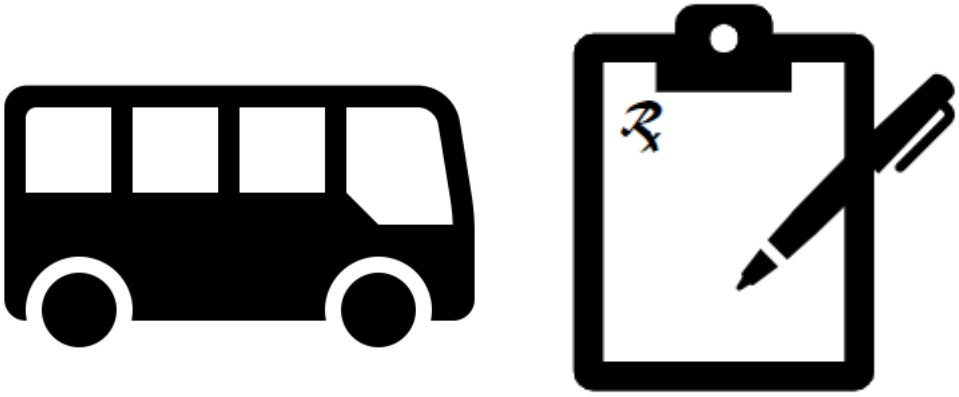

TransitRx: A Prescription for Medicaid Non-Emergency Management Transportation

SIX NEMT PUBLIC TRANSIT SOLUTIONS

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Chapter 1. Volunteer Drivers in the Provision of Medicaid NEMT

VOLUNTEER TRANSPORTATION CENTER, WATERTOWN, NEW YORK

Located in Upstate New York and bordering Lake Ontario and the St. Lawrence Seaway, the three-county region of Jefferson County, Lewis County, and St. Lawrence County is mainly rural in nature and is anchored by the City of Watertown in Jefferson County (see Figure 1). The total populations, service area, and density for three counties and the region in 2023 are shown in Table 1. Watertown is the largest city in the region with a population of 24,685. It is also the commercial and industrial center of Jefferson County and is the location of the largest hospital in the region, Samaritan Medical Center. Jefferson County's largest town is the Town of LeRay, with a population of 25,574 people, attributable to the Army base at Fort Drum. Fort Drum is also the County's largest employer with approximately 15,000 employees. Up until the 2000's there was limited public transit service in Watertown, and no public transit service in St. Lawrence Couty, Lewis County, and outer Jefferson.

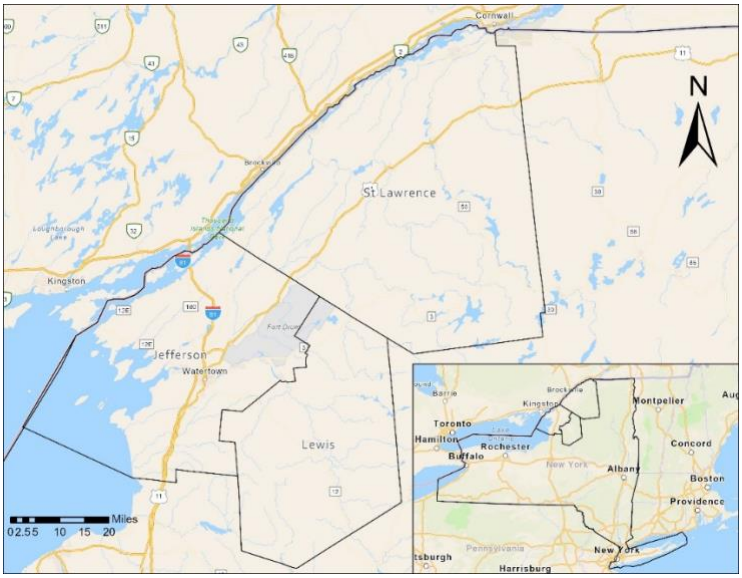

Figure 1. Three-County Region—Jefferson, St. Lawrence, Lewis Counties

Table 1. Three-County Region Population, Area Size, and Population Density (2023)

County	Population	Area Size (sq. mi.)	Population Density (pop/sq. mi.)
Jefferson*	116,721	1,857	62.9
St. Lawrence	107,733	2,680	40.2
Lewis	26,582	1,290	20.6
Three-County Region	**251,036**	**5,827**	**43.1**

1.1 The Challenge & Opportunity

Without a public transit service, many residents were transportation challenged, especially when it comes to receiving needed medical services. A volunteer driver program made sense as a low-cost transportation program to fill the transportation gap.

1.2 The Solution

In 1991, the local United Way created Volunteers of Jefferson County as a way to centralize volunteer services, including volunteer driver services. Through the years, this organization expanded its reach into Lewis and St, Lawrence Counties noting again that the three public transportation systems that now serve Watertown and the Lewis and St. Lawrence Counties had either yet to be established or were limited in its ability to serve the need. This United Way volunteer program in the three-counties predominant type of request was for medical rides, And so, in 2006, Volunteer Transportation Center (VTC) was established as a 501(c)(3) non-profit organization that provides volunteer driver -- and was later expanded to also provide mobility management services in the three counties.

VTC Needed Beyond the Development of Public Transit

In the 2000s, three public transit systems developed in the region:

- Citibus, the public transit service in the City of Watertown consists of five local fixed routes, which use at the Arcade Street Transfer Station, and which operating Monday – Saturday. Citibus also provides an ADA paratransit service.
- The Lewis County Public Transportation system (LCPT), launched in 2009, contracts with Birnie Bus Service to operate seven fixed routes and a Dial-A-Ride service, which involves deviating the bus up to ¾ miles from the route to serve persons with disabilities who cannot get to the nearest bus stop. Dial-a-Ride is a curb-to-curb service. LCPT also provides a connector route to Watertown and service to/from Fort Drum and a summer-only route to/from Old Forge 7.
- St. Lawrence County Public Transit operates 19 routes, most of which run Monday through Friday, while four routes offer weekly or bi-weekly service. This system is operated by the Arc of Jefferson-St. Lawrence. The system also offers a free First Mile Last Mile (FMLM) demand responsive transportation for person living one mile or more from the nearest bus stop.

Still, each of these public transit agencies has a limited reach in the community and the need for volunteer drivers remains. Coverage is especially needed with New York State's upstate Medicaid NEMT broker as there have been a limited number of Medicaid NEMT companies in the area, and the public transit agencies cannot provide trips beyond their respective service areas, at times needed, and are limited in terms of capacity. VTC continues to fill the gap that public transit cannot in the provision of NEMT.

The Details

The following provides a few details about the current VTC operation.

- Staff and Budget – VTC's 2024 operating budget is $6.5 Million with $3.6 Million in mileage reimbursement and $2.3 Million in staffing. The remainder covers overhead items like insurance, rent, etc.
- Ridership - VTC provides approximately 800 volunteer driver trips per day or about 150,000 trips per year, with a roster of 300 volunteer drivers, down for about 450 volunteer drivers prior to the COVID pandemic. Based on ridership, it is one of the largest volunteer programs in the US and may be the largest multi-sponsor coordinated volunteer driver program in the US (i.e., where some of its trips are sponsored by various agencies).
- Medicaid NEMT Trips - About 100,000 or 2/3 of the 150,000 annual trips served by VTC are NEMT trips sponsored by Medicaid, which is administered by the NYS Department of Health's upstate broker. New York State has set the Medicaid billing rate for all volunteer driver organizations at a rate of $7.50 per one-way trip leg plus $1.65 per (live) passenger-mile. Mileage reimbursement to volunteer drivers is at the current IRS rate of $0.67 per volunteer traveled mile (including the non-passenger miles on the way to pick-up or drop-off riders). Thus, in addition to covering the mileage reimbursement rates, the Medicaid revenue goes a long way to cover VTC's administrative costs.
- Trips Sponsored by Other State Agencies - Other sponsoring organizations include various state human service agencies, such as the County-based Child and Adult Protective Services, Mental Health providers, and the Office of Addiction Services and Supports providers. Collectively, these sponsored trips total to about 30,000 trips annually. Rates from these organizations also help to cover VTC's administrative costs.
- Unsponsored Trips - The remaining 20,000 are unsponsored. Revenue for mileage reimbursement for these "charitable" trips come from fund-raising.

