TCRP
SYNTHESIS 65

TRANSIT
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Transit Agency Participation in Medicaid Transportation Programs

A Synthesis of Transit Practice

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TRANSIT COOPERATIVE RESEARCH PROGRAM

TCRP SYNTHESIS 65

Transit Agency Participation in Medicaid Transportation Programs

A Synthesis of Transit Practice

CONSULTANTS
KENNETH I. HOSEN
and
ELISABETH FETTING
KFH Group, Inc.
Bethesda, Maryland

SUBJECT AREAS
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The nation's growth and the need to meet mobility, environmental, and energy objectives place demands on public transit systems. Current systems, some of which are old and in need of upgrading, must expand service area, increase service frequency, and improve efficiency to serve these demands. Research is necessary to solve operating problems, to adapt appropriate new technologies from other industries, and to introduce innovations into the transit industry. The Transit Cooperative Research Program (TCRP) serves as one of the principal means by which the transit industry can develop innovative near-term solutions to meet demands placed on it.

The need for TCRP was originally identified in *TRB Special Report 213—Research for Public Transit: New Directions,* published in 1987 and based on a study sponsored by the Federal Transit Administration (FTA). A report by the American Public Transportation Association (APTA), *Transportation 2000*, also recognized the need for local, problem-solving research. TCRP, modeled after the longstanding and successful National Cooperative Highway Research Program, undertakes research and other technical activities in response to the needs of transit service providers. The scope of TCRP includes a variety of transit research fields including planning, service configuration, equipment, facilities, operations, human resources, maintenance, policy, and administrative practices.

TCRP was established under FTA sponsorship in July 1992. Proposed by the U.S. Department of Transportation, TCRP was authorized as part of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA). On May 13, 1992, a memorandum agreement outlining TCRP operating procedures was executed by the three cooperating organizations: FTA, the National Academy of Sciences, acting through the Transportation Research Board (TRB); and the Transit Development Corporation, Inc. (TDC), a nonprofit educational and research organization established by APTA. TDC is responsible for forming the independent governing board, designated as the TCRP Oversight and Project Selection (TOPS) Committee.

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FOREWORD

By Staff
Transportation
Research Board

Transit administrators, engineers, and researchers often face problems for which information already exists, either in documented form or as undocumented experience and practice. This information may be fragmented, scattered, and unevaluated. As a consequence, full knowledge of what has been learned about a problem may not be brought to bear on its solution. Costly research findings may go unused, valuable experience may be overlooked, and due consideration may not be given to recommended practices for solving or alleviating the problem.

There is information on nearly every subject of concern to the transit industry. Much of it derives from research or from the work of practitioners faced with problems in their day-to-day work. To provide a systematic means for assembling and evaluating such useful information and to make it available to the entire transit community, the Transit Cooperative Research Program Oversight and Project Selection (TOPS) Committee authorized the Transportation Research Board to undertake a continuing study. This study, TCRP Project J-7, "Synthesis of Information Related to Transit Problems," searches out and synthesizes useful knowledge from all available sources and prepares concise, documented reports on specific topics. Reports from this endeavor constitute a TCRP report series, *Synthesis of Transit Practice*.

This synthesis series reports on current knowledge and practice, in a compact format, without the detailed directions usually found in handbooks or design manuals. Each report in the series provides a compendium of the best knowledge available on those measures found to be the most successful in resolving specific problems.

PREFACE

This synthesis documents and summarizes the tasks necessary for a public transit–Non-Emergency Medical Transportation (NEMT) partnership to be successful. The purpose is to report on the real and perceived barriers to NEMT and public transit coordination and to describe case studies of Medicaid transportation program participation by transit agencies. This topic is of interest to transit agency staff at the local level. They might use this report to learn from and compare their experiences with the experiences of other agencies. Opportunities exist for public transit agencies to participate in the NEMT program as providers of service or as brokers.

Findings in this report are based on a literature review; surveys of selected transit agencies, corresponding state department of transportation transit divisions, and state Medicaid agencies; analysis of documentation submitted; interviews; and site visits. Case study descriptions were prepared to reflect geographical diversity; urban, small urban, and rural agencies; and different service delivery models. The case studies are: Broward County, Florida; North Georgia Community Action Agency, Georgia; TriMet, Portland, Oregon; Texoma Area Paratransit System, Texas; and Chittenden County Transportation Authority, Vermont.

Kenneth I. Hosen, KFH Group, Inc., Bethesda, Maryland, collected and synthesized the information and wrote the paper, under the guidance of a panel of experts in the subject area. The members of the Topic Panel are acknowledged on the preceding page. This synthesis is an immediately useful document that records the practices that were acceptable within the limitations of the knowledge available at the time of its preparation. As progress in research and practice continues, new knowledge will be added to that now at hand.

CONTENTS

TRANSIT AGENCY PARTICIPATION IN MEDICAID TRANSPORTATION PROGRAMS

SUMMARY

Non-Emergency Medical Transportation (NEMT) has existed since the mid-1970s. From the beginning of the program, coordination was employed to maximize scarce resources in rural areas. During this period, many rural agencies and some urban agencies successfully coordinated NEMT service with public transit and/or other human service programs. However, opportunities still exist for public transit agencies in both urban and rural areas to participate in the NEMT program as providers of service or as brokers. Although rural transit agencies have historically taken advantage of coordination opportunities, there are a growing number of urban transit agencies that are seeing opportunities for coordination with benefits for customers, transit agencies, and state Medicaid agencies.

Medicaid is a large funding resource for transportation across the country. In rural areas, NEMT funding is often greater than public transit funds and virtually dwarfs other human service transportation programs in terms of funding and priorities. Any coordination effort that does not include Medicaid risks omitting the largest participant.

TCRP requested this synthesis to examine the tasks necessary for a successful public transit–NEMT partnership. This review is conducted to assist transit agencies in exploring opportunities to coordinate services with NEMT programs. The report identifies and examines barriers and actions (at all levels) that can foster or inhibit coordination at the local level. The overall focus of this effort is on how transit agencies coordinate services with NEMT.

A literature review was undertaken to examine coordination efforts between medical transportation and public transportation; NEMT service models (which have a significant effect on the potential for coordination); administrative/management/monitoring issues; and other pertinent concerns, such as cost allocation. Most of the coordination literature focused on state level efforts, although a handful of documents addressed local level coordination with transit agencies. The literature included articles on fixed-route bus service; cost transferring onto Americans with Disabilities Act paratransit; working relationships between NEMT and public transit and among state and local Medicaid officials, state departments of transportation (DOTs), and transit system officials; and uniform service standards.

Next, surveys were conducted to understand the real and perceived barriers to the coordination of NEMT and public transportation, Thirty surveys were distributed to three types of stakeholders; 10 each to transit agencies, state DOTs (transit divisions), and corresponding state Medicaid agencies. A total of 22 stakeholders responded, including 8 state Medicaid agencies, 6 state DOTs, and 8 transit agencies.

The survey results indicated a variety of barriers and challenges at all levels of government. A number of issues emerged, some new and some recurring. It is apparent from the surveys that certain service delivery models encourage coordination, whereas other models do not. Operational issues included the complicated and time-consuming process of trip intake for NEMT, with some agencies indicating that this was such a difficult process that their participation was inhibited. Jurisdictional barriers of crossing service area boundaries and the cost of taking vehicles long distances were discussed as well.

Other issues raised included the need for additional expertise, suggesting that there is a need for additional training and communication for all parties; service standards and the lack of common safety and operational standards; and coordination.

Five case studies were undertaken that reflected geographical diversity; urban, small urban, and rural agencies; and different service delivery models. Problem areas as well as successes were examined. For each case study, a transit system and its relationship with the state Medicaid agency, as well as the relationship between the state Medicaid agency and the state DOT were reviewed.

A number of coordination concerns were evident throughout the study. These concerns can either foster or impede coordination, and some dictate the level of coordination. Key factors that can foster or inhibit coordination as expressed through the literature review, surveys, and the case studies are listed here:

- Success factors—these must be present for coordination to succeed.
- Helpful factors—these elements can help foster coordination; however, without them coordination may still be possible, albeit with more difficulty.
- Challenges—some activities and policies are clear impediments or barriers to coordination. Where these are in place, coordination is more difficult.

CHAPTER ONE

INTRODUCTION

BACKGROUND

Coordination of human service and public transportation has been a valuable tool for transit operators for almost 30 years. Before the creation of rural public transit subsidies in the 1980s, many rural transportation programs saw the coordination of multiple human service programs as the only way they could survive. The U.S. General Accounting Office recognized this in the first of its studies on the coordination of human service transportation (*Hindrances . . .* 1977). This report concluded that the most significant hindrance to coordination was confusion and misperception regarding restrictions to coordination.

In the almost 30 years since that initial study, coordination has been and continues to be important to the well being of many rural transit agencies, whereas urban transit agencies have typically eschewed coordination of paratransit as an unnecessary complication to the Americans with Disabilities Act (ADA) service that is already difficult to operate (a view expressed by many of the ADA paratransit managers interviewed, including San Antonio, Texas; Baltimore, Maryland; Austin, Texas; and Philadelphia, Pennsylvania). However, two large urban agencies that have operated the two programs, Portland, Oregon, and Broward County, Florida, have kept the programs separate. Fixed-route service, however, is a service that some state and local Medicaid programs have used to dramatically reduce their per-trip costs. Fixed-route service can be a cost-effective tool to coordinate Non-Emergency Medical Transportation (NEMT) and urban public transit without disrupting the public transit network.

There are many studies that promote the benefits of coordination from across the country. The economic benefits of coordination have recently been quantified in *TCRP Report 91: Economic Benefits of Coordinating Human Service Transportation and Transit Services* (Westat and Nelson/Nygaard Consulting Associates 2003). This report found that these benefits included increased funding, improved productivity, and economies of scale. In addition, *TCRP Report 70: The Guidebook for Change and Innovation for Small Urban and Rural Transit Systems* (KFH Group and AMMA 2000) noted that rural transit managers recognize the need for funding from as many sources as possible, including human service transportation programs. These managers noted that coordination can be a sound business practice.

NON-EMERGENCY MEDICAL TRANSPORTATION

NEMT as part of Title XIX of the Social Security Act (Medicaid) is the focus of this coordination synthesis. NEMT is significant because of its size as the largest human service transportation program. The Community Transportation Association of America (CTAA) reported that NEMT, nationwide, spends approximately $1.75 billion annually, which is far more than any other human service transportation program (*Medicaid Transportation . . .* 2001). It is funded by a combination of state and federal dollars. The program itself is state run, with each state determining its approach to NEMT. This explains why there are so many variations in service design among the states (and, within some states, each county). The entitlement nature of the program requires that there be no limits to legitimate service needs (as with ADA paratransit). NEMT was initiated in the mid-1970s to ensure that necessary transportation to the nearest appropriate medical facilities was available to Medicaid-eligible clients. The importance of Medicaid's NEMT program in any coordination effort cannot be stressed enough.

PUBLIC TRANSPORTATION AND AMERICANS WITH DISABILITIES ACT

For purposes of this synthesis, public transportation is any transit program funded by the FTA and/or state and local dollars specifically for the public. These programs exist in rural, small urban, and large urban areas—each having different funding match rates for federal funding. For example, large urban transit agencies do not receive federal operating subsidies, relying instead on local and (sometimes) state funding for all operating expenses, whereas small urban and rural agencies are eligible for a 50% match for operating funds.

"Complementary" paratransit is a requirement of ADA—each transit system that operates fixed-route service must operate paratransit within three-quarters of a mile of the fixed route. There are no restrictions on the use of this service other than an eligibility requirement. There is no specific funding for ADA paratransit; however, as with NEMT, there are no limits to the level of service that eligible passengers can take. In large urban areas, these programs do not receive any federal funds.

PURPOSE OF SYNTHESIS

Opportunities exist for public transit agencies in both urban and rural areas to participate either as providers or brokers in Medicaid transportation programs. Although rural areas have historically taken advantage of coordination opportunities, many transit and Medicaid agencies do not coordinate in the provision of NEMT because of real or perceived barriers. This synthesis examines how a public transit–NEMT partnership can be successful and under what types of circumstances.

The purpose of this synthesis is to report on the real and perceived barriers to NEMT and public transit coordination and develop case studies of Medicaid transportation program participation by transit agencies. The synthesis also looked at the positive aspects of coordination; that is, what are the essential ingredients to successful coordination.

Much of the effort focuses on coordination of actual services at the transit system level, rather than on coordination among state agencies. The synthesis reviewed decision-making and operational frameworks for creating a contractual relationship between the Medicaid program and the public transit agency as a direct provider, broker, or subcontractor. It is intended that this document be used by transit agencies to initiate further dialogue regarding this important issue.

SYNTHESIS ORGANIZATION AND METHODOLOGY

Following this introductory chapter, the synthesis reviews the relevant literature in the field (chapter two). Chapter three presents the results of the survey of selected transit agencies, state DOTs, and Medicaid agencies to report on the current state of the practice. Based on the survey results, the literature review, and the researchers knowledge of NEMT programs, case studies were developed to profile innovative and successful practices, as well as lessons learned and gaps in information (chapter four). The final chapter (chapter five) includes conclusions and suggestions for further study.

GLOSSARY

There are a number of terms used extensively throughout the literature that have also gained popular usage in the industry. These terms, however, have a variety of meanings and are clarified here for purposes of this synthesis. The following is a glossary of some of the basic terms used throughout this report. Please see the CTAA's *Medical Transportation Toolkit and Best Practices* (2005) for a more comprehensive glossary of NEMT terms.

Brokerage—Any entity that takes trip requests and distributes the trips to more than one service provider. Brokerages come in all sizes, with different functions and levels of responsibility. Some brokerages are statewide (either for profit or state operated); others are regional or "community based" (including many transit agencies).

Capitated model—Capitation is used to describe a brokerage where the broker is given a set amount of funding per Medicaid recipient for the designated service area. The broker then must provide all appropriate transportation for the set rate.

Coordination—When two or more organizations work together to their mutual benefit to gain economies of scale, eliminate duplication, expand service, and/or improve the quality of service. According to the United We Ride initiative (described later), coordination makes the most efficient use of limited transportation resources by avoiding duplication caused by overlapping individual program efforts and encouraging the use and sharing of existing community resources. There are many levels of coordination, from simple sharing of training resources all the way to full consolidation.

Cost transferring—The term "client shedding" has been in use in the transit industry for a number of years. That term, however, has negative connotations and is not as accurate in describing the essence of the issue, which is the transferring of financial responsibility for a group or class of human service agency clients. For this report, the term "cost transferring" will refer to the transferring of funding for NEMT clients from state and federal NEMT funds to local transit dollars. The transferring of responsibility for funding NEMT to local transit agencies instead of NEMT is a core issue in coordination.

Fixed-route service and ADA complementary paratransit—These are the two predominant modes of transit used by NEMT and public transit. Fixed-route service is typically found in most cities and employs buses following a designated route according to a timetable. Passengers come to the bus stop to wait for the bus. Virtually all fixed-route buses are wheelchair accessible. ADA paratransit, which is much more expensive on a per-trip basis, provides service from a customer's origin to their destination.

