

# Pierce County Coordinated Transportation Plan

Report to the Legislature

December 2010







# Pierce County Coordinated Transportation Coalition

## Members of the Pierce County Coordinated Transportation Coalition

December 2010

- A. Members of the local coalition
  - Pierce County Community Services** – Marge Tully, member; Sherry Martin, alternate
  - Puget Sound Educational Service District** – Jacque Mann
- B. One or more representatives of the public transit agencies serving the region
  - Pierce Transit** – Tim Renfro, member; Jeanne Archer, alternate
  - Sound Transit** – Ella Campbell, member; Michael Miller, alternate
- C. One or more representatives of private service providers
  - Around the Sound** – Steve Hutchins
  - Coastal Transport** – Brent Meldrum
  - Local Motion** – Lyle Bates
  - Transpro** – Rick Maesner
- D. A representative of Civic or Community-Based Service Providers
  - The Mustard Seed Project** – Edie Morgan, member; Amanda Watson, alternate
  - United Way of Pierce County** – Penni Belcher, member; Renee Ghan, alternate
- E. A consumer of Special Needs Transportation
- F. A representative of nonemergency medical transportation/Medicaid broker
  - Paratransit** – Ann Kennedy, member; Christie Scheffer or Teresa Williams, alternates
- G. A representative of Social and Human Services Programs
  - Catholic Community Services** – Penny Grellier, member; Jodie Moody, alternate
  - Pierce County Aging and Long Term Care** – John Mikel
- H. A representative of local high school districts
  - Bethel School District** – Jay Brower
- I. A representative from the Washington State Department of Veterans Affairs



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## EXECUTIVE SUMMARY

The Pierce County Coordinated Transportation Coalition (PCCTC) has been working since the 1990's to improve transportation for people who, due to age, disability or income, are unable to transport themselves or purchase transportation. Pierce County is faced with high rates of unemployment, and a dramatic increase in demand from a growing elderly and disabled population as well as low income families who depend on public transportation. "Coordinated transportation" involves agencies working together to share rides, expand the amount of transportation available and improve the quality of services. A primary focus of the PCCTC has been to find ways to coordinate Medicaid Non Emergency Medical Transportation (NEMT) and Public Transportation in order to save money and maintain or increase transportation services to meet the growing need in times of severely reduced tax revenues, cuts to human services budgets, and cuts to transit services.

There has been a perception that federal regulations prevent Medicaid and Public Transit from sharing information, sharing rides and sharing costs. Both Pierce Transit and the Medicaid Broker, Paratransit Services, Inc, operate vehicles equipped with wheelchair lifts (known as "paratransit"), and each agency provides rides for people who are eligible to use both services. For over ten years the PCCTC worked on a series of projects called "Common Ground" that attempted to find ways for Medicaid and Public Transit in Pierce County to share client information (who is eligible for both services), share rides/trips (schedule rides for both Pierce Transit and Paratransit customers, going to similar locations, on the same vehicle) and share costs for these expensive rides. In 2008, the Department of Social and Health Services (DSHS) withdrew support for the project, ending Common Ground and the attempt to coordinate these services.

The legislature wanted to know what prevents Medicaid and Public transit from sharing rides. In 2009, Engrossed Substitute House Bill 2072 (ESHB 2072) continued the Agency Council on Coordinated Transportation (ACCT) and directed them to appoint a Local Coordinating Coalition (LCC) in Pierce County "to serve in an advisory capacity to the ACCT. An LCC's duties include: 1) considering strategies to address local service needs; 2) implementing pilot projects to test and demonstrate cost sharing and cost-saving opportunities, 3) capturing the value of Medicaid trips provided by public transit agencies for which they are not currently reimbursed with a funding match by federal Medicaid dollars." This report is submitted in compliance with ESHB 2072.

**Coordinating trips between Medicaid and Public Transportation offers great potential cost savings and, with legislative support, could be implemented immediately.**



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In addition to appointing the PCCTC as the /Local Coordinating Coalition and advisory group, SHB2072 also created a “Federal Opportunities Work-group” to meet with our congressional delegation and determine how to resolve the barriers to coordination. Throughout the past year the two groups have reviewed the issues that were believed to prevent coordination. Both groups found that many of the barriers to coordination have been removed in recent years as the result of the federal coordinated transportation initiative “United We Ride” and changes in federal legislation governing Medicaid. With the barriers removed, coordinating trips between Medicaid and Public Transportation offers great potential cost savings and, with legislative support, could be implemented immediately.

### **Local Coordinating Coalition Pilot Program**

The PCCTC designed a pilot project to provide rides to an Adult Day Health program after the legislature decided to remove medicaid funding for transportation to the service. The transportation pilot program implemented in 2010 resolved the federal barriers and saved money:

- Client information sharing - HIPAA regulations do not prevent sharing client information
- Sharing costs - Multiple agencies can split costs without new cost allocation software;
- Sharing rides – One provider, Local Motion, combined passengers formerly served by Paratransit and Pierce Transit, and reduced the number of vehicles in use by filling them to capacity, thereby reducing the cost per trip, and yet increasing customer satisfaction.
- The cost per trip during the project – \$23.24 (includes \$7.50 in Medicaid funds)
- The cost per trip - prior to the start of the project:
  - Pierce Transit - \$38.70 (avge trip length = 8 miles);
  - Paratransit Services, Inc. - \$33.99 (avg trip length = 13 miles);

This project demonstrated the financial benefit of coordinating transportation and grouping passengers. A federal report states “The benefits of providing trips for ADA paratransit clients at the same time and on the same vehicle as human services clients creates much lower per trip costs, thus generating real savings.<sup>1</sup> This savings is needed in Pierce County where the Puget Sound Regional Council indicates that forty percent (40%) of the population is likely to use special needs transportation, giving Pierce County the largest special needs population in the region. The growth in the aging and disabled populations, and the increased demand for transportation

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<sup>1</sup> *Transit Cooperative Research Program – Report 91 – Economic Benefits of Coordinating Human Services Transportation*



that will accompany this growth, emphasizes the need to reform the transportation system in Pierce County, to capture the savings available by grouping more trips.

SHB2072 also asked the PCCTC to “capture the value of Medicaid trips provided by public transit agencies for which they are not currently reimbursed with a funding match by federal Medicaid dollars.” Data provided by DSHS/Medicaid Broker indicated that at least 167,623 Medicaid rides were provided by Pierce Transit’s ADA/SHUTTLE in 2010. At a cost of \$38.70 per trip, that is over \$6.4 million in transportation costs shifted from Medicaid to Pierce Transit. It is time to consider ways that Medicaid can share trips with transit and other funders, to stretch the transportation resources available in local communities. When Medicaid funds the transportation of Medicaid clients, DSHS receives a federal subsidy of \$0.65 on a dollar; when Medicaid shifts expensive paratransit trips onto local public transit, 100% of the cost is borne by the local community, often resulting in a decrease in public transportation. Yet studies in Washington and other states have demonstrated that coordinating Medicaid and Public Transit systems has been proven to save money. A plan for coordinating more transportation between the Medicaid Broker and Pierce Transit, which includes identifying Medicaid passengers and allowing Pierce Transit to become a Medicaid transportation provider, can be implemented immediately with minimal costs.

## RECOMMENDATIONS

The PCCTC hopes this report will help clarify regulations, clear up confusion about policies, and convince people to support continued efforts to implement coordinated transportation practices in Pierce County. The PCCTC drafted these recommendations during December 2010 and January 2011 meetings. The purpose of the recommendations is to inform ACCT and the legislature that we need support to continue the important and money saving work of coordination. While we strive to include the opinion of each PCCTC member, it is not always possible to achieve consensus on every decision. All PCCTC members agree that we need to maintain the systems we have created and put in place in recent years.



### PCCTC RECOMMENDATIONS

#### Recommendation 1:

**1** Recognize and maintain the information services that are a critical link to network the coordinated transportation system.

The PCCTC asks ACCT and the legislature to support funding for 2-1-1 services that are a critical information link in the Pierce County Coordinated Transportation system.

#### Recommendation 2:

**2** Recognize the value of and maintain Volunteer Services (VS), a program of Catholic Community Services of Western Washington, in order to build capacity for transportation and other services in the most economical way.

The PCCTC asks ACCT and the legislature to recognize it is important to provide ongoing funding for Volunteer Services, through Catholic Community Services (CCS) of Western Washington in Pierce County, in order to meet a variety of human services needs efficiently and in a cost-effective manner.

#### Recommendation 3A:

**3A** Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:

- A. To implement procedures that allow the broker in Pierce County to share rides and costs between Medicaid and other agencies, including Pierce Transit, the VA, DVR, and programs such as Beyond the Borders.

The PCCTC asks ACCT and the legislature to encourage DSHS to have the Medicaid Broker fully implement an automated cost sharing formula and adopt policies that will allow providers to share Medicaid rides and non-Medicaid rides, so more transportation can be coordinated in Pierce County.



**Recommendation 3B:**

**3B** Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:

- B. To allow Pierce Transit to be recognized as a Medicaid transportation provider, that invoices the broker for trips based on actual costs.

The PCCTC would like ACCT and the legislature to encourage DSHS to adopt policies that allow the Broker to accept Pierce Transit as a Medicaid transportation provider that, like other transportation providers, invoices the broker for trips based on actual costs.

The PCCTC would like to implement a pilot project to test this coordination in 2011.

**Minority Opinion**

The minority opinion of Paratransit Services, Inc., the Medicaid Broker, is cited via their position paper, located at the back of this report. (Exhibit I)

**Recommendation 4:**

**4** Require human services agencies that receive funding for transportation to use the designated allotment to reimburse any third party that provides the transportation.

The PCCTC would like ACCT and the legislature to encourage DSHS to amend WAC 388-71-0726 and issue a new HCS Management Bulletin to notify Adult Day Health programs that the additional allotment they receive for transportation must be used to reimburse any third party that provides the transportation to the Adult Day Health program.

**Recommendation 5:**

**5** Support adequate funding for special needs transportation, using similar approaches to the way the nickel tax supported highway funding, when new legislation is developed.

In the PSRC “Transportation 2040” plan for the region, the PSRC made a commitment to fund special needs transportation “proportionate to the growth of the special needs population.” The PCCTC asks ACCT and the legislature to make a similar commitment to funding special needs transportation.



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## REPORT TO THE LEGISLATURE

### I. Mandate to Improve Coordinated Transportation

The Pierce County Coordinated Transportation Coalition (PCCTC) has a proud history of working since the 1990's to improve transportation for people with special needs. People with special transportation needs means individuals who, due to age, disability or income, are unable to transport themselves or purchase transportation. This report is submitted in compliance with Engrossed Substitute House Bill 2072 (ESHB 2072), "an Act relating to advancing effective transportation for persons with special transportation needs."<sup>2</sup>

The mission statement of PCCTC is to "work with stakeholders to develop coordinated transportation services and programs that will achieve increased efficiencies and provide enhanced mobility and accessibility to a greater number of Pierce County residents."

Ideally, if 2 (or more) agencies are able to share transportation by having the clients they serve share rides/trips, this will reduce the cost per trip for each client. For over 10 years the PCCTC worked on a series of projects called "Common Ground" that attempted to share client information, share rides/trips, and share costs between Medicaid and Public Transit. In 2008, Common Ground ended when the Department of Social and Health Services (DSHS) indicated that federal Medicaid regulations and the lack of an automated cost allocation system made it "fiscally prudent" to withdraw support for the project. However, coordinating trips between Medicaid and Public Transportation offers great potential cost savings and could be implemented immediately.

In 2009, ESHB2072 directed The Agency Council on Coordinated Transportation (ACCT) to appoint a Local Coordinating Coalition (LCC) in Pierce County. As the result of this legislation, the members of the Pierce County Coordinated Transportation Coalition (PCCTC) were appointed by ACCT as the "Local Coordinating Coalition (LCC) during the June 2009 meeting (See Appendix I). ESHB 2072 says, in part:

"The purpose of a LCC is to advance local efforts to coordinate and maximize efficiencies in special needs transportation programs and services... A LCC serves in an advisory capacity to the ACCT..."

An LCC's duties include:

- Identifying local services and transportation needs...
- Considering strategies to address local service needs...
- collaborating with local service providers and operators ...
- Implementing pilot projects to test and demonstrate cost sharing and cost-saving opportunities."

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2 ESHB 2072



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The legislature assigned parallel tasks – in addition to creating the LCC, ESHB 2072 also directed ACCT to create a workgroup to analyze the federal requirements that prohibit transportation coordination in Washington:

“The agency council on coordinated transportation shall create a workgroup for the purpose of:

Identifying relevant federal requirements related to special needs transportation, and identifying solutions to streamline the requirements and increase efficiencies in transportation services provided for persons with special transportation needs...”

The legislation also says:

“The work group shall immediately contact representatives of the federal congressional delegation for Washington State and the relevant federal agencies and coordinating authorities ... and invite the federal representatives to work collaboratively to:

- a. Identify restrictions or barriers that preclude federal, state, and local agencies from sharing client lists or other client information, and make progress towards removing any restrictions or barriers;
- b. Explore, subject to federal approval, opportunities to test cost allocation models, including the pilot projects established in section 11 of this act, that:
  - i. Allow for cost sharing among public paratransit and Medicaid Nonemergency medical trips; and
  - ii. **Capture the value of Medicaid trips provided by public transit agencies for which they are not currently reimbursed with a funding match by federal Medicaid dollars.”**

### What is “Coordinated Transportation”?

“Coordinated Transportation” is when multiple organizations work together to their mutual benefit, gaining economies of scale, eliminating duplication of, expanding, and/or improving the quality of service in order to better address the transportation needs of the special needs population their agencies serve.”

*Puget Sound Regional Council – Coordinated Transit-Human Services Plan*

“Coordinated Transportation” is many agencies working together to expand the amount of transportation available and to improve the quality of transportation for people who don’t have a car or a means to transport themselves. Transportation plays an important role in people’s lives. Regardless of age or ability, people need to be able to get around in the community so that they can receive medical care and social services, shop for necessities or visit with family and friends. Currently there



is inadequate capacity to meet the special transportation needs of individuals with disabilities, people with low-income and older adults. There is also an inadequate awareness of the transportation resources that do exist. The purpose of coordination is to create partnerships with transportation providers so people of all ages have reliable and accessible transportation, which is key to a full life in the community.<sup>3</sup>

“Coordination is a technique for managing resources. Coordination is also a political process that like other political processes involves power and control over resources. This means coordination efforts are subject to the usual political problems of competing goals and personalities. In order to engage in coordination, people who are not used to working together need to develop the trust, respect and confidence that will permit them to share responsibilities.”<sup>4</sup> The PCCTC has succeeded in implementing some coordination initiatives, in part, due to the collective vision maintained by its member agencies and the determination to find ways to effectively manage the limited transportation resources. (See diagram of PCCTC Vision for Coordinated Transportation, Appendix II)

While coordinating transportation offers substantial benefits to the community, significant investments of time and energy are required to achieve the desired results. The PCCTC meets twice a month to work on coordinated transportation efforts, with the intent of accomplishing some of the economic benefits such as:

- Increased productivity – more trips or more passengers per trip
- Increased efficiency – reduced costs
- Enhanced mobility – increased access to jobs, health care, services, social events, etc.

Even in these challenging economic times the PCCTC and its members have worked to keep the same level of communication and commitment to serve Pierce County. Some of the other impacts of coordinated transportation the PCCTC has produced, not usually expressed in monetary terms, but equally important, include:

- Having transportation available in a larger service area
- Making transportation available to more people
- Improving service quality

“Coordinated Transportation” places the emphasis on special needs transportation populations - older adults, people with disabilities, and people with low-income, and on paratransit services. “Paratransit” is the specialized transportation for people who are not able to use the fixed route bus system; this service picks people up at their door and drops them off at the door of their destination. “Although transit providers and human services agencies operate similar services for similar types of riders,

<sup>3</sup> PCCTC website: [www.piercecountyrides.com](http://www.piercecountyrides.com)

<sup>4</sup> *Transit Cooperative Research Program (TCRP) Synthesis 65 – Transit Agency Participation in Medicaid Programs*



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special needs transportation is often provided through separate, parallel delivery systems. Reasons for this separation include differences in funding sources, and administrative and regulatory requirements. The results of this separation are often duplication of services or of administrative efforts, inefficient use of vehicles and other resources, poor service quality, and unmet transportation needs. A common example of uncoordinated services is the arrival of two paratransit vehicles at a medical facility: a public transit ADA vehicle carrying customers of its paratransit program and a private paratransit vehicle transporting Medicaid recipients to their medical appointments—with both vehicles being utilized at less than their full capacity.”<sup>5</sup>

### What Prevents Coordination?

According to the non-partisan analysis developed for the ESHB 2072 Final Bill Report,

“...federal and state agencies maintain separate client databases, and, **due to real or perceived federal confidentiality requirements**, agencies are not typically willing to share client eligibility information in order to determine the extent to which there might be overlap of services provided or efficiencies that could be achieved.”

The same report also says:

#### “Funding and Program Eligibility and Cost-Sharing Restrictions

The two largest funders of special needs transportation in our state, Medicaid and public transportation agencies are each required by federal law to provide transportation services to Medicaid eligible persons and persons with disabilities, respectively. However, eligibility standards for these programs differ for persons entitled to receive the service as well as for the type of service they can receive. Typically, programs sponsoring special needs transportation programs are required to restrict the use of grant funds for a designated population. As a result, this prevents different programs from sharing resources and costs and from jointly funding a coordinated system of transportation services.”



## The Perceived Challenges

The U.S. General Accounting Office, in the first of its studies on coordinating human services transportation in 1977, concluded that “the most significant hindrance to coordination was confusion and misperception regarding restrictions to coordination.”

*TCRP Synthesis 65 – Transit Agency Participation in Medicaid Transportation Programs - 2006*

According to federal reports, for over 34 years, misperceptions, rather than actual federal regulations, have prevented transportation coordination. The PCCTC encountered the same real or perceived challenges noted in the ESHB 2072 legislative report, regarding sharing information, sharing rides and sharing costs, throughout the course of the Common Ground project. Common Ground was actually a series of projects the PCCTC developed over 10 years, which were an effort to address these problems, so Medicaid Non-Emergency Transportation (NEMT) through the Broker, Paratransit Services Inc. (PSI), and Public Transit, provided by Pierce Transit, could be coordinated in Pierce County. In 2008, the PCCTC stopped work on the “Common Ground” project as the result of the perceived federal barriers. (See Appendix III – email forwarded by Paratransit Services, Inc.)

It has become a challenge to understand what actually prevents the Medicaid Non Emergency Medical Transportation (NEMT) and the Public Transit systems from being able to work together - different explanations have been presented over time. The PCCTC identified these issues, which surfaced during the years of the Common Ground project, and were believed to impede any additional progress at the local level in coordinating Public Transit and Medicaid.

### Common Ground Project – Perceptions about Federal Barriers

1. **When Common Ground ended, the perception was that federal regulations prevent Medicaid NEMT from coordinating with other agencies, particularly with public transit, for these reasons:**
  - a. Sharing information - During a test phase of Common Ground, a short term agreement about sharing passenger information with Public Transit was in effect, but in general, DSHS indicated that Health Insurance Portability and Accountability Act (HIPAA) and other federal regulations prevent the sharing of information regarding Medicaid riders. New agreements must be developed before Medicaid and Public Transit can share information;
  - b. Sharing trips - Medicaid rules prevent the brokers from sharing Medicaid-funded trips/vehicles/ costs with trips/ vehicles funded by other sources, unless the broker has the contract for that funding and schedules those trips.
  - c. Sharing costs – In 2004, during the Common Ground project, ACCT funded



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the development of a complicated “seat shared mile” cost allocation formula. During 2004 the Broker had indicated that, in Pierce County, when the formula is used, it had to be applied manually. In 2008, when the Common Ground project ended, DSHS stated that they were waiting for Paratransit Services, Inc., to develop an automated cost allocation system.<sup>6</sup> A new method of sharing costs must be developed.

- d. Payer of Last Resort - Medicaid regulations about “payer of last resort” mean that all other funding sources must be used before Medicaid can pay for a ride. This has been interpreted to mean that if a community has public transit, that transit has “third party payer liability” for Medicaid passengers. The Broker must utilize public transit for Medicaid transportation rather than provide a more expensive ride by a private Medicaid provider, when it is determined the most appropriate option.
- e. Usual and Customary Fee - Medicaid regulations about “usual and customary fees” mean that Medicaid can only pay transit the same amount the general public pays for a ride. In Pierce County, this would be \$2.00 for a fixed route bus ride, and \$0.75 for reduced fare trip or an ADA paratransit ride on the Pierce Transit “SHUTTLE.”

### **2. Perception that Federal Regulations Need to Be Changed to Allow Coordinated Transportation in Washington:**

- a. Process for communicating with CMS – The Centers for Medicare and Medicaid Services (CMS) must be contacted for clarification of/or changes to federal policies, but it is unclear with the process is for doing this.
- b. Process for changing Medicaid NEMT in Washington - The Washington State congressional delegation needs to pursue changes in federal law or policy that will allow Medicaid and Public Transit to implement coordinated transportation practices in Washington.

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<sup>6</sup> See Appendix III – email from DSHS, withdrawing support for the Common Ground project.



## II. A Brief History of Special Needs Transportation

The PCCTC has placed a high value on transportation choices that improve accessibility and mobility, and has incorporated these values in pursuing projects and partnerships with its member agencies. The PCCTC has accomplished many of the goals of coordinating transportation, including developing new services and increasing community awareness of the transportation choices available. Using a planning process developed by ACCT, the PCCTC has developed several County Human Services-Public Transit Coordinated Transportation Plans over the years to guide the development of resources in the community. As the result of these planning processes, the PCCTC members have identified the special needs transportation population in the county and have developed strategies to meet the need for transportation services. There are two major issues that are always identified:

1. The need for more transportation services;
2. The need for more information about how to access existing services.

The PCCTC encouraged the Pierce County United Way – South Sound 2-1-1 to become the “Transportation Information Hotline” for the county. Using the first call for help approach, South Sound 2-1-1 provides a first point of contact regarding transportation. The 2-1-1 staff is able to assist consumers in identifying the most appropriate and lowest cost transportation choices offered in the community or the region. With the help of 2-1-1, coordinated transportation services are more visible and marketed to a broader audience and ultimately, create a more competitive transportation alternative to the automobile.

The PCCTC has also worked to create new transportation services, which supplement public transit and Medicaid Non-Emergency Medical Transportation. These services often provide the only means of transportation for people who live in outlying areas or for other reasons, including age or disability, are unable to use public transit:

### The Road to Independence – Puget Sound Educational Service District

WorkFirst Van Program provides eligible special needs clients in south King County and east Pierce County free rides to work and employment-related activities. These rides are provided by drivers who are training to earn a Class B Commercial Drivers License, gaining valuable skills while providing a valuable public service.

### Volunteer Driver Program – Catholic Community Service of Western Washington

CCS provides three transportation related services in Pierce County. Volunteer Chore Services provides low-income seniors and disabled adults with rides from volunteers to vital services (medical, food, shopping, etc.) when other transportation options are not available or a viable option. The Bus Buddy Program connects non-driving, non-transit rider with a knowledge and trained “Bus Buddy”, who works one-on-one with participants to make using transit a safe and viable mobility option for them. The



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third service, called the Travel Ambassador program, educates and provides user-friendly information about all of the travel options for special needs users.

### The Mustard Seed Project

The Mustard Seed Project (TMSP) on Key Peninsula partners with CCS, for a volunteer driver program. This program is part of the network of services CCS provides, which helps ensure that, county-wide, drivers are trained according to best practice standards, covered by adequate insurance, and utilized efficiently. Many older adults who live in remote rural areas have found themselves without viable transportation. The volunteer driver program has provided a means to get to medical appointments and other critical services.

### Beyond the Borders – Pierce County Community Connections

The Beyond the Borders program provides rides for all special transportation needs populations in rural south Pierce County, from their residence to the nearest bus stop. Beyond the Borders contracts with the Medicaid Broker, Paratransit Services, Inc., to provide these rides. PCCS's second program funds a Mobility Coordinator, who works with the PCCTC, coordinates the Travel Ambassador program, manages the PCCTC website, assists with pilot projects, and serves as liaison to ACCT .

In addition to transportation services, the PCCTC has developed a public education program. The Travel Ambassador project reaches out to organizations that serve elders and people with disabilities to provide information about how to use public transit. Sound Transit funded the development of a curriculum, "Getting Around Puget Sound" which includes a resource manual of regional mobility options. People who attend a training session receive a copy of the manual and certification as a "Travel Ambassador." The PCCTC also has a travel training program through which "Bus Buddies" may accompany participants on a bus ride, helping people learn to use public transportation. The Travel Ambassador and Bus Buddy programs help more community members learn to use the fixed route bus. Since the bus provides the lowest cost transportation, this public education about how to use the bus is a great service to the community.

- The Travel Ambassador project is a coordinated effort of multiple PCCTC partner agencies:
- Catholic Community Services Volunteer Transportation program;
- Pierce Transit's Travel Training and Learn to Ride programs;
- Puget Sound Educational Service District's Road to Independence (WorkFirst Van program);
- Pierce County Community Connection's Beyond the Borders transportation service;
- Pierce County Community Connection's PCCTC Mobility Coordinator;



- The Mustard Seed's Volunteer Driver and Community Van Programs;
- United Way of Pierce County's South Sound 2-1-1 program;
- Paratransit Service's Medicaid Brokerage services.

All of the services listed above are integral to the Travel Ambassador project. Each organization contributes staff time for the training sessions. However, none of the organizations alone have the staffing capacity to coordinate the trainings, recruit participants, and conduct extensive outreach. Working together extends the reach of the project, communicating transportation options to a broad population.

In addition to these community service agencies, both Medicaid Broker, Paratransit Services, Inc. and Pierce Transit have been valuable long term members of the PCCTC. Medicaid and Public Transit are two of the primary transportation providers in Pierce County, and the challenge regarding coordinated transportation in Pierce County has been to find a way for these two agencies to share information, trips and costs. The following pages provide some background on the two major transportation entities, Public Transit and Medicaid, and some history about how the transportation services have evolved.

### **The Americans with Disabilities Act (ADA)**

The Americans with Disabilities Act (ADA) has played an important part in the development of local resources that can assist states in meeting the Medicaid "transportation assurance" requirement (see "Medicaid Non Emergency Medical Transportation (NEMT) section on page 21). The ADA is civil rights legislation that supports the rights of people with disabilities to participate in the full life of the community. Disability advocacy groups fought for the right to include transportation in the ADA legislation, which requires transportation systems to be accessible. The ADA expects that most individuals with disabilities will be able to use regularly scheduled fixed route services. Pierce Transit operates a fleet of low floor buses that "kneel" to curb level and all of the buses are equipped with a ramp (or a lift for some Sound Transit buses) for boarding. With this equipment, many individuals who use mobility aids and may have required paratransit rides in the past can now use fixed route services.

