to expand and improve fixed route service to meet NEMT needs at lower cost and improve overall mobility in the region.

Based on national trends and the examples we have documented from other states, it will take the following steps to achieve system-wide cost efficiency through negotiating cost sharing among all parties involved.

Negotiate a higher rate of payment from Medicaid for public paratransit service

While Medicaid typically reimburses at the farebox rate for paratransit service (no more than twice the fare charged for fixed-route service based on ADA regulations), the Deficit Reduction Act includes an allowance for negotiating a higher rate of reimbursement. It clarified that the Medicaid program, when using a governmental broker, "pays no more for fixed route public transportation than the rate charged to the general public and **no more for public paratransit services than the rate charged to other State human services agencies for comparable services.**" (42 CFR Part 440.170). Furthermore the final rule 73 FR 77519 (2008-12-19) discusses this issue and states that there is no restriction from "negotiating rates with public transportation providers" and "it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride."[16]

The two key requirements to negotiate a higher payment for Medicaid payment of public paratransit rides are for a public transportation provider to 1) Use a fair methodology for determining an equitable cost allocation among funders, and between services, and 2) have contracts negotiated with another human service agency. If that contract allows for reimbursement of the full cost of the ride, then the public transportation provider has a basis for asking for similar reimbursement from Medicaid.

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[15] Private operators struggle with reimbursement rates in the range of 90% of their costs, but this report focuses on the larger issue of 10% reimbursement when paying only farebox for public demand response.
[16] The discussion in the final rule regarding ADA and public paratransit is included in Supplement D.

Determine the most suitable cost allocation approaches to address the Medicaid NEMT funding gap

We recommend that the Tri-County stakeholders conduct a process similar to the Washington State FOW to assess different cost allocation models and identify one or more approaches that could be feasible for the region and could be tested with a pilot project. To ensure that each funder is invoiced only for their rider's portion of the trip, different cost allocation models can be developed that vary greatly in the level of complexity involved – including investments in technology and administrative cost. For example, in Washington State brokers pay transportation providers for NEMT trips based on a pre-negotiated rate, which may include mileage, time, a flat fee, or other factors. However, in all instances the participating agencies have to agree to accept a system that requires a degree of trust between partners without exact precision in the cost estimates.

Negotiate a rate of payment close to actual cost with one or more human service agencies

This is an important early step because federal regulations require at least one such agreement to serve as the basis for setting public paratransit reimbursement rates at a level above standard farebox. It also begins the assessment of different cost formulas and rules for payment. The transit agency gains a stable and reliable source of income along with increased ridership.

This strategy can increase human service transportation costs in the short term if the agency is currently paying farebox. However, this cost can be balanced by increased efficiency and savings in staff time spent arranging rides. Agencies providing their own transportation likely will save by working with a transportation agency. Either way, by letting the transportation agency provide rides at a fair cost, the human service agency can focus on their mission without shifting the financial burden.

In the long term, if the transit agency is unsuccessful at negotiating fare payment it could be forced by budget constraints to limit demand response service to the legal minimum, leaving many without a ride. By contrast, if improved coordination and fare payment can be achieved, it opens the opportunity to lower systemwide costs.

Design and Implement a pilot project

Washington State's Federal Opportunities Working Group determined the best way to resolve NEMT coordination barriers was to design pilot projects that would provide case studies to test models for improving NEMT efficiency and cost allocation. While pilot projects can be a good way to test and gain support for any of the recommended implementation strategies in this chapter, it can be an especially effective means for resolving the cost allocation issues described above. The following discussion uses the Washington pilot projects as examples for designing Lansing area projects.

Washington State Pilots

In response to coordination and cost allocation challenges, the Washington Federal Opportunities Workgroup (Agency Council on Coordinated Transportation, 2011) recommended three pilot projects that could potentially be models for the Lansing Tri-County area. In general, these pilot projects are focused on sharing trips and working through cost allocations between several funding sources.