ADA complementary paratransit (curb-to-curb or door-to-door)—This is required in all transit service areas that have fixed-route service (within three-quarters of a mile of the fixed route). ADA paratransit is available for persons who cannot ride fixed-route service. Passengers must undergo a certification process to determine if they are eligible for fixed-route, paratransit, or a combination of services.

Freedom of Choice Waiver—NEMT is treated as a medical program if the state chooses to use the medical matching rate, which is usually higher than the administrative rate of 50%. States can allow Medicaid clients to use any registered provider of transportation

or request a Section 1915 (b)(4) waiver allowing the state to limit access to fewer providers. Some states have applied for and received waivers, others use administrative funds, whereas still others allow for some level of freedom of choice.

United We Ride initiative—This is a coordination initiative of the Federal Coordination Council on Access and Mobility, started in December 2003. There are five components of the United We Ride initiative: (1) The Framework for Action—a tool that can be used to assess state and community coordination efforts, (2) state leadership awards that recognize states that have made significant progress in coordination, (3) The National Leadership Forum—a coordination conference, (4) state coordination grants to address coordination gaps, and (5) a technical assistance program.

It should be noted that coordination is not the goal of transit agencies, but is a tool that can be used to achieve the true goals of providing more rides of greater quality, cost-effectiveness, and safety. Furthermore, coordination is not always the best solution to meeting these goals. Therefore, although coordination is discussed in the various states and transit agencies, nothing in this discussion is implied to suggest (one way or another) the quality and/or effectiveness of the states and transit agencies reviewed.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

The first step in the discussion of barriers and potential barriers to NEMT and public transportation coordination was the literature review. The search included a broad review of documents related to coordination of human service transportation in general, coordination of NEMT specifically, any publications that discussed NEMT, best practices guides, and other related information. A number of relevant documents were identified. Of those documents, 11 selected publications are reviewed here in detail.

SELECTED PUBLICATIONS

During the literature review process, it became clear that some of the documents were more pertinent for the purposes of this study than others. The following is an overview of the most appropriate reports and studies.

Bradley, D., et al., *Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs—A Guidebook for State Medicaid Programs,* Health Care Financing Administration and National Association of State Medicaid Directors' Non-Emergency Transportation Technical Advisory Group, Washington, D.C., Aug. 1998

This guidebook was written by the Non-Emergency Transportation Technical Advisory Group (TAG) of the National Association of State Medicaid Directors, which is composed of Medicaid transportation managers from around the country. It addresses some of the issues of note including coordinating NEMT with public transportation, meeting needs in rural areas, provider qualifications and standards, brokerage operations, managed care, and data collection. The use of fixed-route bus passes is also discussed as a method of reducing operating and administrative expenses.

The report recommended that Medicaid agencies work with the state DOTs and local transit agencies to become an integral part of "the local system." The report stated that these agencies should set a higher level of provider qualifications and standards that level the playing field, such areas as driver training, vehicle standards, insurance, and safety. It suggested that the monitoring of service is critical, particularly that of brokers and operators. The report identified a number of efficient local brokers such as in the states of Florida, Oregon, and Washington. The report also indicated that freedom of choice makes coordination problematic.

Transportation-Disadvantaged Populations: Some Coordination Efforts Among Programs Providing Transportation Services, But Obstacles Persist, GAO-03-697, U.S. General Accounting Office, Washington, D.C., June 2003

This report examined the extent to which government agencies are providing and coordinating transportation service to the transportation disadvantaged. The report addressed the federal programs that provide transportation services for the transportation disadvantaged and the types of service provided; federal, state, and local spending; the extent of coordination at the federal, state, and local levels; and any obstacles that may impede coordination.

The report discussed the benefits of coordination through vehicle sharing, consolidating services, and sharing information. Efforts to improve service and achieve cost savings vary, however. In other areas, the researchers saw positive results. The report noted that coordination can lead to improvements, whereas lack of coordination can result in overlap and duplication of services.

There were numerous obstacles cited in the report, which were categorized as follows: (1) sharing vehicles and the low priority given to funding coordination activities; (2) programmatic differences; and (3) limited state, federal, and local leadership and commitment. Three options were recommended to mitigate these difficulties: (1) harmonize standards and requirements among federal programs with transportation, (2) provide and disseminate additional guidance and information, and (3) provide financial incentives or mandates to coordinate.

Raphael, D., *Medicaid Transportation: Assuring Access to Health Care—A Primer for States, Health Plans, Providers and Advocates,* Community Transportation Association of America, Washington, D.C., Jan. 2001

This report briefly describes the NEMT program in general terms. It provides a description of the program, federal reimbursements, the various components, and some of the models used, with an emphasis on brokerage and managed care. There are a number of examples of different structures. Models that use fixed routes such as those in Connecticut and Portland, Oregon, are highlighted. The second half of the report summarizes the state programs and includes the use of public transit (although it does not compare fixed-route versus paratransit costs).

Borders, S., J. Dyer, and C. Blakely, *Texas Medicaid Transportation Program: A Study of Demand Response Services in Texas,* Public Policy Research Institute, Prepared for Texas A&M University, Austin, July 2003

This study sought to determine the reasonableness of the demand-response transportation rates for rural public transit across Texas. The study was commissioned by the Texas Department of Health, which at the time was the Medicaid transportation agency [subsequently it changed to the Texas Department of Transportation (TxDOT)]. The Department of Health believed that they were paying too much for NEMT, especially in rural areas.

The research found no evidence to conclude that the state was overpaying for this service. Costs were commensurate with other programs and states with comparable trip distances. The study did find that the Department of Health did not take full advantage of fixed-route services, citing a rate of 10% fixed-route transit usage in the largest urban areas of the state. The report cited a number of examples of urban areas with more than 50% fixed-route usage, resulting in significant savings.

Medicaid Non-Emergency Transportation: Three Case Studies, National Consortium on the Coordination of Human Services Transportation, Washington, D.C., 2003

This consortium of nonprofit human service and transportation programs conducted three case studies: Delaware, capitated broker; Utah, broker/operator; and New York, county-by-county. Key discussion items included the use of bus passes, freedom of choice waivers, brokerage, tracking, and reporting data. The conclusion recognizes that transportation services are different from medical services and, as a result, different approaches are used. There is little discussion of coordinating service with public transit, other than the purchase of bus tickets.

Sundeen, M., J. Reed, and M. Savage, *Coordinated Human Service Transportation—State Legislative Approaches,* National Conference of State Legislatures, Washington, D.C., Jan. 2005

This study reviewed the effectiveness of state legislatively mandated human service coordination. It reported on a variety of approaches used by the states; 34 states have statutes requiring or authorizing coordination, 21 require specific coordination, and 2 are consolidated (human service and public transit administered together).

The report discusses approaches to legislating coordination, barriers and benefits to coordination, federal coordination guidance, state coordination approaches, and coordination profiles of each state.

The report suggests that each state should look carefully at legislatively coordinating transportation and that it may not be a solution to many of the specialized concerns.

Medicaid Non-Emergency Transportation National Survey 2002–03, National Consortium on the Coordination of Human Services Transportation, Washington, D.C., Dec. 2003

This survey was constructed to review the state of NEMT. For the purposes of this study, there is a review of coordination activities between state Medicaid agencies and state transit agencies. This report provides an overview of state Medicaid programs including review of match-rate issues, service designs, coordination with state transit agencies, and description of each state program.

One of the significant findings was that more than half of the states (and the District of Columbia) have some type of fixed-route bus pass program for at least some of their cities. The agreements are between the state Medicaid agency (or its broker) and the participating transit agencies. The review of each state indicated that some states do not take advantage of fixed-route service, opting instead for more expensive paratransit.

KFH Group, *Maryland Transportation Coordination Manual,* Prepared for the Mass Transit Administration, Maryland Department of Transportation, Baltimore, Jan. 1998

This "how to guide" is intended for the local level coordinators. It focuses on actual steps that can be taken to facilitate and enhance coordination. It takes a realistic look at coordination, including step-by-step sections on planning for coordination, developing a service model, overcoming barriers, implementation, and marketing. It is based on real-world experiences and is applicable for NEMT.

Westat and Nelson/Nygaard Consulting Associates, *TCRP Report 91: Economic Benefits of Coordinating Human Service Transportation and Transit Services,* Transportation Research Board, National Research Council, Washington, D.C., 2003

This report points out that significant economic benefits can accrue when human service transportation is coordinated. It cites many examples of coordination from across the country. First, it reviews and defines coordination. The report notes that under any coordination strategy there are two preconditions that must be met: shared objectives and shared respect. After these preconditions are met, sharing of responsibility, management, and funding can take place.

The report further suggests a variety of strategies from examples of other systems and describes the aggregate potential benefits to human service and transit agencies. The benefits include additional revenue generated by transit, savings generated by using fixed-route service—identified as the single highest potential savings ($90–$300 million), savings associated with human service transportation coordination of their own services, and the benefits to other areas as transit is expanded.

Medical Transportation Toolkit and Best Practices, 3rd ed., Community Transportation Association of America, Washington, D.C., 2005

The toolkit is designed to assist medical institutions and organizations to better serve their clients needs. It is not specifically geared to NEMT programs, but does include chapters on coordination and Medicaid transportation. This document was updated in 2005 and includes a reference guide and glossary.

Burkhardt, J.E., C.A. Nelson, G. Murray, and D. Koffman, *TCRP Report 101: Toolkit for Rural Community Coordinated Transportation Services,* Transportation Research Board, National Research Council, Washington, D.C., 2004

This report documents a wide range of coordination efforts and provides a step-by-step guide to the coordination of rural transit services with human service transportation. It is intended for transit agency and human service transportation managers at the state and local levels. The report also has many examples of coordination and a set of resources for managers. Advantages and disadvantages of coordination are highlighted. The authors concluded that there are no true prohibitions or barriers to coordination, there are just obstacles and challenges.

In summary, the various publications reviewed different barriers and needs to coordination. Most of the reports focused on general coordination issues, with some literature related to public transit and NEMT specifically. These publications and reports suggest a variety of ways to coordinate and improve coordination through administrative and organizational, operational, and legislative approaches.

KEY ISSUES

Administrative and Organizational Issues

The CTAA document had considerable information regarding administrative issues such as rate setting and waivers. The Texas Medicaid review of rates found that the cost models used by transit agencies in rural areas were appropriate and reasonable, whereas coordination and use of urban fixed-route services was not being fully utilized.

Operational Issues

The NEMT TAG report, the TCRP report on economic benefits, and the *Maryland Coordination Manual* included some sound operating and contract management recommendations that can be used by Medicaid transportation managers to assist in coordination efforts. There were a number of studies initiated by Florida concluding that the expanded use of fixed-route public transit and the use of the waiver to eliminate the so-called freedom of choice have saved considerable sums while meeting needs in an appropriate manner. In addition, a number of other studies, including reports by the Texas Public Policy Research Institute and Florida's Center for Urban Transportation, and the CTAA Medical Transportation Toolkit, identified the use of fixed-route service as a practical way to coordinate and lower cost and advocate maximizing the use of fixed-route services. These studies cite fixed-route usage at 50% of NEMT trips in some urban areas.

Economic Benefits and Legislative Issues

One study focused on legislative approaches to coordination, reporting that legislative mandates may help. The GAO report on transportation-disadvantaged populations cited some of the coordination barriers as leveling the playing field; educating federal, state, and local officials; and sharing of resources. The TCRP report on economic benefits (*TCRP Report 91*) quantified the economic benefits by type and cited conditions required for coordination.

Summary of Key Issues

The following summarizes the key issues from the literature review relating to the coordination of NEMT and public transportation:

- Fixed-route bus—An essential component to any coordination effort (where available). The use of fixed-route passes or tickets is extremely advantageous. The Medicaid agency gets an extremely low-cost trip (typically $1 or less), the transit agency boosts ridership for no significant cost, and the customer gains access for more than just medical transportation. Many studies cited the clear benefits of this approach.
- Close working relationship with transit—State and local (where appropriate) Medicaid agencies and the state DOTs and transit agencies should have a good working relationship. The *Maryland Transportation Coordination Manual* (KFH Group 1998) cites the clear benefits to building an atmosphere of trust. The TAG report (Bradley et al. 1998) emphasized the need for a close working relationship. Coordination requires that all participating organizations benefit from the effort.
- Level playing field—Identification of the need for a level playing field operationally is important to any coordination effort. The research (and discussions with operators) indicated that this is a concern. The TAG report (Bradley et al. 1998) firmly grasped the issue. Often, the standards for operating Medicaid transportation service are less stringent than those for public transit operators. This poses challenges to transit agencies in competing with an operator who is willing to conduct less training, have non-ADA-compliant vehicles, and accept operators with less experience.
- Use the waiver—Freedom of choice does not work as effectively in the context of transportation as it does in the medical profession, which is a much more heavily licensed and credentialed profession (see level playing

field). The Florida example cites many benefits to eliminating the choice requirement.
- Legislative mandates—It is not clear to researchers that legislating coordination is effective. One report suggested that each state should look carefully at legislatively coordinating transportation and that it may not be a solution to many of the specialized concerns.
- Cost transferring—One report (TAG) stated that NEMT programs should not "shed" clients onto the ADA paratransit agency, because it would place an undue burden on the local transit agency. The report indicated that a number of Medicaid officials have stated that it is permissible for NEMT managers to negotiate a rate that is higher than the general public fare.

CHAPTER THREE

SURVEY OF STATE MEDICAID AGENCIES, DEPARTMENTS OF TRANSPORTATION, AND TRANSIT AGENCIES

SURVEY METHODOLOGY

To understand the real and perceived barriers to the coordination of NEMT and public transportation, three types of stakeholders were surveyed: transit agencies, state DOTs (transit divisions), and corresponding state Medicaid agencies. Thirty surveys in three different versions were distributed, 10 each to state Medicaid agencies and their corresponding state DOTs, and an additional 10 to transit systems—rural, small urban, and urban. Copies of these surveys are provided in Appendix A.

States were selected based on a variety of considerations, including information derived from the literature and suggestions from the Topic Panel. Unique and innovative approaches were reviewed, such as the pioneering use of large-scale brokerages in Georgia and Florida's innovative approaches to county level coordination. California (Medi-Cal) uses a freedom of choice model, which although not exactly in Medicaid, is unique among large states. A wide variety of other service models were considered including contracted single operators in each service area as in Texas and Maryland and a variety of brokerages—statewide as in Virginia and local community-based brokerages such as those in Massachusetts and Oregon. Geographic considerations were also essential to avoid under- or over-representation in any geographic area.

SURVEY RESULTS

The survey results are detailed here. For the purpose of analysis, the survey responses have also been organized into a series of four tables. The first three tables present information about how NEMT is provided and monitored in the different states and the fourth table provides a listing and categorization of the barriers to coordination that were cited by the respondents. The tables have a wealth of detailed information and should be reviewed in conjunction with the narrative.