- FMLM Trips - The St. Lawrence County Public Transit has a First-Mile/Last-Mile service as mentioned above. VTC provides these free-fare FMLM trips for individuals who live more than one-mile from a bus stop, noting there is no upper limit to the distance from the bus stop as long as the trip origin or destination (e.g., for a return trip) is in St. Lawrence County. Some of these trips can be up to 30 miles or more.
- Reservation Policies - VTC's reservation policy requires customers to place reservations two-days in advance; for such trips, VTC boasts an almost 100% record of successful matches with drivers. VTC also does take next-day trip requests under extenuating circumstances and rarely denies such trips.
- Accessible Service - While most trips served by VTC drivers do not require wheelchair accessible vehicles (WAVs), some do. For trips needing accessible service, VTC owns three WAVs stationed strategically throughout its service area so that response times for on-demand "VIP/Concierge" trips (e.g., discharges from hospitals) are no more than15 minutes. VTC trains its WAV drivers on wheelchair securement, passenger assistance training, and disability awareness. VTA trains the drivers, and covers maintenance, fuel (via a gas card) and insurance.
- Brokering Trips - VTC also assigns/dispatches 30-40 shorter trips per day to taxi companies in Watertown. For shorter trips, taxis are ideal because VTC's out-of-pocket costs are lower, and the reimbursement rate for sponsored trips still covers these costs. In addition, volunteer drivers tend to like longer trips. Also, in support of serving FMLM trips that require WAVs, VTC has arrangements with local NEMT providers with ambulettes (WAVs).

Mobility Management and Coordination Planning - VTC also provides mobility management services throughout the region. Indeed, VTC provides three mobility managers. In addition to various services aimed at connecting individuals with service providers, the roles of these mobility managers focus on how services within the region can be better coordinated. As part of this focus, the mobility managers lead the planning effort for – and prepare -- the 5-year coordination plans for each area they support. (In New York State, the entity that leads the coordinating planning and mobility management efforts must be different than the transit agencies, especially since one of the roles of the mobility managers is to monitor the extent and effectiveness of the coordinated services.)

1.3 Key Insights

The following provides key insights of the VTC operation, supporting technology, and continued challenges.

- The success of any volunteer driver program is largely dependent on having enough drivers to meet the demand. So, having enough drivers to meet demand all boils down to successful driver recruitment and retainage.
- Sam Purington, VTC's Executive Director, believes that the key to driver recruitment is to focus on driver retainage. If volunteer drivers are happy in their job, driver recruitment will "take care of itself" through word of mouth, noting that VTC still does traditional recruiting via social media.
- VTC's success in driver retainage success can in turn be traced to its focus on the way VTC's schedulers assign trips to drivers (which in part relies on a home-grown computer assisted scheduling technology) with a focus on matching the right number and the right type of trips to each driver, based on his/her desires. Keeping drivers happy is a large part of the success of VTC, and, with happy drivers, driver recruitment almost takes care of itself through word of mouth.
- The other key to success, according to VTC management, is screening for kind drivers.

Currently, VTC provides approximately 800 trips per day or about 150,000 trips per year, with a roster of 300 volunteer drivers. Based on ridership, it is one of the largest volunteer programs in the

US. About 100,000 or 2/3 of the 150,000 annual trips served by VTC are NEMT trips sponsored by Medicaid.

Supporting Technology

Having the right technology that helps schedulers match trips to volunteer drivers is essential to driver recruitment (see below). As the volunteer program expanded. It became clear that technology was needed to support the program. VTC management looked at technology offerings from Ecolane, Trip Spark, and Routematch, as well as a few technologies, such as QRyde, that were designed to handle volunteer driver programs. VTC eventually selected Routematch; however, Routematch was experiencing support issues at the time which eventually culminated in legal action.

VTC ended up creating its own software system that can best be described as "computer-assisted" scheduling. What VTC found from using technologies that had been designed for paratransit services was that the automated optimization algorithms had a dearth of capabilities that focused on matching trip types to the desires of individual drivers. In addition, to trip types in general, customers also have preferences, such as vehicle type (sedan vs. SUVO, driver type (female only), and drivers with special certifications. This matching was a key need for both riders and drivers (see below) and in putting together their own system, VTC concluded this this type of matching could not be well programed into an automated process. In short, it is the scheduler (there are five at VTC) who makes the decision as to scheduling certain trips to a certain driver's manifest and how they will be sequenced. But what the system they built does do is provide this "matching" information to the scheduler so that s/he can make an informed decision.

Schedules are provided electronically to each driver's mobile device around 10 am the day before the trip date.

The home-grown package also does a great job entering service statistics directly from the in-vehicle mobile devices, needed for reporting to the sponsors (in support of invoices). This includes GPS date and time stamping of each event, such as the arrival and departure times and location at each stop.

Also planned is a deployment of a customer-facing app where customers can request, confirm and cancel trips, and where ETAs and imminent arrival notices are provided to customers.

Ongoing Challenges

VTC's ongoing challenges, besides not enough funding, include:

- Adapting to a dramatic shift in the type of trips served. In recent years, there has been a dramatic increase in the number of methadone (and other) addiction trips sponsored by both Medicaid and NYS Office of Addiction Services and Supports. Currently, these, trips reflect about 50% of the trips served by VTC. These trips require a special kind of driver to deal with the chaos that typically ensues on the going trips; some VTC drivers refuse to serve such trips.
- Minimizing deadheading, as deadhead miles are included in mileage reimbursement to drivers, but not in revenue from the sponsoring agencies. Thus, instead of sending a driver home in between long going and return trips (e.g., for dialysis trips), schedulers try to fit in a trip in between but are not always successful. Non-revenue deadheading also comes into play with no-shows.
- VTC experiences a lot of same-day cancels, which can put a damper of the effectiveness of the schedules of affected drivers.
- Finding enough driver to serve late night trips is a challenge, as most of VTCs drivers are seniors and retire for the day early.
- Covering the cost of charitable trips and WAV service.

1.4 Summary & Conclusions

A well-managed volunteer driver program can be an important resource of transportation in rural areas where public transit is a non-existent or has a limited reach or is capacity constrained and where the demand-density is insufficient to attract NEMT providers. For NEMTY brokers, volunteer driver programs can provide a high-quality low-cost option for NEMT. And the way in which VTC accommodates the need for wheelchair accessible service – by owning the WAVs and training volunteer drivers to handle wheelchair trips – is a best practice.

Contact Information

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Chapter 2. NEMT Broker's Use of GTFS Data to Optimize NEMT for Public Transit

MODIVCARE'S DATA-DRIVEN SOLUTION

The COVID-19 pandemic significantly reshaped Non-Emergency Medical Transportation (NEMT) services, altering rider expectations and habits. Traditionally, NEMT brokers like Modivcare relied on public transportation as the most appropriate option for ambulatory riders whenever possible. However, during the pandemic, more conventional NEMT modes became prevalent as safety concerns drove a shift toward single-occupant transportation options. As a result, riders grew accustomed to the convenience of private rides, often preferring them over public transit due to added convenience and fewer logistical challenges. This preference was particularly notable in suburban and rural areas, where infrequent schedules meant that missing a bus could lead to long delays.

2.1 The Challenge & Opportunity

With the public health emergency ending in 2023, Modivcare began exploring strategies to reintroduce public transit as a viable NEMT option. The timing aligned with updated guidance from the Centers for Medicare & Medicaid Services (CMS), which in September 2023 reaffirmed that Medicaid transportation should be the "least costly, most appropriate" to meet beneficiaries' needs. While these principles were not new, CMS encouraged managed care plans, states, and transportation brokers to maximize program efficiency by

using public transit whenever feasible as a cost-effective alternative to private rides. These guidelines strengthened Modivcare's focus on public transit as a key component in delivering cost-effective NEMT services.

To operationalize this objective, Modivcare leveraged GTFS (General Transit Feed Specification) data, a standardized data format widely used by transit agencies to share service information, including schedules, routes, and stops. GTFS data, which is publicly available, allows NEMT brokers like Modivcare to analyze transit accessibility and plan routes efficiently. Its standardized format enabled Modivcare to assess transit options systematically, helping to match riders with public transit when schedules and routes align with their needs. This data-driven approach allowed Modivcare to meet CMS's cost-control objectives while ensuring riders had reliable, appropriate transit options.

Additionally, transit agencies played a pivotal role in this strategy by providing GTFS data that enabled Modivcare to identify transit-friendly trips. Historically, transit agencies have been central to coordinating NEMT, especially for Medicaid beneficiaries. However, as Medicaid Managed Care has increasingly shifted NEMT management to private brokers, the role of transit agencies in NEMT has sometimes diminished. Modivcare's strategy, by contrast, illustrates a collaborative path forward: by publishing GTFS data, transit agencies empower brokers to effectively incorporate public transit into NEMT, creating a model that benefits riders, brokers, and transit providers alike. This partnership offers a positive example of how transit agencies can play a vital role in NEMT, supporting both service quality and cost sustainability.