Pierce Transit's ADA paratransit service is called "SHUTTLE." ADA paratransit service is specialized, pre-scheduled transportation service. People call ahead and arrange for a vehicle to pick them up at their home and drop them off at the door of their destination or an approved transfer point. Public transportation providers must offer this so called "ADA complimentary paratransit service" for individuals with disabilities that prevent them from using the fixed route bus system. ADA service must be comparable to fixed route service: the service must be offered in the same areas, at the same time of day, and must be available within a minimum of  $\frac{3}{4}$  of a mile from the fixed route services. ADA paratransit service must be provided **without**



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**restriction on trip purpose or regard for the capacity restraints of the transit agency.** This means a transit company cannot turn down requests for rides. The only way to restrict the amount of ADA rides provided is to reduce the fixed route bus service.

It is important to recognize that when the ADA was passed, it was an unfunded mandate by the federal government. The Act's requirements have severely strained the fiscal resources of public transportation agencies due to the substantial capital investment and high operating costs. ADA rules restrict the amount transit agencies may charge customers to "no more than twice the fare charged to a fixed route bus rider." Such limits, intended to protect ADA customers from high costs, mean that ADA-regulated fares cover only a very small fraction of the actual trip costs. (The fare for a Pierce Transit SHUTTLE ride is \$0.75, while the actual cost for each ride is \$38.70.) If these limits are applied to trips provided to ADA-eligible Medicaid clients, transportation providers will be less likely to help Medicaid programs develop public transportation alternatives. **In recognition of this fact, several regional offices of the federal Center for Medicare and Medicaid Services (CMS) have sent letters to states informing them that Medicaid can pay transportation providers a negotiated rate based on the cost of providing the service.**

### Medicaid

"Assuring access to health care facilities and services has been seen as an ancillary medical service, rather than a goal of public transit."

*Designing and Managing Cost Effective Medicaid Transportation Programs –*

Medicaid is the major public source of financing of health insurance for low-income families and of long-term care services for the elderly and disabled. Medicaid is a federal-state partnership, so both the federal government and the states share in paying for the program services as well as in setting major program policies. States write the "State Medicaid Plan" which is the official statement about what services will be provided and who is eligible to receive them. States have significant flexibility to design their own Medicaid programs. The federal government pays a share of the costs a state spends to provide services for the people who are eligible for Medicaid. This federal share is called the Federal Medical Assistance Percentage or FMAP. It is based on a state's per capita income and is re-evaluated every year. For the state of Washington the FMAP was 62.94 % for federal fiscal year 2010, and 65% for federal fiscal year 2011.

States must use local tax dollars to meet their share of the Medicaid costs – this is referred to as the Medicaid "match dollars." The federal rules require states to spend their own funds first, and then to receive the federal financial match (the FMAP) for services provided. There are no federal limits on program spending. This open-ended



commitment of federal resources invites states to be generous in designing their programs. At the same time, because states share the costs, it encourages states to use federal Medicaid dollars judiciously.

When states are designing their Medicaid programs, they have an incentive to take the opportunity to “maximize” their services because Medicaid will pay for a significant portion of the services. The economic impact of Medicaid is magnified by the matching formula. At the minimum 50 % match rate, states draw down \$1 for every dollar of state funds. The current FMAP match rate for Washington is above the 50% minimum – the FMAP in 2010 was almost 63%; for 2011 it is 65%, so of every dollar spent on Medicaid, the federal government pays 65 cents and the state pays 35 cents.

A primary goal of the federal Medicaid match is to lower states’ costs of providing coverage to low-income residents, thereby encouraging states to undertake initiatives that they would not have done otherwise or to go beyond what they would have done on their own. Medicaid represents the largest share of the federal revenue to states. In 2010, the federal Medicaid program served approximately 60 million people with estimated expenditures of \$427 Billion.

### **Medicaid Non-Emergency Medical Transportation (NEMT)**

Beginning in the 1960’s, government agencies sought to extend health care benefits to low-income, elderly, and disabled individuals through Medicare and Medicaid programs. Federal and state policy makers recognized that many of these individuals lacked access to personal transportation. In many inner city neighborhoods and rural communities, where public transportation alternatives are limited, getting to the doctor becomes a major struggle for people who don’t drive or are too poor to own a car of their own.

Assuring the public’s access to health care facilities and services has been seen as an ancillary medical service, rather than a goal of public transit. That’s why Medicaid and Medicare, our national healthcare programs, have stepped in as major financiers of medical transportation. Medicaid began funding non-emergency medical transportation (NEMT) in the 1970’s. These transportation services save taxpayers money by allowing Medicaid clients to access outpatient services at a lower cost than emergency room services, which might also involve expensive ambulance rides or long emergency room waits. **Federal regulations mandate that each state Medicaid agency specify in its state plan that it will “ensure necessary transportation for clients to and from providers” and “describe the methods that the agency will use to meet this requirement” (42 CFR 431.53).<sup>7</sup>**

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<sup>7</sup> *Designing and Operating Cost Effective Medicaid Non-Emergency Transportation Programs*



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### **The Role of the Medicaid Broker**

Washington developed a Brokerage system in the late 1980s to help control Medicaid Transportation costs. A transportation Broker is a company that contracts with the state agency overseeing Medicaid to coordinate transportation benefits for Medicaid participants; there are multiple Brokers serving 13 Department of Social and Health Services (DSHS) regions. Pierce County is in DSHS Region 5, and Paratransit Services, Inc. (PSI), a non-profit agency, holds the Brokerage contract for this region. As an original NEMT Broker, Paratransit Services, Inc., helped develop this important program and has operated in Pierce County for 22 years. They currently contract with over 20 transportation providers and historically have brokered over 700,000 trips per year in Pierce County.

As one of the most established Brokerage systems in the country, Washington is often cited as a model. The broker is responsible for establishing a network of transportation providers, and they also have many other contractual responsibilities, some of which include:

- Manage NEMT trip intake/maintain a call center to receive trip requests;
- Verify the Medicaid eligibility of the person requesting the trip;
- Verify that the requested trip is for a Medicaid-covered service;
- Arrange trips for consumers;
- Determine the “least cost, most appropriate” mode of available transportation, based on the client’s needs and capabilities;
- Broker the trip to an appropriate transportation provider, issue a transit pass, or preauthorize recipient reimbursement;
- Contact the medical provider to ensure that the scheduled trip took place;
- Pay the transportation provider or reimburse the recipient;
- Monitor transportation providers, and the quality of service to clients;
- Verify that transportation providers meet vehicle and driver standards;
- Compare provider trip sheets to authorized trip records to ensure that no unauthorized trips take place.”

### **Advantages of the Brokerage Model**

There are many reasons states developed brokerage systems to manage Medicaid transportation programs. According to a report on Brokerages produced for the State of Iowa:

“Under a fee-for-service model, consumers are typically responsible for finding an appropriate transportation provider or contacting the local Medicaid office to obtain reimbursement after a trip has been taken. By contrast, a Broker can increase the efficiency of the transportation network by reducing service duplication and



coordinating trips to increase the number of passengers per vehicle. More efficient transportation networks can allow for longer service hours and the provision of more trips. A Broker eliminates fraud and abuse by verifying the Medicaid eligibility of callers, confirming that trip requests are for Medicaid-covered services, ensuring that scheduled trips take place and ensuring that no unauthorized trips take place..."

"In Washington, DSHS contracts with Brokers using a direct cost plus an administrative fee structure for reimbursement. The administrative fees are about \$3.00 per trip. Currently, they serve 4 to 6% of all Medicaid Members (1 million) per month adding up to three million trips at a cost of \$70 million per year."

"... Washington utilizes an administrative fee plus direct cost for reimbursement to the Brokers. This payment method provides less incentive than other forms of payment for Brokers to obtain the least costly trip, but even so, Washington, which has one of the oldest Brokerage systems, has been successful with this structure."<sup>8</sup>

"Table 1 (on the next page) provides the total number of trips and related costs (for year 2006-07) for different transportation modes including ambulatory, paratransit service, and other fixed-route transportation. The average service cost per trip was \$17.16. That increased to \$20.46 when service charges for out-of-state trips were included."



**Table 1. Washington’s NEMT Cost Estimates – (2006-2007)<sup>9</sup>**

Percent of Trips	Transportation Mode	Total Number of Trips	Total Service Cost	Average Cost per Trip
29%	Public Bus	936,263	\$3,069,287	\$3.28
36%	Ambulatory	1,166,516	\$30,199,632	\$25.89
13%	Non-Ambulatory	429,905	\$15,869,797	\$36.91
9%	Public Bus-ADA	302,100	\$496,537	\$1.63
9%	Voucher	286,177	\$2,096,622	\$7.33
1%	Mileage	18,211	\$200,752	\$11.02
1%	Volunteer-Agency	32,613	\$1,904,826	\$58.41
1%	Volunteer-Broker	21,181	\$903,233	\$42.64
<1%	Airline	202	\$58,343	\$288.83
<1%	Commercial Bus	246	\$10,958	\$44.54
<1%	Train	161	\$6,413	\$39.83
<1%	Ferry	10,259	\$71,470	\$6.97
<1%	Foster Parent	0	\$0	\$0
Ancillary	-	-	\$81,576	-
<b>100 Percent</b>	<b>Total</b>	<b>3,203,834</b>	<b>\$54,966,446</b>	<b>\$17.16</b>
Admin			\$271,485	\$2.89
Subtotal			\$64,237,930	\$20.05
Out of State		54	\$20,191	\$373.90
Meals & Lodging in		27,120	\$1,238,590	\$45.67
Meals & Lodging		295	\$15,675	
Vehicle Modify/ Lift		10	\$28,561	\$3,00.46
<b>Grand Total</b>		<b>3,203,888</b>	<b>\$65,540,948</b>	<b>\$20.46</b>

Note some of the costs itemized in the chart above:

- The “admin fee” listed does not include the \$3.00 trip charge (at \$3.00 per trip this would be an additional \$9,611,664.00 in administrative fees paid to the brokers);
- The statewide average for Medicaid trips is \$17.16. This average is partially the result of scheduling 38% of the trips on low cost public transit.
- The Pierce County Medicaid Broker, Paratransit Services, Inc. has reported an average cost of \$11.60 per trip, with 73% of the Medicaid trips scheduled on public transit. However the average Medicaid trip excluding public transportation is \$33.99 per trip.

<sup>9</sup> Iowa Medicaid Non-Emergency Medical Transportation System Review (review of brokerage models in the U.S.)



- Paratransit Services Inc reports scheduling twice as many rides on public transit as the state average.

## Use of Public Transit to Provide Medicaid Transportation

Many years ago, state Health and Human Services agencies began seeking

“Increasing Medicaid recipients’ use of existing public transit bus services was a key feature of many Brokered transportation systems. It has been one of the main reasons Brokerages were able to reduce overall costs per trip. “

*Medicaid Transportation: Assuring Access to Healthcare, Community Transportation Association of America*

alternatives to expensive paratransit services as their Medicaid transportation costs continued to grow. The state of Florida did a study of NEMT costs that resulted in a major change to their transportation system. In 1990, the state typically purchased door to door paratransit rides for patients in Miami at a cost of about \$16.00 per trip. When the client data base was analyzed, they found that many Medicaid eligible individuals were transit dependent and used fixed route buses for daily non-medical trips. These same clients received door to door paratransit Medicaid trips for medical appointments. Florida started the “Metropass” program to shift these clients to fixed route bus service for their Medicaid trips by providing them with monthly bus passes, free of charge. The Florida data showed that almost 5,000 clients had been making at least 12 paratransit trips each month at a cost of \$16.00 per trip. Over an entire year, providing paratransit trips for these clients would have cost the Medicaid program about \$11million.

The creation of Medicaid Brokered transportation systems allowed states to

According to 1999 data regarding the bus pass program in King County, Washington: Metro received \$300,000 in additional revenue from the sale of bus passes to the DSHS broker, while the DSHS Medicaid NEMT program reported saving \$3.6 million for the fiscal year.

*TCRP – Report 91 - Economic Benefits of Coordinating Human Services Transportation and Public Transit Services*

maximize the use of scheduled public transit service for medical trips, reduce costs by using lower cost providers including nonprofit and public transit agencies, and rely on competitive bidding among providers to assure lowest cost. Increasing Medicaid recipient’s use of existing public transit bus services was a key feature of many Brokered transportation systems. In Washington State, according to information provided by DSHS for a 2001 report, Public Transit’s share of Medicaid



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trips rose from 10% in 1990 to 36% in 2000. It has also been one of the main reasons that Brokerages were able to reduce the overall costs per trip.<sup>10</sup>

According to the report Medicaid Toolkit and Best Practices (2005), “Many states that reduced costs by using fixed route transit began to provide monthly bus passes to Medicaid beneficiaries who were able to use public transit. It is more cost effective to issue Medicaid clients a monthly bus pass. The cost of the monthly bus pass is less than the cost of one door to door round trip, resulting in savings for the Medicaid program, and an increase in the quality of life for the client who has greater mobility with a bus pass. Some state Medicaid staff believed that only single bus trip tickets should be issued for Medicaid-funded appointments, but the administrative costs and staffing required to administer single trips resulted in a negative impact on the program. **In 1996, the Centers for Medicare and Medicaid Services (CMS) authorized the use of Medicaid Transit Passes in a letter to State Medical Directors by stating “bus pass programs can be used if they are cost-effective and appropriate to the individual’s needs and personal situation.”**

The cost of a bus pass has gone up over the years, but the original point of comparison was the cost of one round trip paratransit ride versus the cost of a monthly bus pass. In Pierce County, the complexity of the system for purchasing bus tickets and the resulting investment of administrative expense for the staff time involved in purchasing individual tickets may still make bus passes an appropriate Medicaid transportation expense.

### Cost of Bus Pass vs. Cost of One Paratransit Roundtrip

Monthly Pierce Transit bus pass/ ADA	One paratransit round trip by Medicaid provider	One ADA/paratransit round trip by Pierce Transit
\$72.00	(\$33.99 x 2) - \$67.98	(\$38.70 x 2) \$77.70

(In the original model, Metro-Dade Transit (MDT) also received a \$7.20 administrative fee for each bus pass sold to the Medicaid program. According to the TCRP 91, the data from the year 2002 showed that MTD received about \$35,500 per month in Medicaid administrative fees or about \$426,000 in fees annually for the bus pass program. In Washington, the Medicaid Broker, not the public transit, receives the administrative fee for the bus passes. In Pierce County, the Medicaid Broker purchases the bus passes and bus tickets, and receives an administrative fee of \$3.00 per trip (\$2.89 actual cost rounded up) from DSHS, based on the number of bus trips the Medicaid clients report taking. In Pierce County, the Medicaid Broker reported 459,209 Medicaid trips provided on Pierce Transit in fiscal year 2010. At the rate of

<sup>10</sup> Medicaid Transportation: Assuring Access to Healthcare – A Guide to NEMT – Community Transportation Association of America



\$3.00 per trip, this would result in a \$1,377,627 administrative fee paid to Paratransit Services, Inc for scheduling Medicaid trips provided by Pierce Transit.)

Whether the trip is provided on publicly funded transit services or other mode, the screening process is the same: The Brokers screen for client eligibility, perform a needs assessment to determine the appropriate mode of transport, verifies the medical appointment is a Medicaid eligible appointment and then assigns the trip to the most appropriate means of transport. In the case of publicly funded transit service the Broker will mail a bus ticket or pass or load an ORCA card with the appropriate fare.

That same report indicated that “Shifting Medicaid participants, who are safely able and who have access to a bus route, from Medicaid paratransit to fixed route public transit services has been a win-win-win situation. The Medicaid participants gained greater mobility and increased access to health care through frequent and flexible trips, and the independence provided by the monthly bus pass improved the participants overall quality of life. By increasing fixed route bus ridership and revenues, public transportation experienced the benefit with few if any additional costs. The Medicaid agency maximizes the use of transportation dollars and is able to generate a cost savings that can be applied to other program services.”<sup>11</sup>

The DSHS Medicaid Brokers saved approximately \$26.8 million in Medicaid transportation expenses in 2005 by shifting Medicaid trips to local Public Transit.

*Agency Council on Coordinated Transportation (ACCT) – Annual Report to the Legislature for 2007*

The 2007 Agency Council on Coordinated Transportation (ACCT) Report to the Washington State Legislature included this information about the Medicaid savings that resulted from the Brokers scheduling many of the Medicaid trips on public transit:

“Coordination stretches resources through savings and sharing among transportation providers. Ultimately, this allows more rides for a greater number of people with special needs. Washington State saved approximately \$26,830,238 in 2005 through Brokers’ coordination with transit systems. Had the Brokers not arranged any trips with transit systems, the state’s costs in providing transportation to Medicaid clients would have nearly doubled. [This calculation excludes administrative costs. Fixed route and ADA Paratransit (demand response – transit) passenger trips were combined, equaling 1,225,125 total trips on public buses. Dollar amount calculated using the HSRA average demand response (ambulatory) cost of \$21.90 per trip.]”

<sup>11</sup> *Transit Cooperative Research Program (TCRP) – Report 91 – Economic Benefits of Coordinating Human Services Transportation and Public Transit Services*



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### III. Methods

#### Legal Authority and Literature on Coordinated Transportation

Over the past eighteen months, the PCCTC has examined the legal authority regarding Medicaid Transportation and Coordinated Transportation. In addition to federal laws and regulations, there is a great deal of information available about how to create a successful relationship between Public Transit and Medicaid Non Emergency Medical Transportation (NEMT). In developing this report, extensive use was also made of information produced by the federal “United We Ride” initiative and by the Transit Research Board (TRB). One report noted:

“We often face problems for which information about possible solutions already exists. Some of this information may be available in a documented format or as undocumented experience and practice...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.” The Transit Cooperative Research Program (TCRP) reports provide some of the best knowledge available on solving transportation problems.

In order to take a balanced approach, documents from many other sources were reviewed, too, including:

- Designing and Operating Cost Effective Medicaid Non-Emergency Transportation Programs, a report by the federal Health Care Financing and the National Association of State Medical Directors;
- Medicaid Transportation: Assuring Access To Healthcare – a Guide to Non-Emergency Medical Transportation by the Community Transportation Association of America (CTAA),
- Senior Transportation- Toolkit and Best Practices by CTAA.

“Much work has been devoted to investigating the issue of barriers to coordinated transportation. Because some people have succeeded in implementing coordinated systems it is now clear that many coordination efforts have been slowed or halted by **perceived** rather than actual barriers. All of the challenges have been addressed and resolved in one community or another.”

*TCRP 101 – Toolkit for Rural Community Coordinated Transportation*

In the role of advisory committee to ACCT, the Mobility Coordinator presented information on behalf of the PCCTC about the Presidential Executive Order of 2004, requiring federal agencies to coordinate transportation and creating “United We Ride”, and the Deficit Reduction Act (DRA), which allowed states to make significant changes in their Medicaid NEMT systems, at the October 2009 ACCT meeting. The Mobility Coordinator also presented information from the Transit Cooperative



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Research Program (TCRP) Synthesis 65 – Transit Agency Participation in Medicaid Transportation Program, and a copy of the transportation section of the Washington State Medicaid Plan (Appendix IX) to ACCT members during the October and December 2010 ACCT meetings. Other federal reports and studies were also used to understand the resources available to help guide the development of coordinated transportation in Pierce County.

### **Federal Support for Coordinated Transportation**

During the past 20 years, a great deal of effort has been directed to improving coordination of publicly funded transportation services for the special needs transportation population. Despite the progress that has been made, federal reports indicate that transportation systems in local communities are often fragmented, under-utilized or difficult to navigate. Duplication of services, insufficient funds, unmet trip demand, numerous regulatory constraints, lack of interagency coordination, and poor service quality still exist. Service area boundaries often preclude trips from being made by publicly funded transportation to important destinations, such as medical facilities, jobs, and training. In addition, rapid growth and suburbanization in many communities have made it far more costly and difficult to provide accessibility by publicly funded transportation to many destinations.

To address these problems, the President of the United States signed an Executive Order in 2004, creating a federal Inter-Agency Coordinating Council on Access and Mobility (CCAM) and the “United We Ride” initiative, with four main goals:

1. Simplify Customer Access to Transportation;
2. Reduce Duplication of Transportation Services;
3. Streamline the Regulations That Impede the Coordinated Delivery of Transportation Services;
4. Improve the Efficiency of Services Using Existing Resources

Although federal regulations continue to be cited as justification for the lack of coordinated transportation in Pierce County, through the efforts of the “United We Ride” initiative, many of the perceived barriers to coordination have been removed over the past six years. The federal requirement for a local coordinated transportation planning process has helped bring a focus to the things that can be done at the local level. The PCCTC participates in the regional planning process facilitated by the Puget Sound Regional Council. The PCCTC also engaged in a local planning process throughout 2010 in compliance with the tasks outlined for the LCC in ESHB2072.



## Local Transportation Planning Process

The PCCTC is tasked with developing the County Human Service-Transit Coordinated Transportation Plan which allows member agencies to apply for state and federal transportation funds to provide human service transportation. The PCCTC has adopted the federal United We Ride goals for the 2011 County Human Services-Public Transit Coordinated Transportation Plan, which includes:

1. More Rides for Targeted Populations;
2. Simplify Access to Transportation; and
3. Improve Customer Satisfaction.

The PCCTC has devoted many years to building a coordinated transportation system in Pierce County. The vision for the truly coordinated system that allows customers easy access, and shares rides and costs among all providers, is represented in Appendix II. The PCCTC is faced with significant challenges in maintaining the coordinated transportation system. The economic struggles across the United States have left a mark on all transportation agencies, including human services transportation. Contributing to the other financial problems, the changes in Medicaid Non Emergency Medical Transportation (NEMT) in 2009 resulted in two significant issues:

1. the loss of Medicaid NEMT funding for Adult Day Health patients caused a massive shift of expensive paratransit rides to local public transits,
2. The change from administrative match to medical match resulted in many more of the expensive paratransit trips being shifted to public transit, and many other low-income individuals receiving individual bus tickets rather than monthly bus passes through Medicaid. (see chart, page 48)

Cuts in funding to other social services programs have also resulted in the loss of funding for transportation to work, school and other needed services for low-income individuals. These circumstances have drastically changed the financial reality for special needs transportation at the local level. The need for transportation is greater than ever, and the availability is steadily decreasing.

While working to update the county plan, the PCCTC discussed ways to preserve services and to develop better methods to deliver coordinated transportation services to the residents of Pierce County. Using the planning process developed by ACCT, the PCCTC identified the special needs population, the existing local services, and the transportation needs in Pierce County. The PCCTC also considered strategies to meet these needs, and member agencies will continue to seek the funding to support the strategies. The PCCTC worked to develop a county coordinated transportation system that will simplify access, reduce duplication, and improve cost-effectiveness in order to increase special needs transportation services.



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The new county coordinated transportation plan will be distributed to the Joint Transportation Committee of the legislature when it is completed.

### Special Needs Demographics

According to the census data, roughly 40% of the population of Pierce County is in the demographic group identified as having a higher need for transportation services because they are potentially unable to drive due to a disability, age or income. In fact, according to the Puget Sound Regional Council (PSRC) Human Service -Transit Plan, "Pierce County has the highest percentage of the population with potential special transportation needs in the region."

While approximately 7% of the population of Washington has a disability that may limit mobility, 23% of the population of Pierce County has a mobility limiting disability. Studies show that the majority of people with disabilities rely on public transportation.

**"Pierce County has the highest percentage of the population with potential special transportation needs in the region." PSRC Human Service-Transit Plan**

Pierce County also has a large population of older adults. Between 2010 and 2020 the Pierce County population aged 65 and over is projected to grow by one-third, an astonishing 33% increase. This information is important because the American Association of Retired People (AARP) estimates that one in five people age 65 and over do not drive; 50% of non-drivers over age 65 stay home on any given day due to a lack of transportation. This is partially because people tend to outlive their ability to drive by about six to ten years. Many people who do not drive have to rely on special needs transportation. This data showing that the population of people over 65 will be a much larger percentage of the total population in the future means there will be a greater need to provide more special needs transportation services in Pierce County.

Pierce County's size, combined with its population base, mountain ranges and bodies of water would stress any transportation system. Complicating this are institutional land use barriers such as Fort Lewis and McChord Air Force Base, and rural areas such as the Key Peninsula and Mount Rainier, which prohibit easy movement among and between many communities in Pierce County. These factors also inhibit access to many social service and healthcare facilities located in Tacoma, Puyallup, Lakewood and other communities within the core urbanized area. Many people who are eligible for public services are not able to access these services due to a lack of transportation. Funding for special needs transportation in Pierce County has never been adequate to meet the need.



## Rural Pilot Project

The PCCTC/Local Coordinating Coalition engaged in two pilot projects during 2009-2010. The first project involved determining how to provide more coordinated transportation resources, on the Key Peninsula, a rural part of Pierce County. There is a significant population of low-income and older adults living on the Key Peninsula. The Mustard Seed Project (TMSP), one of the PCCTC member organizations, has as their mission providing help to older adults so they may remain in the community and “age in place.” TMSP hosted a number of meetings to engage the community in discussion and gather input about what transportation is available, what is needed, and what strategies could be developed to meet the needs. Pierce Transit currently provides some “Bus Plus” fixed route transit service on the Key Peninsula. Catholic Community Services (CCS) of Western Washington, in partnership with TMSP, provides a volunteer driver program. The local school district provides transportation to and from school. A few community agencies have vans that they use to transport their own clients to services and activities.

The group developed two major project ideas as a means of providing more transportation services. The first project was to work with Pierce Transit to acquire the use of a “community van.” Through their Community Van program, Pierce Transit makes retired “van pool” vehicles available to community agencies for a monthly fee plus a mileage fee. Pierce County Community Connections provided some funding to support the costs of operating the van, and some funding for staff support.

The second major project idea was to utilize school buses during “off hours” to provide community transportation. Dave O’Connell of Mason Transit met with the group to explain the process used in Mason County to develop this kind of transportation service. The Puget Sound Educational Service District (PSESD) helped develop the project idea, which included the creation of a partnership between TMSP, PSESD, and the Peninsula School District. TMSP and PSESD worked together to develop an application for funding, which was submitted to both the Puget Sound Regional Council (PSRC) and Washington State Department of Transportation (WSDOT). The details of the project will be available in the Pierce County Coordinated Human Services – Public Transit Transportation Plan. (See Appendix IV for a brief summary of the project.)