The first part of this section reviews the approaches used by the different entities to coordinate services, provide service (service models), conduct intake of NEMT trips, and set standards and monitoring requirements. The second part reviews barriers and challenges.

Description of Respondent Approaches to Non-Emergency Medical Transportation

State Level Coordination

An important consideration when looking at the coordination of Medicaid and public transportation is the level of coordination that exists between state agencies; that is, state DOTs and state Medicaid agencies. Survey questions explored the working relationship of the state agencies. In all but one of the states that responded to the survey, the coordination of transportation services between NEMT and public transit has been discussed and is encouraged at the state level. Among these states there were four general levels of coordination: (1) periodic contact (Missouri), (2) regularly scheduled meetings (Colorado, Maryland, and Michigan), (3) formal coordination agreements (Kentucky, North Carolina, and Oregon), and (4) legislative mandates (Florida and Texas). Although Florida is currently an example of a state in which public transportation and NEMT are highly coordinated, some Medicaid health maintenance organizations in the state requested permission to provide transportation for their enrollees, effective November 1, 2005. Also, under a Medicaid Reform Pilot Project starting in 2006, transportation services may become part of capitated networks. These changes will affect the state-coordinated transportation system. The details concerning the various levels of coordination activities between NEMT and public transportation are provided in Table 1. Additional discussion of Florida's activities is provided in the case study section of chapter four.

Service Model

The survey data show that brokerages play a significant role in the delivery of NEMT in 9 of the 10 states. The term "brokerage" can be used to describe a wide variety of service models. Most states that use a brokerage approach have a regional or county system, whereby the state is divided into regions (or counties) for the delivery of NEMT. The regional and community-based broker is typically in charge of all aspects of the local program, including trip and client eligibility verification, trip assignment, scheduling, billing, and monitoring. Missouri, Texas, and Virginia are the only states among those surveyed that use a single statewide broker. In the singular case of Texas, the TxDOT operates the brokerage

TABLE 1
COORDINATION

State	Is There State Level Coordination?	Is There Local Level Coordination?	What Is the Level of Coordination?	If Not, Why Not?
California	No	No	None	Medi-Cal covers NEMT when services that DOT provides do not meet the medical needs of the Medi-Cal recipient. The DOT reports that Medicaid trips are provided (by law) only by "for-profits" and social service trips are provided by nonprofits.
Colorado	Yes	Partial	Some services are coordinated. The DOT sponsors a coalition and the Medicaid agency is a participant in the coalition.	
Florida	Yes	Partial	Some services are coordinated, depending on the arrangement in each county. There is a formal coordination agreement. The Florida Commission for the Transportation Disadvantaged procures local brokers to arrange/provide trips for a number of human service agencies, including Medicaid.	
Kentucky	Yes	Yes	The brokers coordinate a variety of services. There is a formal coordination agreement and there are regularly scheduled meetings.	
Maryland	Yes	Yes	Virtually all of the rural operators coordinate Medicaid. Separate services in Baltimore. There are regularly scheduled meetings of the Maryland Coordinating Committee for Human Services Transportation.	
Michigan	Yes	Partial	Regularly scheduled meetings. The coordination program was formalized through the United We Ride Project in 2004.	
Missouri	Partial	No	Broker periodically coordinates service with public systems. Occasional contact at state level.	
North Carolina	Yes	Yes	Virtually all rural systems coordinate, some urban. The state of North Carolina has an Executive Order in place that created the North Carolina Human Service Transportation Council. The council is comprised of representatives from human service agencies and the state DOT. The basic premise of the coordinated arrangements is that the DOT provides financial support for capital equipment and administrative assistance associated with human service transportation, whereas transportation funds from the other state agencies are used primarily for operating assistance.	

(*continued*)

TABLE 1 (*continued*)
COORDINATION

State	Is There State Level Coordination?	Is There Local Level Coordination?	What Is the Level of Coordination?	If Not, Why Not?
Oregon	Yes	Yes	Operationally, Oregon is fully coordinated through the designation of transit systems as regional brokers. Oregon's governor formalized a coordination project in 2001. ODOT and Department of Human Services were directed to coordinate, and they dedicated one transit agency staff person and one human service agency staff person to develop opportunities and reduce barriers. The ODOT discretionary grant program includes the option for state special transportation funds to match local nonmedical transportation projects and coordinate some trips with medical transportation trips.	
Texas	Yes	Yes	Many rural systems coordinate service, few urban systems do. There is a formal coordination agreement and occasional meetings. Recent legislation mandates that the Health and Human Services Commission contract with TxDOT for the provision of client transportation, including Medicaid.	
Vermont	Yes	Yes	The local brokers typically coordinate public transit and human service agency transportation in their respective service areas. There are regularly scheduled meetings between the DOT, state Medicaid agency, and Vermont Public Transit Association (the program administrator).	
Washington	Yes	Partial	Some of the brokers are transit operators (mostly rural). Formal coordination agreement and regularly scheduled meetings.	

in-house. Georgia has five regions; however, these regions are combined so that there are two brokers covering the entire state. Florida, Maryland, Massachusetts, Oregon, and Vermont all use community-based brokers.

The use of brokerages for the provision of NEMT can work in favor of the coordination of services or, depending on the brokerage model, can also be an obstacle to coordination. For example, if a NEMT brokerage only handles NEMT, then the coordination of transportation services is not as likely, as only one trip purpose is served by the broker. In these cases, the public transit operators may or may not participate as a provider within the brokerage. It was determined that in Georgia and Virginia a significant majority of service providers are entities other than public transit operators. For example, in Georgia the number of participating transit operators includes 13 of the 126 transit agencies (36 small and large urban and 90 rural providers). Eight of these coordinated agencies are in urban areas and include the use of fixed-route services (in such cases, the broker has a financial interest in coordinating with fixed-route), whereas, as of September 2005, 5 of the 90 rural transit operators were participating in the Medicaid program. In Virginia, in 2002, the brokerage utilized very few transit agencies with the exception of fixed-route transit in urban areas (information provided by the Virginia Department of Medical Assistance Services). However, in states where the brokers serve multiple funding agencies and/or is the transit agency (e.g., Florida, Oregon, and Vermont), the brokerage system can foster the coordination of transportation services.

Table 2 shows the survey respondents' various methods of providing NEMT, describes how services are delivered, and indicates what entities are responsible for eligibility, screening, and verification.

Standards and Monitoring of Service

NEMT is a federal/state program that has a set of basic federal guidelines. The standards that guide the NEMT service—from standards for paperwork to standards for vehicles and operation of the service—are determined at the state and/or local level. These standards in large part determine the cost of the service. One of the key issues for coordination is that of often dissimilar service and operating standards. The subject of standards was disclosed in a number of surveys and in anecdotal evidence offered by a Medicaid provider in New York State. Because one of the perceived barriers to coordinating was that there are different (typically lower) standards for service for NEMT providers as compared with public transit providers, the survey asked the Medicaid state program managers to indicate if they had standards and, if so, to describe them. The results indicated that in about half of the responding states there are state-mandated standards in place with regard to driver training, driver qualification, vehicles, and, in some cases, insurance levels. These standards typically follow state motor vehicle laws and relate to the type of vehicle being driven.

Some states have very specific and more far-reaching standards (e.g., Georgia includes standards for the broker) and the requirements are set forth in state regulations (Kentucky). In the remaining states, the standards are locally determined. These results indicate that although there are standards in place for NEMT providers, they are often not as inclusive and standardized as those that are in place for public transit providers. For example, in Portland, Oregon, the broker, Tri-County Metropolitan Transportation (TriMet), determines the standards, which are higher than the state-mandated requirements.

States use a variety of mechanisms to monitor the quality of service and guard against fraud. These mechanisms include electronic and paper reporting, field monitoring, customer surveys, inspection of driver and vehicle records, various types of audits, and complaint information. Unlike school bus requirements, which are highly regulated, there is little in the way of a formalized process in some states. There are also indications that, in at least one state surveyed, there was very little monitoring of service. Some states surveyed have not tracked on-time performance and some did not routinely collect safety and accident data. Table 3 provides the survey results with regard to service standards and monitoring of service.

BARRIERS AND CHALLENGES

The major focus of this synthesis is to report on real and perceived barriers and challenges to the coordination of NEMT and public transportation. Barriers or challenges stop the efforts of some, while impeding progress for others. With this focus in mind, respondents were provided with various categories of challenges to choose from. The results indicated a number of real and perceived challenges across many categories. Some challenges could be included in several categories; however, for the purposes of analysis they were assigned to just one. Table 4 presents these challenges, which are highlighted and discussed here.

Regulatory, Legal, and Compliance Issues

Regulatory, legal, and compliance issues relate to a variety of requirements. Regulatory and legal barriers included the Managed Care/Freedom of Choice waiver requirements, whereas compliance included issues related to service monitoring and standards. This category of challenges generated many responses, from both the transit and Medicaid perspectives. One theme that emerged from the urban transit providers and Medicaid representative's responses is that there are different levels of service that are required for trips provided under the ADA; for example, as compared with those required for NEMT. Furthermore, these levels of service are different in different areas, because some transit agencies go above and beyond what is required by the ADA and others do not. Trying to fit the two services in one system

TABLE 2
GENERAL STATE NEMT CHARACTERISTICS

State and FFP Method and Waiver	Method of Providing NEMT	Decision Makers	Description of How Services Are Delivered	Eligibility and Screening
California *Medical*	Private transportation providers enroll as Medi-Cal providers and determine their own service area.	State level staff and upper management Legislature	Medi-Cal recipients contact the provider directly. The provider requests prior authorization. Medi-Cal pays for w/c vans, guerney vans, and nonemergency ambulance service under NEMT.	Authorization is approved if the Medi-Cal recipient has a functional limitation that precludes their use of public or private transportation.
Colorado *Medical*	Several approaches are used, including local and regional brokerages, locally arranged contracts with private transportation providers, and public fixed-route transit.	State level upper management and local level staff	There is a broker for the metro area counties and individual county administration through local departments of social services for the remaining counties.	Broker or local department of social services checks with a statewide verification system that is available through the fiscal agent.
Florida 1915(b) *Medical*	Agency for Health Care Administration (AHCA) contracts with the Commission for the Transportation Disadvantaged for the statewide coordination of NEMT. AHCA pays the Commission a fixed amount each month for services.	State and local level staff	There are local community transportation coordinators/brokers that arrange or directly provide NEMT for clients in their service areas.	Local county coordinators or their contractors handle eligibility and screening.
Kentucky 1915(b) *Medical*	Statewide brokerage. NEMT program is operated under a 1915(b) waiver, allowing the state to restrict freedom of choice.	State level staff and upper management Legislature	Medicaid recipients contact regional broker, and then the broker either approves or requests denial of the trip. If approved, the broker schedules the trip with a provider that has contracted with the broker to provide transportation.	Regional brokers have access to eligibility information via Internet connection. If the broker has a question about eligibility, it contacts the Office of Transportation Delivery, which then verifies the eligibility.
Maryland *Administrative*	Local brokerages, locally arranged contracts with public and private transportation providers, public fixed-route transit, gasoline vouchers, and agency vehicles and staff.	State and local level staff	Marylands 24 j urisdictions are provided funds to arrange for NEMT. In 23 jurisdictions these funds go to the local health departments. In one county the funds go directly to the public transit agency, which is a county DOT.	Either the local health department or the vendor screens for eligibility. The state mandates specific screening questions that must be asked.
Michigan *Administrative*	Local brokerages, locally arranged contracts with private and public transportation providers, and public fixed-route transit.	State level staff and local level staff	The Michigan Medicaid Program has an intradepartmental agreement with the Michigan Department of Human Services (MDHS) to administer the provision of NEMT for the fee-for-service beneficiaries. The qualified health plans are responsible for NEMT for their enrollees. MDHS coordinates NEMT through its local offices and bills Medicaid for the transportation expenses on a monthly basis.	Local MDHS offices are responsible for eligibility and verification.

(*continued*)

TABLE 2 (*continued*)
GENERAL STATE NEMT CHARACTERISTICS

State and FFP Method and Waiver	Method of Providing NEMT	Decision Makers	Description of How Services Are Delivered	Eligibility and Screening
Missouri Administrative (is changing to medical)	Statewide brokerage and state cooperative agreements with public transit and other agencies and schools.	State level upper management	Missouri ensures NEMT through a statewide brokerage. There is one statewide broker that provides transportation arrangements and ancillary services for eligible recipients. There are also state cooperative agreements with public transit and other agencies and schools to draw federal NEMT funds on current funding sources.	Broker verifies eligibility on the date of transport through one of three mechanisms: (1) state agency's interactive voice response system, (2) agency's fiscal agent via the Internet, or (3) point of service terminals that provide a paper printout of eligibility information on a specific date of service.
North Carolina *Medical*	NEMT is arranged locally through each county's Department of Social Services (DSS). Each DSS has a coordinator who is in charge of the local NEMT transportation program.	State and local level staff	Local DSS coordinators use the least expensive modes that meet the needs of the clients. They are strongly encouraged to use the local public transit agencies. State has an Executive Order in place to encourage coordination.	The local DSS offices are responsible for eligibility and verification.
Oregon 1915(b) *Medical*	There are nine transit systems serving as medical transportation brokerages.	State and local staff	Designated regional broker determines the best approach for NEMT using the least expensive appropriate mode.	The regional brokers and their contractors determine eligibility.
Texas *Medical*	State contracts with private transportation providers and public transit agencies. Recent legislation mandates that the Health and Human Services Commission (HHSC) contract with TxDOT for the provision of transportation services to clients of eligible health and human service programs, including Medicaid.	State level staff and upper management Legislature	TxDOT manages nine call centers with state employees. TxDOT headquarters contracts with a wide variety of providers across the state, including both public and private operators. All trips are prior authorized through TxDOT Medical Transportation Program intake workers. The program was recently changed to allow for a pass-through entry between TxDOT and the operator.	HHSC shares (electronically) Medicaid eligibility information with TxDOT. TxDOT's call centers conduct eligibility and screening.
Vermont *Administrative*	Regional brokers coordinate services locally, with oversight from the Vermont Public Transportation Association.	Transit association	Local brokers arrange the trips, which are provided with a variety of modes. There is an extensive network of volunteers who participate with the local brokers.	Eligibility and screening is conducted by the local brokers.
Washington *Administrative*	Regional brokerage—through competitive procurements.	State level staff and upper management	Brokers are responsible for delivering transportation services in their regions.	State provides eligibility information weekly; brokers also have medical eligibility verification as backup if the weekly information is inadequate.