2.2 The Solution

Modivcare used GTFS data to identify members whose NEMT trips were suitable for public transit, aligning with CMS guidelines and cost-efficiency goals. This approach required tackling challenges like data complexity and rider hesitancy, which Modivcare addressed through data analysis and proactive outreach.

Challenges

- **Data Complexity and Rider Preferences:** Modivcare's approach required analyzing GTFS data to ensure that public transit recommendations met individual rider needs and preferences. For transit to be a viable option, trips had to meet criteria for maximum walking distances, number of transfers, and total travel times. Riders, accustomed to the convenience of private rides, also needed encouragement and reassurance to consider public transit again as a comfortable and reliable option.
- **Engaging Riders Effectively:** Recognizing the need to overcome potential rider hesitations, Modivcare piloted an outbound calling program. Staff reached out directly to riders identified through GTFS analysis, providing them with detailed information on how public transit could meet their needs and addressing any questions or concerns. This one-on-one outreach was essential for rebuilding trust in public transit as a viable NEMT option.

Benefits

- **GTFS Data and Open Trip Planner for Precision:** Using GTFS data with Open Trip Planner, Modivcare conducted bulk analyses to identify NEMT trips suitable for public transit. By programmatically filtering trips based on Modivcare's criteria—such as transfer limits, maximum walking distances, and overall travel times—Modivcare was able to tailor recommendations to ensure transit routes aligned with the needs of individual riders. This approach provided a consistent, efficient method for designating public transit as an appropriate option, while ensuring that riders would be comfortable and well-served.
- **Cost-Efficiency:** Public transit rides are significantly less expensive than NEMT-dedicated vehicle services. This strategic shift helped Modivcare lower its average unit cost for NEMT. By aligning NEMT rides with transit services where appropriate, Modivcare reduced the financial burden on the Medicaid system while continuing to provide a high-quality service to its members.
- **Successful Pilot with High Conversion Rates:** The outbound calling pilot proved instrumental in shifting rider perceptions. In this initial phase, Modivcare achieved a 35% voluntary conversion rate among those contacted, showing that one-on-one engagement successfully encouraged a significant portion of riders to consider public transit as a reliable, convenient option for their medical transportation needs. This result validated Modivcare's approach and served as the basis for expanding the program further. The use of GTFS data made this possible by narrowing down the list of people who needed public transit to be contacted based on those individuals who clearly could benefit from the use of Public Transit.
- **Scalable Approach for Broad Impact:** The success of the pilot allowed Modivcare to develop a scalable model that incorporated GTFS data analysis in additional markets. As this approach was implemented more broadly, Modivcare integrated transit-focused communication as a key part of its ongoing NEMT strategy, expanding the reach and impact of the program.

Implementation by the Numbers

To track the effectiveness of the GTFS-based transit strategy, Modivcare used several key metrics:

- **Percent of Ambulatory Rides on Transit**: This metric provided insight into the program's impact on shifting NEMT rides to public transit, measuring the success of GTFS-driven recommendations over time.
- **Complaint Rate Trends by Mode**: Modivcare closely monitored the complaint rates associated with each mode of transportation, including public transit, to ensure that the transition did not negatively impact rider satisfaction. This allowed for comparisons across different modes and helped the team detect any issues early, allowing them to maintain or improve rider satisfaction.
- **Average Unit Cost Trends**: As part of Modivcare's commitment to cost-effectiveness, the team tracked unit cost trends to ensure that the use of public transit supported financial goals.

By employing these metrics, Modivcare could maintain oversight of the program's performance and ensure that cost savings were achieved without compromising service quality.

2.3 Key Insights

Modivcare's use of GTFS data for NEMT optimization offers lessons for brokers and transit agencies. By aligning with CMS guidelines, engaging riders, and collaborating with transit agencies, Modivcare developed a scalable, cost-effective approach to using public transit more effectively in NEMT. These insights reveal the potential for broader adoption and collaborative success across the transportation ecosystem.

- **Alignment with CMS Guidelines:** Modivcare's GTFS-based transit strategy directly supports CMS's 2023 guidance, demonstrating a commitment to providing the "least costly, most appropriate" mode of transportation for NEMT beneficiaries. This alignment reflects Modivcare's proactive stance in adopting data-driven solutions that meet federal standards and promote sustainable Medicaid practices.
- **Effective Outreach and Education for Riders:** The outbound calling pilot highlighted the value of proactive, personal communication in encouraging riders to embrace public transit. By addressing riders' concerns directly and presenting the benefits—such as the cost-effectiveness and added convenience of a monthly pass for medical and personal travel—Modivcare's outreach efforts were key to achieving high conversion rates.
- **Scalability and Broader Applicability:** Modivcare's approach, using GTFS data to evaluate transit feasibility and conducting direct outreach, provides a replicable model for other NEMT brokers. This scalable strategy, when applied across regions with reliable public transit networks, can support Medicaid's objectives of efficiency and accessibility.
- **Opportunity for Collaborative Success with Transit Agencies:** This case demonstrates how GTFS data from transit agencies enables effective collaboration with NEMT brokers like Modivcare. By providing detailed transit data, agencies lay a foundation for brokers to identify trips well-suited for public transit that align with Medicaid Managed Care goals. This collaborative approach allows transit agencies to support NEMT service delivery in a way that enhances ridership while alleviating pressures on ADA paratransit resources. Modivcare's transit strategy shows how brokers and transit agencies can work together toward win-win outcomes, fostering a cooperative environment that benefits service quality, cost sustainability, and accessibility for riders.

2.4 Summary & Conclusion

In conclusion, Modivcare's innovative use of GTFS data to optimize NEMT services demonstrates the transformative potential of data-driven solutions in achieving cost-effective, scalable, and high-quality transportation outcomes. By aligning its strategies with

CMS guidelines, addressing rider concerns through proactive engagement, and fostering collaboration with transit agencies, Modivcare has set a benchmark for integrating public transit into NEMT services. This success would not have been possible without Modivcare's leadership, expertise, and commitment to creating sustainable solutions that benefit riders, brokers, and the broader transportation ecosystem. We are grateful for Modivcare's invaluable contributions to this case study and partnership in advancing the role of public transit in NEMT, paving the way for a more accessible and cost-efficient future in transportation.

Contact Information

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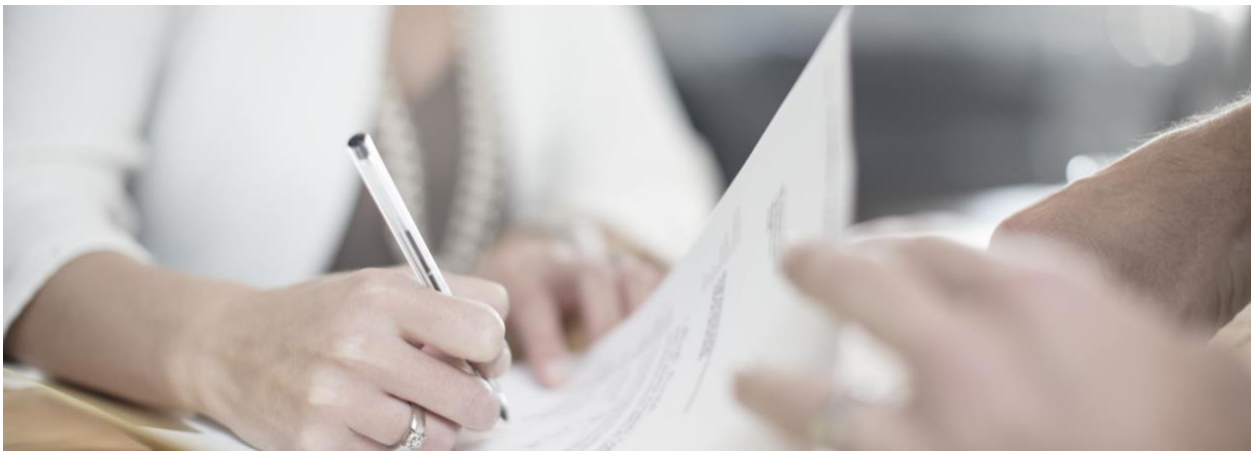

Chapter 3. A Coordinated NEMT Model Enabled by a Medicaid Waiver

KENTUCKY'S COORDINATED PUBLIC TRANSIT NEMT BROKERAGES

In 1996, Empower Kentucky, a gubernatorial advisory committee issued a report recommending the consolidation of the state's human service transportation systems under a managed care model to contain increasing costs of specialized transportation. In 1998, the state's General Assembly enacted several statutes as a result of Empower Kentucky to better coordinate human service transportation programs throughout the state, resulting in the creation of the Human Service Transportation Delivery (HSTD) program within the Kentucky Transportation Cabinet.