King County - This pilot in partnership between King County Metro, the Department of Social and Health Services, and Hopelink focused on: 1) Exploring the possibility of reimbursing transit at a fair, competitive rate for providing demand response NEMT based on actual cost, not fare box rates charged to ADA eligible participants; and 2) Determining whether the investment made by transit for NEMT trips can be used as local match for federal Medicaid dollars

Olympic Peninsula - This pilot in partnership between paratransit services, Department of Social and Health Services (DSHS), Veteran's Affairs (VA) focused on proposing a simple cost allocation model to allow veterans to utilize a Medicaid NEMT brokerage service

Yakima Valley - This pilot in partnership between People for People, the NEMT broker for Yakima County, Yakima County Aging and Long-term Care, Job Access Reverse Commute Grant funder, FTA 5311 formula grant for non-urbanized areas funder, and the Washington State Rural Mobility grant funder, focused on automating the cost allocation process so that multiple eligibility criteria and billing methodologies for multiple contracts with multiple funding sources can be easily accommodated.

Unfortunately, these projects were never implemented, in part due to a lack of clear guidance and participation by CMA at the federal level. In Lansing, if a clear outcome is identified, a pilot project may help test coordination opportunities on public paratransit.

A pilot would seek to meet the following goals:

- **Be manageable** – Select a representative group of motivated stakeholders to test coordination strategies, but do not try to include all possible stakeholders.
- **Encourage resource sharing** – Test opportunities for Medicaid, other funders, transportation providers and human service agencies to cooperate and share resources to support more efficient services.
- **Test technology applications** – Utilize new technology or expand the use of successful existing transportation coordination technologies.
- **Include both rural and metropolitan areas** –Test coordination approaches designed to benefit both rural and urban clients.

The following team members and coordination are recommended to support an effective pilot project:

- Representatives from the county DHS office, MDCH at the state level, and the Centers for Medicaid and Medicare (CMS) at the national level.
- Representatives from Tri-County Regional TCRP, CATA, Clinton Transit, and Eatran.

- Consulting team to coordinate efforts of the greater project team, support team decision making and directions, compile notes and information, manage timeline, and coalesce pilot project information
- Regular coordination with all working groups and other key stakeholders in the Tri-County area focused on these issues (DD Council Transportation Work Group, Regional Interagency Consumer Committees, and others)

The estimated budget for a feasibility-level determination of a suitable pilot project for the Lansing area, including first steps toward implementation in Lansing, is estimated to fall within a range of **$25-60K**. This estimated cost range takes into consideration support for months of meetings and other coordination activities. It also accounts for the possibility of funding during the planning stage assisting agency representatives with their participation.

The timeline for formation of a Lansing pilot will be largely dependent on coordination between the existing working groups. It is critical for key partners and working groups to reach consensus for the pilot project to have maximum support and effectiveness in the implementation phase. Feasibility planning for a pilot project may take between 3-12 months. The recommended length of the pilot project is 2 years with opportunities to refine how the project functions over that 2-year period.

Engage in state level discussions and policy-making

Due to their location in the state capital, the Tri-County region working group members are uniquely positioned to engage in state level discussions and decision-making. Working group members can likely play a role in shaping the policies that will determine what options become available for allocating costs and coordinating to achieve cost efficiency. This engagement is important because Medicaid NEMT policies are in a state of transition throughout the nation and more change is likely with the implementation of the federal Affordable Care Act (ACA). As a first step, it is important to read the funding legislation and associated guidance and regulations for all relevant NEMT funding sources.

Key opportunities for engaging at the state level include the following efforts described under **Error! Reference source not found.** starting on page 4-2.

- Michigan Developmental Disabilities (DD) Council working group focused on getting rides to medical appointments, and the Michigan Disability Rights Coalition's effort to create an Alliance for Michigan Medicaid Access (AMMA)
- The Michigan Public Transit Authority (MPTA) Transit Coordinator's efforts focusing on medical transportation.

Additionally, it will be important for the Tri-County partners to communicate directly with MDCH/MSA concerning any local pilot projects as well as state level policies such as the implementation of brokerages. Objectives of these efforts should include:

- Clearly describing the Medicaid NEMT issue from the perspective of the Tri-County region, and working with MPTA to do the same from the perspective of its members.
- Identifying tools and policies that address the issues.