## Common Destinations

As part of the process for developing the 2007-2011 County Coordinated Transportation Plan, Pierce Transit SHUTTLE and Paratransit Service, Inc. produced lists of the top 50 destinations of their paratransit riders. The agencies providing special needs transportation submitted the destination information again this year and it was determined these top 50 destinations had not changed significantly. As noted in the 2007-2011 coordinated plan, there are various destination clusters around medical facilities and shopping centers in Tacoma, Puyallup and Lakewood



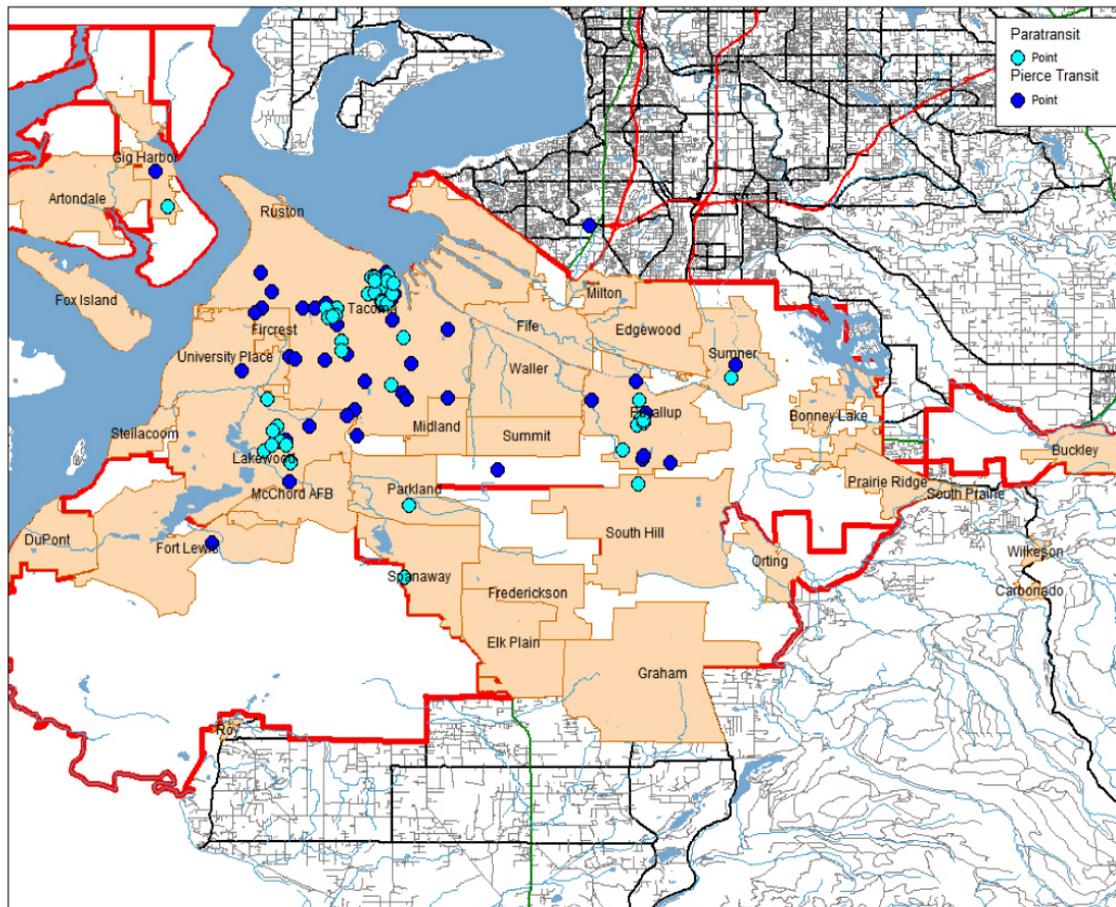
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(see Figure 1). Common medical facilities were Cedar Medical Center, Group Health Tacoma, St Joseph Medical Pavilion and St Joseph's Hospital. On any weekday, several agencies send partially full vehicles to these locations, suggesting an opportunity to coordinate some trips, especially between Pierce Transit and Medicaid.

### Figure 1

#### Common Destinations of Pierce Transit and Paratransit Services, Inc.



With the Special Transportation Needs population identified, and the information about their primary destinations gathered, the PCCTC continued to consider ways to coordinate the transportation resources. In previous years, a review of the common destination data in Pierce County showed that the largest source of demand for specialized transportation, and especially for paratransit service, was MultiCare Adult Day Health (ADH) Program.

In 2008, DSHS reported that there were approximately 72,000 Medicaid trips to several ADH programs in Pierce County. Prior to July 1, 2009, DSHS data showed that about 48% (29,494) of the Medicaid paratransit trips to the MultiCare ADH program



were provided on Pierce Transit ADA/SHUTTLE, and about 52% (31,776) of the trips to the MultiCare ADH Program were given by Medicaid transportation providers. The PCCTC examined approaches to sharing these rides between Pierce Transit and Paratransit Services Inc., in a series of projects called “Common Ground.”

## Common Ground

For over ten years, the PCCTC worked on “Common Ground,” a series of projects that considered how to coordinate transportation for individuals eligible for both Public Transit ADA paratransit and Medicaid NEMT paratransit. Reports from the project indicate that some underlying assumptions of this project included the beliefs: 1) Each agency has an obligation to provide transportation; 2) the two agencies use different terms and measurements for “trips;” 3) the two agencies provide different levels of service; 4) the two agencies have different computer systems, and these systems need to be able to “talk” to each other to share information and billing.

According to “Lessons Learned,” a white paper about the project, the significant accomplishments of the project included:

- A cost allocation model – funded by ACCT in 2004
- A way to share trip information while upholding privacy requirements/addressing HIPAA concerns (2006)
- A demonstration on paper that ADA trips can be routed efficiently with Medicaid Non-Emergency Medical Transportation(NEMT) trips (2007);

The project challenges or lessons learned included:

- A cost allocation formula has to be automated;
- A budget with adequate funding for appropriate staff is needed to implement a shared ride system (approximately \$800,000);
- An evaluation of the impact of removing these trips from the existing providers is needed.

In 2007, executives from the Department of Social and Health Services (DSHS), Pierce Transit, Sound Transit, and Pierce County approved the project and asked staff to develop an implementation plan. However, the project was suspended in 2008, when Pierce Transit and Sound Transit pledged funding for the project, but DSHS was unable to provide funding to continue the project. In an email to the Common Ground partners, DSHS cited these reasons:

“...it has been decided that HRSA [DSHS] is not able to sign the Common Ground (CG) proposal due to a number of factors, starting with current and pending fiscal realities...We believe it is fiscally prudent to suspend the project pending the outcome of some anticipated decisions... The first ...we are still awaiting Federal response on ... ‘usual and customary’ and ‘payer of last resort’... The development of an automated cost algorithm by Paratransit Services is the



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second item of interest. Previously, public money funded a similar effort, with no positive outcomes. We are recommending that it makes more sense to see if Para is successful in developing this product prior to investing more time and effort on this project. Upon being notified that an automated seat share per mile cost algorithm is available, then it would be appropriate for CG to meet to re-evaluate the feasibility on whether to proceed in this endeavor.”



## IV. The Adult Day Health Pilot Project

### Loss of Adult Day Health Medicaid Transportation

Adult Day Health Services, which are authorized now under a Medicaid waiver, were removed from the State Medicaid Plan in 2009. As noted during the Common Ground projects, Adult Day Health programs were the destination for the most Medicaid paratransit trips in Pierce County, and paratransit is the most expensive type of special needs transportation. The Medicaid reimbursement for Adult Day Health service is about \$56 for a 4 hour day of service. At an average \$33.99 per trip, the Medicaid cost for transportation by private providers was almost \$78 per day. To save money on Medicaid expenditures, DSHS and the legislature decided to end Adult Day Health clients' eligibility for brokered Medicaid transportation.

Adult Day Health programs were no longer eligible for NEMT Brokered transportation and the Adult Day Health providers referred clients to Pierce Transit for SHUTTLE services. Many people transitioned to SHUTTLE, but some people lived outside of the public transit service area, or for other reasons, were not eligible for SHUTTLE. DSHS authorized a \$15 per person/ per day fee increase for Adult Day Health Care, and gave the providers the responsibility to "arrange or provide transportation" for their clients. While court action changed the scenario in the fall, by the end of the year, the Medicaid broker was no longer allowed to provide Medicaid funded rides to Adult Day Health Clients.

### The Adult Day Health Express Pilot Project

ESHB 2072, in part, said the "local coordinating coalition shall develop a pilot project...for the purpose of demonstrating cost sharing and cost saving opportunities," and "Capture the value of Medicaid trips provided by public transit for which they are not currently reimbursed with a funding match by federal Medicaid dollars."

The PCCTC considered several options for a pilot project (See Appendix V). One faction supported the idea of writing another white paper regarding lessons learned from "Common Ground." Sound Transit, the first agency to declare financial support for a pilot project, indicated an interest in a transportation project as opposed to another study about coordinated transportation. The PCCTC decided to develop a pilot project to address the problems that resulted from the shifting of Medicaid trips onto public ADA paratransit. Although Medicaid NEMT funding had been withdrawn, many of the other perceived federal barriers of the Common Ground project still remained:

1. Sharing client information between agencies;



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2. Sharing costs across multiple funding sources;
3. Sharing rides (in the most efficient manner).

PCCTC decided a pilot project would provide the opportunity to address many of these long standing issues that had been perceived as barriers to coordination. The pilot project also gave the PCCTC the opportunity to move from studying coordinated transportation to actually implementing a coordinated transportation project. A PCCTC pilot project committee met weekly through the fall of 2009 to design the Adult Day Health Express (ADHE) pilot project. The subcommittee included staff from the Medicaid Broker - Paratransit Services, Inc. (PSI), Pierce Transit, MultiCare Health Services, NEMT providers – Around the Sound, Coastal, Local Motion, and Transpro, Washington State Department of Transportation (WSDOT), and the PCCTC Mobility Coordinator. Don Chartock of WSDOT chaired the committee.

During the development of the “Request for Proposals” the group considered Pierce Transit methods for providing Federal Transit Authority (FTA) regulated ADA services, Paratransit’s methods for providing federally regulated Medicaid NEMT, and WSDOT methods of administering federal and state funds. Steve Abernathy of WSDOT provided valuable information and helped guide the process. Working under a very tight timeframe, the group released the Request for Proposals (RFP) from transportation providers in December 2009.

Local Motion, LLC, was the successful bidder for the transportation provider contract. Local Motion shared client information on a daily basis with both MultiCare and Pierce Transit, electronically transmitting a “Master File” to both agencies. MultiCare communicated all ride requests and changes directly to Local Motion, the transportation provider, and Local Motion formulated the shared trip schedules. Local Motion made daily changes to the routes to accommodate client requests for changes in pick-up or drop-off points. In spite of the need to make daily changes in the routes and schedules, Local Motion performed the transportation services efficiently. Preliminary results indicate that Local Motion managed the project successfully, and reduced costs while increasing customer satisfaction. Many of the issues raised during Common Ground were addressed; many of the barriers that prevented Common Ground from being implemented proved not to be problems during the pilot project.

### **Key Features of the Adult Day Health Express(ADHE) Project**

- The ADHE was neither Medicaid nor Public Transit ADA - it was “human services transportation.” The committee selected NEMT guidelines for driver standards, vehicle standards, requirements for placing ride requests, range of pick-up times, etc.



- Client information was freely shared with all partners of the project; the committee agreed that transportation information is not HIPAA-protected medical information.
- (See Appendix VI for “covered entity” information); however, MultiCare is a HIPAA covered health care entity and, since they contracted with the selected provider, they asked Local Motion to sign a HIPAA “business associate agreement.”
- The committee invited the Medicaid transportation providers, Paratransit Services, Inc. (PSI) and Pierce Transit to offer input about how to bill for transportation:
- The broker’s payment method was based on a base rate plus a mileage rate, which is calculated by actual mileage traveled while the client was onboard. Each provider submits a variety of rates to cover a multitude of ride possibilities, including a shared ride rate. Providers have different rates for lift-equipped vehicles and sedans.
- Pierce Transit proposed a zone rate where there is a uniform cost for picking up riders in a certain area, regardless of the mileage involved.
- A flat fee per trip, based on the zone, was selected for the Request for Proposal process.
- The provider, Local Motion, grouped the trips and planned the routes – this was a key aspect of the project. By coordinating all of the trips through one provider, there was maximum productivity and efficiency, with increased customer satisfaction.
- Local Motion drivers collected data on each trip; Local Motion produced the billing each month.
- Pierce Transit, Pierce County, and MultiCare cross-checked the bill, using their existing computer systems – a multi-agency cost allocation algorithm was not needed.
- The costs were shared and the funding partners included: Pierce Transit, Washington Department of Social and Health Services (DSHS)/MultiCare, Washington State Department of Transportation (WSDOT), Sound Transit, and Pierce County Community Connections (PCCC);
- PCCC was the financial administrator and project manager;
- The “ADHE” only transported people to MultiCare ADH;
- All MultiCare ADH clients were eligible for rides – usually both Pierce Transit and PSI have a process for determining if a person requires a paratransit trip or if they can be transported in a less costly manner. For the sake of this

**By coordinating all of the trips through one provider, there was maximum productivity and efficiency, with increased customer satisfaction.**



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project, any MultiCare ADH client was automatically accepted as a passenger on the ADHE, without a separate eligibility determination; DSHS included \$15 per person per day for transportation as part of the daily ADH fee for Medicaid eligible participants – MultiCare ADH program contributed this fee to the shared cost of the rides (DSHS provided a flat fee per day, not a fair share of the fully allocated costs).

### Comparison of Common Ground and Adult Day Health Express

2008 – Common Ground (Scope of work identified)	2010 ADHE Project
Identify “dually eligible” riders	All ADH patients are eligible
Develop confidentiality agreements	HIPAA – deemed not applicable. However, MultiCare is a HIPAA covered health care entity, and asked Local Motion to sign a HIPAA “business associate agreement.” (pg. 31)
Develop a computerized cost allocation algorithm for shared seat miles	Each agency uses its own billing system
Determine rate structures	Pierce Transit’s zone fare DSHS/MultiCare - \$15 per person per day
Determine service areas	All of Pierce and Thurston Counties
Identify methods used in other states	- - -
Determine measures of success	Cost of trips, number of vehicles used, customer satisfaction
Test the formula	- - -
Develop interagency agreements	Request for Proposals; Contracts between all funders and Pierce County; Pierce County and MultiCare; MultiCare and Local Motion
Develop common standards for policies and processes; Driver training, vehicle maintenance, background checks, etc.	Didn’t develop common standards - Adopted NEMT standards for most things; Mixed ADA and NEMT for some things
Collect and analyze data	Local Motion – daily driver manifests (NEMT) Pierce Transit – archives data (NTD) Transpogroup – evaluation

### Results of the Adult Day Health Express Pilot Project

- The project operated for 6 months, from February through July 2010.
- The provider gave 21,077 rides over 6 months for 212 individuals.
- The cost per trip was reduced.



- The cost per trip during the project –
  - \$23.24 - (includes \$7.50 Medicaid funds);
- The cost per trip - prior to the start of the project:
  - Pierce Transit - \$38.70 (average trip length=8 miles)
  - Paratransit Services, Inc. - \$33.99 (average trip length=13 miles);
- Cost containment through a flat fee structure - cost per trip, based on zones, delineated by distance of travel;
- Cost sharing with multiple funding partners using a simple “share” scheme that is easy to implement because it does not require special software;
- The ADH program arranges customer transportation directly with the provider, which eliminates the need for a broker or a call center;
- Door to door service for ADH participants, including those coming from outside the Pierce Transit Benefit Area and from Thurston County;
- Improvement in customer satisfaction;
- Removal of barriers such as privacy issues, funding silos, and program eligibility criteria;
- Local Motion, LLC, increased productivity (more passengers per vehicle) and efficiency (fewer vehicles) while decreasing transportation costs;

The data gathered indicates that the project met or exceeded all of the goals. One transportation provider, LocalMotion, was able to serve all MultiCare ADH patients, regardless of the location of their residence, and by grouping more rides and using fewer vehicles than were used pre-pilot. The project also demonstrated lower per trip costs than either Paratransit or Pierce Transit.

The PCCTC pilot project committee agreed the evaluation will be based on demonstrated efficiencies:

- Use pre-pilot data gathered by PSI and Pierce Transit from May 2009 and October 2009 as the baseline for number of riders, number of trips, number of vehicles, and cost per trip;
- Include number of riders, number of trips, number of vehicles, cost of trips;
- Examine issues raised in the ten year “Common Ground” project;
- Include “lessons learned” from the Common Ground project.

The transportation provider, Local Motion, kept data on every ride provided. WSDOT provided funding for Pierce Transit to track the data and produce the reports that will be used in the evaluation of the project. There will be a separate project evaluation report issued when the evaluation is completed by Transpo Group (an independent consultant) this spring. Because of the success of the pilot project,



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Pierce Transit has decided to continue the transportation service through June 30, 2011, with two possible extensions of one year each.

### Adult Day Health Challenges

The chart below shows Pierce Transit data regarding the Medicaid rides shifted to Pierce Transit in 2010, when DSHS and the legislature made ADH patients ineligible for Medicaid transportation. This excludes the rides for the month of January 2010, when Medicaid transportation was still provided to MultiCare ADH clients. There are many different ways to analyze the costs involved. The chart below uses the cost per trip that Paratransit Services, Inc (PSI) and Pierce Transit reported during the ADHE pilot project.

### ADH Medicaid Transportation Costs Shifted to Pierce Transit – 2010

Provider	Cost per trip	Number of Trips	Total Cost
Pierce Transit	\$38.70	63,103	\$2,442,086
Paratransit Services	\$33.99	63,103	\$2,144,870
DSHS/Medicaid	37% of Paratransit	63,103	\$793,602

The chart above is hypothetical information. If all of these rides had been performed by Pierce Transit's ADA SHUTTLE service, at the reported average cost of \$38.70 per trip, the cost would have been over \$2.4 million. By comparison, if Paratransit Services had arranged Medicaid NEMT trips at the reported average cost of \$33.99 per trip, the cost would have been over \$2.1 million. However, since Medicaid costs are shared with the federal government, and the Medicaid share in 2010 was 63%, the cost to DSHS would have been \$793,602.

### ADH Transportation Co-pay

In June 2009, when DSHS and the legislature removed the Medicaid transportation funding for Adult Day Health programs, the Washington Administrative Code (WAC) was changed to reflect this. A new Management Bulletin was issued that indicated the ADH programs would receive an additional daily fee of \$15.00 per person to "arrange or provide" transportation. In Pierce County, some ADH programs request rides on public transit ADA for their clients, and keep the extra transportation fee, which the WAC allows. In these cases, public transit bears the full cost for providing transportation while the ADH program keeps the funding. This exemplifies how a service provider receives funds in support of transportation, and shifts the responsibility to public transit for transporting individuals, but fails to pass the allocated funding on to the transit.

### Previous Success with Coordinating Medicaid and Public Transit

It has been suggested that the Adult Day Health Express pilot project was only able to



show positive results because all of the passengers were going to the same location. But this was not the first project funded by ACCT that demonstrated success in coordinating transportation between Medicaid and Public transit. The 1998 ACCT Report to the legislature included a story titled “King County ACCESS Project Tackles Technology Barriers.” The ACCT Report says:

“Facilitated by WSDOT, representatives from DSHS and METRO ...agree[d] to contract with a single broker for the county.” Metro, responsible for providing ADA trips, and DSHS, responsible for Medicaid trips, both used the same scheduling and dispatching software, but each agency required different parameters for trips. The project looked for duplication and ways to share /coordinate trips. Call takers for each system were trained to handle both DSHS and Transit calls, and to use the information available on two separate “drives” of the computer system. A result of the project was upgraded software to allow accurate tracking of trips by funding sources and give access to both operating systems at the same time.”

The Transit Cooperative Research Program (TCRP) – Report 91 - Economic Benefits of Coordinating Human Services Transportation and Public Transit Services also cites the King County Access project:

“King County Metro (headquartered in Seattle, WA) and the Department of Social and Health Services (DSHS) conducted a demonstration of sharing vehicles to save money on ADA and Medicaid transportation. DSHS brokered nearly 35,200 Metro ADA trips; Metro ACCESS brokered almost 5,100 DSHS trips and the overall annual program benefit from ridesharing was nearly \$101,000.” (Note: “the project generated benefits over \$307,000, with costs of over \$181,200, resulting in over \$126,200 in 15 months”)<sup>12</sup>

According to final report for the project:

“Coordinated dispatching systems and vehicle sharing arrangements ensure a highly cost effective application of driver and vehicle resources. Ridesharing can solve a number of the problems associated with non-coordinated transportation systems such as overlapping routes, duplication of service, inefficient route design, and poorly timed schedules. In particular, **the benefit of providing trips for ADA paratransit clients at the same time and on the same vehicle as other human services clients creates much lower per trip costs...**”

The TCRP –Report 91 from 2003 also cites the benefits of using a computerized cost allocation formula to share the costs so rides can be shared between Medicaid and Public Transit. In a section called “Increased Vehicle Utilization through Ride Sharing,” the program People for People – Yakima, Washington is cited as an example of ride sharing and cost sharing:

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<sup>12</sup> TCRP – Report 91 – Economic Benefits of Coordinating Human Services Transportation and Transit Services - 2003



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“Client trip costs are billed to specific funding sources according to a time-based cost allocation formula. For example, if a Medicaid client trip overlaps with a JARC trip or a GTA [Grant Transit Authority] paratransit trip on the same vehicle (shared ride), the cost for the shared portion of the trip is divided by the number of clients on board. PFP’s billing software calculates cost allocations by matching each client trip to a program funding source. Drivers track trip length (minutes) for each trip, which is entered later to complete the calculation. This cost allocation method provides an excellent means for quantifying the overall economic benefit of coordinating human service transportation programs and public transit services through shared rides...PFP estimates that coordinated service provision in the three county area will save almost \$265,000 in FY 2001-2002 alone.”

All three of these projects funded by ACCT over the past twelve years, demonstrated success in coordinating transportation. Each of these projects used a unique approach to sharing passenger information, grouping rides and sharing costs. The Pierce County Adult Day Health Express pilot project was able to overcome some of the perceived problems that usually prevent sharing client information, sharing rides and sharing costs, partially because Medicaid Brokered NEMT funded transportation was not part of the project. However, the King County project and the Yakima County/People to People projects included both Medicaid Non Emergency Medical Transportation and Public Transit, demonstrating that the interpretations about federal regulations may be different in communities outside of Pierce County. **While different agencies may use different approaches to “coordinate” transportation, each of these projects demonstrated that coordination saved money.**



## IV. Findings

The legislation and the literature about coordinated transportation and the perceived barriers to coordination can be summed up by this statement found in one of the Transit Cooperative Research Board studies:

“There has been a misperception that categorical funding does not permit sharing of resources, because much of the funding for specialized transportation originates with federal programs is aimed at specific client groups...There will definitely be challenges in coordination, but it would be inaccurate to say there are barriers that cannot be surmounted...Both the U.S. Department of Transportation (DOT) and the Department of Health and Human Services have issued instructions that are clear – it is possible to have clients from different sponsoring federal agencies riding on the same vehicles at the same time.”<sup>13</sup>

### Deficit Reduction Act - Final Rule Implementation

In Pierce County, throughout the years of the Common Ground project, there was a perception that federal regulations prevented Medicaid and Public Transit from sharing information, trips, and costs. The [“Final Bill Report for ESB2072”](#) also indicated that it would require intervention on behalf of the Washington Congressional delegation to change federal regulations or policies. However, many of these perceptions have been corrected by the fact that Congress passed The Deficit Reduction Act (DRA) in 2005, and the final rules became effective January 20, 2009. The final rule provides states with more State Plan flexibility in implementing a NEMT brokerage program and specifically states that public transit can be a Medicaid transportation provider. The DRA is quoted below, and the legislation is attached as an appendix. (See Appendix VII). The regulations say in part:

“Statutory Authority

The DRA “allows states to amend their State Medicaid Plans to establish a non-emergency medical transportation (NEMT) brokerage without regard to statutory requirements for comparability, state-wideness, and freedom of choice.”

“Analysis of and Response to Public Comments on the Proposed Rule

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



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**“In the case of publicly –provided paratransit services and rides, based on the comments received and the information provided, we believe it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride.”**

“In the final rule we have modified the regulations...to require the **governmental broker** to document that Medicaid is paying for public fixed route transit at a rate no more than the rate charged to the general public and no more than the rate charged to other state human services agencies for public paratransit services...We could have precluded **governmental brokers** from providing transportation or referring beneficiaries to governmentally operated transportation all together. Instead, we provided for safeguards to ensure that governmental brokers operate as independently as non-governmental brokers...”

...“The proposed rule distinguishes between two types of brokers, governmental and non-governmental. **There is no restriction on a non-profit broker that is not a governmental entity from negotiating rates with public transportation providers.**”

“In designing a NEMT brokerage program, **States have the option to direct the broker to include bus passes and mileage reimbursement**”...

### Medicaid Plan

A state’s Medicaid Plan is the comprehensive written statement that explains how the state will provide services and comply with regulations. The Center for Medicare and Medicaid Services (CMS) is primarily responsible for the interpretation and implementation of federal legislation and legislative policy changes, however, Medicaid is administered on a day to basis by the states. States must write a Medicaid State Plan that complies with the federal requirements in order to remain eligible for federal Medicaid matching funds; a state that does not comply with CMS risks the loss of some funds.

There are two formal procedural pathways for states to obtain CMS approval for changes to a State Plan. The first is the State Plan Amendment (SPA); this route is used when a state seeks to make a policy change that is consistent with federal requirements for State Medicaid Plans. The second is a Waiver Request; this route is used when a state wants to make a policy change that is not consistent with one or more federal requirements for state Medicaid plans and it therefore seeks to be excused from complying with the requirement.<sup>14</sup>

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<sup>14</sup> *Nuts and Bolts of Making Medicaid Policy Changes – Kaiser Commission on Medicaid and the Uninsured (2006)*



## How to Change a Medicaid Plan

CMS has developed State Plan “preprint pages” on which state Medicaid programs simply check the transportation policy options they have selected. These forms are submitted by the state agency to CMS for approval as a State Plan Amendment (SPA).

*Nuts and bolts of Making Medicaid Policy Changes – Kaiser Commission on Medicaid*

CMS has well defined procedures regarding Medicaid programs. The process for contacting CMS to change how Medicaid services are delivered is to file a State Plan Amendment. This process is spelled out on the DSHS website. (See Appendix VIII)

States use State Plan Amendments (SPAs) to make program changes that are allowed under current law. In the past, it could be a complicated process to change the State Medicaid Plan. Now CMS has developed State Plan “preprint pages” for transportation, on which state Medicaid programs simply check the policy options they have selected. (See Appendix IX) CMS must approve any State Medicaid Plan or Amendment that meets the State Medicaid Plan requirements, and there are regulations that set timelines for review of SPAs. (They are generally considered approved or disapproved within 90 days of receipt unless CMS requests additional information.) Information about the State Plan amendment Process can be found on the DSHS website.