3.1 The Challenge & Opportunity

The state's mission (and challenge) in providing human service transportation coordination is to "promote accessible transportation in all areas of the state" … which will "combine the transportation resources of participating governmental agencies and private sector providers and … be structured so that it is effective, efficient, and easily administered."

Challenge

Before the HSTD brokerage program was created, the state's transportation delivery process was fragmented, increasingly costly, lacked consistent standards of safety and quality, and was vulnerable to fraud and abuse. According to a 2004 legislative investigation of the HSTD program, it appeared that the brokerage system implemented was containing the cost of NEMT and have reduced the incidence of fraud and abuse.

Opportunity

Kentucky's Department for Medicaid Services (DMS) is authorized by the Centers for Medicaid and Medicare Services (CMS) to implement a HSTD brokerage model through a Section 1915(b)(4) waiver which is renewed every two years. DMS contracts with the Kentucky Transportation Cabinet to manage the HSTD program. The HSTD model is a capitated brokerage that splits the state into 15 regions. Each region's brokerage is awarded to an organization through a competitive bidding process. The capitated rates paid to the brokerages are determined by how many eligible recipients are in the broker's region. The pricing model provides an incentive to brokers to ensure that their providers are not denying eligible trips and are billing appropriately.

The program is overseen by the Coordinated Transportation Advisory Committee (CTAC), composed of members of the state's transportation cabinet, the Cabinet for Health and Family Services (CHFS), and the Education and Workforce Development Cabinet. Brokers are required to serve as regional coordinators, providing rides by assigning trips to subcontractors, providing rides directly to guarantee trips, or act solely as brokers by contracting out all transportation to approved transportation providers This model allows for ample opportunity to coordinate NEMT trips with demand responsive public transit.

3.2 The Solution

Several organizations that provide rural public transit have taken the opportunity to become brokers. The current operators of the brokerages include Audubon Area Community Services (AACS), Pennyrile Allied Community Services (PACS), LKLP Community Action, Federated Transportation Services of the Bluegrass (FTSB), Blue Grass Community Action Partnership (BGCAP), Rural Transit Enterprises Coordinated, Inc. (RTEC), Sandy Valley Transportation Services, Inc. (SVTS), and Licking Valley Community Action Program (LVCAP). All of the operators are non-profit organizations that operate public transit (predominantly, rural transit) in addition to serving as NEMT brokers. Many of the organizations operate public transit in a core service area, and provide NEMT brokerages services in a larger area. The largest brokerage, Federated Transportation Services of the Bluegrass, covers four of the 15 regions, serving 24 counties.

Each broker is required to ensure adequate coverage, or capacity, for their region(s). Adequate coverage means a provider is available to fill every eligible trip request. To guarantee these trips, Kentucky's model coordinates NEMT with all willing and able transportation providers. These providers include public transit agencies, private taxicabs, disabled person vehicle carriers, and passenger carrier companies. Medicaid members living on fixed bus routes in urban areas utilize the fixed route system if medically able, allowing the state to realize additional savings in the NEMT Program as fixed route is an accessible, lower-cost mode of transport.

The state transportation cabinet Office of Transportation Delivery (OTD) operates a hotline for members to contact with complaints about any aspect of service provided by the brokers or their contracted transportation providers. The OTD and DMS maintain a close working relationship and frequent contact to ensure that concerns are addressed. OTD and the brokers require vehicle safety inspections and driver background checks. Parents or guardians are required to ride with minor children. DMS requires that OTD provide monthly reports regarding trip data, hearings held and decisions made, complaints and resolutions. Monthly, publicly advertised CTAC in-person and/or virtual meetings allow for a public forum for brokers, providers and members to address their concerns.

The Details—Other Considerations

OTD provides an annual data report to DMS. The Fiscal Year 2024 (July 1, 2023 to June 30, 2024) report documented 3,155,585 total NEMT trips provided. There were 221,423 unduplicated Medicaid members that received these trips, representing about 15 percent of the state's total Medicaid population of 1,488,084 (as of the CHFS June 2024 Monthly Membership Count).

There were approximately $163 million in capitated payments made to the brokerages in FY 2024. This brought the average cost per trip to $51.57 in direct service costs.

There were 15 registered complaints made to the OTD in FY 2024. The Cabinet denied 9,904 requests for trips after finding that the trips would not be eligible for Medicaid funding. The most common reason for a trip denial was that there was a vehicle in the member's name, followed by insufficient time notice provided by the member. The denied requests represented a savings of approximately $1,021,499.

An annual customer survey was completed by 957 members. The satisfaction rating from the survey respondents was 97.6 percent.

3.2 Key Insights

The following provides key insights in providing a coordinated NEMT model enabled by a Medicaid waiver:

- The Kentucky model, which provides significant opportunities for public transit operators to engaged in NEMT - either as brokers or subcontracting providers - is sustained by a strong working relationship between the state's Medicaid office and the Kentucky Transportation Cabinet. The regional brokerage model has been in place for about 25 years.
- This model allows many of the state's public transit operators to earn a sustainable source of revenue to use as local match for Federal Transit Administration grants. This particularly helps transit systems offer a much-needed, sustainable public transportation service in Kentucky's rural areas.
- In each region, having NEMT and public transit under one "roof" maximizes opportunities for coordinated, shared rides between public transit riders and Medicaid members taking NEMT trips.

3.3 Summary & Conclusions

The Kentucky model hinges on a long-term collaboration between the Kentucky Transportation Cabinet, the Department of Medicaid Services, and the regional public transit operators who win the brokerage opportunities through competitive bidding. This atypical model is enabled by a waiver that the Department of Medicaid Services renews in a biennial basis. The model has significant benefits: simplified access for members, whose NEMT and public transit rides are coordinated through a single point of contact; the opportunity to braid Medicaid and Federal Transit Administration dollars at the agency level; and likely cost efficiencies achieved through reduced administrative burden.

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Chapter 4. Making the Dollars Work

AN OVERVIEW OF NEMT FUND BRAIDING IN COMMUNITY TRANSPORTATION

Various case studies demonstrate a wide range of approaches that have proven effective in coordinating Non-Emergency Medical Transportation (NEMT) with public transportation services in both rural and urban areas. As Medicaid is the single largest funder of human service agency transportation,

1.1 The Challenge & Opportunity

Historically, the integration of NEMT services has proven difficult due to multiple factors, with some of these factors embedded in Medicaid legislation. For example, NEMT could be provided as an administrative service or as a medical service. Many states sought federal reimbursement of NEMT as a medical service as the Federal Medicaid Assistance

Percentage (FMAP) was typically a higher rate than the Medicaid administrative reimbursement rate of 50 percent. However, when offered as a medical service, the state was obligated to:

- Consistently provide NEMT services throughout all areas of the state; and
- Ensure consumer choice in the selection of a service provider.

Challenge

As public transportation availability may not be consistent throughout all jurisdictions of a state and requiring a beneficiary to use a designated provider of coordinated transportation in a local area would be inconsistent with state obligations, these provisions were viewed as problematic.

Moreover, guidance provided to State Medicaid Directors in 1991 also provided policy direction that required a state, when several modes of transportation are available, to use the least costly mode that is appropriate for the physical and emotional condition of the beneficiary.[1] Public transportation may or may not have been the least costly mode of service in the local community. These rules were often viewed as contradictory to policy direction in other federal programs, such as 49 U.S.C. § 5311, the Formula Grants for Rural Areas Program (Section 5311). Congress specifically required that the Secretary of Transportation could not approve a state's program of projects unless it provided for the "maximum feasible coordination" of public transportation services with transportation service assisted by other United States Government sources.[2]

Other challenges to the coordination of public transportation and NEMT related to Medicaid rules in its implementation of rules permitting a state option to establish NEMT brokerages. In a Notice of Proposed Rulemaking (NPRM), Medicaid proposed that a governmental broker could only pay for an NEMT trip no more than that rate charged to the general public.[3]

This concept was embedded in overarching Medicaid rules that prohibited service providers from charging the Medicaid program more than what would be charged to other insured individuals. While the final rule ultimately changed this proposed requirement, the proposal raised significant concerns among public transportation agencies, particularly those that provided fixed route public transportation and corresponding complementary paratransit service. As fares charged to the public are heavily subsidized by Federal, state, and local funding sources, significant budgetary impacts would be felt by transit organizations if clients of other programs only paid the public fare. Under Americans with Disability Act (ADA)

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[1] State Medicaid Director Letter(SMDL) guidance on payment for of transportation and the assurance of transportation issued March 7, 1991.