- Developing positive working relationships between transportation providers and human services agencies.
- Communicating with officials at the local DHS, state and federal levels because often they may have different interpretations of regulations.
- Identifying discrepancies between policies at the different levels.
- Identifying regulatory flexibility that allows for creative collaborative approaches.
- Identifying officials and agencies that will actively advocate and support collaborative mobility management approaches.

3. Enhance clients' experiences finding services and planning trips

Find-a-ride trip planning services include all forms of marketing and outreach to target populations including websites, call centers, hard copy materials and travel training programs. The following recommendations include expanding the scope of CATA's existing Mobility Broker program along with other efforts to improve information and services available to clients trying to navigate the complex options for accessing NEMT.

Expand the scope of the Mobility Broker program to provide information about all transportation providers

Currently, CATA's Mobility Broker program only provides information about CATA's NEMT services. Moreover, information is not easily accessible or usable to individuals and human service agencies learning to access NEMT in the Tri-County area. For example, the websites for the three public transportation providers offer little or no information for customers seeking to make connections between services; and they provide no information about NEMT transportation services offered by private providers or human service agencies.

The Mobility Broker program could help fill this need if its scope were expanded to provide information about all public, private and human resource agency transportation options available to those seeking NEMT services. Federal regulations would allow this information service to be provided with federal funded as long as the program provides unbiased information about all transportation options it is aware of.

Expand marketing of Mobility Broker program to include human service transportation

The CATA website provides good information about their paratransit and other curb-to-curb services[17]. However, to effectively promote NEMT services something comparable to the CATA's Clean Commute website needs to be developed. The Clean Commute website is a high quality gateway for commuters seeking transportation alternatives. CATA's Mobility Broker has run the Clean Commute program and also conducts outreach concerning NEMT services. These roles can continue to be shared by the same person. However, a newly branded, human services oriented program separate from Clean Commute needs to be created to promote NEMT and other human services related transportation services.

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[17] http://www.cata.org/RidingCATA/HowtoRideCATA/PlanaCurbtoCurbTrip/tabid/89/Default.aspx

Ideally, the Mobility Broker program could create a similar one-call one-click website with information about NEMT services available through CATA as well as all other public, private and human service agency providers.

Collaborate with 2-1-1 and human service agencies to provide one-call one-click NEMT information

Work with the regional 2-1-1 call center and human service agencies to create a comprehensive regional NEMT directory with information on all NEMT service options. This directory could be published in hard copy and made available through the websites and other communications efforts of agencies serving target populations. The directory would also be a valuable resource for agency personnel who serve clients seeking NEMT services.

The Tri-County partners should also work together to take advantage of web-based and print opportunities, along with other public education opportunities to promote the updated 211 service being developed through the Veteran's Transportation Initiative.

Through these efforts the Tri-County partners could develop an ongoing coordinated marketing campaign that would make NEMT information much easier for customers to find and use.

Additionally, the partners should explore the possibility of providing centralized trip planning services that provide clients comprehensive assistance with all NEMT options.

Finally, these efforts are dependent on, and should be closely coordinated with developing and maintaining a comprehensive NEMT inventory and other data documenting needs and opportunities as discussed in more detail under Priority 4.

Continue to "unravel the spaghetti" of NEMT funding programs

The "spaghetti" refers to the complexity of federal transportation funding as illustrated in Figure 2-1 and to the often-complex regulations attached to this funding. This project focused primarily on developing a more in-depth understanding of the barriers and opportunities presented by Medicaid NEMT funding. However, other NEMT funding sources should also be explored in greater detail to understand how rides are being paid for, what transportation services are available, and how much demand there is for different services. Developing a sophisticated understanding of all significant NEMT funding in the Tri-County region will be necessary for taking advantage of opportunities to improve coordination and achieve cost efficiencies.

The Federal Transportation Service Matrix in Supplement B is a useful resource for quickly identifying how different types of federal funding can be used. It is more difficult to research the barriers to coordination that may be connected to different funding sources. Barriers fall into three categories:

- Barriers to pooling resources and developing contracts for service.
- Barriers to steering NEMT riders toward public transportation if appropriate.
- Barriers to using a funding source as match for FTA funding.