TABLE 3
SERVICE STANDARDS AND MONITORING

State	State or Local Monitoring	Contractually Required Service Standards	How Are Services Monitored?
California	Both state and local	Driver training, driver experience, and vehicle standards are set in accordance with established state regulations pertaining to the type of vehicle and the transportation involved.	Services are monitored through electronic and paper reports, field monitoring, customer surveys, and the inspection of driver and vehicle records.
Colorado	90% state and 10% local	There are very specific standards in the provider contracts. There are standards for the type of driver training required and the type of drivers hired (with regard to type of license, driving record, criminal record, etc.). There are also specific requirements with regard to vehicles and their accessibility, maintenance, upkeep, and cleanliness. Every vehicle must be insured for a minimum $500,000 combined single limit.	Services are monitored through electronic and paper reports, customer surveys, and program integrity audits.
Florida	100% state	There are specific standards that are defined in the contract between the Agency for Health Care Administration (AHCA) and the Commission. Local coordinators often add to these minimums to make them compatible with public transit.	Services are monitored through electronic and paper reports, field monitoring, and the inspection of driver and vehicle records. Local coordinators conduct their operational monitoring.
Kentucky	50% state and 50% local	There are specific requirements in a number of areas (i.e., drivers, training, vehicles, broker responsibilities, etc.). These requirements are set forth in Kentucky State Regulations—603 KAR 7:080: Human Service Transportation Delivery.	Services are monitored through electronic and paper reports, field monitoring, customer surveys, and the inspection of driver and vehicle records.
Maryland	30% state and 70% local	Contractually required service standards are locally determined.	Services are monitored through annual customer surveys, field monitoring, and the quarterly submission of complaint logs.
Michigan	Local	Contractually required service standards are left to the discretion of the local Michigan Department of Human Services offices.	Services are monitored through electronic and paper reports.
Missouri	State	There are specific requirements with regard to driver training, driver experience/driving record, vehicle maintenance and inspections, as well as first aid and safety requirements.	Services are monitored through electronic reports and customer surveys (quarterly).
North Carolina	Local	There are required standards with regard to safety and risk management. Local transit systems set higher standards.	Services are locally monitored through different mechanisms including examining the trips for a particular date and/or random sampling of trips.

(*continued*)

TABLE 3 (*continued*)
SERVICE STANDARDS AND MONITORING

State	State or Local Monitoring	Contractually Required Service Standards	How Are Services Monitored?
Texas		All Requests for Proposals and contracts with individual providers are handled through TxDOT headquarters. A new process is pending. Previous standards for drivers, vehicles, safety, and other requirements were well below standards for public transit. New requirements have stronger standards.	An annual assessment of the Medicaid Medical Transportation Program is scheduled to begin in FY2006. It is anticipated that the assessment will include the following elements: — Review trip eligibility determination — Surveys — Review of safety — Review of telephone service — Fixed rate usage — Quality review — Driver and vehicle records.
Washington	Both state and local	There are standards with regard to driver training, driver experience, and vehicles.	Services are monitored through electronic and paper reports, field monitoring, customer surveys, and the inspection of vehicle records.

has proven difficult. Broward County Transit (Florida) and TriMet (Oregon) both operate ADA and Medicaid services in their regions; however, each is a separately managed and operated program within the organization.

Another barrier cited was that different laws and rules apply to public transit operators than to NEMT providers; specifically, drug testing, vehicle (ADA compliance), and Commercial Drivers License requirements. These requirements typically result in higher costs for the transit agencies, making it difficult to compete against those operating under a less stringent set of policies and procedures.

One state found that the Centers for Medicare and Medicaid Services (CMS) process for requesting waivers is a major barrier that requires a significant amount of administrative work. One state did not actually use a waiver and eliminated the freedom of choice requirement.

Jurisdictional Issues

There were two jurisdictional issues indicated that could be considered real challenges to the coordination of services. The first is that, in some rural areas, the public transit provider does not have enough vehicles to allow one to leave the service area for an entire day to provide a long distance medical trip. Another real barrier can be found in small cities where the service mode is fixed-route and the operator does not have the proper authority to travel outside the service area.

In North Carolina, the many rural county transit agencies (typically coordinated with Medicaid) often cross two or three jurisdictional lines to transport passengers to a regional medical facility, often without coordinating with the agencies in the counties they cross. The North Carolina DOT has begun an initiative to identify and coordinate those services.

Financial Issues

The financial issues listed by the respondents appear to be real and significant challenges to the coordination of services between NEMT and public transportation. One major issue in urban areas, which has been discussed for many years without resolution, is the question of which agency should pay for the trip of an ADA paratransit-eligible Medicaid client to travel for a medical need—the state Medicaid agency or the local transit agency. Following this same issue, should the Medicaid agency pay the regular fare (which includes federal, state, and local subsidies, but not in urban areas where only local money is used), the entire local share of the cost, or the fully allocated cost? One NEMT manager did not understand that large urban areas (more than 200,000 population) do not receive federal operating subsidies. Some state transit agencies require that their transit grantees collect the fully allocated costs for human service agency trips (e.g., Virginia) rather than the general public fare, whereas one state attorney general ruled that Medicaid can only pay the regular general public fare (Idaho). CMS has determined that it is appropriate for NEMT to pay a rate higher than the general ADA fare.

Other financial concerns listed included the business decision of whether the reimbursement rate is too low for Medicaid trips and would cause transit agencies to lose money by subsidizing the trip. In cases where a third-party administrator

TABLE 4
CHALLENGES

Regulatory/Legal/ Compliance Issues	• The level of service required for paratransit trips provided under the ADA is higher than the level of service required for Medicaid trips, thus making it difficult to coordinate these trips together in a cost-effective manner. • The transit system is subject to more stringent standards than those required by Medicaid with regard to vehicles, equipment, driver licensing, drug testing, and training, etc. These regulations result in higher costs than would be found among providers that exclusively carry Medicaid clients. • Drug testing makes ADA service cost more than Medicaid service. • Coordinating Medicaid transportation with general public service is a challenge because the state human service agency staff does not understand the complexity of transit regulations. For example, for vehicle fleet size the state DOT uses the FTA-funded services as the guide to peak need. Contracted services (including Medicaid) are not included, which leaves the impression that the state DOT has a negative view of Medicaid transportation. • Some public transit agencies see the drug testing and commercial drivers license requirements as a means for establishing standards for quality mobility providers (not as a barrier). • The 27 different transit agencies in the state have very different ADA structures and regulations. • The regulatory/legal/compliance issues attached to transit funding sometimes prohibit coordination. The belief is that $1 of federal money in a coordination project compels compliance with all FTA regulations. • Many of the local transit agencies and human service agencies believe that they cannot coordinate because of regulatory issues who can and cannot ride on the bus. • The Centers for Medicare and Medicaid Services process for requesting waivers is a major barrier. It is a lot of administrative work to pull together all of the information that is necessary to request a waiver.
Jurisdictional Issues	• The transit boundaries are much smaller than the Medicaid transportation brokerage region boundaries. • Some rural transit agencies are unwilling to provide long distance NEMT to urban areas for specialized care. • The state Medicaid agency requires prior approval to transport clients out of the county for services. Obtaining this approval is an administrative burden. • There are different standards for vehicle and driver licensing and permits in the different counties. • There are jurisdictional issues for small urban transit providers who operate in towns where there are not major medical facilities—the small fixed-route providers are not always able to travel out of their service area.
Financial Issues	• The state's billing and reimbursement mechanism requires expensive software customization, contractual services for electronic eligibility verifications, full-time monitoring, and the payment for services is not always processed in a timely manner. • The state Attorney General ruled that Medicaid can only pay the regular fare for the purchase of transit service (instead of the cost). • The Medicaid system is cumbersome and efforts to reduce costs result in no or inadequate payment to providers. • The brokers and third-party administrators of the NEMT program, especially in the capitated rate scheme, have included penalty provisions in their contracts with mobility providers (transit providers) to shift some of the financial risk to the providers. These penalty provisions include minor irregularities such as late reporting or incomplete reporting as determined by the broker. Several mobility providers have made a business decision not to participate in NEMT as a result of those disadvantageous contract provisions. • The reimbursement for brokers and providers. • Low reimbursement rates limit the number of available NEMT providers. • The transit system is required to carry a higher level of insurance than is required for Medicaid trips, thus increasing the cost of the ADA service. • Fleet needs and the sources to fund them. • Dual eligibility—Medicaid and ADA paratransit. When an ADA customer requests a medical ride, Medicaid should pay for the trip instead of the transit agency.

(*continued*)

TABLE 4 (*continued*)
CHALLENGES

Information/ Technology Barriers	• The Medicaid agency has electronic billing requirements that can be difficult for transit agencies to meet without significant software expenses. • Combining ADA and Medicaid would tax the ability of the paratransit scheduling program that is currently in place. • The different record keeping requirements add to the overhead cost of providing mobility services. This is especially the case when coordinating many human service transportation programs, just one of which is NEMT. • Health Insurance Portability and Accountability Act is a potential barrier. • Many agencies do not want to share client information. • Technology varies between private and public programs.
Different Goals	• Transit is interested in meeting ADA requirements, which are narrower in scope than Medicaid requirements. • From the transit agency perspective it is more effective to issue Medicaid clients a monthly bus pass. The cost of the monthly pass is less than the cost of one door-to-door round trip, resulting in savings for the program and an increase in the quality of life for the client. Some state Medicaid staff believed that only single-trip passes should be issued for Medicaid-funded appointments, but the administrative costs and staffing required to administer these trips would have a negative financial impact on the program. • Medicaid agencies are interested in transporting their clients and not overall public transportation.
Eligibility	• The eligibility process is difficult and time consuming. The transit agency does not always have the needed information to determine a client's eligibility status. • Ensuring the eligibility is in place before providing the trip is a major challenge. • Penalizing the transit provider for performing a noneligible trip when that trip was ordered by the NEMT broker is unfair. Eligibility ought to be the sole responsibility of the broker and once the trip is assigned by the broker to the transit provider; no inquiry into the eligibility of the client by the transit provider should be needed. • The state recently increased the client eligibility requirements for NEMT, which has increased the number of people seeking medically related rides under other programs, such as general public transit. This cost shifting has led to transit vehicle capacity problems, especially for rural transit providers. • Medicaid limits eligibility to those with no other means of transportation. • Mixing of funding streams—one bus may carry five different types of clients with different funding sources. • The different funding sources have different service requirements and eligibility. • Dual eligibility between ADA and Medicaid—who should pay for the trip?
Operational Barriers	• The provision of NEMT service can cause significant disruption to all facets of an established paratransit system owing to the following: the eligibility process, the billing system, the customer service staffing, the no-shows and cancellations, and the database maintenance. • Medicaid clients share rides with ADA clients, which prompts them to request paratransit trips for which they are not eligible. A high level of monitoring is necessary to deal with this issue. • Educating transit systems on how to schedule and dispatch fully coordinated services is challenging. • Some clients need a higher level of personal care than the (public transit) staff is prepared to provide. • Some agencies expect the transit provider to be the liaison for the client with the medical provider. • NEMT has a 30-min pick-up and will-call return pickup requirement that require most transit providers to have their drivers wait with the client rather than use the driver's time more productively by delivering trips for other programs or even other NEMT trips to different destinations. • Medically fragile people have different service needs than able-bodied people. • With a central dispatch center and shared vehicles there are issues with regard to which agency should pay for maintenance, which agency should provide the local match, etc. • The hours of operation are different, the frequency of service is different, and all public transit vehicles must be ADA-compliant. • Transit agencies have higher standards with regard to driver training.

(*continued*)

TABLE 4 (*continued*)
CHALLENGES

Other Barriers	• Transit agencies are typically not just coordinating NEMT, but also senior transportation programs, mobility programs for persons with developmental disabilities, Head Start transportation, and many others. Each of these programs has their own, and sometimes conflicting rules, requirements, and limitations. • There are information barriers to the extent that clients as well as sponsoring agencies are not aware of all the existing mobility services that are available to them. • Identification of entities. Medicaid agencies' documentation requirements versus public transit's personnel and time constraints.

exists, there are penalty provisions for minor irregularities and difficulties with invoices that make participation by public transit agencies difficult.

Another financial concern, which is also a technology issue, is that some states' billing and reimbursement mechanisms require expensive software customization, contractual services for electronic eligibility verifications, and full-time monitoring. Also, the payment for services is not always processed in a timely manner. This makes participation in NEMT difficult for smaller rural public transit agencies.

Intake Responsibility

The responsibility for trip intake is expensive and time consuming in both urban and rural areas. The functions of trip intake are complicated and require the following multistep process:

- Verification of Medicaid eligibility,
- Assessment of need (in some states, the intake is required to determine if the individual requesting service has a car or can get a ride elsewhere),
- Verification of trip purpose (is the individual requesting service going to an eligible service?), and
- Determination of what mode of services the individual is eligible for; fixed-route, paratransit, volunteer, etc.

Often, the responsibility for trip intake rests with the broker or directly with the service provider. In some states, the transportation vendor (sometimes this is the public transportation operator) performs these functions, whereas in other states, the broker or local health or Department of Social Services handles eligibility, screening, and verification (in Texas it resides with TxDOT). Regardless of where this function occurs, this information is typically available electronically, although not always in a timely manner (as noted in the barriers section).

Transit agencies reported that the intake process is difficult and time consuming and that the agency does not always have the required information before the trip. This could pose difficulties for those smaller transit agencies that do not have the staff to manage this effort. This problem can have financial implications if the trip is provided, but then is not reimbursed. Another concern for transit agencies, particularly those in rural areas, is that the same vehicle may have clients from six different agencies on board, each of which has a different set of eligibility criteria. In one state it was noted that the Medicaid eligibility verification requirements were increased, resulting in additional costs for public transit.

Operational Barriers

One transit agency reported that the provision of NEMT can cause significant disruption to all facets of an established ADA paratransit agency for a number of reasons, including the intake process, the billing system, the customer service staffing, the no-shows and cancellations, and the database maintenance.

It was also reported in one state that NEMT has a 30-min will-call/return pick-up requirement that requires that transit providers have their drivers wait with the client, rather than using the driver's time more productively by undertaking trips for other programs or by taking other NEMT trips to different destinations. In addition, some Medicaid clients require a higher level of care than what the public transit agency staff is able or willing to provide.

Information and Technology Barriers

The requirements for the use of technology in billing and operational areas make participation by smaller agencies difficult. These agencies have difficulty investing in the technology and often cannot afford the staff necessary to maintain it. One significant barrier that could be classified under "information technology" is that there are significantly different record keeping requirements for NEMT when compared with public transit. This is particularly true in urban areas, where the only information collected from a general public passenger is the fare that was paid. This is less of a barrier in rural areas operating demand-response service, because the public transit agencies are already collecting information needed to provide the trip.

Other Challenges

One major barrier is that Medicaid agencies have the single goal of ensuring that beneficiaries can access their medically necessary appointments for the lowest cost that meets the clients' needs. In urbanized areas, this goal can often be achieved in a cost-effective manner by issuing bus passes to Medicaid-eligible clients. However, in some states this does not occur because the Medicaid focus is single-trip oriented. Medicaid agencies do not always realize that the administrative costs associated with issuing single-trip passes are equal to or greater than the cost of a multiride pass.

Confidentially of records is also a potential barrier, because public transit agencies may not be equipped to keep the medical information necessary to provide the trip as confidential. One survey respondent indicated that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a potential barrier. However, this is a misunderstanding, because transit agencies do not come under this requirement, although at least one agency reported problems in this area.