2 49 U.S.C. § 5311(b)((2)(C)(ii).
3 Medicaid Program; State Option to Establish Non-Emergency Medical Transportation Program, 72 Fed. Reg. August 24, 2007.

regulations, a public entity (or its contractors) could not charge an eligible user more than twice the fare that would be charged to an individual paying full fare (i.e., without regard to discounts) for a trip of similar length, at a similar time of day, on the entity's fixed route system.[4]

Since the passage of the ADA, transit agencies were concerned that other organizations that were responsible for client transportation services would increasingly rely on ADA paratransit services to meet these client needs. More than a decade ago the General Accountability Office (GAO) cited this trend (which was referred to as "ride shedding") as one of two causal factors in dramatic increases in complementary paratransit usage.[5] Transit agencies had valid concerns as such actions merely shifted the financial burden from one federal sponsoring agency to another. This has been particularly true since the widespread adoption of statewide or regional NEMT brokerages, primarily run by for-profit corporations that sought to provide the service at the lowest cost possible. This sometimes created conflicts in cases of dual NEMT and ADA eligibility, wherein brokers sought to arrange for NEMT rides at the paratransit fare.

This position contrasts with ADA regulations and final guidance on the establishment of NEMT brokerages. The ADA regulations previously cited addressed the concept of ride shedding. A covered entity has always been allowed to charge a higher fare to a "social service agency or other organization for agency trips."[6] U.S. DOT explained that transit agencies were free to negotiate rates with these agencies that were guaranteed to the agency for its use. Additionally, the final regulation on NEMT brokerages clarified its payment policies for such trips noting the broker must document that the Medicaid program is paying no more for public paratransit services than the rate charged to "other state human services agencies for comparable services."[7]

Finally, it must be recognized that as a Federal/state partnership, the Medicaid program dwarfs Federal transit programs; whereas the annual Federal Transit Administration (FTA) budget is approximately $25 billion per year, KFF reports Medicaid expenditures in FY 2023 at $860 billion – more than 34 times the size of the FTA budget.[8] More importantly, it is estimated that NEMT comprises less than *one percent* of overall Medicaid expenditures (although even the Centers for Medicare and Medicaid (CMS) reports that it cannot accurately estimate actual NEMT expenditure due to differences in billing practices across

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[4] 49 CFR § 37.131(c).

[5] GAO, ADA Paratransit Services: Demand Has Increased but Little is Known about Compliance, GAO-13-17 (Washington, D.C.: November 15, 2012).

[6] 49 CFR § 37.131(c)(4).

[7] This final rule modified the NPRM to include this provision, found at 42.CFR § 440.170(a)(4)(ii)(B)(4)(iii)).
[8] KFF, State Health Facts, downloaded from: https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

the states).[9] The vast difference in scale has presented problems with interagency communication and/or the establishment of state-level interagency councils and local efforts to promote further coordination of federally assisted programs.

Opportunity

Despite these longstanding challenges, opportunities to enhance and expand the coordination of NEMT and public transportation have never been greater. Many of these favorable developments have been the direct result of actions generated by the Coordinating Council on Access and Mobility (CCAM). CCAM is a federal interagency council that works to coordinate funding and provide expertise on human services transportation. The CCAM focuses on programs for three targeted populations: people with disabilities, older adults, and individuals of low income.

In June 2020, CCAM issued its Cost Sharing Policy Statement. The statement provides key transportation cost-sharing information to encourage greater state and local cost sharing, including principles specific to the provision of Medicaid non-emergency medical transportation (NEMT). The statement begins with a broad proactive declaration on the role of the Federal government in the promotion of the coordination of transportation funding resources, to the extent feasible, thereby addressing General Accountability Office (GAO) recommendations in this regard.

The policy establishes a principle that in any such vehicle or ridesharing arrangement, the participants in such an agreement should first develop a strategy to equitably distribute the costs of the service to the benefiting parties. Inherent in any cost-sharing agreement, the parties must:

- Incorporate the general and program-specific principles articulated in the policy statement
- Adhere to any Federal, state, or local laws and regulations related to vehicle and ridesharing and cost allocation

CMS goes on to articulate additional principles relative to NEMT participation in a cost sharing arrangement:

- Medicaid will not pay directly for unloaded miles (miles driven when the Medicaid beneficiary is not in the vehicle) or for missed trips. However, Medicaid may pay indirectly for these costs and other indirect costs, such as vehicle depreciation, when they are built into the rate methodology for completed trips.

[9] Centers for Medicare and Medicaid, Expanded Report to Congress, Non-Emergency Medical Transportation in Medicaid, 2018 – 2022, June 20, 2023.

- Medicaid will not pay any additional costs that arise from sharing rides with local partners' beneficiaries, such as costs associated with longer trip times.[10]

The first principle embraces the practices that many state Medicaid agencies have implemented over the past decade: Medicaid will only pay for loaded miles (e.g., only those vehicle miles when the Medicaid beneficiary is physically onboard the vehicle). This principle suggests that Medicaid will not pay for an NEMT provider's "deadheading," or the time/distance incurred getting to/from the beneficiary's location to originate the trip. This principle notwithstanding, every NEMT provider will incur costs for operating deadhead miles. Thus, to break even (in the case of a public or nonprofit provider) or to make a modest profit (in the case of a for-profit entity), the NEMT provider must incorporate these costs into its billing practices in some form or fashion. The principle recognizes this fact; the policy goes on to note that "Medicaid will pay indirectly for these costs, and other indirect costs, such as vehicle depreciation when the cost allocation agreement incorporates indirect costs into the overall rate that all participants pay for completed trips."[11] This passage suggests deadhead be included in the shared costs that are then allocated as a shared cost and incorporated into the rate.

In the following illustration, a typical vehicle tour where the transit agency is transporting multiple passengers is depicted; Medicaid sponsors two of the four passengers. The transit agency determines that the first illustration represents the economic way to schedule and deliver these four trips. Note, however, that PU2, is not transported directly to the passenger's destination, two additional pick-ups are made before the PU2 Medicaid passenger is delivered to their destination, In the second illustration, the dashed line represents that direct path between the Medicaid passenger's origin and destination – the miles that Medicaid is willing to pay.

[10] Coordinating Council on Access and Mobility, Cost-Sharing Policy Statement (August 2020).

[11] Ibid.

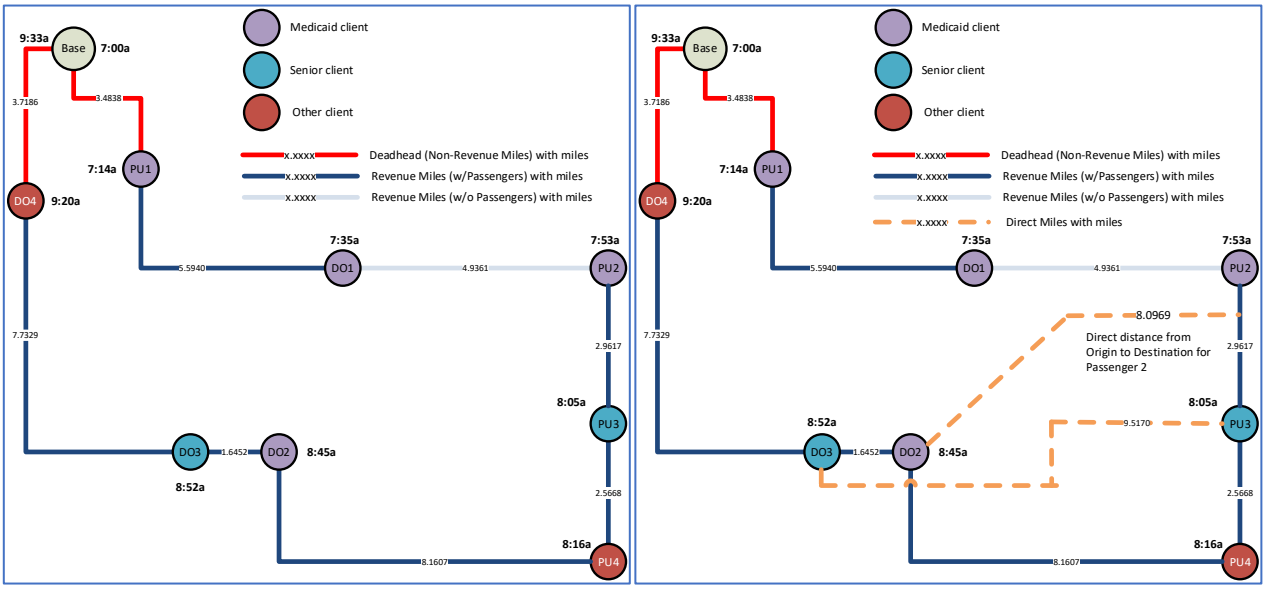


Figure 2. Example of Typical Demand Response Route and What NEMT Seeks to Pay

4.2 The Solution

Existing cost allocation models (such as the National Rural Technical Assistance Program (RTAP)) Cost Calculator can accurately compute the fully allocated cost of a service based on the hours or miles of service operated; the resulting output (regardless of mode) is a lump sum amount based on the hours and miles of services provided by the transit operator. This amount is rarely used as the price for service, as the consumers of the service typically seek to pay on a unit rate basis. Common unit rates are:

- Price per mile
- Price per hour
- Price per passenger

By using these existing methodologies as a base, transit providers can, based on full cost recognition concepts, build new pricing structures based on the price per loaded passenger mile to address all Medicaid cost-sharing principles thereby enabling Medicaid's greater use of public transportation to provide NEMT services.