Gaining an understanding of the two types of funding sources described below will help the Tri-County partners continue to develop a clearer picture of the region's needs and opportunities.

Collecting this information will require a combination of surveying and interviewing human service agencies, and communicating with federal officials at the regional and federal levels.

Non-Medicaid NEMT funding – Identify the amount of funding, the recipients, and how the funding is being used. Also, what do recipients believe are the primary barriers associated with each funding source? If any of the public transit providers need local match to leverage state and federal FTA dollars, assess the feasibility of working with human service partners to use these funding sources as match. Two of the best funding sources to work with are Aging Services Title III and Community Development Block Grants.

Veteran's Administration (VA) funding – VA will pay for fares if public transportation serves VA facilities. We are not aware of VA funding going to anything other than fares. The VA operates a completely separate volunteer-staffed NEMT transportation system, and they have the reputation of being resistant to participating in pooled resource strategies. However, we are aware of situations in other communities where a need for veterans NEMT was created due to poor siting of VA facilities, a lack of available volunteer drivers, and/or a lack of volunteers and vehicles capable of transporting disabled veterans. There are examples of public transportation providers around the nation that have had success coordinating with VA on NEMT services, including Berkshire RTA in Pittsfield, MA (www.berkshirerta.com/). Additionally, the National Conference of State Legislatures (NCSL) recently released a report containing a large amount of useful information, case studies, and recommendations: Transportation & Veterans: A Match in the Making (www.ncsl.org/issues-research/transport/mission-to-serve-report-veterans-transportation.aspx)

4. Manage data to document NEMT needs and coordinate services

Good data is essential for understanding needs, inventorying services currently available, assessing and documenting problems, and designing solutions. Data is the backbone of any cost sharing structure, and is also necessary for creating one-call one-click services and for planning and designing fixed bus routes and other transportation services. However, NEMT data can be particularly hard to collect because of the large number of stakeholders, services and funding sources involved. For Medicaid-funded NEMT the necessary data is either not collected or extremely difficult to access. Data is needed on how Medicaid NEMT funding is being spent including populations served, number of rides, types of rides and destinations accessed.

The following actions will help the Tri-County partners collect and maintain the data they need to coordinate and improve NEMT services. Because many of the most promising strategies for the Tri-County region will depend on state level policy-decision, it will be particularly important to collect data that documents needs, problems and opportunities.

Create a data structure that is easy to use and easy to update

Before launching a data collection effort it will be important to carefully plan the types of data that will be needed, and how to structure the database to ensure ease of use. Collecting this valuable information is a significant investment, and much of the value of that investment will be

lost unless a systems engineering process is used to carefully design a data structure that can be used for multiple purpose.

Coordinate with 2-1-1

Any find-a-ride services that are developed in the Tri-County region should be closely coordinated with 2-1-1 and the underlying data should use the same data structure to ensure that data can be easily shared. The regional 2-1-1 call center has useful data available such as transportation requests they received, the agencies they referred these requests to and requests for which they were unable to find available service. Ongoing data collection efforts involving human service agencies should be closely coordinated with 2-1-1 because 2-1-1's full time Resource Specialist communicates at least annually with each agency in the 2-1-1 database, sending them a complete document of their information for review & corrections. The Resource Specialist also periodically attends community collaborative meetings and is on their meeting distribution lists to learn of updates that happen throughout the year. Perhaps most importantly, the 2-1-1 staff interviewed for this project were eager to collaborate.

Explore data available from the Michigan Data Warehouse

Unlike most other states, Michigan may have much higher quality Medicaid NEMT data in the Michigan Data Warehouse, but we were unable to get access to this data for this project. The Data Warehouse may have valuable data about which organizations in the region are using Medicaid funding to provide transportation services; the types of transportation services being provided; the populations being served; and the destinations being accessed. The Tri-County partners should work with the officials in charge of the Data Warehouse to determine whether such information is available and how an ongoing working relationship can be structured to use this data for regional NEMT planning.