Finally, many rural transit agencies are typically coordinating not just NEMT, but also senior transportation programs, mobility programs for persons with developmental disabilities, job access, and other programs. Each of these programs has their own, and sometimes conflicting rules, requirements, and limitations.

CHAPTER FOUR

CASE STUDIES OF MEDICAID AND PUBLIC TRANSIT COORDINATION

The case studies introduced in this chapter focused on five transit agencies and were selected based on review of the data, the literature search, panel suggestions, geography, whether a large or small urban area, and general knowledge of the subject. Most of the case studies were successful examples of coordination, whereas one was not, and many lessons can be learned from that example. There were many excellent examples of transit agencies that would have met the needs of this effort; however, only five could be selected, and these are representative of different operating styles and approaches. The case studies reviewed five different agencies in five states and how they and the Medicaid agencies approach coordination of NEMT. The case studies focus on one agency in each state and how it has coordinated Medicaid transportation with its public transit. The case studies helped identify the impediments or barriers to coordination, as well as what actions facilitated coordination.

The case studies include agencies whose states have various models of service delivery, such as exclusive contracts, a private for-profit broker, or a transit system as broker. An attempt was made to ensure geographical diversity and present a variety of transit settings in urban, small urban, and rural areas. Survey respondents were all but one of the case studies.

EMERGING COORDINATION THEMES

Based on the results of the literature search and the survey, themes emerged that suggest a number of identifiable barriers and approaches to coordination at all levels of government. These themes were examined in the case studies.

- Service delivery model—It is apparent that certain models encourage or foster coordination, whereas other models are not coordination friendly.
- Service standards—There are significant differences in the service quality requirements of Medicaid contractors. In some cases, those state and local standards are less stringent than the standards typically employed by public transit operators. This is a significant problem with ADA paratransit agencies, which must maintain rigorous standards of safety and performance that are not required for many Medicaid customers. In one case, the union requirements of a NEMT operator required higher standards than NEMT.
- Political—There are a number of states where the legislature has intervened in the coordination issue. Texas is one such example, where, in 2003, the state legislature mandated that the TxDOT in essence assume control of all human service transportation.
- Eligibility/compatibility—Some agencies have reported that there are complicated eligibility issues associated with NEMT service. In addition, other agencies have noted compatibility concerns in a variety of areas including customer compatibility (some passengers ride for free, whereas others must pay) and technology compatibility.
- Jurisdictional—These concerns typically include agencies that cannot or will not transport people outside of their jurisdictions. Medicaid agencies often want a provider that will travel where required by an individual's medical needs.
- 1915(b)(4) Waiver/Freedom of Choice—Freedom of choice is, by its nature, the opposite of coordination in that this approach encourages many small providers and little in the way of control. Freedom of choice does not work as well for transportation as it does for example the heavily regulated and credentialed medical field. According to some, the hurdles of overcoming the requirements of the waiver can be extensive.
- Local level working relationship—One of the key elements of successful coordination is trust and the ability of local stakeholders to work together. In at least one state, decisions were based on the mistrust of the rural operators and a feeling that the operators were overcharging.
- Need for additional expertise—The kind of transportation provided through Medicaid is unique and requires a specific expertise. Many of those making transportation decisions for state and local Medicaid agencies do not have the background or the training in these types of transportation issues. Similarly, public transit managers do not understand the nuances of NEMT. Decisions, at times, are based on questionable assumptions. This subject suggests that there is a need for additional training and communication for all sides.
- Business sense—From a transit operator's perspective, any coordination arrangement must make business sense. That is, it cannot negatively affect existing customers, must be relatively straightforward to operate, and must be financially feasible.

BACKGROUND

The objective of the following case studies is to provide an in-depth review of five transit agencies and their experiences

with NEMT. These studies test the findings from the literature review and surveys previously conducted. The case studies were selected to reflect a balance of operators in terms of geographical diversity (as many regions of the country as possible and urban, small urban, and rural agencies), demographics, coordination level, and service delivery model. Successes as well as coordination efforts that were less than successful were examined. For each case study, the transit agency and its relationship with the state Medicaid agency, as well as the relationship between the state Medicaid agency and the state DOT were reviewed. The case studies

- Review relationships between stakeholders,
- Describe the state service delivery model,
- Provide a description of the transit agency and approach to NEMT, and
- Review the activities that foster or inhibit coordination.

The five case studies can be summarized as follows:

1. Broward County Transit (Florida)—Florida has long been a model for coordination at the county level as mandated by the state. This case study focused on Broward County and examines why the county ultimately ended its relationship with the state Medicaid agency.
2. North Georgia Community Action Agency (Jasper, Georgia)—An early practitioner of the large-scale brokerage, Georgia has fine-tuned its approach and serves as an excellent case study to examine how this type of brokerage affects coordination. A multicounty rural transit agency that has a good relationship with its broker is profiled.
3. TriMet (Portland, Oregon)—Oregon has designated regions where local brokers manage all aspects of NEMT. Each of the brokers are transit agencies. Here the focus is on Portland.
4. Texoma Area Paratransit System (Texas)—The Texas Legislature mandated coordination by placing most human service transportation operations under the control of TxDOT. This review examines their progress 30 months after the legislation was passed. The Texoma Area Paratransit System (TAPS), a multicounty system, was examined.
5. Chittenden County Transportation Authority (Vermont)—Vermont's Medicaid agency uses the state transit association to administer the Medicaid transportation program. Contracts are local and typically with transit agencies. Burlington's transit agency will be reviewed.

FLORIDA—BROWARD COUNTY TRANSIT

Introduction

Broward County is a large urban/suburban county (population 1.7 million) with sizable cities such as Ft. Lauderdale and rapidly growing suburbs. The county manages the transit agency directly and contracts the day-to-day operation of its paratransit to a number of private providers. Broward County Transit (BCT) operates throughout Broward County providing 36 million fixed-route trips and 1.3 million paratransit trips annually.

Florida has been a leader of the coordination effort since the advent of its Transportation Disadvantaged (TD) program. BCT was selected for this synthesis, not because of its success, but rather to examine why Broward County decided that coordinating the service in the manner required was not in BCT's best interests. It should be noted that Florida has had a number of successful urban transit coordination efforts. However, the researchers believe, in this case, that there are more lessons to be learned from the county's experience than from a more successful effort.

Relationship Between Stakeholders

Florida, by legislation, created the Florida Commission for the TD as part of the Florida DOT (FDOT). The TD Commission is responsible for the coordination of a wide variety of human service transportation programs including Medicaid. To that end, the TD Commission has a contract with the Agency for Health Care Administration (AHCA), which is the state agency charged with the responsibility of the Medicaid program, to provide oversight and management of the NEMT program. This arrangement has reduced costs by 30% during the past 10 years. Much of the savings was attributed to the expanded use of bus passes.

Although AHCA has ceded day-to-day operating authority, it continues to look at different ways of managing and controlling the service. The 1915(b) waiver submitted by the agency allows the use of the local county Community Transportation Coordinators (CTC) to control expenditures to the NEMT. AHCA is now considering a change in the program. The agency previously tried to eliminate the county brokers from the NEMT and procure a statewide broker, but the procurement was rescinded.

Recently, AHCA determined that it needed to reduce funding for NEMT by $11 million in one year and this resulted in at least one large transit agency opting out of the program. Others are considering reducing their role as well. The TD Commission is also considering a termination of the relationship with AHCA as the funding continues to be reduced.

State Medicaid Service Delivery Model

As stated previously, AHCA contracts with FDOT's TD Commission to manage the statewide program. The TD Commission designates a CTC for each county. The CTC functions in a role as coordinator (or broker) of services; actively addressing coordination, monitoring, and reporting.

There are a wide variety of approaches used by the CTCs in Florida's counties. Flexibility at the local level is considered one of the keys to success. The designated CTC can be a transit agency, county government, Metropolitan Planning Organization (MPO), nonprofit agency, or other entity. Typically, the transit agency is given an opportunity to participate.

Broward County Transit—Coordination Efforts

BCT, an arm of county government, is the public transit operator for the county. BCT is also the designated CTC for the county and between 2002 and 2005 successfully managed and operated the NEMT program in the county as well. BCT had integrated ADA paratransit with NEMT. Customers called BCT to register for the NEMT program. For rides, customers called their designated contract provider who verified eligibility (monthly) and then determined trip eligibility before scheduling and providing the trip.

According to BCT management, NEMT was a difficult program to operate in conjunction with ADA paratransit. The programs were separate, but were operated by the same group of contractors who coordinated service at the contractor level. BCT did not have the staff available to certify NEMT customers for paratransit versus fixed-route service. Consequently, fixed-route ridership was low (although it increased from 90 passes per month to 1,000). The large numbers of new riders (averaging 500 per month) were taxing staff ability to keep pace with applications. BCT management chose not to expand their ADA eligibility certification staff and instead provided paratransit for those who requested the door-to-door service.

Ultimately, at the highest level of county government, decisions were made to discontinue the county's involvement in the NEMT program. BCT continues to act as the CTC, coordinating a variety of other human service transportation services.

Activities That Affect Coordination

- Communication with AHCA—BCT cited difficulty in communicating with AHCA and being unable to provide input into the funding changes. The TD Commission echoed those remarks. AHCA is proposing a number of changes, and both AHCA and the TD Commission are considering termination of the agreement.
- Local control and flexibility—Services are brokered at the county level, allowing for significant local control in how services are delivered, the development of standards, and other functions that allow flexibility and can encourage coordination. Throughout the state there are many models of local service delivery.
- Business/financial sense—The county was clear that its primary reason for terminating its participation in the NEMT was financial. The county was unwilling to provide a subsidy to the program in the face of shifting funding by AHCA.
- Difficulty of operating in conjunction with ADA—ADA and NEMT are demanding services that are both (individually) difficult to operate successfully. Adding additional (and also demanding) service can overwhelm an agency. In this case, the eligibility certification staff (determining the use of fixed-route or paratransit service) was not able to conduct NEMT certifications while simultaneously dealing with significant growth in its ADA certification.
- HIPAA interpretations—There were misperceptions of confidentiality issues limiting vital information to the contractors. One interpretation was that certain client groups cannot mix with others, lest these riders discover where the first group is going (confidential information).
- Different service standards—BCT provided an ADA level of service that is higher than the requirements for Medicaid. The higher level of service costs more money than a service that does not meet these stringent requirements. This creates two separate agencies with different standards of safety and quality.

GEORGIA—NORTH GEORGIA COMMUNITY ACTION AGENCY, JASPER

Introduction

Thirteen transit agencies in Georgia coordinate with Medicaid. Several transit agencies have successfully coordinated the programs of all three state agencies and one of these will be reviewed here. This agency, the North Georgia Community Action Agency (NGCAA), operates public transportation, has an agreement to provide social service transportation (Title III—Aging), and also has a contract with one of the brokers to operate Medicaid service. NGCAA operates in six counties of north Georgia (population—310,000), with its base in the town of Jasper. They provide a variety of paratransit services, typically within each county, with vehicles infrequently traveling out of county. The FY 2004–05 ridership was 240,000 one-way trips. Approximately 40,000 trips are provided for NEMT through the regional broker.

Relationship Between Stakeholders

Georgia has been working recently to coordinate services on the state level. The state has three separate transportation programs in three agencies, two of which are actively engaged in coordination activities. The local level has also seen significant coordination of two of the programs. The three major programs—all administered separately by three agencies—are:

- Georgia Department of Transportation (GDOT)—public transportation,
- Department of Human Resources (DHR)—social service transportation and management of the FTA Section

5310 program that provides funding for transportation for the elderly and persons with disabilities (the funding is used to purchase vehicles in support of their programs), and
- Department of Community Health (DCH)—Medicaid transportation, which is managed by one of two brokers.

Public transit funding is distributed at the county level. There are some regional multicounty transit agencies; however, most service is provided and coordinated at the county level. DHR and public transit are coordinated frequently, yet only 10% of the transit agencies in the state coordinate with NEMT.

There had been little in the way of coordination efforts at the state level in the past. However, this is changing, as GDOT and DHR have been discussing further coordination of their services. DCH operates a separate set of brokerages for its service. The NEMT Request for Proposal (RFP) used in 2004 by DCH called for coordination of services with public transit to the maximum extent feasible.

State Medicaid Service Delivery Model

Georgia's DCH uses a capitated brokerage to manage its NEMT program. That is, the brokers are given a set rate based on the number of Medicaid-eligible clients who reside in their service areas. There are five regions that were available for firms to place bids using an RFP process, resulting in two for-profit firms being selected to operate the capitated brokerage in the five regions. These firms then contracted with a variety of public and private entities. The service model used by at least one of the brokers is designed to maximize fixed-route usage.

Clients call the broker who then verifies eligibility for NEMT and determines the most appropriate/lowest cost provider to meet the client's needs. The broker then contacts the provider and informs them of the trips for the next day.

North Georgia Community Action Agency Activities That Affect Coordination

NGCAA is under contract to one of Georgia's two brokers. The broker takes all trip requests, verifies eligibility and trip purpose, and distributes the trips to their providers, one of which is NGCAA. NGCAA's sole responsibility is to provide the trips as requested by the broker. The broker in the NGCAA service area uses them for service in-county during NGCAA's operating hours (7:00 a.m. to 4:00 p.m., Monday through Friday). Trips going out of county or during hours that NGCAA does not serve will go to another local provider. The transit agency is paid by the trip with one rate for ambulatory and a second for nonambulatory riders.

NGCAA operates using its public transit and GDOT standards, which are higher than Medicaid according to NGCAA management. NGCAA has operated NEMT in various ways for more than 20 years and as long as it has been providing transportation it has coordinated its service. Management is pleased with the current arrangement and appreciates that it only does trips in its regular service area and does not have to conduct the intake.

Activities That Affect Coordination

- Local level initiatives—NEMT coordination, when it does happen, is, in large part, a result of activities initiated and successfully implemented by the local participants. There are some fully coordinated agencies in the state (agencies that operate all three major programs for the three agencies). The decision to coordinate or not was, in large part, a result of actions taken at the local level.
- Capitated brokerage—By its nature, the large-scale capitated brokerage model is dependent on receiving the lowest cost per trip possible. This is compounded by the playing field set by the broker and/or the state Medicaid agency. The broker attempts to contract with as many providers in an area as possible, often encouraging small providers to initiate service. This makes coordination with public transportation difficult to achieve, because public transit must compete for service on price, rather than quality.
- Lack of coordination of NEMT at the state level—GDOT and DHR have made significant efforts to coordinate their services and their models are compatible at the local level. DCH has chosen a capitated brokerage model that does not encourage coordination.
- Service standards—The NEMT program maintains a high level of standards for drivers and vehicles, ensuring a reasonably level playing field.