The CCAM will be establishing a new CCAM Technical Assistance Center (CCAM TAC) in 2025; one of the products or support services that will be offered by the Center will be an NEMT cost allocation model that will provide a tool for all NEMT providers to use to compute costs following these principles.

The Details

To realize this concept, the provider must know its fully allocated costs and calculate a cost per loaded mile of operation. Once this metric is known, the cost of any individual trip would be computed as follows:

$$Cost = [(Fully\ Allocated\ Cost \div \Sigma\ Load\ Passenger\ Miles) \times \Sigma\ Loaded\ Miles - Sponsoring\ Agency\ n\}$$

Where:

- *Cost = the cost of the provider agency to provide a trip*
- *Fully Allocated Costs ÷ Σ Load Passenger Miles = the loaded passenger-mile unit cost*
- *Σ Loaded Miles – Sponsoring Agency n = the total number of loaded passenger miles consumed by a sponsoring agency on the least path route between origin and destination*

To illustrate this concept, assume the route depicted in Table 1 consumes 39.4 total vehicle miles and two hours and six minutes. The cost to the agency (using a cost allocation method) is determined to be $108.94; the agency typically charges sponsoring users on a price-per-mile basis of $2.21 per mile.

In a shared ride situation, the agency currently distributes the trip costs to the three sponsoring users based on the ratio of passengers on the run (Table 3).

Table 2. Traditional Approach to Allocated Shared Costs on a Coordinated Demand Response Route

Sponsor	Passengers	Allocation Percent	Cost to Sponsor
Medicaid	2	50%	$54.17
Senior Center	1	25%	27.09
Other Client	1	25%	27.09
Total	4	100%	$108.34

To embrace new cost sharing principles, the transportation provider computes a new pricing structure based on cost per loaded mile, computed as $2.75797[12].

Note that since this unit rate is predicated on the fully allocated costs in providing all transportation, this rate also includes deadhead (or non-revenue) expenses. Thus, the rate structure meets Medicaid's cost sharing principles. Applying this rate structure, the provider computes its user charges for the run (Table 4).

[12] To ensure full cost recovery, all cost allocation models may be subject to rounding errors if rate computations are not computed to multiple places of decimal precision. In this case, the provider computes its unit costs to five decimal places.

Table 4. Allocated Shared Costs Based on Load Mile Rates

Sponsor	Passengers	Loaded Direct Distance Miles	Loaded Mile Rate	Cost to Sponsor
Medicaid	2	13.7	$2.76	$37.78
Senior Center	1	9.5	$2.76	$22.89
Other Client	1	17.5	$2.76	$48.26
Total	4	39.5		$108.34

4.3 Key Insights

The following provides key insights in NEMT fund braiding.

Cost vs. Price Considerations

By adopting transparent costing strategies, any NEMT provider can demonstrate that it is meeting Federal cost-sharing principles with a high degree of confidence that the charges to sponsoring agencies – whether Medicaid or any other Federal program – will result in the provider recovering the full costs to deliver the service.

Note that there is a distinction between cost and price. Previous research has suggested that there may be three approaches to using costs to price transit services:

- **Philanthropic Approach** – In this scenario (perhaps used by a nonprofit agency), the driving factor is ensuring the provider provides mobility to necessary services; the nonprofit realizes that it must seek revenues from other than end-users or sponsoring agencies to support the service. In this scenario, the cost may be higher than the price.
- **Business Approach** – In this scenario, the goal is to ensure that revenues equal expenses. Thus, these organizations set pricing to fully recover their costs and may not be concerned with profit. In this approach, cost equals price.
- **Entrepreneurial Approach** - For-profit entities must generate profit if the entity is to remain a viable business concern or invest in rolling stock replacement/upgrades and other capital items. This entity would employ an approach that ensures that revenues exceed costs and provides for suitable profit.[13] In this scenario, the price will be higher than the cost.

[13] The goal of profit realization is tempered by market forces and the desire to remain competitive, particularly in light of Medicaid rules that require the use of the most appropriate, low-cost provider.

Use of Medicaid Contract Revenues as Local Match

Increased delivery of NEMT trips can substantially assist recipients of FTA funding due to unique legislative match requirements found at 49 U.S.C.§5311(g)(3)(C). Under this provision, revenues derived from the provision of service to other public or nonprofit state or local human services can be used as match, even if the source of those funds is another Federal program. Funding levels under most FTA programs are at historic high levels; in many communities, generating the local match has proven problematic, meaning that some organizations cannot fully utilize the allocation of Federal funds.

By providing service under contract to a broker or managed care organization to deliver NEMT trips, an organization creates the option of using that contract revenue as match to its FTA grant awards.

Consider the example in Table 3.

Table 3. Illustrative Differences in Funding Scenarios Using Contract Revenues as Match

Category	Scenario 1: Contract Revenues Counted as Fare	Scenario 2: Contract Revenues Counted as Local Match
Total Operating Expenses	$850,000	$850,000
Total Operating Revenues		
Farebox and Related Revenues		
Fares	$82,000	$82,000
Contracts	$165,000	
Net Cost of Service	$603,000	$768,000
Federal Share of Operations	$301,500	$384,999
Non-Federal Share of Operations		
Local/State Revenue	$301,500	$219,000
Contract Revenue		$165,000

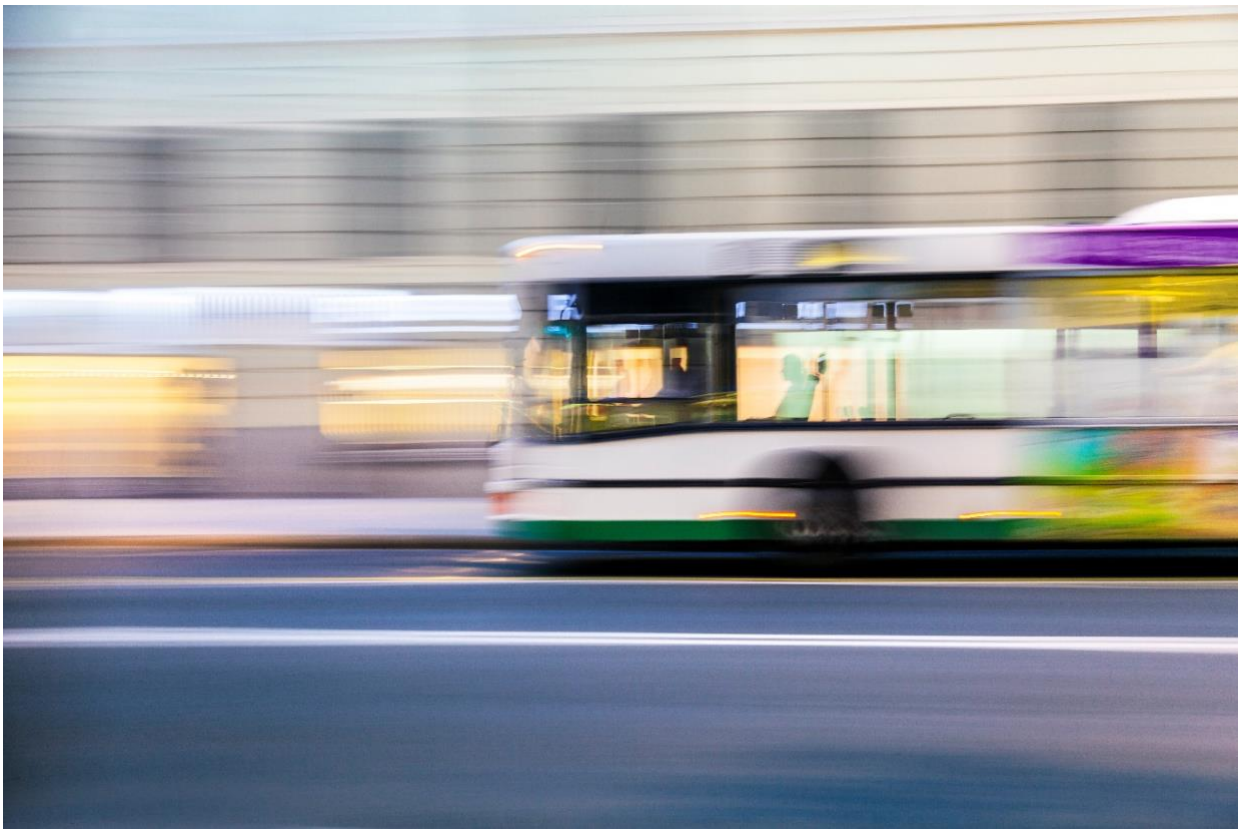
In the first scenario, an FTA recipient/subrecipient opts to count contract revenues as related revenue and reduces the net cost of service. While this lowers the Federal share, it also reduces the amount of the local share that must be drawn from local or state sources ($301,500). In the second scenario, the recipient/subrecipient elects to use the contract revenue as match. While this increases the net cost of service, the amounts needed from local or state sources have been reduced by $82,500.