States can implement Medicaid program changes not allowed under current law by requesting a waiver. Longstanding federal policy requires waivers to be “budget neutral” meaning federal costs under a waiver cannot be more than projected federal costs without the waiver. (For example, home and community based services waivers are allowed because states demonstrate that it is less expensive to maintain a person in a local group home than in an institutional setting such as a nursing home.) There is no comparable requirement for SPAs, some of which by definition will result in additional federal spending. If the SPA is consistent with the federal Medicaid requirements, CMS is obligated to approve it, even if it results in additional federal expense.<sup>15</sup>

## Single State Agency

The responsibility for administering the state Medicaid plan rests with a “single State agency.” In Washington, DSHS has been designated as the “single State agency” and therefore has the responsibility for communication with CMS regarding changes to the state Medicaid plan. DSHS attached a fiscal note to ESHB 2072, prior to passage, which said:

“The Department of Social and Health Services (DSHS) is the sole agency for

<sup>15</sup> *Nuts and Bolts of Making Medicaid Policy Changes – Kaiser Commission on Medicaid and the Uninsured (2006)*



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Medicaid per the State Plan for Medical Assistance, which requires “a single State agency to administer or to supervise the administration of” the State Plan (42 U.S.C.139a (a) (5)). NonEmergency Medical Transportation (NEMT) services are part of the state plan. Any part of this bill that could be read as another entity, such as the Agency Council on Coordinating Transportation (ACCT) or Dept of Transportation (DOT), administering part of the Medicaid program, or entering into contracts on behalf Medicaid could be seen as having multiple state agencies administering the State Plan. That could jeopardize federal matching dollars and result in the state having to use General Fund-State dollars for the services.”

The comments above from DSHS staff seem to indicate that if ACCT or the Workgroup want to ask for permission to change the way Medicaid NEMT transportation is funded or provided, they would contact DSHS (the single State agency). The process the Center for Medicare and Medicaid Services (CMS) has implemented for changing the State Medicaid Plan is for the “single State agency” (DSHS) to submit a State Plan Amendment (SPA). This process is spelled out on the DSHS website. (See Appendix X)

### Authority of the Broker

DSHS has indicated that many decisions about coordinating transportation actually are delegated to the local broker. It is not clear that the Medicaid Brokers have the authority to choose whether or not to follow a DSHS Medicaid policy. Title 42 of the Public Health laws states: “Authority of the single State agency. In order for an agency to qualify as the Medicaid agency (1) The agency must not delegate, to other than its own officials, authority to (i) Exercise administrative discretion in the administration or supervision of the plan, or (ii) Issue policies, rules, and regulations on program matters ... (3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.”<sup>16</sup>

### Payer of Last Resort

According to Designing and Operating Cost Effective Non-Emergency Medicaid Transportation Systems, a report prepared by the federal Health Care Financing – the precursor to CMS - Medicaid rules do state that Medicaid is always the payer of last resort. However, this means that a person has “No other transportation services available free of charge. Since Medicaid is the payer of last resort, states generally require clients to use available free transportation before authorizing services through their NEMT programs. Free transportation may include that provided by friends, family members, unpaid volunteers, or nonprofit agencies.”<sup>17</sup>

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<sup>16</sup> <http://cfr.vlex.com/431-10-single-state-agency-19812194#ixzz1C5i5VHuz>

<sup>17</sup> *Designing and Operating Cost Effective Non-Emergency Medicaid Transportation Systems*



In Washington, people have come to believe that Public Transit has a “third party liability” to provide Medicaid paratransit rides. But the fact that a community has a public transit agency does not mean that transit agency must assume financial responsibility to provide Medicaid paratransit rides, while Medicaid pays the passenger fee. In fact the Government Accounting Office (GAO) website says:

“Problems states have faced in ensuring that Medicaid is the payer of last resort fall into two general categories – verifying that Medicaid beneficiaries have private health coverage and collecting payments from third parties.” The Centers for Medicare and Medicaid Services (CMS) website says: “Medicaid by law is the payer of last resort; all other available third party sources must meet their legal obligations to pay claims before the Medicaid program pays for care. Examples of third parties which may be liable to pay for service include: group health plans, self-insured plans, managed care organizations, Medicare, long term care insurance, worker’s comp.”

As noted above, the Deficit Reduction Act also discusses third party payers in relation to transportation: “In the case of publicly provided transportation on fixed routes, while there are other third party payers (for example State Human Service agencies) that often cover and reimburse these trips for their clients, we have been informed that such third parties or agencies generally pay the same amount as the public is charged for these rides. Therefore, we are prohibited from paying more than the public is charged for public transportation on a fixed route.” This seems to indicate that payer of last resort is a concept related to the responsibility of health insurance companies, or other groups who may supply funding for Medicaid recipients, not to the responsibility of local transit agencies.

In regard to Medicaid trips on the ADA/paratransit service, the Deficit Reduction Act makes it clear that neither “usual and customary fee” nor “payer of last resort” apply to restrictions on the amount Medicaid can and will pay for paratransit trips provided on public transit. The DRA clearly says: “In the case of publicly-provided paratransit services and rides, based on the comments received and the information provided, we believe **it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride.**” (Emphasis added).

## Medicaid Rides Provided on Public Transit

The charts on the next pages provide data from Medicaid’s fiscal years 2008, 2009 and 2010. Paratransit Services, Inc., the broker in Pierce County, provided this statement:

“This data is extrapolated from activity reports provided to DSHS... The data represents the number of one way trips provided by fixed route, [Medicaid] sub-contracted providers and possible ADA usage. The broker distributes full fare, discounted fare or youth fare to Medicaid clients to be used on fixed route to get



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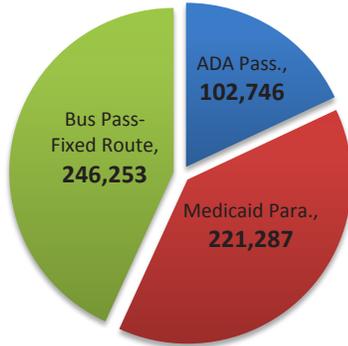
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to their medical services. Due to Pierce Transit policies, if a Medicaid client has been issued a discounted bus pass, and they are eligible for ADA, the clients can exercise their right to choose whether they want to ride the Pierce Transit Shuttle or, the fixed route. The broker has no way of knowing how many actual ADA rides might be used – the broker is only able to track the number of discounted passes purchased and the number of appointments an individual reports.”

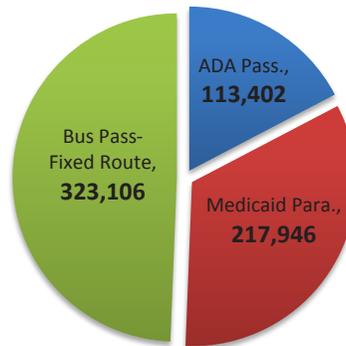


## Medicaid Non-Emergency Transportation Services in Pierce County Trips by Mode

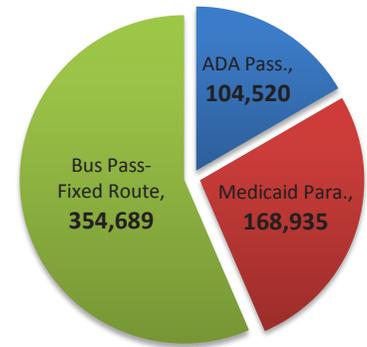
**Fiscal Year 2008 Trip Total**



**Fiscal Year 2009 Trip Total**



**Fiscal Year 2010 Trip Total**



### Medicaid NEMT Trip Count for Pierce County by Mode

Mode	FY 2007	FY 2008	FY 2009	FY 2010
Medicaid Providers	224,596	221,287	217,946	168,935
Fixed Route Bus Pass	218,399	246,253	323,106	354,689
ADA Pass (Discounted)	88,167	102,746	113,402	104,520



### Transferring Medicaid Costs to Pierce Transit

#### Cost Transferring

The term “client shedding” has been used 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 a class of human service agency clients. The term “cost transferring” will be used to refer to the transferring of responsibility for funding for NEMT clients from state and federal NEMT funds to local transit dollars. The transferring of responsibility for funding NEMT is a core issue in coordination.

*TCRP Synthesis 65 – Transit Agency Participation in Medicaid Transportation Programs*

The charts on the previous page show a steady increase in the overall number of Medicaid funded trips as well as a steady increase in the number of trips scheduled on public transit. Reports have been cited that explained the obvious financial benefit to the Medicaid program from shifting passengers to fixed route buses. In 1999, DSHS reported that shifting Medicaid clients to fixed route transit buses saved over \$3.6 million in Medicaid funds that year in King County alone. It was also noted that providing bus passes to the people who were shifted to fixed route service was seen as a win-win-win situation, for the rider who had more mobility with a bus pass, for the transit company that received the bus pass fare, and for the Medicaid agency that reduced costs.

It is a different situation when Medicaid paratransit rides are shifted to public transit. The increasing number of Medicaid trips provided by the Pierce Transit ADA paratransit “SHUTTLE” program means increased costs for Pierce Transit. Pierce Transit reports that SHUTTLE trips cost \$38.70 each, yet the Medicaid broker pays just \$0.75 per trip. That means Pierce Transit has to pay the other \$37.95 in trip costs, in effect subsidizing the Medicaid trips.

It was previously reported that the statewide average for Medicaid ADA-paratransit trips is about 9% of the total trips. However, the number of trips given on the Pierce Transit SHUTTLE is a much greater percentage (18% in FY2008), and continuing to increase.



## Medicaid Trips in Pierce County -2008

2008	Number of Trips	% of total trips
Pierce Transit - bus	246,253	43%
Pierce Transit - ADA	102,746	18%
Sub total	(348,999)	(61%)
Paratransit Services, Inc	221,287	39%
Total	570,286	100%

Paratransit Services, Inc., reported that 570,286 Medicaid trips were provided in Pierce County in fiscal year 2008. Of those Medicaid trips, 61% (43+18 = 61) were provided by Pierce Transit.

## Medicaid Trips in Pierce County- 2010

2010	Number of Trips	Percent of Total Trips
Pierce Transit - bus	354,689	56%
Pierce Transit - ADA	104,520 (+ 63,103 ADH)	17%
Sub total	459,209	73%
Paratransit Services, Inc	168,935	27%
Total	628,144	100%

In fiscal year 2010, Paratransit reported an increase of overall Medicaid trips to 628,144, with Pierce Transit providing 73% of the Medicaid trips. It should also be noted that during fiscal year 2010 all of the Adult Day Health Medicaid paratransit trips were shifted to Pierce Transit ADA, so these former Medicaid trips are not be captured in this percentage. (104,520 + 63,103= 167,623 paratransit trips)

By 2010, Pierce Transit was providing over 104, 520 Medicaid paratransit trips; according to the information the patients give to the Broker. Considering the other 63,100 trips for ADH patients (which are no longer eligible for transportation through the Medicaid Broker), that is over 167,000 ADA/ paratransit trips for Medicaid patients to Medicaid services. At a cost of \$38.70 per trip (167,623 trips x \$38.70) that equals over \$6.4 million in costs shifted to Pierce Transit and the taxpayers of Pierce County in one year alone.



**2010 Medicaid Paratransit Trips on Pierce Transit**

<b>Number of trips</b>	<b>Pierce Transit per trip cost</b>	<b>Paratransit per trip cost</b>	<b>DSHS cost (37.06%)</b>	<b>Difference</b>	<b>Possible savings</b>
167,623	\$38.70	\$33.99	(37.06%)		
Total	\$6,487,010	\$5,697,505	\$2,108,077	Pierce Transit cost minus DSHS Cost	\$4,378,933

As the Medicaid broker, Paratransit Services, Inc. is able to schedule Medicaid paratransit rides with the lowest cost providers. Paratransit reports paying an average of \$33.99 for paratransit rides scheduled with private providers. If Paratransit Services, Inc. had scheduled the same rides with Medicaid transportation providers the cost would have been about \$5.6 million

However, for Paratransit Services/DSHS this would have been a Medicaid expense. Since NEMT qualifies for “medical match”, and in 2010 the match rate was about 63% (as of 10/1/2010 it increased to 65%). This expense would have been matched by the federal government so final cost to DSHS would have been about \$2.1 million. This would have saved the local community over \$4.3 million in one year. The cost that would have been paid by the taxpayers of the state of Washington is considerably less than the cost paid by the citizens of Pierce County for the same trips. This is even before any money is saved by implementing coordinated transportation practices.

**Why Do We Need More Coordinated Transportation?**

We are in the middle of the worst economic downturn since the Great Depression. We are faced with high rates of unemployment, severely reduced revenues, and an increased demand for special transportation services. This region will experience an even more dramatic increase in the need for special needs transportation in the coming decade as our aging population has to rely on these services to reach critical life line services and to meet the daily needs of living.

The Puget Sound Regional Council (PSRC) reports that there are over 3.5 million people in the Puget Sound area and up to one third of them require special needs transportation because of age, disability or income. According to population projections and transportation models there will be a 32% increase in the demand for paratransit services, or an increase of about 64,000 thousand individuals by 2020. The PSRC also indicates that the population likely to use special needs transportation is even higher in Pierce County, where 40% of the population meets this definition – giving Pierce County the largest special needs population in the region. These models do not even consider the human services changes that result in the need for more transportation such as the continued implementation of Home and Community



Based waivers to Medicaid, that support more people living in the community rather than in institutions, or the change to an outpatient medical treatment model, which often require numerous follow-up visits. All of these things will result in increasing the need for more specialized transportation.

### Formerly Medicaid Funded Transportation

In transferring the cost of Adult Day Health Transportation to the local public transit, DSHS also shifted 100% of the cost to the local tax payers. When Medicaid funds the transportation of Medicaid clients, DSHS receives a federal subsidy of \$0.63 on a dollar, thereby reducing the cost to taxpayers in the state of Washington. When the Medicaid Broker provides bus fare for Medicaid trips on public transit, it is transferring costs, not coordinating transportation. Yet studies in Washington and other states have demonstrated that truly coordinating Medicaid and Public Transit systems has been proven to save money. Policies that will allow costs and rides to be shared, rather than transferred to another agency, need to be adopted in Washington.

### MultiCare ADH Transportation to Thurston County – Approximate costs

Thurston Riders	Flat Rate	ADH share	Remaining cost
400 trips/month	\$42/per trip	\$7.50/per trip	
	\$16,800/month	\$3,000/month	\$13,800/month

When the PCCTC subcommittee designed the Adult Day Health Express pilot project, the clients who lived outside of the Pierce Transit service area were included in the project. Medicaid had previously provided transportation for these individuals, so in order to have an “apples to apples” comparison of transportation with Medicaid funding and without it, the pilot transported everyone who was a client of MultiCare ADH on 1/1/2009. The agreement was that the service for people who lived out of county would end on 7/31/2010 when the project and the grant funded ended.

The cost to transport ADH clients from outside of the county is about \$84 per day per person, while the DSHS contribution for this transportation is \$15 per day. This is a health care issue and a policy issue, not just a transportation issue. One consideration might be to have DSHS and MultiCare explore the option of creating an Adult Day Health program in Thurston County so people don’t have to be transported long distances, across county lines in order to receive services. Another consideration might be for DSHS to increase the transportation allotment for individuals who need to be transported long distances. This is an issue that needs more consideration.



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### **Medicaid, a Transportation Resource**

Medicaid needs to be considered more seriously as a source for helping to fund transportation for our aging population. Medicaid represents the single largest source of federal grant support to the states. Medicaid is also the dominant source of coverage and financing for long term care. The Deficit Reduction Act (DRA) gave states new options to offer “Home and Community Based Service” (HCBS), Medicaid-funded services that allow people to live in community settings rather than in nursing homes/institutions. The Patient Protection Affordable Care Act (ACA), the major health reform legislation, will also give Medicaid and the states an expanded role in decisions about using health care resources. ACA has a number of new long term care options designed to increase community based long term care placements. As DSHS continues to implement these services, and place up to ninety (90) more people in the community through the federal “Money Follows the People” grant, DSHS should be encouraged to exercise the option to include transportation in the Medicaid-funded services. As of October 2011, the federal government is providing additional match to states that expand the amount of funding they spend on HCBS to reduce the amount spent on institutional service. As these new services are developed, and additional federal funding is available, this is the perfect time to include Medicaid-funded transportation as part of the package of services, and stop the practice of shifting these costs to local transits.

### **Need for Structural Change**

The expected growth in the aging and disabled populations, and the subsequent increased demand for transportation that will accompany this growth, emphasizes the need to reform the current system. A structured and comprehensive strategy for coordinating transportation needs to be created. The PCCTC spent the past year working on a new County Coordinated Transportation Plan. The planning process included examining the needs of the community and the development of two pilot projects; one was the implementation Adult Day Health Express, providing free rides to MultiCare Adult Day Health patients; the second was a pilot project to increase transportation on the Key Peninsula, a rural area of Pierce County. The PCCTC focused on exploring the existing transportation resources, understanding the needs in the county, and developing the resources to address these transportation needs. Detailed information about this pilot project will be available when the new Pierce County Coordinated Transportation Plan is finished. The planning process also reaffirmed the need to continue the comprehensive approach to coordination the PCCTC has been working on for many years. The planning process identified the need to sustain the information services and expand the ride services the PCCTC has developed.

While the need for paratransit services has increased, federal and state resources to provide the services have not. Public transits will find it increasingly difficult to provide services to a broader range of individuals, many of whom were previously



transported by human services agencies that have faced drastic cuts to their funding. Public transit agencies also cannot afford to expand services to outlying rural areas due to low ridership and the high cost of providing service. Yet the lack of low cost fixed route bus service in an area puts a greater demand on community based and nonprofit agencies to stretch their funds to provide transportation. Currently there is insufficient funding both for public transit and for human services agencies to provide adequate special transportation to meet the needs of the growing population of older adults, individuals with disabilities, and people with low-incomes.

According to the Transportation 2040 plan, produced by the Puget Sound Regional Council, the system of transportation finance that has been in place in recent decades is beginning to fail. A new finance system at the local, state and federal levels must be developed to pay for transportation investments. Years of research, demonstrations, and evaluations have shown that coordinating transportation services is a management strategy that can generate significant benefits. Coordination can lead to significant reductions in per trip operating costs. One approach to securing additional needed funding for ADA services is to develop cost sharing agreements with health and human service agencies to ensure that transit is able to continue to provide the level of service needed. Cost sharing arrangements can provide the underpinning of a coordinated approach to the transportation service delivery system.<sup>18</sup>

## Information Sharing

Federal Regulations do not prevent local attempts to coordinate transportation. When the PCCTC began the Adult Day Health Pilot Project, the information sharing issues that were barriers throughout the ten years of the “Common Ground” project surfaced. It was quickly determined that Health Insurance Portability and Accountability Act (HIPAA) specifically applies to “covered entities.” A covered entity is a health care provider, a health plan or a health clearinghouse. Transportation is not a healthcare service; a transportation provider is not a covered entity. (See Appendix VI) MultiCare Adult Day Health is a healthcare provider and therefore a covered entity. MultiCare included a HIPAA “Business Associate” agreement in the contract with Local Motion, the transportation provider. All project information was shared freely between MultiCare, Local Motion, Pierce Transit and Pierce County.

The Federal Opportunities Workgroup also determined that HIPAA regulations do not prevent DSHS/ Medicaid Transportation Brokers from sharing information about clients to coordinate trips. FOW recommendations request additional clarity in implementation of the federal law as it relates to transportation providers.

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18 *Medicaid Transportation; Assuring Access to Healthcare a Primer for States, Health Plans, Providers and Advocates (January 2011 – Prepared by David Raphael – CTAA)*



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### State Decisions about Medicaid Services

According to federal Medicaid regulations, states are given great freedom to select the services they wish to provide, set the eligibility for receiving services, and determine how the services will be delivered. Therefore, each state provides Medicaid services and related NEMT differently, though they must follow federal guidelines. Since the majority of states have managed to find ways to coordinate their NEMT services and Public Transit, it is likely that a state's choice about what to include in the State Plan would be the reason transportation could or could not be coordinated.

The Deficit Reduction Act changed a lot of the processes involved in completing the transportation portion of the State Medicaid plan. It is now possible for a state to use a brokerage system to manage the transportation, without using the waiver process. To simplify the process even more, there are pre-printed pages with checkboxes. There is nothing in the current State Medicaid Plan which should prohibit DSHS from allowing Brokers to share rides and costs with other agencies, including public transit.

### Allowable Expenditures

1. Bus Passes - During these difficult economic times many agencies have suffered budget cuts and this has resulted in drastic cuts to transportation services for low-income individuals. Since the change to "medical match" more Medicaid beneficiaries are receiving bus tickets rather than bus passes. PCCTC members have noted that the poorest people in the community are being left without adequate transportation to meet their basic needs as they lose their Medicaid bus passes. The language in the DRA indicates that "states have the option to direct the broker to include bus passes..." Since the law seems to allow bus passes, and since the State Medicaid Plan does not forbid them, it would be very beneficial for some of the poorest people in Pierce County to be able to continue to receive them. Brokers are not prevented from issuing bus passes, but indicate they must compare the cost of the pass to the cost of a bus ticket and only provide a bus pass when the trip requires enough bus tickets that the cost would surpass the cost of the bus pass.
2. "Usual and Customary Fee" – The Deficit Reduction Act (DRA) makes it clear that Medicaid intends to pay the same fee for fixed route bus service that an individual would pay for the same trip. This means that in Pierce County the Medicaid Broker will either purchase a bus pass for an individual, or will pay the individual ticket price which is currently \$2.00 per trip. The DRA also makes it clear "In the case of publicly –provided paratransit services and rides... **it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride.**"



3. “ Payer of Last Resort” - Transit’s do not have the legal responsibility to transport Medicaid clients to Medicaid appointments. Transit’s can opt to become Medicaid transportaton providers, in which case **“There is no restriction on a non-profit broker that is not a governmental entity from negotiating rates with public transportation providers” according to the Deficit Reduction Act of 2005.**
4. Ride sharing – Transportation providers, including Public Transit need to be able to share rides with Medicaid in order to have a coordinated transportation system that produces efficiencies by sharing costs and sharing vehicles.

## Use of Technology

The federal United We Ride Initiative encourages the use of technology to assist in coordinating transportation. Various brokers in the state report using technology to plan routes and group trips, prior to selecting or assigning the transportation provider. This approach of grouping or sharing rides also results in the cost of the trips being shared. Using technology to create routes and group trips provides more likelihood that the cost per trip will be lower. Transportation providers may realize more efficiency and reduce overall costs if they are able to group the trips of riders supported by multiple funding sources. Grouped ride scheduling and dispatching systems should be available to Medicaid Brokers, and the systems should be fully functional and fully implemented.

In Pierce County, more trips could be coordinated and more money could be saved by strengthening the partnership between the Medicaid Broker and the other PCCTC members. Through the work on “Common Ground” and the Adult Day Health pilot project, the financial implications for coordinating more Medicaid trips with Public Transit and other funders have been recognized. Three factors impact the costs – the approach to scheduling rides, sharing rides, and billing for rides/sharing costs. The ride sharing approaches used in Yakima and King County could be implemented in Pierce County to increase the amount of coordination and reduce the per trip cost for all funders.

**Using technology to create routes and group trips provides more liklihood that the cost per trip will be lower.**

Implementing more practices involving sharing rides and sharing costs in Pierce County would provide two ways to immediately ensure greater cost savings for both Medicaid and other funders. In the current PCCTC County Coordinated Transportation Plan, there is a diagram that pictures a coordinated transportation system (See Appendix II.) When the PCCTC members agreed to this model of



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coordinated transportation, where a customer only has to make one telephone call to request a ride, and all of the trips are available through one computerized system, this was a “vision for the future.” Now there is the capacity to create a true coordinated transportation system where all of the available resources, both public and private, can be used. The technology exists today to have all information shared among all transportation providers and all special transportation trips listed on a web-based computer system. A true coordinated transportation system will reduce costs by grouping rides and sharing costs between multiple funding sources, rather than shifting rides and costs from one agency to another.



## CONCLUSIONS

**The PCCTC feels a sense of urgency to address the increasing demand for special needs transportation and the decreasing funding to support it, and believes some steps could be taken immediately to coordinate more transportation in Pierce County.**

In Pierce County, our focus is on coordinating transportation and saving money. The PCCTC has spent many years working on ways to remove the barriers to coordinated transportation. Even before ESHB2072 was passed, the PCCTC had conducted several in-depth planning process to:

- Identify local services and transportation needs...
- Consider strategies to address local service needs...
- Collaborate with local service providers and operators ...
- Implement pilot projects to test and demonstrate cost sharing and cost-saving opportunities.

The PCCTC is proud of having a comprehensive County Human Services-Transit Coordinated Transportation Plan. As the result of this plan PCCTC member agencies have sought funding to support both transportation services and services that provide transportation information and travel training. The PCCTC members, including public transit companies, the Medicaid Broker, private transportation providers, human services agencies and non-profit agencies, meet monthly and try to work cooperatively to serve the growing special needs population in the county by developing more coordinated transportation. The PCCTC plans to continue working with partner agencies to implement stronger coordination.

The PCCTC also completed a pilot project this year to “capture the value of Medicaid trips provided by public transit agencies for which they are not currently reimbursed with a funding match by federal Medicaid dollars.” This project demonstrated the definite financial benefit of coordinating transportation, as well as the amount of costs shifted to local transit. The studies about coordinated transportation say that coordination is an effective strategy that can assist in saving money in communities where there is unused vehicle capacity. That is because coordination can help eliminate inefficiencies that result from overlapping and duplicative services. Both Pierce Transit and Paratransit report low productivity – meaning the vehicles on the road are rarely filled to capacity. Both agencies provided lists of top 50 Destinations that showed considerable overlap. Currently, Pierce Transit and Paratransit send partially full vehicles to the same medical facilities. If Medicaid rides were grouped and costs were shared it would have a substantial impact on bringing down costs for all funders. The PCCTC is poised to take the next steps in coordinating transportation, and is asking for the support of the legislature to implement more coordination between Pierce Transit and Paratransit Services, Inc.



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Throughout the past year both the PCCTC, as the advisory committee to ACCT, and the Federal Opportunities Workgroup have reviewed the issues that were perceived to prevent Medicaid and Public Transit from sharing information, sharing rides and sharing costs. The evidence presented in the reports to the legislature should help clear up the lingering misperceptions:

- 1. Information Sharing** - Health Insurance Portability and Accountability Act (HIPAA) specifically applies to “Covered Entities.” A covered entity is a health care provider, a health plan or a health clearinghouse. Transportation is not a healthcare service; a transportation provider is not a covered entity; the information transportation providers share is not medical information. (Appendix VI)
- 2. Cost Sharing** – The Deficit Reduction Act specifically states “There is no restriction on a non-profit broker that is not a governmental entity from negotiating rates with public transportation providers”
- 3. Ride Sharing** – Numerous reports demonstrate that Medicaid trips can be shared with trips supported by other funding sources, including Public Transit. “Coordinated Transportation,” where rides are grouped, and both rides and costs are shared, has been demonstrated to save money both in Washington State and in other places throughout the country.