OREGON—TRIMET, PORTLAND

Introduction

TriMet, the large urban transit agency in the Portland, Oregon, area (population 1.3 million), operates fixed-route bus service, various light-rail lines, ADA paratransit, and NEMT. Fixed-route and light-rail ridership is approximately 98 million passenger trips, with a paratransit ridership of 920,000 annually. TriMet entered into its brokerage arrangement in 1994 as the first transit agency broker in Oregon and provides one of the best examples of coordination of public transit and Medicaid in an urban area. It also serves as an excellent example of a public–private partnership because the operations are contracted to private providers.

Oregon's Office of Medical Assistance Programs (OMAP), in conjunction with the Oregon DOT (ODOT), chose to work directly with a variety of transit agencies that serve as brokers of service. This de facto coordination serves as an excellent example of how state agencies can work with

transit professionals to provide service that meets local needs. The first brokerage was initiated in 1994 after two years of discussion, with others following over the next few years. All of the brokerages are public transit operators.

Relationship Between Stakeholders

In 1991, OMAP initiated discussions with TriMet, which culminated with an agreement for management of the brokerage that has been in place since 1994. TriMet management stated that relations among OMAP, ODOT, and TriMet were excellent, because all parties have a common goal. Communication is rarely a problem, because all parties work closely together to solve problems. ODOT provides seed money to brokers as needed to ensure successful implementation.

State Level Service Delivery Model

OMAP has placed control of the service at the local level. By allowing these regional brokers the flexibility to operate a program that meets the needs of the community, coordination has flourished. The regional brokerages are all operated by transit agencies. Each agency uses its own approach to the provision of NEMT. Brokers are paid based on an average trip cost, which is calculated quarterly. All billing is done electronically.

TriMet Coordination Activities

TriMet maintains a separate "contact center" for each program and a separate contracted operation owing to the complexities and differences of each program. Until recently, the services were managed by two different entities. Last year, both centers were contracted to one management firm. The centers are on TriMet property with TriMet staff working alongside the contractor, allowing for ease of service monitoring.

Customers call the NEMT Contact Center, which then assigns trips to one of 50 subcontractors (some are exclusive to TriMet, whereas others, such as taxicabs, pick up other passengers). Selection of the contractor and mode is dependent on need (most appropriate mode) and cost. Fixed-route ridership for NEMT is 35% of total ridership, down from 50% as a result of the elimination of certain groups from the Medicaid program. These groups had a very high level of fixed-route use. TriMet does not conduct a formal assessment of the ability of Medicaid clients to ride fixed-route transit (unlike the ADA program), preferring to "take the word" of the customers. Management feels that this approach, coupled with communication with case workers and field observation, is more effective and less intrusive.

Activities That Affect Coordination

- Communication and trust—OMAP, TriMet, and ODOT have an excellent working relationship and work toward a common goal of continuing to improve the brokerages.
- Interagency agreements—By contracting with other governmental entities, as opposed to a competitive procurement, OMAP has been able to ensure coordination by involving transit agencies as brokers.
- Local level flexibility—As with most large and diverse states, Oregon has a wide variety of transportation needs. Solutions in Portland may not work in the cities of Bend or Salem. This approach recognizes that the local level is the best place to determine needs and a service model(s). In addition, TriMet works directly with caseworkers to ensure the most appropriate mode.
- Cost-effective—The broker is always seeking the lowest cost per trip and has a variety of options available.
- Use of fixed-route service—The brokers appear to be taking advantage of fixed-route services and this has resulted in significant savings.
- Service standards—TriMet determines the service standards for the NEMT program (over and above state minimum levels). TriMet uses its own standards to ensure a quality service.
- Contract oversight—TriMet is aggressive in monitoring service—frequent field observations, inspections, and communication with caseworkers can only be done at the local or regional level.
- Fair/reasonable payment for service—The cost of the service is closely monitored to ensure that the payment per trip is reasonable for all parties.

TEXAS—TEXOMA AREA PARATRANSIT SYSTEM, SHERMAN AND DENNISON

Introduction

The Texoma Area Paratransit System (TAPS) is a nine-county rural transit agency and a small urban operator for the cities of Sherman and Dennison in north Texas. The service area population is approximately 110,000. The agency is predominantly demand-response with a series of commuter fixed-route services serving various employment sites in the Dallas/Ft. Worth metropolitan area and the Dallas Area Rapid Transit's (DART) light rail station in Plano.

TAPS contracts with the Medicaid Transportation Program (MTP) in nine counties (four under subcontract) and has coordinated a wide range of types of human service transportation for more than 20 years. TAPS is similar in size and coordination levels to a number of other rural agencies in Texas.

Texas has a long history of coordination at the local level, especially in rural areas, where many of the agencies have a 30-year history of coordinating Medicaid, Title III Aging transportation, job access, and other programs with public transit. Almost all of the rural transit agencies in the state coordinated at least one other human service program, and most more than one.

Relationships Between Stakeholders

The Texas Legislature has taken a unique approach to the coordination of transportation at the state level. In 2003, the state legislature passed legislation requiring the Texas Health and Human Service Commission (HHSC) (responsible for Medicaid, Title III, and other programs) and the Texas Workforce Commission (TWC) to cede control of their transportation programs to TxDOT. However, HHSC and the TWC retain policy control over their programs (i.e., HHSC is still the single state agency responsible for Medicaid). To date, TxDOT has transferred the entire MTP staff (more than 150 individuals operating the 8 call centers), as well as seven staff members to support the software used by TxDOT. The program has remained basically the same as it was when it was at HHSC. No other programs have been affected at this time.

State Medicaid Service Delivery Model

TxDOT operates the regional brokerages directly (using state employees), and each region uses multiple operators to cover their regions. In essence, TxDOT is directly involved in the day-to-day operation. Clients call their designated TxDOT regional broker who verifies client and trip eligibility and then determines the most appropriate mode. The MTP office then schedules the trip and contacts (or posts on the web) the most appropriate service operator at 5:00 p.m. the day before the trip.

Use of fixed-route service by TxDOT is low in the major cities where most of the population resides. In the 1980s, more than 50% of urban Texas Medicaid clients using MTP rode on fixed-route; currently, it is below 15%.

The previous approach implemented in the late 1990s by the Texas Department of Health was to conduct competitive procurements throughout the state. The RFP standards developed previously by the Department of Health for drivers, vehicles, maintenance, and safety were considerably lower than that of most of the public transit operators. As a consequence, some of the rural public transit agencies that had been operating MTP service for 20 years lost their contracts based on price. This resulted in a net loss of coordination in parts of the state, whereas other rural operators continued to operate in a coordinated manner. This loss continued with the most recent procurement (discussed here).

The new RFP issued as this study was being completed indicates that TxDOT is beginning to level the playing field by making operating requirements more stringent. The RFP does not require coordination, although it is encouraged. TxDOT has designated the 24 council of government regions as MTP regions. It is conducting a competitive procurement to select one operator or sub-broker who will receive the calls from TxDOT (the broker) to be responsible for all service in the region. These trip requests will then be forwarded to the service operator. It is not clear at this point how this procurement will affect coordination with public transit, nor is it clear how fixed-route usage will be increased.

State Level Coordination

As stated previously, the rural transit agencies have evolved into very highly coordinated transit agencies that compare favorably with other states. TxDOT has recently implemented a planning requirement for 24 designated areas covering the entire state. All major agencies and stakeholders are involved. It is not clear how the results of these meetings will affect or influence Medicaid transportation (procured outside the influence of this planning process) and the other programs. It should also be noted that without Medicaid transportation, there is little left to coordinate because MTP contributes the vast majority of human service funding and customers.

Texoma Area Paratransit System Coordination Efforts to Date

TAPS is a fully coordinated transit agency that, in addition to public transportation, contracts with TxDOT to operate Medicaid transportation. The recent changes place a sub-broker between TAPS and TxDOT. TAPS also assists a number of senior centers and the TWC. Employment transportation is coordinated directly with employers and employee organizations. TAPS also works with other small agencies to assist them in their transportation needs.

TAPS has taken the initiative to coordinate NEMT with public transit for its entire 20-year existence. Management believes that "all coordination is local" in that all of the activities necessary for coordination have been conducted at the local level. During those 20 years, TAPS was required to engage in a competitive procurement conducted by MTP and, at this time, has retained its contract. TAPS must work with two separate TxDOT MTP managers and two different TxDOT public transit coordinators. Now it must also work with an MTP sub-broker.

Innovation to Enhance Coordination

TAPS and one of its TxDOT MTP field managers have initiated a pilot program in four of the TAPS counties. TAPS sells bus passes for travel within each county. The MTP office in Dallas purchases discounted passes and distributes them to riders with demonstrated need. The customer then calls TAPS for their trip and is treated as any other customer. This eliminates the need for expensive invoicing and processing for both the operator and the MTP. It allows the transit provider to control the scheduling process, which also enhances their productivity. Record keeping is kept to a minimum as well. Lastly, it allows the MTP customers to gain a familiarity with the agency.

Activities That Affect Coordination

TAPS management was clear in its statement that all coordination is local. Management has worked hard to build a high level of trust. It credits considerable work at the local level for all of the coordination success TAPS has had over the years. Following are the factors that affect coordination in TAPS service area.

- Local level success and trust—TAPS and other Texas rural operators have a long history of successful coordination at the local level. These coordination efforts are built on trust and the development of relationships between partnering entities.
- Communication issues—Working with four different TxDOT field staff for two programs makes for communication issues. Perceptions and priorities are not always compatible between these programs and with TAPS.
- Unclear decision-making authority—In addition to the previous concern, it is not yet clear how the new planning process will be used to determine the level of coordination. There does not appear to be a link between the planning process and the NEMT procurement.
- State and federal government—TAPS management believes that the state and federal governments have no effect on TAPS coordination efforts. However, neither does government pose a barrier, with the possible exception of MTP.
- Sound business practice—TAPS will consider any coordination opportunity where they will not lose money. The objective is to provide more service.
- Flexible Medicaid funds—In rural areas, TAPS can use a portion of its MTP funds as part of its local match, giving a financial incentive to coordination in rural areas.
- Service standards—The previous procurement (when MTP was at the Department of Health) called for a lower level of safety and operating standards than rural operators provide. This made it difficult for transit agencies to compete with providers that offer the least stringent standards. This situation was improved in the latest procurement.

VERMONT—CHITTENDEN COUNTY TRANSPORTATION AUTHORITY, BURLINGTON

The focus of this case study is on Burlington's transit agency, the Chittenden County Transportation Authority (CCTA), which has a service area population of 87,000. CCTA is a small urban agency that also operates the transit service in the state capital of Montpelier. CCTA has been designated the broker for its Burlington service area and uses a variety of methods to meet the needs of Medicaid customers in a cost-effective manner. The agency provides more than 1.6 million fixed-route trips and 29,000 paratransit trips annually. Of this total, 172,000 were NEMT trips, with 75% of these on fixed routes.

Vermont, a predominantly rural state, has a unique approach to the coordination of Medicaid and public transportation. The state contracts with the Vermont Public Transit Association (VPTA) to administer and manage the NEMT program. VPTA, which is made up of the public transit operators, then contracts with those public transit operators who coordinate the service with their public transit.

Relationship Between Stakeholders

There is a very high level of trust between VPTA, the operators, and the state Medicaid agency. These agencies have been working together for 19 years. This trust has fostered a cooperative relationship that has enabled a high level of coordination.

State Level Service Delivery Model

The service delivery model places VPTA as the administrator of all Medicaid transportation in the state. VPTA contracts directly with nine public transit and paratransit agencies in the state. The operators serve as brokers, placing Medicaid customers on either fixed-route or paratransit and utilizing a strong network of volunteers. The volunteer programs, requiring significant effort to maintain, have a long tradition of assistance in this state, where fewer resources are available than typically found in large states and cities.

This service delivery approach is fully coordinated and, as seen in other regional and local models, very flexible in meeting local needs. For example, the urban areas of Burlington and Rutland rely on fixed-route service, whereas rural Addison County relies just as heavily on an extensive volunteer network.

State Level Coordination Efforts to Date

VPTA's operation of the program began in 1986 when the state's Agency of Human Services contracted with VPTA to manage the NEMT program. VPTA serves as the program manager and is the single point of contact and accountability for the medical transportation programs of nine regional Medicaid brokers in the state. The objective of the VPTA Medicaid/Reach Up Transportation Program is to provide the most cost-effective, appropriate transportation based on individual needs, medical circumstances, and available community resources. A corps of volunteer and professional drivers transport several hundred thousand rides to medical services, employment, and training centers each year.

The VPTA brokerage system is the major provider of NEMT for Vermont's Medicaid-eligible citizens. Broker organizations include public transit agencies and paratransit providers. Involvement in the Medicaid transportation program requires brokers to be subject to service approval, claims processing, and utilization review. During FY 2004,

VPTA members used fixed-route buses (36%), a network of hundreds of volunteers (27%), taxis (20%), and vans (8%), to provide 490,383 Medicaid/Reach Up trips statewide.

VPTA and the Agency of Human Services have coordinated for 19 years, and there is a very high level of trust between the organizations. VPTA also works closely with the Agency of Transportation (AOT). VPTA management reports state that NEMT was the impetus for initiating public transit in rural areas of the state and was the framework for transit services, with transit service areas coinciding with Medicaid catchment areas.

One concern that could affect coordination across the state is that the AOT believes that the Medicaid/Reach Up program should pay for depreciation of AOT-sponsored vehicles. This issue is currently under discussion and likely to be resolved by the state.

CCTA Coordination Efforts

CCTA is a small urban transit operator serving the greater Burlington area. In addition, CCTA operates and manages Green Mountain Transit, a rural transit agency in the state capital of Montpelier. CCTA was designated the broker for its service areas. As broker, CCTA's first priority is to place as many Medicaid customers on fixed-route service as possible. Currently, more than 80% of the Medicaid trips in the county that use Medicaid/Reach Up are on fixed routes and use bus passes. Demand-response trips are provided by taxi and coordinated through the nonprofit agency that contracts for ADA service.

Activities That Affect Coordination

- The Medicaid agency trust level—There is a high level of trust between the state Agency for Human Services and VPTA, built over years of cooperation. Their trust level extends to the operators.
- Coordination of state agencies—Each of the agencies and the brokerage work well together and discuss issues on a regular basis in a variety of forums.
- Using the operators as brokers—This decision was critical to the coordination effort and is an excellent example of the state facilitating coordination.
- High utilization of fixed-route service—Vermont has a high level of fixed-route use (36% for 11% of the cost). Considering that Vermont is a very rural state makes it even more impressive. According to VPTA, the cost for a fixed-route trip is less than 20% of the average cost for the other modes.
- Adequate funding for NEMT—Each of the brokers is reimbursed for the trip provided (volunteer or transit), as well as for expenses related to administration and trip intake. The costs of trip intake are almost as much as the trip itself and are related to:
  - trip and eligibility verification and assignment of most appropriate mode, and
  - recruitment, training, administration payment, verification, and programs designed to retain volunteers.
- Level playing field—VPTA determines the service standards that all brokers must comply with. The playing field is level.

SUMMARY—CASE STUDIES

NEMT is essentially a state designed and managed program; therefore, there are a variety of effective approaches to coordination and service delivery. The five case studies represented in this synthesis illustrate the flexibility states have in designing a NEMT program.