As local circumstances may vary, there is no recommended best practice with respect to the treatment of contract revenues; however, Scenario 2 provides options for entities that may be struggling to generate local match.

4.4 Summary & Conclusions

By adopting new CCAM cost sharing principles, transportation providers will be able to demonstrate transparency in their rate-setting processes and enhance their ability to attract

new or additional NEMT ridership. As demonstrated in this project, many states have adopted a brokerage or managed care approach to the management of Medicaid services (including NEMT) wherein a third party coordinates the delivery and assignment of NEMT trips to providers. The use of these principles will enhance the viability of the provider to deliver quality services at a fair price.



Chapter 5. Use of Fixed Route Transit as a First NEMT Option

FIXED ROUTE NEMT BENEFIT TO MEDICAID, PUBLIC TRANSPORTATION, AND CLIENT

When covering non-emergency medical transportation, state Medicaid programs must pay for the least costly mode of transportation that most appropriately meets the needs of a member to access covered services. Fixed route public transit generally offers the lowest cost option for NEMT. Medicaid pays for fixed route public transit by purchasing fares for members. Federal regulations prohibit Medicaid from paying for fixed route service at a rate that is more than the rate charged to the general public. Medicaid can pay for ADA paratransit and demand response at a higher rate than the standard passenger fare but may not pay more than the rate charged to any other state human services agencies for comparable services.

5.1 The Challenge & Opportunity

State Medicaid programs benefit when members are able to use fixed route public transit because the cost of service is the fixed route fare. Therefore, Medicaid NEMT program administrators

generally look for ways to promote fixed route utilization by members. Public transit agencies benefit as more passenger trips increases the fixed route system productivity (carrying more passengers per revenue hour), and not cost, if the system has adequate capacity. NEMT programs vary in their emphasis on fixed route. Some states explicitly require fixed route to be used by members as a first option when feasible for the individual

5.2 The Solution

For the states that require fixed route use as a first option Medicaid NEMT programs (including contracted NEMT brokers) screen members for their ability to access to fixed route public transit. A member can use fixed route when their residence and medical appointment location are located within walking distance of a route, and the route operates when the appointment is scheduled to occur. NEMT programs use different distance thresholds for determining what "walking distance" means, generally it is a half mile or three-quarters of a mile. NEMT programs use tools such as GTFS/Google Maps, transit system web sites, and other information sources to determine whether the member has access to a fixed route. NEMT programs implement a variety of policies and procedures to ensure that members who can use fixed route, do.

Travel Training

Some NEMT programs use travel training to help members understand how to use fixed route public transit. For example, MTM, Inc. is a NEMT brokerage operating in Nevada that employs a travel trainer who assists members with planning their fixed route trips, to understand how to use fare payment systems, and other aspects of the riding experience. The travel trainer may also screen for the member's ability to use fixed route. In some cases, this one-on-one interaction is the only way to determine whether a member has the physical and cognitive capacity to ride fixed route. MTM, Inc. generally relies on local transit systems' paratransit eligibility processes to make the determination on use of fixed route transit. Travel trainers may advocate for a member to receive demand responsive NEMT if the member does not qualify for complementary paratransit depending on circumstances.

Exceptions to the Fixed Route Requirement

NEMT programs can make exceptions to their fixed route policies based on the appropriateness of the mode of service for the individual. Some groups, such as pregnant women, may get a blanket exception by the NEMT program. For others, the exception is granted on an individual basis based on conditions. For example, in some southwestern U.S. cities, extreme heat creates a seasonal barrier to riding fixed route for physically frail individuals. NEMT programs in these areas may grants exceptions for these individuals and pay for other modes of transportation during the hottest months.

In general, NEMT program personnel consider the member's unique circumstances when deciding whether to make an exception and provide the member with a higher level of service (most commonly a curb-to-curb ride provided by a contracted transportation provider). Members have been granted exceptions when their appointment is time-sensitive and there are concerns about the member's ability to use fixed route transit and be on time for their appointment. When members are not granted such exceptions, they may be provided with the opportunity to appeal.

In some states, members must work with their medical care providers to complete an application for exemption from the requirement to use fixed route transit. This system helps increase fixed route utilization by putting some level of burden on the member to justify their need for a higher level of service. For example, in New York City, all members are required to use fixed route transit unless they have applied for, and been granted, access to taxi or other demand responsive service.

Transit Passes

Medicaid generally provides transit tickets, tokens or passes to members to use on fixed routes. These fare media are provided to members through a variety of methods. Many NEMT programs mail passes to members in advance of their appointments. In New York state, Medicaid works with healthcare providers to distribute passes to members at the time of their appointments. In Nevada, the NEMT broker loads a debit card with funds that members use to purchase bus passes. In Vermont, where only one fixed route transit system charges fares (the rest are now fare-free), members pick up their passes at the system's main office or receive them by mail.

To obtain bulk trip fares, such as monthly bus passes, NEMT programs generally require members to demonstrate that they have an adequate number of scheduled medical appointments to make a bus pass cost-effective. For example, MTM in Nevada provides a trip log form that members use to track their medical appointments and obtain their provider's signature for verification of each appointment. This form is required for them to receive ongoing funding to purchase a monthly bus pass. If they fail to submit their monthly log form, they lose access to their bus pass funding.

In some places, Medicaid offices, brokers, and transit systems are working together to develop ways for Medicaid to pay for members' fixed route fares through online portals and reloadable fare media. In the four states that were directly consulted for this case study (Nevada, New York, Oklahoma, and Vermont), this technology was either unavailable, is in development, or has been attempted but experienced difficulties during implementation.

5.3 Key Insights

The following provides some key insights for fixed-route transit as an NEMT option:

- NEMT programs use a variety of approaches to promote fixed route utilization by members. This often means that programs must work one-on-one with members to understand the transit routes and schedules in their areas, sometimes providing travel training. Many smaller fixed route systems (often in rural areas) have limited routes and hours of operation. In these cases, NEMT programs must consider the specifics of the available services and the member's capacity to use fixed route in order to determine if fixed route is the most appropriate mode of transportation.
- NEMT programs want to find more efficient ways to cover the costs of transit passes. Many are still relying on sending passes in the in mail or directing members to pick up passes at physical locations. Existing technologies for electronic fare payment are not meeting this need, although some transit systems are working with NEMT programs to upgrade technologies for this purpose.
- Some NEMT programs have found that fixed routes have become less reliable post-COVID due to transit system staffing shortages. In some cases, this has prompted NEMT programs to pay for more costly modes of service for affected members.
- In places where NEMT programs report strong fixed route utilization, there is some level of communication or collaboration occurring between the NEMT program staff and transit systems. Robust collaboration between the NEMT broker and public transit in Nevada has led to a high

rate of utilization, with about 40 percent of NEMT trips occurring on fixed route transit (primarily in the Las Vegas area). By comparison, in Oklahoma, only one percent of NEMT trips are transported on fixed routes.