### Coordination Requires Mutual Benefits

Coordination implies and requires mutual benefits; each agency must find the arrangement acceptable from a business perspective. There is no question that using fixed route public transit buses to provide Medicaid transportation saves money. Washington, one of the first states to develop a brokerage system for Medicaid rides, reported that in 1988, the average NEMT trip cost \$38, and public transportation was rarely used. After the brokerage system was introduced, average trip cost dropped to under \$20.00, with about 40% of the rides utilizing public transportation. While this is an accepted money-saving strategy, this approach is most beneficial to Medicaid and least harmful to transit when used with fixed route transit.

The Medicaid practice of shifting expensive paratransit customers to transit is not “coordination.” Medicaid expenses are shared with the federal government – for NEMT in Pierce County, DSHS is currently paying about 35% of the cost. Yet when Medicaid rides are shifted to Pierce Transit SHUTTLE, the citizens of Pierce County are paying 100% of the cost. It does not make sense for a transit agency to subsidize Medicaid NEMT.

### Coordination is a Local Operational Issue

In the long history of coordination, most of the successes were a result of local level coordination based on needs and sound business decisions. According to federal



reports, coordination of NEMT and public transit is fostered and implemented at the local level, whether inhibited or encouraged by state and federal government. The PCCTC has demonstrated success in grouping more trips and saving money with the Adult Day Health Pilot project. The PCCTC is ready to work on the next step of transportation coordination, by implementing a pilot project with Pierce Transit as a Medicaid transportation provider.

When expensive paratransit trips are shifted from Medicaid transportation providers to public transit, it is not “coordination” – that is simply shifting the costs. In many states, public transit is a provider of Medicaid paratransit trips, and receives appropriate payment for these services. Studies of these coordinated transportation services indicate there are some activities and policies that are clear impediments or barriers to coordination. Where these are in place, coordination is more difficult.

A true coordinated transportation system can be created where all of the available resources, both public and private, can be used in the system. The technology exists today to have all special transportation trips listed on a web-based computer system. Technology exists to have “community-wide coordinated dispatching and vehicle sharing arrangements that allow for all vehicles in use to accommodate all types of passengers at all times” as the projects in Yakima and Seattle demonstrated in 1998. The technology exists to implement the PCCTC “vision” for coordination and to operate a fully coordinated transportation system in Pierce County today. A true coordinated transportation system will reduce costs by grouping more rides and sharing more costs between multiple funding sources, rather than shifting rides and costs from one agency to another.

### **The PCCTC Vision for a Pilot Project**

The PCCTC is proud of its history of addressing the challenges of coordinated transportation and is ready work on the next step. Federal reports indicate that by working through administrative, interpersonal, and institutional obstacles, transportation operators have found it possible to coordinate local transportation. Part of the nature of coordination involves stepping into the territory of another person’s interest and jurisdiction, and this creates obvious challenges. “The major institutional barrier to coordination is the need to work with people from different agencies, having different perspectives. To be successful, coordination requires a willingness to learn new information, and the flexibility and confidence to work cooperatively along paths that are only defined as one proceeds along the journey.”<sup>19</sup>

In spite of ongoing challenges over the past year, a majority of the PCCTC are ready to take the next steps in coordinating transportation in Pierce County. Now that it is clear that information about transportation for Medicaid passengers can be shared, the Mobility Coordinator has worked in cooperation with staff at Pierce Transit to develop a plan for coordinating more transportation between the Medicaid Broker

<sup>19</sup> *TCRP 101 – Toolkit for Rural Community Coordinated Transportation Services*



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and Pierce Transit. This proposal, which includes identifying Medicaid passengers, and allowing Pierce Transit to become a Medicaid provider, can be implemented immediately with minimal costs.

The PCCTC is ready to implement these procedures as part of a pilot project on coordinating public transit and Medicaid transportation at no cost but will require the support of the state Medicaid program. Definite performance indicators would be used to measure the outcomes of the project. We will select some months for which “pre-pilot” data is gathered. Each agency will use their existing computer system and staff to run the pre-pilot reports; and run monthly reports to track the progress in coordinating transportation. These monthly reports will be shared with the PCCTC steering committee, and the impact on each agency will be monitored for 6 months. In order to clarify that all of these things are possible, it would be beneficial for the state Medicaid program to issue an official document approving these measures.

The Federal Opportunities Workgroup is proposing a similar pilot in King County, however the PCCTC strongly believes the diverse nature of Pierce County is more representative of the state as a whole.



## RECOMMENDATIONS

The PCCTC believes some steps could be taken immediately to coordinate transportation in Pierce County. ACCT has funded several successful pilot projects over the years, in Pierce County, in King County, and in Eastern Washington that demonstrates that coordination works, and it saves money. The pilot projects gave us some new ideas about how to coordinate transportation services, and how to stretch our limited financial resources. With the federal emphasis on coordination and the implementation of the federal Deficit Reduction Act (DRA), the perceptions about the barriers to coordinating transportation are changing. The Washington Department of Transportation (WSDOT), the Washington Department of Social and Health Service (DSHS), the Medicaid Broker in Pierce County, Paratransit Services, Inc. (PSI), and Pierce Transit should be encouraged to continue the work started over a dozen years ago on improving transportation coordination.

The PCCTC hopes this report will help clarify some regulations, clear up confusion about some policies, and convince people to renew the effort implement coordinated transportation practices. The PCCTC drafted these recommendations during December 2010 and January 2011 meetings. The purpose of the recommendations is to inform ACCT and the legislature that we need support to continue the important and money saving work of coordination. The PCCTC members agree that we need to maintain the systems we have created and put in place in recent years. We also need support to take the next steps in coordinating transportation in Pierce County. We need to open our thinking to new possibilities in order to maintain our current level of service.

### **1. Coordination Requires Access to Information**

In local and regional planning efforts, the message from the public is clear – people want easy access to information about transportation services. 2-1-1 is the three digit telephone number assigned by the Federal Communications Commission for the purpose of providing quick and easy access to information about health and human services. The Pierce County United Way 21-1 program is an integral partner in the PCCTC serving a vital role for the special needs population as it provides a “gateway” to a multitude of services. Without these avenues for information dissemination, it would be much more difficult for individuals with special needs to discover the services that may be available to them, including low cost transportation alternatives.



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### ***PCCTC Recommendation 1:***

**1**

***Recognize and maintain the information services that are a critical link to network the coordinated transportation system.***

- a. Information services play a vital role for the special needs population providing a gateway to the many transportation services offered in Pierce County.
- b. The PCCTC has identified South Sound 2-1-1 call center as the Transportation Information and Referral service for our coordinated transportation system.
- c. South Sound Call Center is part of the Washington Information Network 2-1-1 (WIN-2-1-1), a statewide network of call centers. Washington's 2-1-1 system has been seriously impacted by recent budget cuts. Without funding for 2-1-1, Pierce County and other regions of Washington are in jeopardy of losing 2-1-1 Special Needs Transportation Hotline services, an essential component of the county coordinated transportation system.
- d. **The PCCTC asks ACCT and the legislature to support funding for 2-1-1 services that are a critical information link in the Pierce County Coordinated Transportation system.**

## **2. Coordination Must Address the Needs of the Elderly**

This region will experience a dramatic increase in the need for special needs transportation in the coming decade as our aging population has to rely on these services to reach critical life line services and to meet the daily needs of living. The number of individuals aged 65 and older will increase each year over the next twenty years as the "baby boomers" age. An aging population eventually faces limits to their mobility as the percentage of senior drivers in a community declines with age. A recent study of driving expectancy reported in an article in *The American Journal of Public Health* indicates that there is a difference in life expectancy and driving expectancy. The implication is that both men and women will live for a period of time (as many as 6 years for men and 11 years for women) when they will be transportation dependent. According to demographic data, the situation is most critical in rural areas where nearly 40% of the population lacks access to public transportation. The high percentage of this population is due in part to the large percentage of older adults, and their growing demand for specialized transportation due to frailty is viewed as one of the major challenges that must be met by transportation providers.<sup>20</sup>

Our aging population will rely more and more on special needs transportation services. Senior conditions of frailty, poverty, and lack of family can affect the

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<sup>20</sup> *Transportation Innovations for Seniors – A Synopsis of Funding in Rural America* The Beverly Foundation and CTAA



transportation options people have. The PCCTC works together to provide a network of transportation services to address a variety of needs. Many older people are not able to use public transit, or live outside of the Pierce Transit service area. Catholic Community Services (CCS) of Western Washington provides rides for low-income seniors through a volunteer driver program. CCS provides the most economical transportation for Pierce County elders who are unable to use public transit.

## ***PCCTC Recommendation 2:***

**2**

***Recognize the value of and maintain Volunteer Services (VS), a program of Catholic Community Services of Western Washington, in order to build capacity for transportation and other services in the most economical way.***

- a. In 1981, when Washington State was in a severe financial crisis, legislation creating the Volunteer Chore Services (VCS) was enacted.
- b. In the current fiscal crisis, when many social services will be reduced or eliminated, the present statewide Volunteer Services infrastructure offers the capacity to recruit, organize and mobilize volunteers to meet a variety of social needs.
- c. Budget cuts at the state level will result in a reduction of services, including transportation, to low-income elders and disabled adults who have no other resources to get to life sustaining services.
- d. VCS saves tax dollars for Washington State - without the assistance of volunteers, many people would require more costly care in assisted living or nursing homes.
- e. **The PCCTC asks ACCT and the legislature to recognize it is important to provide ongoing funding for Volunteer Services, through Catholic Community Services (CCS) of Western Washington in Pierce County, in order to meet a variety of human services needs efficiently and in a cost-effective manner.**



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“It is vital to understand that primary decisions about Medicaid-funded transportation services reside at the state not the federal level.”

*TCRP 101 – Toolkit for Rural Community Coordinated Transportation*

### 3. Coordination Will Require Change

Neither federal regulations nor the existing Medicaid State Plan appear to prohibit ride sharing and cost sharing. The literature holds countless examples of rides and costs being shared, including studies of projects in both King and Yakima Counties in Washington that have done so with success. It may be that the State Medicaid Plan needs to be amended; it may be that DSHS can allow the Broker in Pierce County to make the suggested changes by modifying or clarifying state policies and procedures.

#### ***PCCTC Recommendation 3 A:***

***Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:***

**3A**

***A. To implement procedures that allow the broker in Pierce County to share rides and costs between Medicaid and other agencies, including Pierce Transit, the VA, DVR, and programs such as Beyond the Borders.***

- a. DSHS needs to institute changes that allow brokers and transportation providers to share rides funded by Medicaid with those funded by other sources, including public transit.
- b. By making these changes, DSHS would allow the Broker to implement a more fully coordinated transportation system, sharing rides and costs across multiple funders, including public transit, which will eliminate the duplication of services and reduce costs.
- c. **The PCCTC asks ACCT and the legislature to encourage DSHS to have the Pierce County Medicaid broker fully implement automated ride sharing resources, and a cost sharing formula, and adopt policies that will allow providers to share Medicaid rides and non-Medicaid rides, so more transportation can be coordinated in Pierce County.**



***PCCTC Recommendation 3 B:***

**3B**

***Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:***

***B. To allow Pierce Transit to be recognized as a Medicaid transportation provider, that invoices the broker for trips based on actual costs.***

- a. Years of research, demonstrations, and evaluations have shown that coordinating Medicaid transportation and Public Transit services is a management strategy that can generate reductions in per trip operating costs. Previous reports include successful results from People to People in Yakima and King County Metro that demonstrate cost savings through coordination.<sup>21</sup>
- b. One approach to securing funding for ADA services is to develop cost and ride sharing policies with Medicaid that ensure public transit is able to continue to provide the level of service needed. Cost sharing/ ride sharing arrangements can provide the underpinning of a coordinated transportation delivery system.
- c. The Deficit Reduction Act states “There is no restriction on a non-profit broker that is not a governmental entity from negotiating rates with public transit providers.” That makes it clear that DSHS can allow the broker to contract with Pierce Transit as one of the transportation providers in the Medicaid provider pool.
- d. **The PCCTC would like ACCT and the legislature to encourage DSHS to adopt policies that allow the broker to accept Pierce Transit as a Medicaid transportation provider that, like other transportation providers, invoices the broker for trips based on actual costs. The PCCTC would like to implement a pilot project to test this coordination in 2011.**

**4. Coordination Requires That Resources Are Used Fairly**

DSHS provides Adult Day Health (ADH) services through a Medicaid “Home and Community-Based Services (HCBS) Waiver” that allows the state to help people live in a community setting rather than a nursing home care. Since many of the people who attend ADH services required paratransit rides, the transportation to ADH programs was one of the most expensive services for both Medicaid NEMT and Pierce Transit for many years. In 2009, DSHS and the state legislature removed transportation as a Medicaid funded service under the HCBS waiver. Patients are still eligible for ADH service under the waiver, but they are no longer eligible for Medicaid transportation to get to the service. Instead, ADH programs now receive a per patient/per day subsidy for transportation through DSHS/Aging and Disability Service Administration (ADSA). In Pierce County, the ADH programs either request

<sup>21</sup> *Designing and Implementing Cost Effective Medicaid Non-Emergency Transportation Programs*



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special considerations, or do not give the funds to transit in support of the ADA rides the Medicaid patients receive to the ADH programs. The ADH programs should be required to use the transportation subsidy to pay for transportation services.

### ***PCCTC Recommendation 4:***

4

***Require human services agencies that receive funding for transportation to use the designated allotment to reimburse any third party that provides the transportation.***

In 2009, DSHS reported 72,000 paratransit rides annually for Medicaid patients receiving Adult Day Health services. ADH patients became ineligible for Medicaid Non Emergency Medical Transportation. ADH patients were referred to Public Transit;

- a. The policy change shifted the cost for transporting Medicaid patients to a Medicaid-funded service to Public Transit.
- b. DSHS/ADSA authorized an extra fee (per person, per day) for ADH programs, which providers were instructed to use “to arrange or provide transportation.” Some ADH programs “arrange” rides for patients on Public Transit, and keep the extra funds; some programs demand special consideration (i.e. transporting clients from out-of-county).
- c. **The PCCTC would like ACCT and the legislature to encourage DSHS to amend WAC 388-71-0726 and issue a new HCS Management Bulletin to notify Adult Day Health programs that the additional allotment they receive for transportation must be used to reimburse any third party that provides the transportation to the ADH program.**



How do we use government funds to assure that people can get around to all of the places they need to go? Since the early 1970's, transportation providers, advocates and others have pointed out the problems of fragmented service delivery. The greatest issue is resource scarcity. Communities simply do not receive enough funds to perform an adequate job of providing transportation, and many of the "barriers to coordination" are the result of trying to meet the needs of a growing population with an insufficient amount of funding. It is possible that the resource constraints can be eased through increased funding for public and community transportation and allowing better management of the billions of dollars spent on Medicaid/Medicare transportation.

*Senior Transportation – Toolkit and Best Practices (2003)*

## 5. Coordination Requires Adequate Funding

Many of the challenges related to special needs transportation are also related to a growing need for access to healthcare and essential services. This region will experience a dramatic increase in the need for special needs transportation in the coming decade as our aging population has to rely on these services to reach critical life line services and to meet the daily needs of living. The continued implementation of Home and Community Based waivers to Medicaid, that support more people living in the community rather than in institutions, as well as the ongoing change to an outpatient medical treatment model, which often requiring numerous follow-up visits, will result in increasing the need for more specialized transportation. The Department of Social and Health Services (DSHS) and the state legislature have adopted policies that encourage people to live in the community rather than in institutions. These policies have produced cost savings because it is less expensive to support individuals in community settings than in nursing homes or state run hospitals and facilities. However, if people are going to live in the community, they need transportation to a wide variety of appointments and services. As DSHS continues to move institutionalized people to the community through the federally funded "Money Follows the Person" the cost of special needs transportation services needs to be recognized. When new public programs are put into place that serve the elderly, children, low-income or people with disabilities, funding for transportation should be included. The state legislature could encourage DSHS to provide adequate planning and funding for special needs transportation for individuals who will be maintained in community settings rather than in institutional placements. This might include language in Medicaid waivers that would allow transportation as a billable expense and encouragement to have case managers include transportation in individual case plans.

The expected growth in the aging and disabled populations, and the subsequent increased demand for transportation that will accompany this growth, emphasizes



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the need to reform the current system and create a structured and comprehensive strategy for coordinating transportation. While the need for paratransit services has increased, federal and state resources to provide the services have not. Public transits will find it increasingly difficult to provide services to a broader range of individuals, many of whom were previously transported by human services agencies that have faced drastic cuts to their funding. Currently there is insufficient funding both for public transit and for human services agencies to provide adequate special transportation.

### ***PCCTC Recommendation 5:***

**5**

***Support adequate funding for special needs transportation, using similar approaches to the way the nickel tax supported highway funding, when new legislation is developed.***

- a. Transportation costs have been increasing for decades, and the funding available can't meet the demand for services. The Nickel Tax paid for many highway projects, and similar funding is needed for special needs transportation.
- b. The Puget Sound Regional Council (PSRC) reports that there are over 3.5 million people in the Puget Sound area and up to one third of them require special needs transportation. A stable funding source to address the growing need for special transportation must be a priority.
- c. In this depressed economy, public transit's dependence on sales tax may result in a cutback in fixed route bus services as well as ADA paratransit services, which are only provided within  $\frac{3}{4}$  of a mile of fixed route, causing more people to rely on human services transportation.
- d. Public Transits cannot afford to provide services in outlying geographic areas, due to low ridership and high costs, yet the lack of low cost fixed route bus service puts a tremendous strain on community-based transportation providers that must stretch limited resource to try to meet the need.
- e. As the state is forced to cut budgets for human services programs, the ongoing funding for transportation to needed services is also at risk.
- f. **In the PSRC "Transportation 2040" plan for the region, the PSRC made a commitment to fund special needs transportation "proportionate to the growth of the special needs population." The PCCTC asks ACCT and the legislature to make a similar commitment to funding special needs transportation.**

# Appendix A

## Position Statement from Paratransit Services





## **2010 PCCTC REPORT TO THE LEGISLATURE: POSITION STATEMENT FROM PARATRANSIT SERVICES**

Paratransit Services is a founding member of the Pierce County Coordinated Transportation Coalition (PCCTC) which evolved into the Local Coordinating Coalition (LCC) formed under HB 2072. Paratransit Services is a non-profit company, and the Non-Emergency Medical Transportation (NEMT) Broker for nine counties in Washington State, including Pierce County.

For 31 years throughout Washington and the Western United States Paratransit Services has been actively involved in efforts to coordinate transportation resources and services with a variety of agencies, partners, and coordinated transportation coalitions. We have demonstrated our commitment to furthering the objectives of the State of Washington to find ways to maximize our state's transportation resources through the coordination of services.

We take issue with some of the language and recommendations in the PCCTC 2010 *Report to the Legislature*. We wish to clarify our position on the following:

- Item 1 Recommendation 3A
- Item 2 Recommendation 3B
- Item 3 The NEMT Brokerages and Paratransit Services regional coordination activities

Paratransit Services *agrees* with the basic principles stated in the *Report*. However, we feel that the general tone of the *Report* does not fairly portray the important work done by the state's regional NEMT brokers, particularly their role with respect to regional transportation coordination. This leads to recommendations that are already in place and that request legislative changes that are already permissible under current law.

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### *Item 1: PCCTC Recommendation 3 A*

*Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:*

*(A) To implement procedures that allow the broker in Pierce County to share rides and costs between Medicaid and other agencies, including Pierce Transit, the VA, DVR, and programs such as Beyond the Borders.*

*The PCCTC asks ACCT and the legislature to encourage DSHS to have the Medicaid Broker fully implement an automated cost sharing formula and adopt policies that will allow providers to share Medicaid rides and non-Medicaid rides, so more transportation can be coordinated in Pierce County.*

**Paratransit Services' Position:** Paratransit Services does support these principles, but does not support the recommendation because it is unnecessary. PCCTC suggests as new policy, procedures that are already occurring and in place.

The Washington State NEMT Brokers, including the Pierce County NEMT Broker, already share rides across multiple funders when allowed by funder guidelines and when appropriate based on the needs and capabilities of the riders. It is foundational to the Broker model!

As the NEMT Broker for Pierce County, Paratransit Services has a demonstrated history of



successful coordination of a variety of transportation programs in Washington State, which are reviewed in this document. Paratransit Services has employed both a manual cost allocation formula when scheduling rides across multiple funders, as well as developed an automated cost allocation tool. Paratransit Services has selected the seat-share mile cost allocation method as it insures that no agency cross-subsidizes another, insures compliance with Centers for Medicaid and Medicare rules regarding cost allocation and will meet state and federal audit requirements.

Regardless of the method employed, Paratransit Services has continued to look for opportunities to increase the coordination of NEMT trips and when possible, other funded transportation. Utilization of a manual cost allocation tool has not impeded our ability to share trips across funders.

### **A note about sharing rides**

The brokerage system is foundationally a shared ride system. There are situations where clients have a single ride, but in general they are shared whenever possible. Paratransit Services has Medicaid and non-Medicaid contracts in Pierce County. Some of the non-Medicaid contracts serve vulnerable adults and school children and there are typically restrictions or limitations regarding shared rides, which may limit ride sharing opportunities between funders. Ride sharing opportunities in rural communities may be limited due to reduced trip number, time of day and direction of trip. Despite these challenges, every effort is made to share rides when possible.

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### *Item 2: PCCTC Recommendation 3 B*

*Encourage DSHS to make changes to the State Medicaid Plan if needed, or adopt changes in policy:*

*(B) To allow Pierce Transit to be recognized as a Medicaid transportation provider, that invoices the broker for trips based on actual costs.*

*The PCCTC would like ACCT and the legislature to encourage DSHS to adopt policies that allow the broker to accept Pierce Transit as a Medicaid transportation provider that, like other transportation providers, invoices the broker for trips based on actual costs.*

*The PCCTC would like to implement a pilot project to test this coordination in 2011.*

**Paratransit Services Position:** Current law does not prohibit an NEMT Broker from contracting with a transit agency to provide NEMT trips. Historically, Paratransit Services has contracted with two transit agencies in the past to provide NEMT transportation services and has requested that Pierce Transit become a contracted transportation provider for NEMT services as far back as 2004 and most recently in 2010.

In regards to transit “*invoicing the broker for trips based on actual costs*” this would first require review, fiscal analysis, and approval by DSHS Executive Leadership, Washington State office of Financial Management and approval by Centers for Medicaid and Medicare Services.

In regards to implementing “a pilot project to test this coordination in 2011,” this same project is proposed in King County through the Federal Opportunities Workgroup (FOW), created through

the 2009 HB 2072 and the Pierce County proposed project is a duplication. It is Paratransit Services position that we should (1) await the outcome of the Centers for Medicaid and Medicare review and approval of the FOW project and (2) the outcome of the King County pilot.

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### *Item 3. The Current NEMT system in Washington State*

The State of Washington currently provides special needs Medicaid transportation throughout the state by using a system consisting of 6 regional transportation brokers. These brokers manage call centers for processing transportation requests, determine the most appropriate, cost effective mode of assistance for eligible clients, and maintain rosters of qualified subcontracted ride providers. The cost savings to the State of Washington resulting from this approach are well documented and clients receive quality service from a well-monitored network of ride providers.

The regional Non-Emergent Medical Transportation (NEMT) Brokers have a track record of problem-solving and saving costs to the State while at the same time improving access, quality and cost of services to clients and communities, for the past 23 years. They have made *significant* progress in coordinating transportation at the community level.

Paratransit Services and other Brokers have been instrumental in the development of regional transportation resources. The Brokers provide assistance to potential ride providers as these providers work to obtain the necessary licenses and certifications. The Broker also offers training programs to instruct drivers in the special skills required for the safe transport of special needs passengers. In addition, Paratransit Services has instituted several programs that have broadened the *modes* of transportation assistance available to Medicaid clients. These include programs for the administration of bus passes, fuel vouchers, and volunteer drivers.

#### **Paratransit Services: A History of Pierce County Coordination**

With the infrastructure in place for the NEMT brokerage and with the support of DSHS, Paratransit Services and the NEMT Brokers have demonstrated that *other transportation programs* can be incorporated successfully into the system, thereby enhancing regional coordination and ride sharing of transportation resources. Variations of transportation coordination projects exist across Washington State as each NEMT Broker responds to their unique community needs in their coordination efforts.

Examples of programs Paratransit Services has incorporated into the Medicaid transportation system include:

*Work First Program* – Paratransit Services teamed up with DSHS working with Pierce County and a portion of the Olympic Peninsula to help provide transportation to clients in the Welfare to Work Program in Pierce and Kitsap Counties, since 2000. Paratransit Services administers this program by accepting and maintaining eligible client information, mailing bus passes, scheduling rides, and performing reporting functions.

*“Beyond the Borders.”* Pierce County subcontracts with Paratransit Services to coordinate shared ride transportation for special needs residents of the rural areas of South Pierce County, outside the area served by Pierce Transit. Paratransit Services looks for opportunities to share rides appropriately between Beyond the Borders riders as well as other funders. This program has been running since April 2004 and is currently providing approximately 750

trips per month. This project is supported by Job Access Reverse Commute (JARC) funds and WSDOT Special Needs Formula Grant dollars.

*Transportation for "McKinney" Schoolchildren* – In September 2004, Paratransit Services began a joint demonstration project with the Tacoma School District (TSD) in Pierce County to provide transportation to school for children who are homeless. Paratransit Services expanded the pilot to include various school districts in both Pierce and Snohomish counties and continues to serve as transportation broker for participating districts, arranging rides with its extensive roster of NEMT subcontracted ride providers.

*Aging and Long Term Care programs* – In 1991, Paratransit Services contracted with Pierce County Human Services through their Aging and Long Term Care office to provide transportation for low-income elderly persons to meal sites, and to Adult Day Health (ADH) and Respite programs. In July 1994, some services were incorporated into the Pierce Transit Shuttle program. Paratransit Services continued to provide transportation for ADH medical trips until the program became ineligible for NEMT transportation in 2010.

In 1996 we were awarded a contract to provide door-to-door transportation services three days per week to the Red Cross meals program at the Eatonville Center. (*Currently this is managed by Catholic Community Services*). Today, we continue to provide this service, and also support the COPES and Family Caregiver Support transportation programs. We broker trips for these programs for the Pierce County Department of Human Services to the lowest cost, most appropriate provider, and coordinate the trips with other funding sources to reduce the cost to all funding agencies.