Build and maintain a regional data inventory

The data inventory effort should start with the data already collected through the current 2-1-1 inventory of human service agencies and transportation providers, and the inventory data from the 2008 Coordination Plan and the Power of We Consortium (PWC) study. Regularly updating this data will provide a comprehensive inventory of stakeholders. However, additional types of data will be needed as well:

- **Funding data** – To fully understand the resources currently available, and to identify the best opportunities for collaboration it will be important to collect Information about the different NEMT funding sources being used in the region, which organizations are using this funding and how it is currently being used. This data will also be important for identifying potential opportunities for leveraging new sources of funding
- **Data necessary for cost allocation agreements** – In order to negotiate cost sharing, it is essential to track and report the total operating costs of providing different types of rides. The best way to appropriately share costs and revenue is to have accurate passenger counts, passenger mile count estimates, and other statistical bases on which fare revenues are assigned.

Demand response management systems offer most but not all of the necessary data for cost allocation agreements on paratransit. All three transit systems using these management systems, but future upgrades will be required if a complex cost allocation model is implemented.

For fixed routes, electronic fareboxes ease payment and improve data tracking. Automatic passenger counters (APCs) can complement electronic fareboxes and add the capability to better track passenger miles, but the cost of APCs has prevented its wide use. Neither technology may be cost suitable for Eatran or Clinton Transit at this time.

A systematic approach will need to be developed for updating and maintaining the data. We recommend a survey conducted annually or bi-annually. The project team researched appropriate tools for maintaining an ongoing inventory and chose LimeSurvey. A key advantage of this open source surveying tool over Survey Monkey, the most prevalent online survey tool, is the ability to update and import previously created data. The methodology requires some simple programming knowledge but is relatively easy to learn and use on the administrative end. The other major advantage over Survey Monkey is the ability to easily export and import from other databases and spreadsheets.

It will also be important to periodically conduct interviews with key stakeholders to develop a deeper understanding of needs and opportunities, and to verify data. Interviews are an essential tool for developing a true understanding of needs and opportunities, and perhaps most importantly for building relationships. Human service agency personnel have the most in-depth and nuanced understanding of the needs of NEMT riders and interviews are the best tool for tapping into this knowledge.

7 Bibliography

Agency Council on Coordinated Transportation. (2011, February 23). *Federal Opportunities Workgroup Final Report.* Washington State Legislature, Joint Transportation Committee, Olympia, WA. Retrieved April 25, 2013, from Washington State Department of Transportation: http://www.wsdot.wa.gov/acct/documents/FOW/JTC_FOWFinalReport.pdf

Alexander, D., & Brown, P. (2013, May). Capital Area Transit Authority. (L. Ballard, Interviewer)

Altarum Institute. (2005, October). TCRP Web-Only Document 29: Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation. Washington, D.C.: Transportation Research Board of the National Academies. Retrieved from www.trb.org/publications/tcrp/tcrp_webdoc_29.pdf

American Public Transportation Association. (2013). *Hot Topics: Mobility Management*. Retrieved April 23, 2013, from APTA.com: http://www.apta.com/resources/hottopics/mobility/Pages/default.aspx

American Public Transportation Association. (2013, April 23). Hot Topics: Mobility Management. Retrieved from http://www.apta.com/resources/hottopics/mobility/Pages/default.aspx

Ballard, L., & Lange, T. (2012). *Muskegon County Transportation Assessment.* Current Transportation Solutions. Washington, D.C.: Smart Growth America.

Ballard, L., et. al. (2007). *Mobility Management Plan for a Remote Rural California Region.* Alturas, CA: Modoc County Transportation Commission, Community Transportation Association of America.

Bogren, S. (2012, December 12). Commentary: Reframing the value of community and public transportation. *Community Transportation Digital*, pp. p. 11-12.