5.4 Summary/ Conclusions

NEMT trips represent a ridership-building opportunity for transit systems with fixed routes. Transit systems can engage with their state's NEMT programs to build relationships that ensure that NEMT programs, including brokers where applicable, are familiar with fixed route systems. NEMT programs can be partners in travel training and broader rider outreach initiatives. Many NEMT program personnel are highly familiar with fixed route systems because they have spent considerable time educating members about using them.

NEMT programs and transit agencies can investigate ways to collaborate on electronic fare payment technology, especially in areas where there is more extensive fixed route service. Riders, transit agencies, and NEMT programs all benefit when it is convenient for third-party payors to cover fares.

In summary, fixed route utilization is a goal that is shared by transit systems and NEMT programs. Both entities win when more NEMT members use fixed route service. Members also may view fixed route positively because it offers same-day service without advanced reservations, providing greater flexibility. Even small systems with only one fixed route can offer a substantial cost savings to NEMT programs that would otherwise pay for curb-to-curb rides. Transit systems can reach out to state Medicaid offices or local points of contact, including brokers, to build relationships that can lead to effective collaboration.

Chapter 6. A Transit System as a NEMT Brokerage

ROGUE VALLEY TRANSPORTATION DISTRICT, MEDFORD, OREGON

Rogue Valley Transportation District (RVTD) provides fixed route and demand responsive public transportation services in Jackson County, Oregon, including the greater Medford area. The transit agency has operated a NEMT brokerage since 2001. With involvement from ODOT, the Oregon Health Authority (OHA) had approached a number of the state's transit systems about assuming NEMT brokerage duties from county Department of Human Service offices. RVTD started with two or three counties, eventually growing to serve seven: Coos, Curry, Douglas, Jackson, Josephine, Klamath and Lake. RVTD operated the brokerage under contract to OHA for 13 years. In 2014, OHA transitioned to a mixed Medicaid services model of managed care organizations and in-house management offered under the Oregon Health Plan. Managed care organizations in Oregon are called coordinated care organizations (CCOs). Now under the mixed model, the majority of Medicaid recipients (about 90 percent) are enrolled in a CCO in Oregon. Medicaid recipients not enrolled in the CCOs (about 10 percent) are provided NEMT through OHA fee-for-service (FFS) contracts with brokers. After the transition to the CCO model, several transit systems discontinued as brokerages with now only two public transit agencies operate as brokers—RVTD and Lane

Transit District. RVTD is the broker for two CCOs and holds a contract with OHA to provide NEMT as an FFS:

- Jackson Care Connect for members residing in Jackson County
- Cascade Health Alliance for members residing in Klamath County
- OHA to transport Fee for Service members in all seven of its original counties.

6.1 The Challenge & Opportunity

The shift to the CCO model added complexity and challenges to RVTD as a NEMT broker and provided opportunity.

Challenge

RVTD challenges include in particular capacity constraint challenges, increased oversight, and policy and procedure differences.

Capacity Constraints

Since CCOs often contract with multiple brokers to transport members in the same CCO coverage area, brokers compete to attract local transportation providers as subcontractors. The result is that brokerages like RVTD may not have adequate supply of providers to serve the demand. When a brokerage does not have adequate provider capacity in an area, they must send providers from other areas to transport members. Often, these providers travel long distances to provide these trips, increasing the trip cost to the brokerage.

Increased Oversight and Policy/Procedure Differences

The CCOs provide a higher level of broker oversight that include comprehensive annual audits. The CCOs also include specific service policies and procedures in the broker contracts. CCO policy and procedures include areas such as denials of service, call center scripts, data tracking and reporting, provider criminal background checks, subcontractor oversight, fraud prevention, and much more. The service policies and procedures may not be consistent with public transit policies and procedures. The cost associated with ensuring compliance can be a challenge of serving as a brokerage without adequately trained staffing, and operations oversight.

Opportunity

In spite of the challenges of operating a NEMT brokerage under Oregon's managed care model, RVTD has decided to stay in the game and continue to serve Medicaid members. Members benefit from having a long-term, stable, community-based organization coordinate their transportation. The organization benefits from the increased breadth of programming and revenue, which has allowed it to support a larger, more developed staff than it would have if it only operated public transit.

6.2 Solution

RVTD has found success in its brokerage function by developing its expertise in contracting, growing its staff, leveraging brokerage revenue to provide value-added trips, and increasing ridership through covering bus pass costs for members.

Contracting

It has been critical for RVTD to understand the complexities and negotiate contracts with the CCOs that insulate RVTD from undue risks. RVTD must be able to cover its costs with CCO revenue. This requires understanding every CCO expectation related to the brokerage function, including policy and procedure requirements that are part of the OHA contract with the CCO, which is incorporated by reference in the CCO-brokerage contract. Brokerages must understand what OHA requirements the CCO may be delegating through the contract. Factors that impact brokerage costs include the frequency of out-of-county rides, the availability of medical care providers within the local service area, or a CCO's preference to provide origin to destination service (over fixed route) in order to ensure that members follow through with recommended care. One benefit is that a broker is paid under a per-member, per-month (PMPM), and the negotiated PMPM rates have covered the RVTD cost.

RVTD works with 17-22 subcontracted transportation providers on average, who have a total of 220-280 vehicles and 250-300 drivers. These providers are located throughout the state so that RVTD has network capacity where they need it. Most of the providers are located in Jackson and Klamath Counties where most of the CCO membership resides. They also have providers sprinkled across Oregon with most in the larger towns and cities (e.g., Portland, Salem and Eugene).

Increased Ridership and Performance Incentives

Because CCOs, as managed care organizations, have some flexibility in how they administer Medicaid benefits, they have introduced some beneficial programs and incentives that were not available under OHA. The CCO model allows RVTD to provide "flex rides" on top of standard NEMT. These are rides for members to meet daily health-related needs such as grocery shopping or visits to the gym. Also, the CCOs provide financial incentives to brokerages for improvements in performance. One CCO has provided funding to RVTD to make investments to expand its provider capacity and improve service.

For January through September of 2024, RVTD has provided about 70,000 ambulatory one-way passenger trips and about 19,000 trips for wheelchair passengers. A nearly equal number of trips have been provided through personal vehicle mileage reimbursement. By comparison, RVTD provided just under 30,000 one-way trips paratransit and human service transportation passenger trips during the same time period.

The brokerage also provides bus passes to members for use on fixed route services. Under RVTD's main CCO contract (Jackson Care Connect/CareOregon), RVTD has provided monthly bus passes to cover around 18,600 one-way NEMT trips, and an additional 1,100 one-way NEMT bus tickets for 207 unduplicated members for the period of January through September of 2024.

Organizational Enhancement

The scale of the brokerage has allowed RVTD to grow and professionalize as an organization. The agency's Accessible Services division staffs the brokerage and operates ADA paratransit. There are 14 employees for the brokerage and two for paratransit, with all cross-trained in both programs. The brokerage staff functions include areas such as member eligibility, trip scheduling, provider oversight, quality assurance, and more.

The Details—Other Considerations

In addition to the demands of administering a complex, highly regulated program, RVTD reported some challenges that it faces in meeting the need for NEMT.

Rural Concerns

The cost of providing NEMT is increasing. This is partially due to inflation but is aggravated by a shortage of health care providers in rural areas. CCOs have struggled to find adequate numbers of care providers in RVTD's service area, causing members to have to travel longer distances for medical appointments. The resulting mileage increases cause an upward strain on the rates RVTD has negotiated in its current contracts to subcontracted transportation service providers.

Time Delay When Member Moves

When a member moves out of the CCO service area, it can take months or even years for the member to be transferred to a new CCO, forcing the brokerage to continue serving that member even though they live in another part of the state.

6.3 Key Insights

It is critical that transit agencies serving as brokerages for managed care organizations understand every expectation associated with the role, and the costs of fulfilling these expectations. NEMT brokerages are subject to myriad contractual requirements, which can create a financial challenge. Although managing these contracts is sometimes burdensome, the revenue is helpful in offsetting costs and funding improvements to call center infrastructure and resources. In addition to understanding these requirements, agencies must be aware of external issues such as the availability of – and competition for – contracting transportation providers, and the frequency that longer-distance trips are necessary to connect members to care.

6.4 Summary & Conclusions

Public transit agencies can serve as local or regional NEMT brokerages in multiple states other than Oregon. It is a challenging role that requires a high level of commitment and expertise. However, the role offers benefits to transit systems that elect to take it on. With added functions come not only added revenue, but more opportunities for organizational development and capacity. A larger, more professionalized staff can potentially provide a stronger public transit service, because there are more resources to leverage.

Contact Information

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