*Transportation Links for Pierce County* – Beginning in January 2000, Paratransit Services worked with DSHS and Pierce County Community Services to develop a program that would provide *demand response transportation* for Pierce County residents who live beyond the ¾ mile service limits of the Public Transportation Benefit Area (PTBA) in the areas of Eatonville, Roy, Sumner, Lake Tapps, and Bonney Lake. This service was available to residents who met HUD Section 8 low-income criteria, and to seniors, persons with disabilities, domestic violence victims, migrant farm workers, and homeless persons. It provided transportation to jobs, medical appointments, nutrition and exercise programs, DSHS and WIC offices, Employment Security offices, and other work related or social service related activities.

Paratransit Services' staff collaborated with numerous governmental and social service agencies to design this program, to be funded by a Community Development Block Grant. There was high demand for services and the demonstration was considered successful.

*After-school Transportation Program* – A special contract between Paratransit Services and Pierce County (Washington) Boys and Girls Club was implemented for the 2002-03 school year to provide *after-school transportation* for Elementary School children of predominantly low-income families in the Bethel School District.

Through a contact person at the school, Paratransit would confirm how many of the students would need rides for the after-school program, and arrange for a vehicle to be at the school at 6:00 P.M. each day. Paratransit Services ensured that drivers who were to operate the vehicles for this program were fingerprinted and checked for criminal history.

*Copes Transportation Services* – Beginning in 1996, Paratransit Services implemented separate contracts with Lewis-Mason-Thurston Area Agency on Aging, Olympic Area Agency on Aging, and Pierce County Aging and Long-Term Care/COPEs Transportation Brokerage to broker and/or provide transportation services for Community Options Program Entry System (COPEs) recipients. We continue to provide transportation brokerage service for the Pierce County office.

*Jobs Access Program* – In 2000, Paratransit Services began a collaborative effort with Puget Sound Educational Service District (PSESD) to provide *transportation services* in Pierce County for low income and disabled passengers. Together with PSESD, DSHS, the Private Industry Council, and Pierce Transit, we developed a program for transporting low-income residents of Pierce County and the Key Peninsula who live outside of Pierce Transit’s service area to job training programs and to worksites. Paratransit Services administered the program by maintaining eligible client information, scheduling rides, routing and dispatching, and performing reporting functions. We coordinated this transportation service with PSESD, Pierce Transit, and other local transportation providers. PSESD has obtained grant funding in support of this program, and Paratransit Services is no longer needed for administrative support.

*Working with Native American Tribes* – Paratransit Services is proud of our success at coordinating our transportation services with our local Native American Tribes. We were the first NEMT Broker in Washington to successfully establish working agreements with Native American Tribes for participation in the NEMT program. Paratransit Services *currently* contracts with the Lower Elwha Tribe, the Jamestown S’Klallam Tribe, the Port Gamble S’Klallam Tribe, the Shoalwater Bay Tribe, Stillaquamish Tribe and the Makah Tribe. We continue to dialogue with each Tribal Nation in our service Regions to see if we can assist in their Medicaid transportation needs.

In addition to the coordination projects listed above, Paratransit Services continues to develop opportunities to coordinate transportation services across multiple funders, decrease trip costs and eliminate duplication when possible. Additional projects include:

### **Veterans Transportation**

Paratransit Services has been working with the Washington State Department of Veterans Affairs to explore ways the Broker could help improve Veterans Transportation. These efforts have included planning meetings with the John Lee, the Director of Veteran Affairs and Lourdes “Alfie” Alvarado-Ramos, Deputy Director of Veterans Affairs as well as state and regional staff from the Disabled American Veterans program (Seattle, Olympic Peninsula, Pierce County), Puget Sound Health Care Systems (King, Snohomish and Pierce Counties), Veterans Medical Center staff (King, Snohomish and Pierce counties), VA Puget Sound Health Plan Management and Social Work and Voluntary Services from the VA PSHC system.

*VA Medical Center Pilot Project* – For the past six months, Paratransit Services has been working directly with the VA Puget Sound Medical Center to develop a pilot project where the VA Health Care system would utilize the NEMT Broker system to increase transportation options for Veterans and coordinate shared ride transportation for veterans in 12 counties in Washington state (including Pierce County). The grant funds are in response to a Congressional Mandate to improve veteran’s transportation services. A variety of pilots were funded in the

United States, but the Washington State pilot is unique in that it is the only VA Medical Center that has elected to utilize the NEMT Broker model in its pilot project.

*Federal Opportunities Work Group* –Enacted during the 2009 Washington State Legislative session, Engrossed Substitute House Bill 2072 [ESHB 2072] directed the creation of a Federal Opportunity Workgroup to focus on a number of tasks related to the coordination of transportation: removing federal and state barriers to sharing costs between transportation funders, safely sharing client information, streamlining performance and cost reporting systems, and establishing consistent terms and definitions. The Agency Council on Coordinated Transportation (ACCT) established the Federal Opportunities Workgroup (FOW) in June 2010 to conduct this work. Paratransit Services asked to be allowed to participate in this workgroup and has been an active participant in the FOW since its formation.

Paratransit Services proposed a Pilot Project titled: *Olympic Peninsula – Simple Cost Share for Medicaid and Veteran Trip*. The purpose of the pilot is to increase transportation options for veterans. We originally approached veteran transportation partners at American Lake Health Center, located in Pierce County, to explore the ideas for the pilot. The general consensus was there was stronger interest in a pilot for the Olympic Peninsula. The key objective is to develop a simple and agreeable cost allocation method that would allow for non-DSHS riders (Veterans) to share an NEMT trip, at an established flat zone rate.

*Washington DC ‘Listening’ session* – Oregon State had convened a task force to study the issue of Veterans Transportation. The Oregon Task Force coordinated a ‘listening session’ (to take place in Oregon) with federal agency representatives to review their findings. The ACCT Council arranged to have the federal representatives attend a WA State ‘listening session’ to learn of Washington States efforts toward improving Veterans Transportation.

The federal attendees included: the Director of VA Transportation, the Deputy Associate Administrator for FTA Program Management, Director of United We Ride, the Regional Administrator for Region 10 FTA, a Senior Policy Advisor, Office of Disability Employment Policy, Department Of Labor and Department of Defense.

Paratransit Services presented their pilot project to the federal attendees. The pilot generated a great deal of interest and discussion. Doug Birnie from United We Ride asked to be kept informed the progress and viewed the project as a potential national best practice.

## **Shuttle Projects**

*Community Shuttle Program* – Paratransit Services has been developing a pilot to create community shuttles built on the foundation of NEMT repeater trips in rural communities with few or no transportation options. Paratransit Services has reviewed the pilot concept with State NEMT Program Managers, Pierce County staff, DOT staff and the Thurston Regional Planning Council. We are proposing to launch the pilot in Pierce, Lewis and Thurston counties.

Paratransit Services has successfully launched a ‘shuttle’ model in the past and will build upon these lessons learned when further developing the model. In Snohomish County, Paratransit Services and the Stillaguamish tribe partnered to provide transit link to an Alternate Opiate Treatment facility built on Stillaguamish lands that was not served by the local Transit authority. Paratransit Services encouraged the Stillaguamish Tribe to apply for Safetee-Lu funds through the DOT to obtain a community shuttle van and then obtain certification as a NEMT ride provider for Paratransit Services. We reimbursed them to operate a shuttle during treatment

hours from the closest transit stop to the treatment facility. This provided a critical link for their tribal members as well as other DSHS riders, and allowed Paratransit Services to utilize appropriately the lower cost transit mode for our DSHS clients and reduce costs to the program. It was a great success!

*I-5 Medical Shuttle* – Both Paratransit Services and Hopelink, the Broker for King and Snohomish counties are working collaboratively to develop an I-5 Corridor Medical Shuttle. The key objectives are to coordinate transportation services traveling north and south on the I-5 corridor to medical center destinations in Pierce, King and Snohomish counties and reduce transportation costs for the NEMT Transportation system while preserving the quality of the service. The initial project proposes to establish the I-5 Shuttle in Lewis, Pierce, King and Snohomish counties and eventually extend it to the north and south borders of Washington State.

Once the Shuttles are in place, seats can be purchased by the general public on an availability basis, increasing transportation options for rural communities and reducing costs to the NEMT Program.

### **Coordination with Transit**

*Common Ground* – For over ten years, the PCCTC worked on “Common Ground,” a series of projects that considered how to coordinate transportation for individuals eligible for both Public Transit ADA paratransit and Medicaid NEMT paratransit. Paratransit Services committed significant staff time and technical resources to analyze shared ride data, develop the cost-allocation model and the planning and development phases of the series of projects related to Common Ground.

*Transit and NEMT Transportation Provider* – In an effort to facilitate an environment for enhanced shared ride opportunities between NEMT Broker and transit, Paratransit Services established contracts with two transit agencies, for the transit to provide NEMT transportation services. Paratransit Services offered to contract with Pierce Transit in 2004, but Pierce Transit declined. Paratransit Services requested Pierce Transit staff consider this option as recently as 2010, but Pierce Transit indicated they were not ready to pursue this option.

*Adult Day Health (ADH) Project* – Paratransit Services participated in the ADH project by providing technical assistance and working extensively on the scope of work, standards and contract utilized in the project. Although Paratransit Services was not utilized as a ‘Broker’ in the project, the transportation provider selected for the project was an authorized NEMT transportation provider from the provider network established and monitored by Paratransit Services. The decision was made to utilize an NEMT provider, as they would meet all DSHS established standards for drivers, vehicles, safety, quality, insurance and regulatory requirements.

### **“Regional Mobility Management”**

As you can see, Paratransit Services has become, in effect, a “Regional Mobility Managers.” We possess several key ingredients that have allowed us to serve as focal points for additional transportation programs:

- A broad network of subcontracted transportation providers—Paratransit Services subcontracts with more than 42 subcontracted transportation companies which operate more than 457 vehicles in 9 counties. In Pierce County, we contract with 14 transportation subcontracted transportation providers which operate more than 218 vehicles

- A high-capacity telecommunication systems.
- Sophisticated scheduling software to schedule, coordinate, dispatch and monitor ride requests.
- Call center staff who undergo extensive training in the skills required for call intake, eligibility and trip request screening, ride scheduling and billing.
- Ensures system safety and regulatory compliance regarding standards for Operators, Training, Vehicle, Service, and Reporting Standards as well as Insurance requirements,

## **Relationships with PCCTC members**

The Pierce County report states that *“more trips could be coordinated and money saved by strengthening the partnership between the Medicaid Broker and other PCCTC members”*. Paratransit Services has in fact established these partnerships and is coordinating a variety of services with nine PCCTC member agencies to either utilize Paratransit Services as a Broker or to provide transportation services for Paratransit Services. The members include Pierce County, DSHS, Catholic Community Services, Veterans, Area Agency on Aging, and four transportation subcontractors: Local Motion, Transpro, Around the Sound and Coastal Transport. Additionally, we previously contracted with Puget Sound Educational Services and have been involved in coordination projects with Pierce Transit for over 10 years.

## **Technology**

Paratransit Services has a long tradition of utilizing the best available technology to support our transportation programs. Paratransit Services has a variety of tools that support a productive NEMT brokerage operation and increase the cost efficiency of the subcontractors, resulting in reduced trip costs.

- An online trip scheduling tool for transportation, fuel and mileage. Riders and facilities can request, cancel and confirm transportation requests, thereby improving customer service, reducing the call volume and cost of the program.
- An online trip broker model that allows providers to download their trip data and perform billing online.
- A completely online process for Interpreter services.
- An online scheduling tool for facilities to request multiple trips.
- An IVR system that calls all riders the day before their scheduled trip to remind them of their trip. This has reduced no-shows and costs to subcontractors and DSHS.
- A Broker Dashboard that identifies shared ride opportunities
- Tools created to support accurate provider billing and reduce provider staff time.
- A cost allocation tool that tracks trip costs, by funder, utilizing a seat-share-mile calculation.

## **Conclusion**

The Members of the Joint Transportation Committee require accurate information in order to make good decisions. Paratransit Services felt it imperative to provide clarification on these important elements of the PCCTC Report to the Legislature.

Washington State does not have the time or the resources to design programs or enact legislation that is in response to redundant recommendations or misinformation.

Although there are other sections within this report that require additional clarification, we have addressed what we believe to be the most critical elements.

In closing, the Washington State Medicaid transportation Brokers, have been in the forefront of regional coordination efforts for 23 years. They have the expertise and the systems in place, to continue to take the lead in meeting the coordination goals of the DSHS and the JTC.

Paratransit Services is a founding member and a very active participant in Pierce County Coordinated Transportation Coalition (PCCTC). We are also one of the state's regional Non-Emergency Medical Transportation (NEMT) Brokers and believe our activities are representative of the WA State Broker model. We will continue to focus our attention on local, regional and statewide special needs transportation coordination.

### **Contact:**

Paratransit Services  
(360) 377-7176  
4810 Auto Center Way, Suite Z  
Bremerton, WA 98312

# Appendix B

## Supporting Information





# APPENDIX

## Appendix I



# Pierce County Coordinated Transportation Coalition

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## Members of the Pierce County Coordinated Transportation Coalition

June 2009

A) Members of the local coalition

Pierce County Community Services - Marge Tully member; Sherry Martin, alternate  
Puget Sound Educational Service District - Jacque Mann  
Washington DSHS - Medicaid Transportation - Paul Meury

B) One or more representatives of the public transit agencies serving the region

Pierce Transit - Tim Renfro, member; Jeanne Archer, alternate  
Sound Transit - Ella Campbell, member; Michael Miller, alternate

C) One or more representatives of private service providers

Around the Sound - Steve Hutchins  
Local Motion - Lyle Bates  
Transpro - Rick Maesner

D) A representative of Civic or Community-Based Service Providers

The Mustard Seed Project - Edie Morgan  
Tacoma Goodwill - Pam Rang  
United Way of Pierce County – Penni Belcher, member; Renee Ghan, alternate  
Washington DSHS - Developmental Disabilities - Rose Barnard

E) A consumer of Special Needs Transportation

F) A representative of nonemergency medical transportation/Medicaid broker

Paratransit - Ann Kennedy, member; Christie Scheffer or Teresa Williams, alternate

G) A representative of Social and Human Services Programs

Catholic Community Services - Penny Grellier, member; Jodie Moody, alternate  
Pierce County Aging and Long Term Care - John Mikel  
Washington DSHS, Region V - WorkFirst - Mike Wilkins

H) A representative of local high school districts

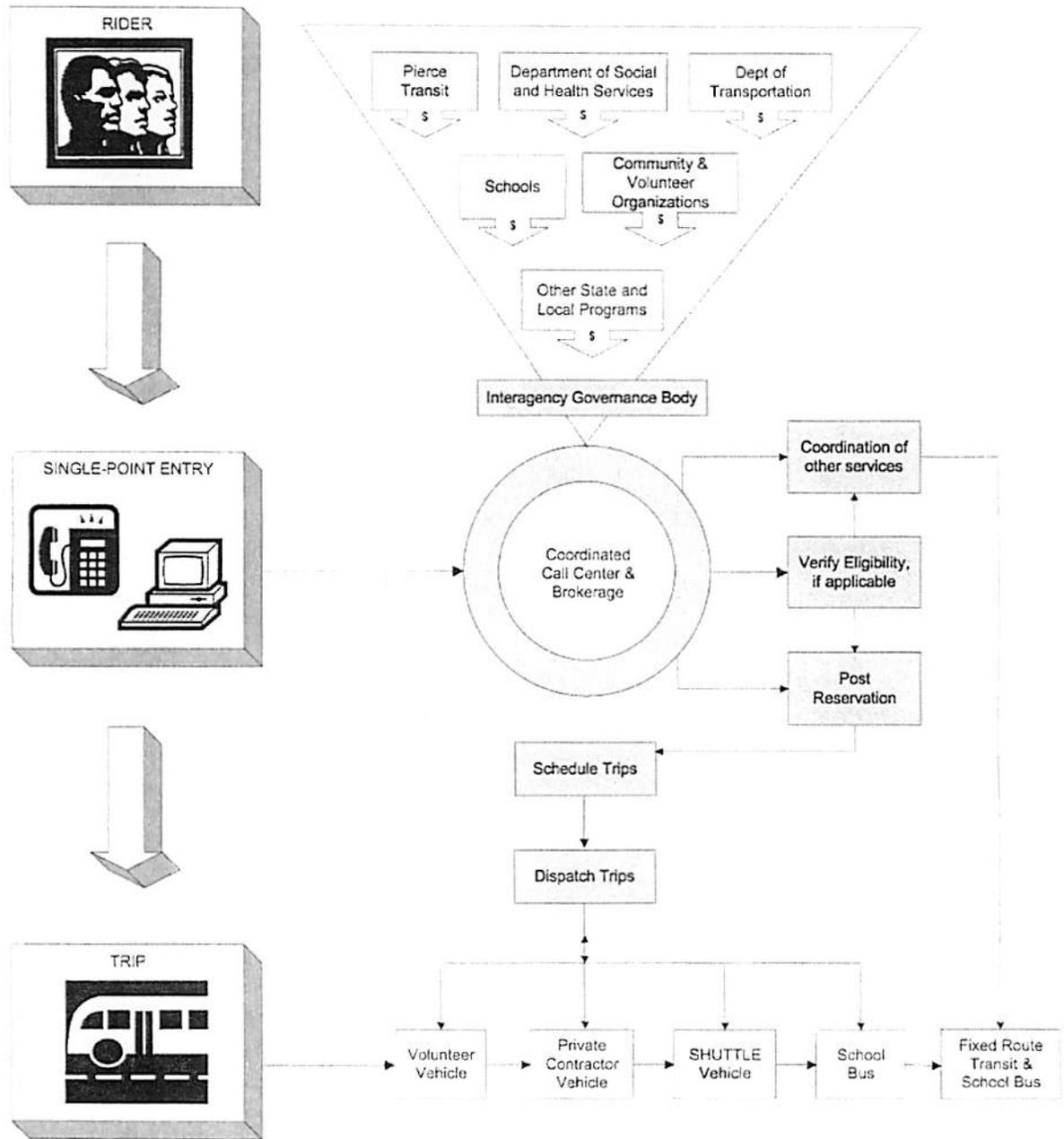
Bethel School District - Jay Brower

I) A representative from the Washington State Department of Veterans Affairs

Figure 1.1: Pierce County Coordinated Special Needs Transportation Model

# Coordinated Transportation System

Coordinated Process Model



**Christie Scheffer - RE: Common Ground: Phase I Proposal, Draft**


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**From:** "Miller, Michael" <michael.miller@soundtransit.org>  
**To:** "Meury, Paul (DSHS/HRSA)" <MEURYPA@dshs.wa.gov>, "Margaret Tully" <MTULLY@co.pierce.wa.us>, "Ann Kennedy" <atk@paratransit.net>, "Lennie Laramore" <llaramore@piercetransit.org>, <TRenfro@PierceTransit.org>, "Sherry Martin" <SMARTII@co.pierce.wa.us>, <rhendrickson@piercetransit.org>, "Teresa Williams" <tjw@paratransit.net>, "Tom Young" <tomy@transpro.org>  
**Date:** 5/27/2008 8:57 AM  
**Subject:** RE: Common Ground: Phase I Proposal, Draft  
**CC:** "Porter, Doug (DSHS/HRSA)" <PORTEJD@dshs.wa.gov>, "Faith Trimble" <faitht@fltconsulting.com>, "Gray, Tom (DSHS/HRSA)" <GRAYTR@dshs.wa.gov>

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As you know, the Sound Transit contribution was contingent on the other partners funding the remainder of the project. Since DSHS is now not participating and providing funding, Sound Transit will not be contributing either unless the remaining partners are able to provide the balance of the project funds.

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"The only disability in life is a bad attitude"

Scott Hamilton

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**From:** Meury, Paul (DSHS/HRSA) [mailto:MEURYPA@dshs.wa.gov]  
**Sent:** Friday, May 23, 2008 4:25 PM  
**To:** Margaret Tully; Ann Kennedy; Lennie Laramore; TRenfro@PierceTransit.org; Sherry Martin; Miller, Michael; rhendrickson@piercetransit.org; Teresa Williams; Tom Young  
**Cc:** Porter, Doug (DSHS/HRSA); Faith Trimble; Gray, Tom (DSHS/HRSA)  
**Subject:** RE: Common Ground: Phase I Proposal, Draft  
**Importance:** High

**Common Ground Collaborators;**

After meeting with Doug Porter, it has been decided that HRSA is not able to sign the Common Ground (CG) proposal due to a number of factors, starting with current and pending fiscal realities. In these difficult times, we and our partners are dealing with positions which cannot be filled, potential fiscal deficit forecasts, and budgeting deadlines not aligned within the current CG timelines.

We believe it is fiscally prudent to suspend the project pending the outcome of some anticipated decisions. The first involves information that was included in a Federal Register – we are still awaiting the Federal response to their request for comments on “usual and customary” and “payer of last resort.”

The development of an automated cost algorithm by Paratransit Services is the second item of interest. Previously, public money funded a similar effort, with no positive outcomes. We are recommending that it makes more sense to see if Para is successful in developing this product

prior to investing more time and effort on this project. Upon being notified that an automated seat share per mile cost algorithm is available, then it would be appropriate for CG to meet to re-evaluate the feasibility on whether to proceed in this endeavor.

Thank you for all for the hard work on Common Ground.

Paul

Paul A. Meury

Medical Transportation Program Manager

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## **COMMUNITY USE VAN**

The Mustard Seed Project, with assistance and partnership with the LCC members and the Pierce County Mobility Manager, used ARRA stimulus funds to develop and successfully implement a pilot project to provide a Community Use Van, which is rented through Pierce Transit for a monthly fee plus mileage used, for area residents to travel to and from frequent destinations on and off the Key Peninsula.

The Community Use Van has been successful in many ways as a new program and to offer a new mode of transportation to an underserved area, but has also proved very beneficial in other ways. Many of the riders on this project are ineligible for other available transportation assistance because they do not meet the more focused requirements for programs based on age, income level, physical ability and even location. Many of these clients were very close but just outside the minimum requirements and found themselves without any viable transportation without relying on friends and family, if they had any close by that were available.

The kinds of trips the Van riders typically request are to programs that occur multiple times each week, such as the local senior lunches and senior fitness programs. In addition to getting riders to these wonderful programs, we are also able to “pair” other riders who are going to locations on or close to the main destinations. Most often, we get clients who need to get into the Post Office, bank, pharmacy or grocery store, and if their time is flexible, we can schedule them to ride in the van in one of trips that travels twice a week to the fitness program or the senior meal site.

In addition to gas and environmental savings, this kind of trip/ride sharing is invaluable in the amount of time and availability it opens up for the drivers participating in our other local volunteer ride program. While we may have been scheduling three different rides twice a week to the meal site, we can now send all three clients in the Van and we open up 12 trips a week that can be provided to other clients.

Since hiring an on-site, Transportation Program Coordinator, the availability of transportation services and the number of trips, volunteers and clients has increased dramatically.

- In the first six months of operation the Community Use Van program has qualified four of the maximum six drivers through Pierce Transit’s Defensive Driver Training program
  - Provided a total of 429 trips to local destinations, averaging 71 trips per month
  - Has a regular and occasional ridership of 52, or 8 riders per month
  - Partnered with local agencies and organizations to provide van service for area residents to and from local events and activities
-

**KEY PENINSULA RURAL TRANSPORTATION PILOT PROJECT (this is more of a recap of what the community meetings were aiming to/did do)**

The Mustard Seed Project hosted a number of community meetings, with our Pierce County Community Services Mobility Manager facilitating, throughout the last year with members of the public and also members from the LCC to engage in discussion and gather input on what kinds of transportation is needed, what is available and what could be changed.

After several sessions of brainstorming and discussion, the group broke down into a smaller ‘task force’ that began to work through the ideas culled from the community meetings and worked on strategies, planning and evaluation of the viability of different solutions to the identified needs.

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**KEY PENINSULA SCHOOL BUS CONNECTIONS with the COMMUNITY (SBCC) PROJECT**

On October 1<sup>st</sup>, a grant was submitted to the PSRC (and will be submitted to WSDOT in December) to request funding to create a partnership between the Mustard Seed Project, PSESD and Peninsula School District.

The one piece that became very clear was the need to include this program – by the exact name we listed on our grant application – in other local plans and documents, so if this is included, it should be referred to specifically as the Key Peninsula School Bus Connections with the Community (SBCC) Project.

I’m including the actual draft of the grant (at least the section pertaining to our program) in case you want to pull language directly from there, but I’ve included some details from the plan are below on the basic concept

- There are district school buses that sit unused during much of the day, after the morning and prior to afternoon school bus route trips and again once the afternoon routes are finished.
- Additionally, the location of the district Bus Barn requires that the empty buses travel back and forth from one end of the Key Peninsula to the other in order to park between route times. Pierce Transit operates a modified bus service that only connects to specific points up along the main corridor, while the school buses travel throughout neighborhoods and residential roads before returning to the main corridor.
- The Mustard Seed currently operates a Community Use Van, which will be used (in part) to provide ‘feeder’ or ‘connector’ transportation to the school buses, if necessary, and will also provide the schedule/dispatch/coordination aspect of this component.

- The school buses will serve as a 'feeder' or 'connector' to the Pierce Transit route and any other major stops directly along the corridor back off the Peninsula on its way back to the Bus Barn. Drivers would be compensated at their regular rates, as per their union contract, to drive these additional routes. The Transportation Director would serve as contact for the agency.
- PSESD operates a program called, Road to Independence, which helps low-income parents obtain paid driver training, experience and eventually certification and possible driving jobs in their local areas. The Key Peninsula has a high number of families that qualify for this program/service. These individuals would be potential sources for driving the Mustard Seed Van and would also be reimbursed for their time through PSESD.
- Additional shared resources such as driver training, certification, background and driving record checks would be other benefits.

## VI. Project Description

Responses in Section VI (Questions 1 through 6) are limited to the space provided, or may be expanded on the supplemental page if additional space is needed.

1. Provide a detailed description of the project.

The Key Peninsula, home to more than 16,000 residents, is a finger of land in western Pierce County extending 25 miles southward and up to seven miles across into Puget Sound . There is a sharp contrast between impressive waterfront residences and the intense poverty of numerous locales in the interior of the Peninsula. There are many small, distinct communities located throughout the Key Peninsula with seven of these containing rural commercial centers. Public transit is limited to the Key Center community on the Peninsula including Bus Plus connections. The remainder of the Peninsula is unserved. It takes multiple transportation systems to meet the needs of all the residents, including seniors, low-income, and other special needs populations.

Key Peninsula: School Bus Connections with the Community (SBCC) project will bring together two programs that will facilitate new transportation opportunities and also provide driver training to promote jobs for low-income and special needs individuals.