Carlson, M. (2013, May 31). Chief Executive Officer. (T. Lange, Interviewer)

Centers for Medicare and Medicaid Services. (2013, April). Medicaid Statistical Information System (MSIS) State Summary Datamarts. Baltimore, MD. Retrieved May 13, 2013, from http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html

Centers for Medicare and Medicaid Services. (2013). *Michigan Medicaid Statistics*. Retrieved May 2013, from Medicaid.gov: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/michigan.html

Chartock, D. (2013, May 31). Rural and Coordinated Transportation Administrator, Public Transportation Division of WSDOT. (T. Lange, Interviewer)

Chartock, D. (2013, May 22). Rural and Coordinated Transportation Administrator, Public Transportation Division of WSDOT. (T. Lange, Interviewer)

Community Transportation Association of America. (2010). *Medicaid Webinar Parts I and II.* Retrieved October 27, 2011, from Medical Transportation: http://web1.ctaa.org/webmodules/webarticles/anmviewer.asp?a=16&z=40

Crain & Associates, Inc., et.al. (1997). *TCRP Report 21: Strategies to Assist Local Transportation Agencies in Becoming Mobility Managers.* Washington, D.C.: Transportation Research Board, National Research Council.

Crain & Associates, Inc., et.al. (1997). *TCRP Report 21: Strategies to Assist Local Transportation Agencies in Becoming Mobility Managers.* Retrieved from Transit Cooperative Research Program: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_21-a.pdf

Doig, J. C. (2013, April). *Policy Report: Issues and Opportunities Related to Access to Medicaid for People with Disabilities.* Retrieved from Alliance for Michigan Medicaid Access (AMMA) withing Michigan Disability Rights Coalition (MDRC): http://www.michigan.gov/documents/mdch/Master_Policy_Report_2x_418164_7.pdf

Dresevic, A., & Kalmowitz, C. F. (2011, April). *OIG Again Views Complimentary Transportation Services Favorably.* Retrieved October 18, 2011, from AHRA Link: http://www.thehealthlawpartners.com/lawyer-attorney-1410853.html

Federal Highways Administration. (2007, January). *Systems Engineering for Intelligent Transportation Systems - an Introduction for Transportation Professionals.* Retrieved January 3, 2012, from FHWA Systems Engineering Guide: http://www.ops.fhwa.dot.gov/publications/seitsguide/index.htm

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

Federal Transit Administration. (2007, April 1). *Nonurbanized Area Formula Program Guidance and Grant Application Instructions.* Retrieved October 29, 2011, from FTA Circulars: http://www.fta.dot.gov/legislation_law/12349.html

Federal Transit Administration. (2010, May 1). *Urbanized Area Formula Program: Program Guidance and Application Instructions.* Retrieved October 29, 2011, from FTA Circulars: http://www.fta.dot.gov/legislation_law/12349.html

FHWA-California Division and Caltrans. (2009, November). *Systems Engineering Guidebook for Intelligent Transportation Systems Version 3.0.* Retrieved January 4, 2012, from FHWA Systems Engineering Guidebook: http://www.fhwa.dot.gov/cadiv/segb/index.htm

Florida International University. (2013). *Integrated National Transit Database Analysis System (INTDAS)*. Retrieved May 27, 2013, from Florida Transit Information System: http://www.ftis.org/intdas.html

Groenfeldt, T. (2011, October). Michigan saves $1 million per day with data warehouse. *WTN News*. Retrieved May 11, 2013, from http://wtnnews.com/articles/9088/

Information and Referral Federation of Los Angeles County. (2012). The AIRS/211 LA County Taxonomy of Human Services. Retrieved from http://www.211taxonomy.org/

Kaiser Family Foundation. (2011). Summary of the Affordable Care Act. Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf

KFH Group. (2006). TCRP Synthesis 65: Transit Agency Participation in Medicaid Transportation Programs. Washington, D.C.: Transportation Research Board of the National Academies. Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_syn_65.pdf

Michigan Department of Community Health. (2011). Michigan Medicaid Fee-for-Service Handbook. Lansing, MI. Retrieved from http://www.michigan.gov/documents/mdch/MDCH-Pub_669_Medicaid_Fee_for_Svc_204662_7.pdf

Michigan Department of Community Health. (2013, February). Michigan Medicaid State Plan. Lansing, Michigan. Retrieved May 2013, from www.michigan.gov/mdch/0,4612,7-132-63157_63210-225474--,00.html

Michigan Department of Human Services. (2013, March). Green Book Report of Key Program Statistics. Lansing, MI. Retrieved May 13, 2013, from http://www.michigan.gov/dhs/0,4562,7-124-5459_61179_7696_10830---,00.html

Michigan Department of Transportation. (2011). *Public Transportation Management System Performance Indicators Report.* Lansing, MI: Michigan Department of Transportation.