The case studies indicated that there are a number of lessons to be learned and that there are a variety of factors and actions that can determine coordination potential at the transit agency level. The most important are discussed here.

- Lesson 1: Coordination of fixed-route service is encouraged by most states—Florida, an early practitioner of fixed-route bus passes, has seen considerable cost savings using this approach. Vermont and Oregon are also practitioners of the use of fixed-route service. Georgia's private brokers see financial gain through the use of fixed-route service and presumably the state Medicaid agency benefits from this approach. However, although in the 1980s and early 1990s Texas relied heavily on fixed-route service, its use has been reduced since that time. With some exceptions, most states have seen significant financial savings through the use of fixed-route service.
- Lesson 2: Cost transferring onto paratransit is problematic—Paratransit, the mode used by many clients, operates differently from fixed-route service. Where the use of fixed-route service can benefit all riders, paratransit typically requires fully allocated costs to be successful.
- Lesson 3: Service model—The service model used will, in part, determine the level and ability of the transit agencies to coordinate. The service model used by Vermont is built on trust at the local level and through state initiative with the transit association; this has introduced a model of service delivery that is the epitome of coordination. Oregon also has a strong coordination model. In each of these cases, the transit agencies serve as brokers or operators of service. Florida's model also fosters coordination between transit agencies. NEMT has seen some transit agencies withdraw or consider withdrawing from the NEMT program owing to funding cuts. In the past, Texas was a highly coordinated state through the strength of its transit agencies. The recently introduced RFP is a coordination neutral approach and several systems lost

their contracts. Low price and other factors will determine the selection process. Finally, Georgia has a model that makes coordination difficult to achieve through its large regional brokers.

The approach used by each state will help determine coordination potential; however, coordination can still occur even with a model that does not necessarily encourage coordination. The local transit agency will also, in large part, determine if coordination will be used.

- Lesson 4: Building on trust—As in any business relationship, coordination is built on trust. In Vermont and Oregon the trust level is high at all levels of management. The other case studies indicated significant trust at the local level where coordination was successful.

CHAPTER FIVE

CONCLUSIONS

There were a number of coordination factors evident throughout the synthesis. These factors can foster or impede coordination, and some can dictate the level of coordination. For example, certain capitated brokerages will encourage competition among providers that is the opposite of coordination. It was also determined that rural areas are well ahead of their urban counterparts in coordinating public transit with Non-Emergency Medical Transportation (NEMT).

The following are the elements of success—key factors that can foster or inhibit coordination as expressed through the literature review; surveys of transit agencies, state departments of transportation and Medicaid agencies; and the case studies. Not all agencies encountered all of these elements; however, each of the issues listed occurred multiple times and were credited with influencing coordination. These factors are listed based on their affect on coordination: success factors, helpful factors, and challenges to coordination are discussed here.

SUCCESS FACTORS

These are the factors that must be present for coordination to succeed. By themselves however, these factors do not guarantee success.

- Operational coordination is local—Coordination of NEMT and public transit is fostered and implemented at the local level whether encouraged or inhibited by state and federal government. In the long history of coordination, most of the successes were a result of local level collaboration based on needs and sound business decisions. In the states reviewed as part of this synthesis, many local operators coordinated, whereas the state agencies were not involved.
- Building trust—In a number of cases, the trust level becomes very important at the local level. The trust between entities and their management will, in part, determine the level of coordination. Some of the transit agencies reported that they built this trust over many years.
- Service delivery model—The service model will, to a significant extent, dictate the potential levels of coordination. Some models clearly foster coordination, some give coordination a lower priority, and others are indifferent. The Oregon and Vermont models are examples of successful coordination, whereas other models do not encourage or discourage coordination.
- Urban and rural areas—It was determined that rural transit is far ahead of its urban counterpart in the area of coordination in general and for Medicaid transportation as well. This was originally accomplished out of necessity; however, it has become an integral part of most rural transit agencies in the nation.
- Use of fixed-route service—The appropriate use of fixed-route service is cost-effective and fosters mobility for the clients served. It is true coordination where all parties benefit. Where possible, bus passes should be used. According to the literature and operator responses, the distribution of bus passes is often administratively more effective than distributing tickets two at a time.
- Make business sense—Coordination implies and requires mutual benefits; that is, each entity must find the arrangement acceptable from a business perspective. The alternative is for a transit agency to subsidize NEMT.

HELPFUL FACTORS

If in place, these elements can help foster coordination; however, without them coordination may still be possible, but more difficult.

- Understanding of transit concerns—Although NEMT is typically the largest source of transportation funding in rural areas, its managers often have no experience or knowledge of transportation subjects. This lack of understanding has been cited as a major barrier to coordination by transit managers. NEMT managers cite concerns similar to those of transit managers when it comes to NEMT services.
- State legislation/mandates—To date, legislative efforts have had mixed results across the country based on the information collected for this study, as well as a report by the National Conference of State Legislatures.
- Level playing field—A number of transit operators cited the difficulty of competing when the Medicaid service standards are low. Driver training requirements, minimum standards, vehicle standards, safety standards, and other requirements typically adhered to by transit are not always required by Medicaid agencies. This encourages two different levels of service—one for public transit and a lower standard for Medicaid clients.

- State level coordination—Coordination of services occurs at the local level, whether the state agencies have coordinated or not. This is seen in states where there is an indifference to coordination at the state level and even where the state is resistant to coordination. Unfortunately, coordination is far less likely when the state agencies are not cooperating.

CHALLENGES

There are some activities and policies that are clear impediments or barriers to coordination. Where these are in place, coordination is more difficult.

- Cost transferring—One large broker reported that it was its intention (in a state not reviewed in this synthesis) to transfer as many clients to American with Disabilities Act (ADA) paratransit as possible; shifting the financial burden from the broker to public transportation and local taxpayers. This is the direct opposite of coordination and will only result in distrust.
- Jurisdictional—Medicaid trips by nature often require long distance transportation for specialty medical needs, crossing transit jurisdictional lines. Some operators have cited (local level) problems with the crossing of jurisdictional lines.
- Freedom of choice—The Medicaid Freedom of Choice requirement treats transportation as it would a medical program, allowing customers to use any provider they choose. Furthermore, this approach makes coordination problematic by encouraging more small providers.

SUGGESTIONS FOR FURTHER RESEARCH

Based on the surveys, literature review, case studies, and first-hand observation, coordination can happen in most settings. It is evident that further research to facilitate actual NEMT coordination at the transit agency level is necessary in a number of areas. The following issues can be viewed as starting points for in-depth research:

- Identification of uniform service standards—One of the primary observations of this study is the difficulty in coordinating when service standards are different between NEMT and public transit. Research could identify NEMT and public transit safety and quality standards and activities that can "level the playing field." Areas for research include reviewing NEMT and public transit safety (e.g., accidents, incidents, and training) and quality (e.g., on-time, missed trips, vehicle breakdowns, and driver experience).
- Cost transferring—Cost transferring typically occurs when an NEMT program decides to shift its paratransit riders to the general public ADA service; shifting the burden of funding NEMT from the state Medicaid agency to the local transit agency. Research could identify how widespread this practice is, who benefits, and who pays for this approach. The research could identify a policy to address this issue as well.
- Use of fixed-route service—Fixed-route service is clearly beneficial for clients, NEMT, and public transit. Research might help identify where this practice is used and how other states could increase their use of fixed-route service. It would also be helpful to NEMT program managers in understanding how customers can be identified as being able to use fixed-route service (something ADA agencies have been perfecting over the past 15 years).
- Tools and strategies for local level coordination—More national research is needed on how to coordinate at the local level. How do successful managers of coordinated agencies build trust, operate service, and manage multiple funding sources?
- Education for leaders/policy makers—NEMT and public transit are very specialized programs. Frequently, the managers of these programs are not well versed in the issues and needs of the other program. A national forum could be developed to identify the concerns, provide the necessary dialogue, and educate leaders of both communities. Local elected officials should also be involved in this effort.
- Efforts geared toward communication and trust—The importance of local level coordination cannot be overstated. Research can help identify how trust can be built and maintained.
- Freedom of choice—The freedom of choice requirement for transit is not equivalent to the choice of medical professionals. Research should look into the effectiveness of this requirement for transit—an industry that is not as closely regulated as for example the medical profession.

REFERENCES

Borders, S., J. Dyer, C. Blakely, A. James, and D. Raphael, *Texas Medicaid Transportation Program: A Study of Demand Response Services in Texas*, Prepared for the Public Policy Research Institute, Texas Department of Health, Austin, July 2003.

Bradley, D., et al., *Designing and Operating Cost-Effective Medicaid Nonemergency Transportation Programs—A Guidebook for State Medicaid Programs*, Health Care Financing Administration and the National Association of State Medicaid Directors' Non-Emergency Transportation Technical Advisory Group, Washington, D.C., Aug. 1998, 124 pp.

Burkhardt, J.E., C.A. Nelson, G. Murray, and D. Koffman, *TCRP Report 101: Toolkit for Rural Community Coordinated Transportation Services,* Transportation Research Board, National Research Council, Washington, D.C., 2004, 438 pp.

Hindrances to Coordinating Transportation of People Participating in Federally Funded Grant Programs, GAO/RCED-77-119, U.S. General Accounting Office, Washington, D.C., Oct. 17, 1977.

KFH Group, Inc., *Maryland Transportation Coordination Manual*, Prepared for the Maryland Department of Transportation, Mass Transit Administration, Baltimore, Jan. 1998.

KFH Group and AMMA, *TCRP Report 70: Guidebook for Change and Innovation at Rural and Small Urban Transit Systems*, Transportation Research Board, National Research Council, Washington, D.C., 2000, 249 pp.

Medicaid Non-Emergency Transportation National Survey 2002–03, National Consortium on the Coordination of Human Services Transportation, Washington, D.C., Dec. 2003.

Medicaid Non-Emergency Transportation: Three Case Studies, National Consortium on the Coordination of Human Services Transportation, Washington, D.C., 2003.

Medical Transportation Toolkit and Best Practices, 3rd ed., Community Transportation Association of America, Washington, D.C., 2005.

Raphael, D., *Medicaid Transportation: Assuring Access to Health Care—A Primer for States, Health Plans, Providers, and Advocates*, Community Transportation Association of America, Washington, D.C., Jan. 2001, 37 pp.

Rural Ambulances, Medicare Fee Schedule Payments Could Be Better Targeted, Report to the Honorable Thomas A. Daschle, U.S. Senate, U.S. General Accounting Office, Washington, D.C., July 2000.

Sundeen, M., J. Reed, and M. Savage, *Coordinated Human Service Transportation—State Legislative Approaches*, National Conference of State Legislatures, Washington, D.C., Jan. 2005.

Transportation-Disadvantaged Populations: Some Coordination Efforts Among Programs Providing Transportation Services, But Obstacles Persist, GAO-03-697, U.S. General Accounting Office, Washington, D.C., June 30, 2003.

Westat and Nelson/Nygaard Consulting Associates, *TCRP Report 91: Economic Benefits of Coordinating Human Service Transportation and Transit Services*, Transportation Research Board, National Research Council, Washington, D.C., 2003, 173 pp.

BIBLIOGRAPHY

Annual Performance Report, Prepared by the Florida Commission for the Transportation Disadvantaged, Tallahassee, Jan. 1, 2005.

Borders, S., J. Dyer, and C. Blakely, *An Assessment of the Medical Transportation Program of Texas: A Survey of THSteps Recipients and Providers,* Prepared for the Texas Department of Health, Austin, Jan. 2002.

Controlling Medicaid Non-Emergency Transportation Costs, Office of Inspector General, Department of Health and Human Services, Washington, D.C., Apr. 1997.

Health Access Non-Emergency Medical Transportation: Issues of Statewide Planning Significance, Mar. 22, 2005, Ontario, California Conference.

Independent Assessment: Florida Non-Emergency Medicaid Transportation Waiver, Bureau of Economic and Business Research, University of Florida, Gainesville, Oct. 2003.

"MEDICAID States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight," Statement of K. Allen, Testimony before the Committee on Finance, U.S. Senate, June 28, 2005.

Rubel, T., P. Psilos, P. Kalomiris, and J. Mueller, *Improving Public Transportation Services Through Effective Statewide Coordination,* NGA Center for Best Practices, Washington, D.C., 2002, 44 pp.

Sommers, A., A. Ghosh, The Urban Institute, and D. Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories,* Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., June 2005.

Standard Rate Structure Report, Prepared by the Government Services Group for the Florida Commission for the Transportation Disadvantaged, Tallahassee, Mar. 2003.

Stefl, G. and M. Newsom, *Medicaid Non-Emergency Transportation: National Survey 2002–2003,* Prepared for the National Consortium on the Coordination of Human Services Transportation, Washington, D.C., Dec. 2003.

"Transit—Buses, Paratransit, Rural Public Buses, and Intercity Transit; New Transportation Systems and Technology; Capacity and Quality of Service," *Transportation Research Record 1791,* Transportation Research Board, National Research Council, Washington, D.C., Oct. 2002.

Transportation-Disadvantaged Populations: Federal Agencies Are Taking Steps to Assist States and Local Agencies in Coordinating Transportation Services, GAO-04-420R, U.S. General Accounting Office, Washington, D.C., Feb. 24, 2004.

TranSystems Corporation, Center for Urban Transportation Research, Institute for Transportation Research and Education, and Planners Collaborative, *TCRP Report 105: Strategies to Increase Coordination of Transportation Services for the Transportation Disadvantaged,* Transportation Research Board, National Research Council, Washington, D.C., 2004, 85 pp.

APPENDIX A

Surveys

TRANSIT COOPERATIVE RESEARCH PROGRAM
SYNTHESIS PROJECT J-7, TOPIC SB-13
Transit Agency Participation in Medicaid Transportation Programs
Survey Questionnaire for State Public Transit Departments

Purpose:	*The objective of this synthesis is to research the real and perceived barriers to coordinating public transit services with Medicaid transportation services. The results of this survey will report on these barriers and develop case studies that profile innovative and successful practices, as well as lessons learned and gaps in information.*

Please return this survey to Elisabeth Fetting, Senior Transportation Planner, KFH Group via e-mail: efetting@kfhgroup.com. If you have any questions concerning the survey or the study, please call Ken Hosen or Elisabeth Fetting at (301) 951-8660.

STATE CONTACT INFORMATION

Name of State Public Transit Department:

Address: City: State: Zip:

Contact Person: Title:

Phone: ( ) Fax: ( )

E-mail:

1. Does your department coordinate with your state's Medicaid agency?
   ☐ Yes ☐ No

   If yes, what is the level of coordination?
   - ☐ Formal coordination agreement
   - ☐ Regularly scheduled meetings
   - ☐ Occasional contact
   - ☐ Other, please describe:

   If no, why not:

2. Would you consider the relationship between your agency and your state's Medicaid agency as:

   ☐ Coordinated—actively pursue ways to coordinate Medicaid transportation services with public transit services.