1) **TRANSPORTATION SERVICES:** Peninsula School District will utilize school buses to provide no-fare transportation to residents throughout points in the Peninsula or to link with Pierce Transit or The Mustard Seed Van Program's Community Use Van program. This Van Program transports seniors to the Senior Lunches in the community of Home and to the Silver Sneakers at the Gig Harbor YMCA, as well as to shopping, appointments and post office runs. School Bus drivers will stop at designated locations before and after they transport students. Riders will be seniors, low-income and others with special needs who have no alternate transportation.

The project will incorporate the best practices of award-winning Mason Transit, which has been operating in collaboration with Shelton School District since 1998. PSESD, project lead, will contract with Peninsula School District for drivers, trainers and buses to transport residents during the school year. The Mustard Seed Project will offer dispatch services and link senior travel needs with the Mustard Seed's existing volunteer Community Use Van program.

2) **TRAINING PROGRAM:** The project will operate a commercial driver training program at a central site on Key Peninsula to low-income individuals, such as parents of children in Early Childhood Education Assistance Program (ECEAP). Other individuals are referred to the program through community and social services agencies that serve low-income and other special-needs clients. The project will also offer defensive driver training for The Mustard Seed Project Van Program drivers.

Once trained, these individuals may be eligible to obtain jobs as commercial or school bus drivers. Through the project's six month driver training, offered twice per year, participants earn a Class B Commercial Driver's License with an S endorsement and customer service skills. These skills help participants secure unsubsidized employment in transportation fields such as transit, school bus, coach, courier drivers, or other driving occupations. This project will be on a smaller scale, but will also offer defensive driving classes (Type II) for volunteers with the Mustard Seed senior center.

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face up

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Code : okay on touch pad

10003

Image send button

Address book on pad

M - push me ; To button - go



# Pierce County Coordinated Transportation Coalition

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## Possible Pilot Projects.

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### Common Ground

In 2003, the PCCTC started this project to determine the feasibility of coordinating Pierce Transit ADA Shuttle and DSHS Non-Emergency Medical Transportation trips going to the same destination. Last year a summary report was issued and the project was suspended. The proposal is to amend the report to include information about the impact of the recent changes regarding transportation of Adult Day Health customers.

### Adult Day Health Transportation

This project would create a transportation service that improves service quality while demonstrating cost savings through increased service coordination and cost sharing. The adult day health program would enroll the clients in the transportation program – other eligibility requirements would be waived. The project will demonstrate cost sharing for human services transportation.

### Key Peninsula – Community-based Transportation Network

The proposal is to expand the Senior Ride program, which is a collaboration between Catholic Community Services and the Mustard Seed Project to recruit volunteer drivers, and phase in a community based transportation network. The network could include use of local vans, Pierce Transit Community Use Vans and Vanpools, Puget Sound Educational Service District Van Driver Training program, and increasing the use of Ride Match and connections to Pierce Transit's Bus Plus.

### Veterans Transportation

Last year, Community Transportation Association of America (CTAA) held a forum on Veteran's Transportation issues at American Lake. Two main issues emerged: veterans face difficulties traveling to/from medical appointments; and veterans are often unaware of available travel options. Next steps could include continuing to develop a stronger relationship with Veterans program staff and riders, and developing plans to improve transportation services for Veterans in Pierce County.

# Covered Entity Charts

Guidance on how to determine whether an organization or individual is a covered entity under the Administrative Simplification provisions of HIPAA

**Background:**

The Administrative Simplification standards adopted by HHS under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply to any entity that is:

- a health care provider that conducts certain transactions in electronic form (called here a “covered health care provider”),
- a health care clearinghouse, or
- a health plan

An organization or individual that is one or more of these types of entities is referred to as a “covered entity” in the Administrative Simplification regulations, and must comply with the requirements of those regulations.

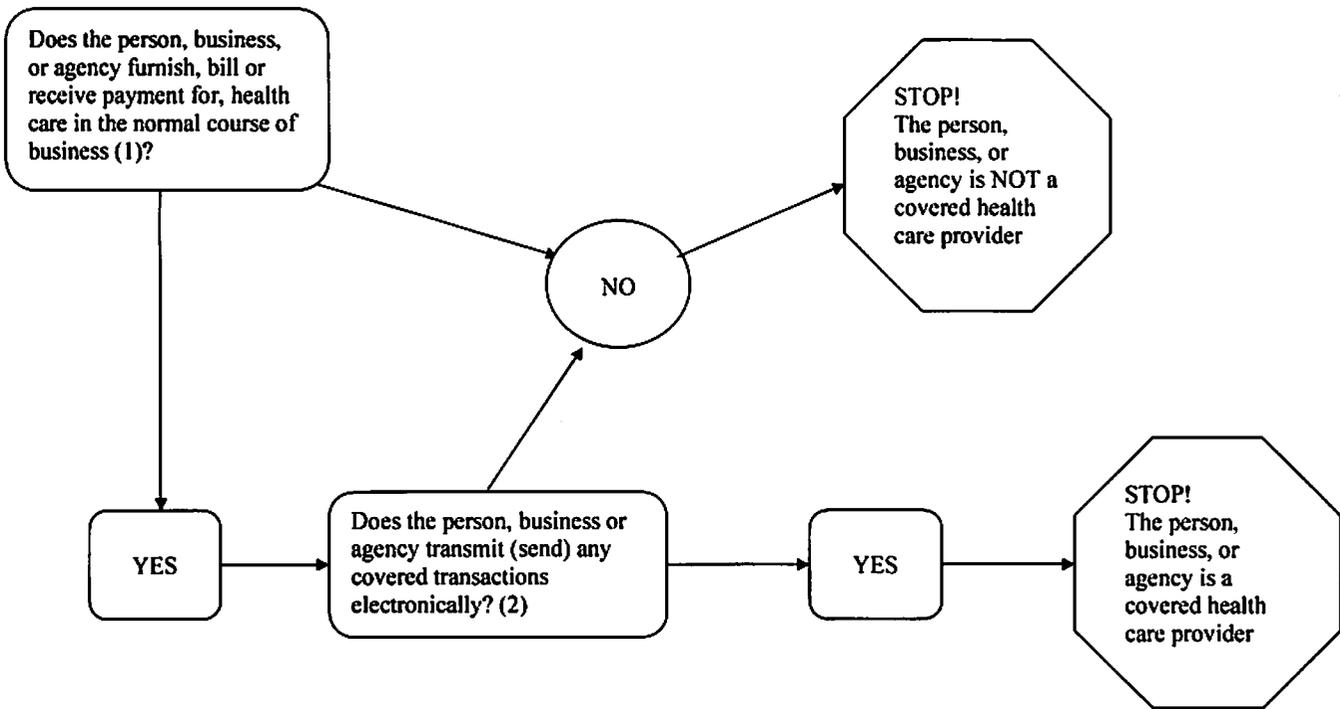
**How to Use These Charts:**

To determine if a natural person, business, or government agency is a covered entity, go to the chart(s) that apply to the person, business, or agency, and answer the questions, starting at the upper left-hand side of the chart(s).

If you are uncertain about which chart(s) applies, answer the questions on all of the charts.

Many terms used in the charts are defined terms or have a special meaning. The definitions or special meanings are set out in the endnotes. The number for the appropriate endnote appears at the end of the question, if the defined term or special meaning is used in, or is relevant to, the question.

## Is a person, business, or agency a covered health care provider?



medical assistance percentage matching rate. This authority supplements the current authority that States have to provide NEMT to Medicaid beneficiaries who need access to medical care, but have no other means of transportation.

**DATES:** *Effective date:* These regulations are effective January 20, 2009.

**FOR FURTHER INFORMATION CONTACT:** Fran Crystal (410) 786-1195.

**SUPPLEMENTARY INFORMATION:**

**I. Background**

*A. General*

For more than a decade, States have asked for the tools to modernize their Medicaid programs. The enactment of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171, February 8, 2006) provides States with new options to create programs that are more aligned with today's Medicaid populations and the health care environment. Cost sharing, benefit flexibility through benchmark plans, health opportunity accounts (HOA), and the flexibility to design cost-effective transportation programs provide opportunities to modernize Medicaid, make the cost of the program and health care more affordable, and expand coverage for the uninsured.

*B. Statutory Authority*

Section 6083 of the DRA amended section 1902(a) of the Social Security Act (the Act) by adding a new section 1902(a)(70), which allows States to amend their Medicaid State plans to establish a non-emergency medical transportation (NEMT) brokerage program without regard to statutory requirements for comparability, state-wideness, and freedom of choice. This final regulation sets out provisions for implementing the brokerage programs which are within the flexibility granted by the statute.

**II. Provisions of the Proposed Rule**

*A. Overview*

The Department of Health and Human Services (DHHS) began issuing guidance about the new flexibilities available to States within months of the enactment of the DRA. On March 31, 2006, DHHS issued a State Medicaid Director letter providing guidance on the implementation of section 6083 of the DRA. We issued an NPRM on August 24, 2007 (72 FR 48604). This proposed regulation proposed, among other things, to formalize the guidance issued on NEMT programs. The proposed regulation would add a new paragraph (4) to 42 CFR 440.170(a).

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Centers for Medicare & Medicaid Services**

**42 CFR Part 440**

**[CMS-2234-F]**

**RIN 0938-A045**

**Medicaid Program; State Option To Establish Non-Emergency Medical Transportation Program**

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule.

**SUMMARY:** This final rule implements section 6083 of the Deficit Reduction Act of 2005, which provides States with additional State plan flexibility to establish a non-emergency medical transportation (NEMT) brokerage program, and to receive the Federal

### B. Requirements for State Plans

Under § 431.53, States are required in their title XIX State plans to ensure necessary transportation of Medicaid beneficiaries to and from providers. Expenditures for transportation may be claimed as administrative costs, or a State may elect to include transportation as medical assistance under its State Medicaid plan.

Before enactment of the DRA, if a State wanted to provide transportation as medical assistance under the State plan, it could not restrict beneficiary choice by selectively contracting with a broker, nor could it provide services differently in different areas of the State without receiving, under section 1915(b) of the Act, a waiver of freedom of choice, comparability, and state-wideness otherwise required by section 1902(a) of the Act. These waivers allowed States to selectively contract with brokers and to operate their programs differently in different areas of the State.

The DRA gives the States greater flexibility in providing NEMT. States are no longer required to obtain a section 1915(b) waiver in order to provide NEMT as an optional medical service through a competitively contracted broker. A State plan amendment for such a brokerage program eliminates the administrative burden of the 1915(b) biannual waiver renewal. Under new section 1902(a)(70) of the Act, a State may now use a NEMT brokerage program when providing transportation as medical assistance under the State plan, notwithstanding the provisions of sections 1902(a)(1), 1902(a)(10)(B), and 1902(a)(23) of the Act, concerning state-wideness, comparability, and freedom of choice, respectively.

Current regulations provide that when a State includes transportation in its State plan as medical assistance, it is required to use a direct vendor payment system that is consistent with applicable regulations at § 440.170(a)(2), and it must also comply with all other requirements related to medical services, including freedom of choice, comparability, and state-wideness. To implement the provisions of section 1902(a)(70) of the Act, we proposed revising § 440.170(a) to add a new paragraph (4), "Non-emergency medical transportation brokerage program," to reflect the increased flexibility allowed by the DRA.

We proposed allowing, at the option of the State, the establishment of a NEMT brokerage program. We believe that this may prove to be a more cost-effective way of providing

transportation for individuals eligible for medical assistance under the State plan, who need access to medical care or services, and have no other means of transportation.

As provided by the statute, we proposed specifying in § 440.170(a)(4) that the broker could provide for transport services that include wheelchair vans, taxis, stretcher cars, bus passes, tickets, secured transportation and other forms of transportation otherwise covered under the State plan. We interpreted "secured transportation" at section 1902(a)(70)(A) of the Act to mean a form of transportation containing an occupant protection system that addresses the safety needs of disabled or special needs individuals.

The DRA also provides that other forms of transportation may be included as determined by the Secretary to be appropriate. We did not propose to determine any additional transportation services to be generally appropriate. However, as noted above, we proposed to allow States to identify additional transportation alternatives that were otherwise covered under the State plan and which were not limited to services already available through transportation brokers. We proposed to review these alternatives in the State plan amendment approval process for transportation services generally. In that process, we proposed that CMS should consider the individual circumstances in the State and apply utilization controls as necessary. For example, air transportation could be appropriate in States with significant rural populations and low population density, but not in other States. Even in those States, air transportation might only be suitable with appropriate utilization controls. Thus, we proposed to make this determination in the context of our review of State plan amendments based on the information furnished by the State.

At § 440.170(a)(4), we proposed that the competitive bidding process be consistent with applicable DHHS regulations at 45 CFR 92.36, based on the State's evaluation of the broker's experience, performance, references, resources, qualifications and cost, and that the contract with the broker include oversight procedures to monitor beneficiary access and complaints, and ensure that transport personnel are licensed, qualified, competent, and courteous. We proposed that State and local bodies that wish to serve as brokers compete on the same terms as non-governmental entities.

We proposed in paragraph § 440.170(a)(4)(ii) to include

prohibitions on broker self-referrals and conflict of interest, based on the prohibitions on physician referrals under section 1877 of the Act (42 U.S.C. 1395(nn)). Section 1877 of the Act generally prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies. In addition, to prevent other types of fraud and abuse, the anti-kickback provisions in section 1128B(b) of the Act (42 U.S.C. 1320a-7b(b)) and the provisions in the civil False Claims Act (31 U.S.C. 3729) also would apply to this transportation program as they apply to the Medicaid program generally.

We believe the statute provides that section 1877 of the Act and the applicable regulations be used as a model for establishing broker prohibitions on referrals, conflicts of interest, and impermissible kickbacks, in order to prevent fraud and abuse.

As we stated in the proposed rule, a financial relationship, as defined in the regulations implementing section 1877 of the Act at § 411.354(a), includes any direct or indirect ownership or investment interest in an entity that furnishes designated health services and any direct or indirect compensation arrangement with an entity that furnishes designated health services (DHS).

Section 1877 of the Act includes exceptions to certain ownership, investment, and compensation arrangements. In addition, section 1877(b)(4) of the Act allows the Secretary to create an exception in the case of any other financial relationship that does not pose a risk of program or patient abuse.

For purposes of new § 440.170(a)(ii)(A), we proposed that the term "transportation broker" include contractors, owners, investors, Boards of Directors, corporate officers, and employees.

We proposed to use the definition of "financial relationship" as set forth in regulations at § 411.354(a) by means of cross-reference, with the term "transportation broker" substituted for "physician" and "non-emergency transportation" substituted for "DHS." We proposed to use the definition of "immediate family member" or "member of a physician's immediate family" as set forth in the physician self-referral provisions in § 411.351, with the term "transportation broker" substituted for "physician."

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

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

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

*Comment:* Many commenters disagreed with the requirement for governmental brokers to document with respect to the individual's specific transportation needs that the government provider is the most appropriate and lowest cost alternative, and that the Medicaid program is paying no more than the rate charged to the general public. The commenters said that the documentation requirement

will result in additional and costly recording-keeping. One commenter objected to any requirement that a governmental broker using other governmental entities as transportation providers document that the transportation is the least costly and most appropriate for each beneficiary because it precludes government social service agencies from being used by the broker to provide transportation.

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

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

*Comment:* Many of the commenters disagreed with the proposed requirement that Medicaid pay no more than the rate charged to the general public for the same type of ride when a governmental broker is a provider of transportation or refers to or subcontracts with another governmental transportation provider. Commenters

expressed concern that the actual cost of providing public transportation, particularly publicly provided paratransit rides (that is, door-to-door or curb-to-curb services usually provided to those who are disabled) to the Medicaid population far exceeds the fees charged to the general public because public transit services are subsidized by Federal, State, and local funds, which allows the fares paid by the general public to be set lower than the actual cost of providing the ride. The commenters maintain that prohibiting Medicaid from being charged its fully allocated cost will shift the financial burden of public transit and paratransit trips to State and local entities that fund public transportation. Therefore, the public fare, particularly for paratransit rides, should not be used as a measure to set Medicaid's payment. Medicaid should be charged the fully allocated costs for paratransit rides consistent with this provision and Medicaid's responsibility to assure NEMT.

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

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

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

sound rules for State Medicaid brokerage programs. However, the commenter thought that the conflict of interest provisions were overly broad and suggested that the provisions be modified as follows: (1) The broker should be permitted the discretion to use its own resources or refer to another provider with which it has a financial relationship when deemed necessary by the broker to provide timely, cost-effective and quality transportation, or to otherwise protect the health and welfare of the beneficiary; (2) the broker should be subject to a 10% limit on self-referral in a calendar month, except during the first 90 days of the brokerage contract, when there should be no limit on broker self-referral.

*Response:* We do not agree with the suggestion that the broker be given blanket discretion to use its own resources or to refer to another provider in which it has a financial interest when deemed necessary by the broker to comply with the contractual requirements of timeliness, cost-effectiveness and quality. Allowing the broker unlimited discretion would be contrary to the prohibitions on self-referral that we believe are required by the statute, and could create opportunities for conflict of interest. We recognize that due to unforeseen circumstances a gap may occur in the provider network from time to time. However, should such a gap occur, we expect the State to: Determine when the broker may temporarily step in to fill such a gap; assure that insufficiencies in the provider network are not chronic or lengthy; and assure that the broker is fulfilling its contractual obligation to maintain an adequate network of available qualified contracted providers. We also expect the State to provide sufficient oversight to ensure that when contracting with transportation providers the broker does not offer reimbursement that is so low that local transportation providers are unwilling to participate, thus creating a need for the broker to provide the transportation itself.

Allowing the broker to self-refer no more than 10 percent of the time during a calendar month or to self refer an unlimited number of times during the first 90 days of the brokerage contract would not achieve the purpose of the prohibition against self-referral. By the starting date of the brokerage program the broker must have a contracted network of providers that is sufficient to provide adequate access for beneficiaries, and the broker should also be ready to meet all other requirements of the contract with the State.

*Comment:* One commenter wrote that the final rule should include other exceptions found in the Stark regulation so that "innocent and appropriate" financial relationships between a broker and a NEMT provider do not preclude the provider from participating in the network. The commenter also suggested that the final rule include provisions that allow the broker to have a contract with a NEMT provider for a line of business that is unrelated to the NEMT brokerage business, such as: Rental of space and equipment; personal services arrangements; payments for bona fide services; fair market value compensation arrangements; risk sharing arrangements; compliance training; indirect compensation arrangements; community wide health information systems; charitable donations; and isolated transactions, found at § 411.357(a), (b), (d), (f), (i), (j), (l), (n), (o), (p), and (u), and exceptions for publicly traded securities and mutual funds at § 411.356(a) and § 411.356(b). The commenter also requested that the final rule address the scenario in which the broker also provides emergency medical transportation (EMS) in the same community in which it acts as a NEMT broker. The commenter requested that the broker explicitly be permitted to provide NEMT services or make a referral to another transportation service provider even though a financial relationship for EMS services existed between the parties.

*Response:* We considered the commenters' suggestion that we include in the final rule additional exceptions for certain kinds of financial relationships similar to those found at § 411.356 and § 411.357. We are very concerned about financial relationships that may directly or potentially affect the financial interests that are attributed to either the broker or the subcontracted provider. Compensation relationships such as leasing agreements and contracts for similar lines of business between the broker and a potential subcontracted transportation provider, although seemingly innocent or unrelated, may pose the risk of program abuse. Therefore, in this final rule we have decided not to change the prohibitions or exceptions found in the NPRM.

*Comment:* Many of the commenters believed that the proposed rule contravenes the policies, concepts, and principles of Executive Order 13330 and the Interagency Coordinating Council on Access and Mobility (CCAM), which stresses the importance of coordination of public transportation at the Federal level. These commenters argued that the

proposed rule would defeat the efforts of the CCAM and United We Ride to coordinate transportation. A number of commenters also stated that the proposed rule was inconsistent with the statutory creation of a locally-developed, coordinated public transit human service transportation planning process established by the Safe, Accountable, Flexible, Efficient Transportation Equity Act (SAFETEA-LU), Public Law 109-59 (codified at 49 U.S.C. sections 5301, *et seq.*) and carried out by the Federal Transit Administration (FTA). These commenters suggested that CMS withdraw the proposed rule and submit the matter to the Federal Interagency Transportation Coordinating Council on Access and Mobility (CCAM) and United We Ride program to ensure that the new CMS rulemaking is consistent with CCAM policy and the United We Ride Program initiatives.

*Response:* Executive Order 13330 (69 FR 9185, February 24, 2004) stresses the importance of coordination of public transportation at the Federal level. However, it does not direct Federal agencies to ignore the policies and rules of their particular programs in order to do so. For programs such as Medicaid, the policies of the CCAM are appropriate as long as they do not conflict with the policies and rules of the Medicaid program. The provisions of the proposed rule did not preclude State Medicaid agencies from participating in efforts to coordinate the use of transportation resources consistent with the guidance issued by the CCAM, as long as those coordination efforts recognize that the Medicaid program's responsibility is limited to ensuring cost-effective transportation for beneficiaries to and from Medicaid providers.

In terms of financing, Medicaid is not responsible for the general operation or deficit financing of public or private transportation providers. Medicaid is a joint federal-state financed program. Federal Medicaid funding must be matched by non-federal funding unless there is express authority under federal law for other federal funds to be used for purposes of the non-federal Medicaid matching share, and no such Medicaid authority currently exists. We understand that the FTA SAFETEA-LU statutory language at 49 U.S.C. 5310, 5311, 5316, and 5317 allows States to use Federal Medicaid dollars to fulfill State requirements to draw down Federal transportation grant funds. In that circumstance however, where Federal Medicaid matching funds are included as State match when drawing down FTA grants, Federal Medicaid

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

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

*Comment:* Several commenters disagreed with the requirements of the proposed rule and felt that States were best equipped to design their own systems to prevent the kind of abusive practices and conflicts of interest that might arise when a broker is involved in direct service delivery. These commenters believed that States should be permitted to decide how to institute proper controls that would eliminate any conflicts of interest. A number of commenters said that regional transportation systems and public transportation systems operating as the

NEMT broker have the best opportunity and means to coordinate transportation for the benefit of the public. One commenter believed that the State's Department of Transportation and not the Health and Human Services Medicaid program should coordinate Medicaid transportation.

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

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

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

*Comment:* Several commenters said the language requiring the contract with a governmental broker to "provide for payment that does not exceed actual costs calculated as a distinct unit, excluding personnel or other costs shared with or allocated from parent or related entities," is ambiguous and can be read two ways, either to include or exclude these costs in the final analysis. Several commenters opposed requiring the public entity broker to be a distinct governmental unit. One commenter expressed the need for further clarification of the requirement that a public broker be a distinct governmental unit and was concerned that the brokerage function would be required to

be devoted to only Medicaid-funded transportation, which is directly contrary to the policies established under EO 13330. Another commenter believed that this language was too restrictive and would potentially limit the number of entities that would be eligible to bid.

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

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

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

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

that use of the definition of "rural area" found at § 412.62(f) would cause confusion, and that CMS should instead use the term "non-urbanized area" as defined in Federal transit laws.

*Response:* The statute allows both the State and the broker to take responsibility for ensuring that transportation is provided in a competent and courteous manner. In considering whether to define these terms in the final rule, we concluded that States, working with the broker, must determine the competency and courtesy of transport services and staff.

We understand that some commenters believe it would be less confusing if we replaced the term "rural area" with "non-urbanized area" and use the Federal Transit Administration definition. However, whenever possible, Medicaid regulations have maintained a long history of being consistent with Medicare regulations. For the purposes of this final rule the definition of "rural area" as defined at § 412.62(f)(1)(iii) will remain consistent with the definition as exists in the Medicare program.

*Comment:* Two commenters said that our proposed definition of "secured transportation" is unclear and must be clarified. Moreover, one commenter said that as written in the preamble to the proposed rule, it appears that standard airbags in a sedan would qualify, and if the intent of CMS is to address vehicle standards, including wheelchair security and occupant restraints such as those contained in 49 CFR 38.23(d), the regulation should so specify.

*Response:* In the proposed rule we requested comments on the definition of "secured transportation" but received only two comments. These comments expressed the need for clarification and one suggested that we adopt 49 CFR 38.23(d) as the definition of secured transportation if our intent was to define vehicle standards. In requesting comments on the definition of "secured transportation" it was not our intent to solicit comments on how to define vehicle standards. We therefore believe the definition in the proposed rule is sufficiently general to permit the State ample flexibility in the design of their brokerage program and have not changed this definition in the final rule.

*Comment:* One commenter, representing a State, said that some States delegate responsibility for NEMT to multiple regions or counties within the State, and that the rule should be amended to specifically allow a State to submit and receive State Plan approval of a general brokerage program template, including contract language, that would be used by each county or subdivision for implementing individual broker

arrangements. Approval of such a template would eliminate the need for CMS to approve each individual brokerage program regardless of whether it was included in the initial SPA or added at a later date.

*Response:* We recognize that some States have chosen to delegate responsibility for the NEMT brokerage program to individual counties or regions of the State rather than contracting with a state-wide broker. In this model, each county or region operates a separate brokerage program that meets the needs of its beneficiaries, and each brokerage program may vary from area to area within the State. We believe that under this type of model we are obligated to review and approve each separate brokerage program in order to ensure that no conflict of interest exists in any of the various brokerages within the State and that each brokerage program complies with the other statutory and regulatory requirements of a brokerage program.

*Comment:* Several commenters said that the requirement that government entities and public transportation operators must compete in a competitive bidding process on the same terms as non-governmental entities conflicted with current State laws that allow government entities the right of first refusal. They believed that requiring governmental entities to compete on the same terms as non-governmental entities would create an additional burden just to avoid the perception that there is some inherent conflict of interest for governmental transportation providers that operate as a broker.

*Response:* While some States may have laws that allow governmental entities the right of first refusal, it is important to note that Section 6083 of the DRA expressly requires competitive bidding, and it did not specifically exempt State and local bodies that wish to serve as brokers from being selected through a fair and open competitive bidding process. We proposed to adopt the applicable provisions of the methodology for competitive bidding set out at 45 CFR 92.36 and do so in the final rule. We are adopting those provisions of 92.36 applicable to the competitive bidding program set out at 92.36(b)-(i). However, we note that we are excluding 92.36(a), which does not set out competitive bidding standards.

*Comment:* One commenter said that the regulation mirrors the DRA provisions in which the general Medicaid principles of freedom of choice, comparability, and state-wideness do not apply and that both the statute and the proposed rule

contravene the intent of the Medicaid program by granting the State the authority to offer a higher level of service to some Medicaid beneficiaries but not to all.