Michigan Developmental Disabilities Council Transportation Work Group. (2012, December). Medicaid Non Emergency Medical Transportation Committee. *Meeting Minutes*.

Mross, R. (2011, September 12). United we Ride Ambassador Perspectives on Michigan Transportation. (L. Ballard, Interviewer)

National Transit Database. (2013, May 25). *Integrated National Transit Database Analysis System (INTDAS)*. Retrieved May 27, 2013, from Florida International University: http://www.ftis.org/intdas.html

Norcross, N. (2013, March). Policy Analyst for Medicaid Transportation, Michigan Department of Community Health. (T. Lange, Interviewer)

Proshaska, Thomas, et.al. (2012). Assessing the Intersection Between Health and Transportation. Easter Seals Project Action. Retrieved from http://www.projectaction.org/Initiatives/HealthTransportation.aspx

Rosenbaum, S., Lopez, N., Jorris, M. J., & Simon, M. (2009). *Policy Brief: Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform.* Washington, D.C.: George Washington University School of Public Health and Health Services. Retrieved from http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_377A5480-5056-9D20-3DF264AA41CFBDEC.pdf

Ryus, P., & et.al. (2010). *TCRP Report 141: A Methodology for Performance Measurement and Peer Comparison in the Public Transportation Industry.* Washington, D.C.: Transit Cooperative Research Program, Transportation Research Board.

Sanders, P. (2013, April 3). Transportation Coordinator, Montana Department of Health and Human Services. (L. Ballard, Interviewer)

Sprecher, M. H. (1997). Michigan Data Warehouse Spurs Medicaid Efficiency. Government Technology. Retrieved May 11, 2013, from http://www.govtech.com/magazines/gt/Michigan-Data-Warehouse-Spurs-Medicaid-Efficiency.html

Sych, L., & Senter, R. a. (1999, September). *Lessons from Cases of Consolidated Pupil/Public Transportation in Michigan.* Retrieved October 29, 2011, from Michigan Departement of Transportation - Coordination Studies: http://www.michigan.gov/documents/lessons_23026_7.pdf

Texas Transportation Institute. (2011, December). Performance Measures for Public Transit Mobility. College Station, Texas. Retrieved April 22, 2013, from http://tti.tamu.edu/documents/0-6633-1.pdf

The Hilltop Institute. (2008, September). Non-Emergency Medical Transportation (NEMT) Study Report. Retrieved from http://www.hilltopinstitute.org/publications/Non-EmergencyMedicalTransportationStudyReport-September2008.pdf

Thompson, J. J. (2006, September 7). Memorandum Re: Requirement and Funding for Specialized Transportation Services. Lansing, Michigan: Michigan Department of Education.

Thompson, J. J. (2006, September 7). Memorandum Re: Requirement and Funding for Specialized Transportation Services. Lansing, Michigan: Michigan Department of Education. Retrieved from http://www.michigan.gov/documents/OSE-EISMemo03-23_74315_7.pdf

United We Ride. (2007). *Federal Funding Eligibility Chart.* Retrieved November 11, 2012, from United We Ride: http://www.unitedweride.gov/1_1254_ENG_HTML.htm

Use of Volunteers in the New Freedom Program: Clinton Transit. (n.d.). Retrieved from Michigan Department of Transportation:

http://www.michigan.gov/documents/mdot/UseOfVolunteersInNewFreedomProgram_ClintonTransit_409377_7.pdf

Weaver, P., & Vander Broek, N. (2011, October). *Kansas TransReporter.* Retrieved November 15, 2011, from Kansas University Transportation Center (KUTC): http://www.kutc.ku.edu/pdffiles/KTR2011-Oct.pdf