- ☐ Cooperative—participate in coordination efforts when asked, but do not actively pursue such arrangements.
- ☐ Non-existent—do not participate in any coordination efforts.

3. Please describe any efforts your department has undertaken to foster coordination with your state's Medicaid agency.

4. Please indicate what your department's official position is with regard to non-emergency medical transportation:

   - ☐ There should be cooperative arrangements between non-emergency medical transportation and public transportation.
   - ☐ Non-emergency medical transportation and public transportation should be coordinated.
   - ☐ Non-emergency medical transportation and public transportation should be consolidated.
   - ☐ Non-emergency medical transportation and public transportation should be completely separate.
   - ☐ We have no official position concerning the relationship between non-emergency medical transportation and public transportation.

5. Do you consider any of the following issues to be barriers to coordinating Medicaid transportation services with public transit services? *Please explain each barrier.*

   - ☐ Transit regulatory/legal/compliance issues—such as the Americans with Disabilities Act (ADA), drug testing requirements, and Commercial Driver's Licensing (CDL) regulations.

   - ☐ Jurisdictional boundary issues that may occur when a client needs to travel from his home to a facility that is not in the transit provider's operating area.

   - ☐ Financial restrictions such as the need for the Medicaid agency to find the lowest cost trip, given the other modes that may be available at no cost to the client, and the need for the transit agency to receive the fully allocated cost of the trip.

   - ☐ Political barriers, such as the perception of the misuse of transit passes by Medicaid clients and/or the level of political work necessary to effect coordination.

   - ☐ Information/technology barriers, such as the need to collect and confidentially store client data that transit agencies do not typically collect concerning riders or problems with the compatibility of technologies.

☐ Different goals among the participants—i.e., the Medicaid agency is interested only in their clients accessing appointments in the most cost-effective way versus the transit agencies' need to fulfill all of the communities' transit needs.

☐ Other barriers:

6. Are there operational barriers to coordinating public transit services with Medicaid transportation services?

☐ Yes ☐ No

If yes, please categorize and describe these barriers:

☐ Differences in the level of driver training needed:

☐ Eligibility concerns:

☐ Different equipment requirements:

☐ Different liability requirements:

☐ Different service standards:

☐ Service design not compatible with public transit:

☐ Other, please describe:

7. Are there any other barriers or issues regarding the coordination of NEMT and public transit on which you would like to comment?

Thank you for your input!

Please return this survey via e-mail to efetting@kfhgroup.com

TRANSIT COOPERATIVE RESEARCH PROGRAM
SYNTHESIS PROJECT J-7, TOPIC SB-13

Transit Agency Participation in Medicaid Transportation Programs
Survey Questionnaire for Transit Agencies

Purpose: *The objective of this synthesis is to research the real and perceived barriers to coordinating public transit services with Medicaid transportation services. The results of this survey will report on these barriers and develop case studies that profile innovative and successful practices, as well as lessons learned and gaps in information.*

Please return this survey to Elisabeth Fetting, Senior Transportation Planner, KFH Group via e-mail: efetting@kfhgroup.com. If you have any questions concerning the survey or the study, please call Ken Hosen or Elisabeth Fetting at (301) 951-8660.

SYSTEM AND CONTACT INFORMATION

Name of Transit Agency:

Address: City: State: Zip:

Contact Person: Title:

Phone: ( ) Fax: ( )

E-mail:

1. Please categorize your transit system (*check all that apply*):

☐ Urban ☐ Fixed-route and paratransit
☐ Rural ☐ Paratransit only
☐ Suburban ☐ Other, please describe:

Please indicate your annual ridership:
Total annual one-way trips—Fixed-route:
Total annual one-way trips—Paratransit:

2. Please indicate how many vehicles you have in your fleet:

No. fixed-route vehicles: _____

No. paratransit vehicles: _____

3. Please indicate the appropriate organizational arrangement for your transit system:

   ☐ City or county agency
   ☐ Transit authority
   ☐ State agency
   ☐ Private non-profit agency
   ☐ Other:

4. Are your transit services operated directly by agency employees or do you contract with a transit service provider?

   ☐ Operate services directly
   ☐ Contract the direct operation of transit services, but not the administration
   ☐ Contract the direct operation of transit services and the administration of transit services
   ☐ Use a mix of contracted and directly provided services—Please describe:

   ☐ Other arrangements—Please describe:

5. Does your transit system provide transportation services for human service agency clients on a contractual basis?

   ☐ Yes ☐ No

   If yes, what percentage of your total ridership is represented by human service agency transportation?

6. Does your agency provide or has it ever provided brokerage services for non-emergency Medicaid transportation?

   ☐ Yes ☐ No

7. Does your transit agency provide or has it ever provided transportation services for Medicaid recipients to access their medical appointments?

   ☐ Yes ☐ No

   a. If yes, are these trips provided as general public passenger trips or do you provide Medicaid transportation on a contractual basis with your local Medicaid agency?

      ☐ General public ☐ Medicaid contract

   b. If yes, does your agency provide local trips only, or both local and long distance trips?

      ☐ Local only ☐ Long distance and local

   c. If yes, please indicate by percentage what modes are used to transport Medicaid clients to their appointments:

      % of Medicaid trips provided using fixed-route services: %

      % of Medicaid trips provided using paratransit services: %

   d. If yes, does the Medicaid Agency pay their full share of the costs incurred to transport Medicaid clients to their medical appointments on paratransit?

      ☐ Yes ☐ No

e. Please explain the arrangements that you currently have with your local Medicaid agency:

8. Who makes the decision whether or not to participate in the provision of non-emergency Medicaid transportation?

- ☐ Transit agency board
- ☐ City or county government
- ☐ Transit agency management staff
- ☐ Transit agency staff
- ☐ Other:

9. What level of funding does your agency receive each year for the provision of non-emergency medical transportation:

Annual funds for direct operation of services: $

Annual funds for administering the program: $

10. What is your fully allocated cost per trip for paratransit trips?

$ per trip

11. Do you consider any of the following issues to be barriers to coordinating Medicaid transportation services with public transit services? *Please explain each barrier.*

- ☐ Transit regulatory/legal/compliance issues—such as the Americans with Disabilities Act (ADA), drug testing requirements, and Commercial Driver's Licensing (CDL) regulations.

- ☐ Jurisdictional boundary issues that may occur when a client needs to travel from his/her home to a facility that is not in the transit provider's operating area.

- ☐ Financial restrictions, such as the need for the Medicaid agency to find the lowest cost trip, given the other modes that may be available at no cost to the client, and the need for the transit agency to receive the fully allocated cost of the trip.

- ☐ Political barriers, such as the perception of the misuse of transit passes by Medicaid clients and/or the level of political work necessary to effect coordination.

- ☐ Information/technology barriers, such as the need to collect and confidentially store client data that transit agencies do not typically collect concerning riders, or problems with the compatibility of technologies.

☐ Different goals among the participants—i.e., the Medicaid agency is interested only in their clients accessing appointments in the most cost-effective way versus the transit agencies' need to fulfill all of the communities' transit needs.

☐ Other barriers:

12. Are there operational barriers to coordinating public transit services with Medicaid transportation services?

☐ Yes ☐ No

If yes, please categorize and describe these barriers:

☐ Differences in the level of driver training needed:

☐ Eligibility concerns:

☐ Different equipment requirements:

☐ Different liability requirements:

☐ Different service standards:

☐ Service design not compatible with public transit:

☐ Other, please describe:

13. For those agencies that do not participate in the provision of Medicaid transportation services, would you be interested in providing or brokering these services in the future?

☐ Yes, fixed-route only

☐ Yes, paratransit only

☐ Yes, fixed-route and paratransit only

☐ Yes, brokerage

☐ No

If yes, under what conditions would you be interested in providing or brokering these services?

If no, why not?

Thank you for your input!
Please return this survey form via e-mail to efetting@kfhgroup.com

TRANSIT COOPERATIVE RESEARCH PROGRAM
SYNTHESIS PROJECT J-7, TOPIC SB-13

Transit Agency Participation in Medicaid Transportation Programs

Survey Questionnaire for State Medicaid Agencies

Purpose:	*The objective of this synthesis is to research the real and perceived barriers to coordinating public transit services with Medicaid transportation services. The results of this survey will report on these barriers and develop case studies that profile innovative and successful practices, as well as lessons learned and gaps in information.*

Please return this survey to Elisabeth Fetting, Senior Transportation Planner, KFH Group via e-mail: efetting@kfhgroup.com. If you have any questions concerning the survey or the study, please call Ken Hosen or Elisabeth Fetting at (301) 951-8660.

STATE CONTACT INFORMATION

Name of State Medicaid Agency:

Address: City: State: Zip:

Contact Person: Title:

Phone: ( ) Fax: ( )

E-mail:

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1. Please categorize the way in which non-emergency medical trips are provided in your state under the Medicaid program (*check all that apply*):

   ☐ Brokerage, locally arranged within individual cities or counties
   ☐ Brokerage, regional in nature, involving several cities/counties
   ☐ Brokerage, statewide
   ☐ Direct service delivery using Medicaid agency employees
   ☐ Locally arranged contracts with private transportation providers
   ☐ Statewide contracts with private transportation providers
   ☐ Locally arranged contracts with public transit agencies (please provide examples)
   ☐ Statewide contracts with public transit agencies (please provide examples)
   ☐ Public fixed-route transit, with clients using vouchers/cards/tickets of some sort
   ☐ Freedom of choice
   ☐ Other:

2. Who makes the decision regarding the design of service for the provision of non-emergency medical trips?

   ☐ State level staff
   ☐ State level upper management
   ☐ Local level staff

☐ Local level political leaders
☐ Others:

3. Please provide a brief description of how services are delivered in your state:

4. How is the eligibility screening and verification process handled in your state?

5. Are you satisfied with the way in which non-emergency Medicaid transportation services are delivered in your state?
   ☐ Yes ☐ No

   If no, what areas need to be improved?

6. Does your agency coordinate with your state Department of Transportation?
   ☐ Yes ☐ No

   If yes, what is the level of coordination?

   ☐ Formal coordination agreement
   ☐ Regularly scheduled meetings
   ☐ Occasional contact
   ☐ Other, please describe:

   If no, why not?

7. Please describe the following service standards required in provider agreements/contracts:

   a. Driver training requirements:

   b. Driver experience/driving record:

   c. Vehicle standards/types of vehicles and accessibility:

8. How are services monitored (*check all that apply*)?

   ☐ Reports, electronic
   ☐ Reports, paper
   ☐ Field monitoring
   ☐ Customer surveys—Please list frequency
   ☐ Inspection of driver records
   ☐ Inspection of vehicle records
   ☐ Other:

9. Are services monitored at the local or state level?

☐ Local
☐ State
☐ Both, please indicate percent local versus state: % state % local

Please send us a sample copy of a contract with a public transit system or a recent RFP used to procure services or a broker.

10. Do you consider any of the following issues to be barriers to coordinating Medicaid transportation services with public transit services? *Please explain each barrier.*

☐ Medicaid regulatory/legal/compliance issues—such as waiver requirements, freedom of choice requirements, the need to provide the same level of service across the state, and prior approval requirements.

☐ Transit regulatory/legal/compliance issues—such as the Americans with Disabilities Act (ADA), drug testing requirements, and Commercial Driver's Licensing (CDL) regulations.

☐ Jurisdictional boundary issues that may occur when a client needs to travel from his/her home to a facility that is not in the transit provider's operating area.

☐ Financial restrictions, such as the need for the Medicaid agency to find the lowest cost trip, given the other modes that may be available at no cost to the client, and the need for the transit agency to receive the fully allocated cost of the trip.

☐ Political barriers, such as the perception of the misuse of transit passes by Medicaid clients and/or the level of political work necessary to effect coordination.

☐ Information/technology barriers, such as the need to collect and confidentially store client data that transit agencies do not typically collect concerning riders.

☐ Different goals among the participants—i.e., the Medicaid agency is interested only in their clients accessing appointments in the most cost-effective way versus the transit agencies' need to fulfill all of the communities' transit needs.

☐ Other barriers:

11. Are there operational barriers to coordinating public transit services with Medicaid transportation services?
    ☐ Yes ☐ No

    If yes, please categorize and describe these barriers:

    ☐ Differences in the level of driver training needed:

    ☐ Eligibility concerns:

    ☐ Different equipment requirements:

    ☐ Different liability requirements:

    ☐ Different service standards:

    ☐ Service design not compatible with public transit:

    ☐ Other, please describe:

12. Are there any changes planned for your state's non-emergency Medicaid transportation program? If yes, please describe.
    ☐ Yes ☐ No

13. Are there any other barriers or issues regarding the coordination of NEMT and public transit on which you would like to comment?

Thank you for your input!
Please e-mail this survey back to efetting@kfhgroup.com

APPENDIX B

State Departments of Transportation, Medicaid Agencies, and Transit Systems Responding to the Surveys

Transit Agencies

Broward County Transit, Florida (BCT)
Chittenden County Transportation Authority, Burlington, Vermont (CCTA)
Hill Country Transit, Texas
Jacksonville Transportation Authority, Florida (JTA)
King County Metro Transit, Seattle, Washington
Ottumwa Transit Authority, Iowa
Tri-County Metropolitan Transportation District of Oregon, Portland, Oregon (TriMet)
Virginia Regional Transportation Association

State Medicaid Agencies

California
Florida
Georgia
Maryland
Missouri
Oregon
Texas
Vermont

State Departments of Transportation

Florida
Georgia
Maryland
Missouri
Oregon
Texas

Abbreviations used without definitions in TRB publications:

AASHO	American Association of State Highway Officials
AASHTO	American Association of State Highway and Transportation Officials
ACRP	Airport Cooperative Research Program
ADA	Americans with Disabilities Act
APTA	American Public Transportation Association
ASCE	American Society of Civil Engineers
ASME	American Society of Mechanical Engineers
ASTM	American Society for Testing and Materials
ATA	American Trucking Associations
CTAA	Community Transportation Association of America
CTBSSP	Commercial Truck and Bus Safety Synthesis Program
DHS	Department of Homeland Security
DOE	Department of Energy
EPA	Environmental Protection Agency
FAA	Federal Aviation Administration
FHWA	Federal Highway Administration
FMCSA	Federal Motor Carrier Safety Administration
FRA	Federal Railroad Administration
FTA	Federal Transit Administration
IEEE	Institute of Electrical and Electronics Engineers
ISTEA	Intermodal Surface Transportation Efficiency Act of 1991
ITE	Institute of Transportation Engineers
NASA	National Aeronautics and Space Administration
NCFRP	National Cooperative Freight Research Program
NCHRP	National Cooperative Highway Research Program
NHTSA	National Highway Traffic Safety Administration
NTSB	National Transportation Safety Board
SAE	Society of Automotive Engineers
SAFETEA-LU	Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (2005)
TCRP	Transit Cooperative Research Program
TEA-21	Transportation Equity Act for the 21st Century (1998)
TRB	Transportation Research Board
TSA	Transportation Security Administration
U.S.DOT	United States Department of Transportation