*Response:* The statute provides that NEMT brokerage programs be implemented without regard to freedom of choice, comparability, and state-wideness in order to allow States to use competitive bidding to identify and select the most cost-effective and efficient NEMT broker. Because NEMT needs may differ from region to region it may be necessary to offer certain services in one area of the State but not in another. In creating this new option for States, the statute provides States with the greatest flexibility to customize their brokerage programs to meet the needs of all beneficiaries in all areas of the State, and for States to take advantage of the cost saving measures that NEMT brokers can offer. We note that for a number of years States have implemented NEMT brokerage programs under 1915(b) waiver authority in selected areas of the State without regard to freedom of choice, comparability, and or state-wideness. Both the statute and this final regulation make it possible to provide NEMT through a broker without regard to freedom of choice, comparability, and state-wideness, while maintaining the highest level of services for all Medicaid beneficiaries.

*Comment:* One commenter believed that the requirement that the beneficiary have no other means of transportation found in § 440.170(a)(4) of the proposed rule could significantly limit the number of Medicaid-enrolled individuals who could benefit from the Medicaid NEMT program. The commenter believed that CMS failed to take into account beneficiaries who normally have another means of transportation but cannot utilize it due to their current medical condition, and that this failure could lead to these beneficiaries being denied transportation assistance. The commenter requested that we amend the language to read "that the beneficiary must have no other available" means of transportation.

*Response:* We did not adopt in this final rule the commenter's suggestion that we amend the language in § 440.170(a)(4) by adding the word "available," because we believe that States and brokers understand that they must take into consideration the beneficiary's physical condition when determining if the beneficiary has another means of getting to and from a medical service.

*Comment:* One commenter requested that we clarify treatment of a federally qualified health center (FQHC) with regard to NEMT services because FQHC services, including transportation, are mandatory and the State can include transportation costs in the Prospective Payment System (PPS) per visit payment or in its Alternative Payment Methodology (APM) per visit payment. The commenter further stated that a State's decision to contract with a broker does not eliminate the legal obligation to allow an FQHC to continue to provide and be reimbursed for transportation through the PPS or APM payment.

*Response:* In agreeing with the commenter we wish to clarify that a State's decision to establish a NEMT brokerage program does not preclude the State from allowing an FQHC to continue to provide for and be paid for transportation as part of the Prospective Payment System per visit payment or as part of the Alternative Payment Methodology per visit payment. We assume that a State's request for proposal would indicate this in accordance with the State's policy.

*Comment:* The August 24, 2007 proposed rule proposed an exception to the prohibition on self-referral for governmental brokers that prohibited Medicaid from paying more than the general public rate for public transit services. Many of the State transportation agencies that commented believed the regulation would create an unfunded mandate by shifting costs to State and local governments. These commenters contended that even though the general public fare is heavily subsidized by State and Federal funds it still does not accurately represent the full cost of providing paratransit services. The commenters also said the increased financial burden on States that would be created should Medicaid not pay the full cost of a paratransit trip, along with the additional capital costs that would be needed to fund the resulting increased demand for paratransit services, would exceed the \$120 million dollar threshold for a major rule. Many commenters disagreed that the proposed rule would have no consequential effect on State, local and tribal governments and requested that CMS either reconsider this requirement and allow a Medicaid governmental broker to pay the fully allocated cost for public paratransit, or withdraw the regulation and perform and make publicly available a detailed study of the number of trips likely to be shifted to local responsibility, as well as the financial impact of those trips.

*Response:* We considered all of the comments on the governmental broker not paying more than the public rate and have revised § 440.170(a)(4)(ii)(B)(4)(iii) in this final rule so as to now require that in the case of a governmental broker, the rate paid by Medicaid for publicly provided fixed route transportation be no more than the rate paid by the public, and the rate paid by Medicaid for public paratransit represent reasonable costs and be comparable to the rate paid for similar paratransit trips by other State human services agencies. We therefore believe that this final rule does not create an unfunded mandate for States, localities, tribal governments, or the private sector.

*Comment:* In the proposed rule two commenters suggested that the collection of information requirements were significantly understated. One commenter said that according to their experience it took five hours to initially complete the State plan amendment preprint, and an additional nine hours to respond in writing to requests from CMS for additional information. Another commenter noted that the level of documentation required for governmental entities that are brokers is extensive, costly, and unnecessarily duplicative of the annual monitoring of expenditures that is required by the Department of Transportation.

*Response:* In order to minimize the amount of time needed to complete a State plan amendment establishing a NEMT brokerage program, we designed a five-page preprint that allows the State to complete almost all of the sections by checking a box next to each answer. We expect that prior to completing the preprint a State will have fully developed the information that describes the brokerage program and can insert or attach this information to the preprint. With that assumption in mind, we estimated that it would take no more than 12 minutes to check off the appropriate boxes and to insert or attach any already created information concerning the NEMT brokerage program that is necessary to complete the State plan amendment.

With regard to additional documentation requirements created by the proposed rule, Medicaid laws and regulations, as well as CMS guidance, have always required States to maintain documentation of the medical services that are provided to beneficiaries. The requirement in the proposed rule that States, through the broker, document each specific ride that was provided and that a Medicaid reimbursable service other than transportation was actually provided on the date transportation was

provided is not a new collection of information.

In this final rule we revised the requirement that governmental brokers document that Medicaid paid no more for public transportation than the rate charged to the general public and have instead included a requirement that in the case of a governmental broker, there be documentation that Medicaid paid no more for public fixed route transportation than the general public, and no more for public paratransit services than the rate charged to other human services agencies for a comparable ride. We believe this documentation requirement to be relatively simple and to require no more than an annual comparison of the fees paid by Medicaid under the brokerage program to the fees charged to the general public for fixed route transportation, and a comparison of the fees paid by Medicaid (under the broker program) for public paratransit services to the fees paid by other human services agencies for comparable public paratransit services. We do not believe that the documentation requirement for government brokers set forth in the proposed rule represents any substantial additional time and cost. Therefore, we have not revised the collection of information estimate in this final rule.

#### IV. Provisions of the Final Regulations

We are maintaining the majority of the provisions set out in the August 24, 2007 proposed rule, with several exceptions. The provisions of this final rule that differ from the proposed rule with comment period are as follows:

- (1) We have modified the regulations text at § 440.170(a)(4)(i)(B) by adding the additional requirement that the broker have oversight procedures to monitor and ensure the timeliness of the transportation provided to beneficiaries.
- (2) We have modified the regulations text at § 440.170(a)(4)(ii)(B)(4) by removing the requirement that the broker be a "distinct government entity." However, in § 440.170(a)(4)(ii)(B)(4)(i), we continue to expect the governmental broker to maintain an accounting system as though it were a distinct unit, such that all funds allocated to the Medicaid brokerage program and all costs charged to the brokerage program will be completely separate from any other program. We have also clarified that costs shared with other governmental entities cannot be allocated to the brokerage program.
- (3) We have modified the regulations text at § 440.170(a)(4)(ii)(B)(4)(iii) by removing the requirement that the broker document that the Medicaid

that use of the definition of "rural area" found at § 412.62(f) would cause confusion, and that CMS should instead use the term "non-urbanized area" as defined in Federal transit laws.

*Response:* The statute allows both the State and the broker to take responsibility for ensuring that transportation is provided in a competent and courteous manner. In considering whether to define these terms in the final rule, we concluded that States, working with the broker, must determine the competency and courtesy of transport services and staff.

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arrangements. Approval of such a template would eliminate the need for CMS to approve each individual brokerage program regardless of whether it was included in the initial SPA or added at a later date.

*Response:* We recognize that some States have chosen to delegate responsibility for the NEMT brokerage program to individual counties or regions of the State rather than contracting with a state-wide broker. In this model, each county or region operates a separate brokerage program that meets the needs of its beneficiaries, and each brokerage program may vary from area to area within the State. We believe that under this type of model we are obligated to review and approve each separate brokerage program in order to ensure that no conflict of interest exists in any of the various brokerages within the State and that each brokerage program complies with the other statutory and regulatory requirements of a brokerage program.

*Comment:* Several commenters said that the requirement that government entities and public transportation operators must compete in a competitive bidding process on the same terms as non-governmental entities conflicted with current State laws that allow government entities the right of first refusal. They believed that requiring governmental entities to compete on the same terms as non-governmental entities would create an additional burden just to avoid the perception that there is some inherent conflict of interest for governmental transportation providers that operate as a broker.

*Response:* While some States may have laws that allow governmental entities the right of first refusal, it is important to note that Section 6083 of the DRA expressly requires competitive bidding, and it did not specifically exempt State and local bodies that wish to serve as brokers from being selected through a fair and open competitive bidding process. We proposed to adopt the applicable provisions of the methodology for competitive bidding set out at 45 CFR 92.36 and do so in the final rule. We are adopting those provisions of 92.36 applicable to the competitive bidding program set out at 92.36(b)-(j). However, we note that we are excluding 92.36(a), which does not set out competitive bidding standards.

*Comment:* One commenter said that the regulation mirrors the DRA provisions in which the general Medicaid principles of freedom of choice, comparability, and state-wideness do not apply and that both the statute and the proposed rule

contravene the intent of the Medicaid program by granting the State the authority to offer a higher level of service to some Medicaid beneficiaries but not to all.

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*Response:* We did not adopt in this final rule the commenter's suggestion that we amend the language in § 440.170(a)(4) by adding the word "available," because we believe that States and brokers understand that they must take into consideration the beneficiary's physical condition when determining if the beneficiary has another means of getting to and from a medical service.

**DSHS**

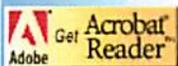
Appendix VIII

Washington State Department of Social &amp; Health Services

Washington State Medicaid

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## Medicaid State Plan

### What is the State Plan

The State Plan is the officially recognized statement describing the nature and scope of Washington State's Medicaid program.

As required under Section 1902 of the Social Security Act (Act), the Plan was developed by our state and approved by the United States Department of Health & Human Services (DHHS). Without a State Plan, Washington State would not be eligible for federal funding for providing Medicaid services. Essentially, the Plan is our state's agreement that it will conform to the requirements of the Act and the official issuances of DHHS.

The State Plan includes the many provisions required by the Act, such as:

- Methods of Administration
- Eligibility
- Services Covered
- Quality Control
- Fiscal Reimbursements.

Once the original Plan has been approved by DHHS, all future changes to the Plan must also be approved by DHHS before they can become effective. Plan changes are submitted by the state to DHHS as State Plan Amendments (SPAs). DHHS, through the Centers for Medicare and Medicaid Services (CMS), reviews each SPA to determine whether it meets federal requirements and policies. The Plan is updated when CMS issues final approval of a SPA.

A state can also ask DHHS to waive certain federal requirements to allow it greater flexibility to institute such programs as primary care case management systems, and home and community-based services in lieu of institutionalization.

By law, a state's request to DHHS to approve a proposed State Plan, a SPA, or a waiver of a requirement, must be approved, disapproved, or additional information requested within 90 days of receipt. Otherwise, the request is considered to be approved.

The Plan on this website is for informational purposes only and is not legally binding. The official Plan is maintained by CMS Region X. The files on these pages are available as read-only in Word and in Portable Document Format (PDF), which requires the use of Adobe

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONMETHODS OF ASSURING TRANSPORTATION

Transportation is provided as an administrative activity in accordance with 1902(a)(4)(A) of the Act and 42 CFR 431.53 in regions: 5, 8, 10, 11, 12, 13

## Broker regions:

- #5: Mason-North, Clallam, Jefferson, and Kitsap counties;
- #8: Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima counties;
- #10: Ferry, Pend Oreille, and Stevens counties;
- #11: Adams, Grant, and Lincoln counties;
- #12: Spokane County;
- #13: Asotin, Garfield, and Whitman counties.

Not Provided

Provided

The State of Washington manages and monitors non-emergency medical transportation (NEMT) "brokerage" contracts. NEMT services are provided through regional brokers.

Brokers are competitively procured through rigorous nationally advertised processes. For-profit brokers are not prohibited from competing for brokerage contracts during procurements.

Brokers operate access management centers and interact with eligible Medicaid clients requesting access to eligible Medicaid services – trips are only authorized after brokers verify client eligibility and determine that clients do not have other transportation resources/options.

To directly save Medicaid medical funds (and as examples), brokers may authorize trips to Veterans' Hospitals, Shriners' Hospitals, and for services where Medicare and/or private insurance is primary and Medicaid coverage is secondary. Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities. Brokers utilize low cost options first, such as fixed route tickets/passes, gas reimbursement, mileage reimbursement, and only authorize higher cost options such as taxi and wheelchair lift-equipped vehicles based on the individual needs of clients.

Clients have the right to request a fair hearing and an appeal to a hearing decision, except in relation to provisions that are inapplicable under 42 CFR 440.170. Fair hearings are conducted before an impartial administrative law judge in accordance with the state's administrative hearings procedures (the same process as for other Medicaid healthcare services).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Methods of Assuring Transportation (cont)

The Broker for Region #5 does not directly assign trips to itself as a provider; however, the broker's parent agency did subcontract with a transit agency to provide ADA complementary paratransit services, and some of those trips were funded by Medicaid until 09/30/2009. The State is not requesting FMAP for trips in Region #5 under this amendment. This region will provide NEMT as an administrative activity.

Each of the brokers in the regions below is allowed to themselves provide a contractually limited percentage of non-transit trips. The contractual limits are as follows, as well as the percentage of non-transit trips provided by the broker itself, for state fiscal years 2008 and 2009:

Region	Limit of non-transit trips	Trips provided by broker	
		SFY 2008	SFY 2009
#8:	15%	4.7%	1.8%
#10:	7%	0.5%	1.7%
#11:	30%	0.3%	0.2%
#12:	20%	16.6%	15.1%
#13:	15%	12.1%	12.2%

These regions will provide NEMT as an administrative activity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE  
MEDICALLY NEEDY GROUP(S): ALL

- 23. a. Transportation
  - (1) Ambulance transportation is provided as an optional service for emergencies or as required by state law.
  - (2) Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

20,000  
 40,000  
 }

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## 23. a. Transportation

## (a) non-governmental entity

- The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

- (1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

- (1) state-wideness (indicate areas of State that are covered)

Broker regions:

- #2 Snohomish County  
 #3 King County  
 #4 Pierce County  
 #6 Grays Harbor, Lewis, Mason-south, Pacific, and Thurston Counties  
 #7 Clark, Cowlitz, Klickitat, Skamania, and Wahkiakum Counties  
 #9 Chelan, Douglas, and Okanogan Counties

- (10)(B) comparability (indicate participating beneficiary groups)

- (23) freedom of choice (indicate mandatory population groups)

## (2) Transportation services provided will include:

- wheelchair van  
 ■ taxi  
 ■ stretcher car  
 ■ bus passes  
 ■ tickets  
 ■ secured transportation  
 ■ other transportation (please describe)

When cost effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas vouchers, mileage reimbursement, grouped-ride vehicle, volunteers, parking, tolls, ferries, and air transport; and, will provide lodging and meal reimbursement as outlined at 42 CFR 440.170 (a) (3) (ii).

[Note: Grouped or shared-ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations; or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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23. Transportation (cont)

- (3) The State assures that transportation services will be provided under a contract with a broker who:
  - (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
  - (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;
  - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
  - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).
  
- (4) The broker contract will provide transportation to the following medically needy populations under section 1902(a)(10)(C):
  - Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose
  - Parents or other caretaker relatives with whom a child is living if Child is a dependent child
  - Aged (65 years of age or older)
  - Blind
  - Disabled
  - Permanently or totally disabled individuals 18 or older, under title XVI
  - Persons essential to recipients under title I, X, XIV, or XVI
  - Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
  - Pregnant women
  - Newborns

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## 23. Transportation (cont)

## (5) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other

Non-governmental brokers are paid a set monthly amount for brokers' internal costs to distribute trips that are to be provided by subcontractors.

Non-governmental brokers pay their subcontractors for services with Medicaid funds received from the state. Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities.

Non-governmental brokers (in the designated regions for which FMAP is requested) are not allowed to directly provide transportation services.

Non-governmental brokers receive an invoice, detailed by trip, from the subcontracted transportation provider; the broker reviews the invoice and determines if the trip is invoiced correctly, and whether the trip is payable.

Non-governmental brokers submit monthly summarized invoices to the state, by region. The broker invoices have separate amounts for (1) the broker's contracted monthly fee, and (2) the direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers). The back-up documentation to the invoice includes comprehensive trip data reports. These reports include but are not limited to: trips and costs by mode, by program served, most costly clients, and subcontracted transportation provider. The state pays the broker, which then pays the subcontracted transportation provider.

This quantity and quality of trip/cost data facilitates state cost containment initiatives, as well as program oversight and management. As a result, Washington NEMT operates at one of the lowest estimated per capita costs in the country.

(B) Who will pay the transportation provider?

- (i) Broker
- (ii) State
- (iii) other

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## 23. Transportation (cont)

(6-1) The broker is a non-governmental entity (see description in 8) and assures that:

- (A) the broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(a)(4)(ii)

(6-2) The broker is a non-governmental entity (see description in 8) and assures that:

- (B) the broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:
  - (i) transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker
  - (ii) transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
  - (iii) the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

- (7) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation and the State assures that the governmental broker will (see description in 8):

- (A) maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.
- (B) document that with respect to each individual beneficiary specific transportation needs, the government provider is the most appropriate and lowest cost alternative.
- (C) document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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## 23. Transportation (cont)

- (8) Please describe how the NEMT brokerage program operates.

Non-governmental brokers serving the following contract regions are all private non-profit 501 (c) 3 organizations: regions 2, 3, 4, 6, 7, and 9

The State of Washington manages and monitors non-emergency medical transportation (NEMT) "brokerage" contracts. NEMT services are provided through regional brokers.

Brokers are competitively procured through rigorous nationally advertised processes. For-profit brokers are not prohibited from competing for brokerage contracts during procurements.

Brokers operate access management centers and interact with eligible Medicaid clients requesting access to eligible Medicaid services – trips are only authorized after brokers verify client eligibility and determine that clients do not have other transportation resources/options.

To directly save Medicaid medical funds (and as examples), brokers may authorize trips to Veterans' Hospitals, Shriners' Hospitals, and for services where Medicare and/or private insurance is primary and Medicaid coverage is secondary. Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities. Brokers utilize low cost options first, such as fixed route tickets/passes, gas reimbursement, mileage reimbursement, and only authorize higher cost options such as taxi and wheelchair lift-equipped vehicles based on the individual needs of clients.

Clients have the right to request a fair hearing and an appeal to a hearing decision, except in relation to provisions that are inapplicable under 42 CFR 440.170. Fair hearings are conducted before an impartial administrative law judge in accordance with the state's administrative hearings procedures (the same process as for other Medicaid healthcare services).

(b) governmental entity

- The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

- (1) The State will operate the broker program without the requirements of the following paragraphs of section 1902(a);

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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## 23. Transportation (cont)

- (1) state-wideness (indicate areas of State that are covered)

Broker regions:

#1 Island, San Juan, Skagit, and Whatcom Counties

- (10)(B) comparability (indicate participating beneficiary groups)

- (23) freedom of choice (indicate mandatory population groups)

## (2) Transportation services provided will include:

- wheelchair van
- taxi
- stretcher car
- bus passes
- tickets
- secured transportation
- other transportation (please describe)

When cost effective, appropriate, and necessary to ensure access to eligible medical services, will consider using/authorizing gas vouchers, mileage reimbursement, grouped-ride vehicle, volunteers, parking, tolls, ferries, and air transport; and, will provide lodging and meal reimbursement as outlined at 42 CFR 440.170 (a) (3) (ii).

[Note: Grouped or shared-ride vehicles are a cost-effective method to transport groups of clients with similar trip origins and destinations; or more than one client in a locale similar to an airport shuttle. Brokers pay transportation subcontractors on a contracted mileage-based or time-based system; costs are allocated equitably to the clients' specific medical program account codes.]

- (3) The State assures that transportation services will be provided under a contract with a broker who:
- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
- (ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed, qualified, competent, and courteous;

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## 23. (3) Transportation (cont)

- (iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services;
- (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

(4) The broker contract will provide transportation to the following medically needy populations under section 1902(a)(10)(C):

- Children under age 21, or under age 20, 19, or 18 and reasonable classifications as the State may choose
- Parents or other caretaker relatives with whom a child is living if Child is a dependent child
- Aged (65 years of age or older)
- Blind
- Disabled
- Permanently or totally disabled individuals 18 or older, under title XVI
- Persons essential to recipients under title I, X, XIV, or XVI
- Blind or disabled as defined in section 1614 with respect to States not eligible to participate in the State plan program under title XVI
- Pregnant women
- Newborns

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

## 23. Transportation (cont)

## (5) Payment Methodology

(A) The State will pay the contracted broker by the following method:

- (i) risk capitation  
 (ii) non-risk capitation  
 (iii) other

The governmental broker is paid monthly on a cost reimbursement basis with a contract limit for the broker's internal costs to distribute trips that are to be provided by subcontractors.

The governmental broker is not allowed to directly provide transportation services.

The governmental broker pays their subcontractors for services with Medicaid funds received from the state. The governmental broker assigns trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities.

The governmental broker receives an invoice, detailed by trip, from the subcontracted transportation provider; the broker reviews the invoice and determines if the trip is invoiced correctly, and whether the trip is payable.

The governmental broker submits monthly summarized invoices to the state, by region. The broker invoices have separate amounts for (1) the broker's internal costs, and (2) the direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers). The back-up documentation to the invoice includes comprehensive trip data reports. These reports include but are not limited to: trips and costs by mode, by program served, most costly clients, and subcontracted transportation provider. The state pays the broker; the broker pays the subcontracted transportation provider.

This quantity and quality of trip/cost data facilitates state cost containment initiatives, as well as program oversight and management. As a result, Washington NEMT operates at one of the lowest estimated per capita costs in the country.

(B) Who will pay the transportation provider?

- (i) Broker  
 (ii) State  
 (iii) other

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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23. Transportation (cont)

(6-1) The broker is a non-governmental entity (see description in 8) and assures that:

- (A) the broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(a)(4)(ii)

(6 - 2) The broker is a non-governmental entity (see description in 8) and assures that:

- (B) the broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship and:
- (i) transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
  - (ii) transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.
  - (iii) the availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

(7) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation and the State assures that the governmental broker will (see description in 8):

- (A) maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.
- (B) document that with respect to each individual beneficiary specific transportation needs, the government provider is the most appropriate and lowest cost alternative.
- (C) document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other State human services agencies for the same service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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23. Transportation (cont)

- (8) Please describe how the NEMT brokerage program operates.

Governmental broker serving Region 1

The State of Washington manages and monitors non-emergency medical transportation (NEMT) "brokerage" contracts. NEMT services are provided through regional brokers.

Brokers are competitively procured through rigorous nationally advertised processes. For-profit brokers are not prohibited from competing for brokerage contracts during procurements.

Brokers operate access management centers and interact with eligible Medicaid clients requesting access to eligible Medicaid services – trips are only authorized after brokers verify client eligibility and determine that clients do not have other transportation resources/options.

To directly save Medicaid medical funds (and as examples), brokers may authorize trips to Veterans' Hospitals, Shriners' Hospitals, and for services where Medicare and/or private insurance is primary and Medicaid coverage is secondary. Transportation for clients who also have Medicare Part D is provided at the same level of service as, and under the same restrictions for, prescription drug pickups.

Brokers assign trips to the most appropriate and cost-effective available transportation services subcontractor based on each client's mobility status and personal capabilities. Brokers utilize low cost options first, such as fixed route tickets/passes, gas reimbursement, mileage reimbursement, and only authorize higher cost options such as taxi and wheelchair lift-equipped vehicles based on the individual needs of clients.

Clients have the right to request a fair hearing and an appeal to a hearing decision, except in relation to provisions that are inapplicable under 42 CFR 440.170. Fair hearings are conducted before an impartial administrative law judge in accordance with the state's administrative hearings procedures (the same process as for other Medicaid healthcare services).

The broker serving Region 1 is a governmental entity (a council of governments) and serves Island, San Juan, Skagit, and Whatcom counties. This broker does not directly provide trips, but does purchase trips on two public transit system (in Skagit and Whatcom counties). This broker also authorizes trips using other available modes of transportation as listed in Section (2).

- (A) The State pays for direct transportation expenses (e.g., cost of the trips by subcontracted transportation providers, bus tickets, gas vouchers) per detailed report. The State pays separately for the governmental broker's cost of operating the brokerage (call center, etc.) on a monthly reimbursement basis.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONAMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO THE  
MEDICALLY NEEDY GROUP(S): ALL

## 23. (8) Transportation (cont)

The governmental broker maintains an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program. The governmental broker maintains an accounting system as required by this authority. The broker is both required by law and committed to assuring that all agency costs are allocated to the appropriate activity and fund source. All costs clearly attributable to a specific activity and fund source are direct charged to that fund source. Activities which benefit all programs operated by the organization are allocated based upon a cost allocation plan (this applies to a portion of the broker's cost of operating the brokerage).

- (B) The governmental broker has a procedure related to evaluating each individual beneficiary's specific needs and making a determination related to the most appropriate, lowest cost trip, with a specific focus on the procedure related to government providers (i.e., public transit). These determinations are made on a case-by-case basis each month.
- (C) For Medicaid beneficiaries the governmental broker pays the same rate/fare as the general public pays for all fixed route transportation. The cost of the bus pass may not exceed the total cost of all trips a beneficiary would make to Medicaid providers to obtain Medicaid services, were the trips purchased individually. The governmental broker also pays the same rate as the general public for paratransit trips, which is no more than human service agencies pay for the service. The public rates are utilized in determining whether public transit will be the most appropriate low cost service for a specific beneficiary's needs in any given month. In general, public transit trips in the broker's region are significantly lower in cost than other modes of transportation available.

## **Amending the Title XIX State Plan**

### **What is a State Plan Amendment(SPA)?**

A SPA is the means by which a state changes its Title XIX Medicaid State Plan. Every proposed plan change is submitted to the U.S. Department of Health and Human Services (DHHS) in a SPA.

### **Who can request a SPA?**

Staff in the state agencies that are responsible for Title XIX Medicaid and related programs can request a SPA.

### **Where SPAs submitted?**

Washington's SPAs are sent to the Region 10 (Seattle) Centers for Medicare and Medicaid Services (CMS) for review. Region 10 then forwards SPAs to DHHS for final review and approval.

### **When is a SPA submitted?**

A SPA is submitted when any information in the Plan is no longer current.

### **Who submits a SPA?**

The State Plan Coordinator in the Department of Social and Health Services' (DSHS), Health and Recovery Services Administration (HRSA) submits all SPAs to Region 10 CMS. The Coordinator:

- Maintains the official file;
- Obtains necessary signatures; and
- Coordinates all communications and responses between CMS and state agencies.

### **How do I prepare a SPA for the Coordinator to submit?**

1. Identify the page(s) in the State Plan that need to be amended.
2. Copy and paste those page(s) from the Word version of the Plan on this website to make your own document. Make your changes and highlight them.
3. Contact the State Plan Coordinator at [myersea@dshs.wa.gov](mailto:myersea@dshs.wa.gov) or 360-725-1345. The Coordinator will guide you through the process.