Potential Impacts of Federal Health Care Reform on Public Transit

DETAILS

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POTENTIAL IMPACTS OF FEDERAL HEALTH CARE REFORM ON PUBLIC TRANSIT

This digest presents the results of NCHRP Project 20-65, Task 39, "Impacts of the New Health Care Bill on Mass Transit," by ICF International and Nelson\Nygaard Consulting Associates. The research was conducted by Antonio Santalucia of ICF International and Bethany Whitaker and Ellen Oettinger of Nelson\Nygaard, with support from Richard Weiner of Nelson\Nygaard.

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EXECUTIVE SUMMARY

Introduction

In March 2010, President Obama signed into law the most dramatic overhaul of the American health care system since the creation of Medicare in 1965. When fully phased in, the Patient Protection and Affordable Care Act (ACA) will (1) mandate that Americans purchase health insurance, (2) significantly broaden the eligibility requirements for Medicaid, and (3) provide subsidies for the purchase of health insurance. The Congressional Budget Office (CBO) has estimated that by 2022, the law will have added about 30 million newly insured people to the U.S. health care system (*1*). Therefore, transit agencies and operators can expect changes in demand for transportation to and from health care services.

Project Purpose

The purpose of this report is to highlight the provisions of the ACA that are likely to have the largest and most direct impacts on public transit agencies and operations, particularly those in rural and small urban areas. The report also describes pre-existing legal requirements that govern the roles public transit can currently play in transportation related to health care, including: (1) the laws and regulations laying out how public transit can participate in the provision of non-emergency medical transportation (NEMT) for Medicaid participants, and (2) the Americans with Disabilities Act (ADA) and related regulations of the Federal Transit Administration (FTA). The report then uses five case studies to illustrate how the ACA could affect four particular transit systems and one broker of human services transportation that are operating in different geographic and policy environments. Finally, the report assesses ways in which transit agencies and government agencies can monitor and communicate the effects of the ACA on public transit.

Findings

Provisions of the ACA of Most Relevance to Public Transit

Based on a review of the ACA, as well as analyses by health care policy researchers and public transit organizations, the research

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team concluded that the provisions of the ACA that will likely have the largest and most direct impacts on public transit services are intended to improve access to health care by (1) increasing the number of Americans with health insurance coverage, and (2) improving the availability of health care services in underserved areas. In addition, the provisions of the ACA intended to reduce the incidence of health care fraud are likely to affect transit agencies that choose to provide transportation services to Medicaid participants.

Increasing the Number of Americans with Health Insurance Coverage. One of the primary means by which the ACA increases the number of Americans with health insurance is through expansion of Medicaid eligibility to nearly everyone under age 65 up to 133 percent of the federal poverty line. CBO has estimated that this provision will result in approximately 7 million people gaining Medicaid coverage in 2014, rising to 11 million people by 2018 (*1*). (These projections take into account the effects of the Supreme Court's June 2012 ruling on the ACA, which largely upheld the law but allows states to refrain from broadening Medicaid eligibility without losing existing Medicaid funding.) Most Medicaid participants are entitled to transportation to and from Medicaid-funded health care services, and public transit agencies are currently participating in the management and delivery of NEMT for Medicaid participants. Therefore, the ACA's expansion of the Medicaid program is a primary focus of this report.

The other principal means by which the ACA will increase the number of Americans with health insurance is by establishing state-based insurance marketplaces known as health benefit exchanges, as well as subsidies and tax breaks to help low-income individuals and small businesses buy coverage in the exchanges. CBO has estimated that approximately 25 million people will obtain private coverage through these insurance exchanges by 2017, although about 7 million of these will have had previous insurance coverage via other means (*1*). Some studies have shown that providing health insurance to the previously uninsured results in increased utilization of health care services (*2*). Therefore, it is possible that newly insured individuals who are transit-dependent will increase their use of transit services, at least temporarily. The research team was not able to estimate the aggregate impact of these provisions on public transportation providers, but the report does assess options for transit agencies to monitor and report on changes in ridership to and from health care destinations.

Increasing the Availability of Health Care Services in Underserved Areas. The ACA contains numerous provisions intended to improve access to health care services in underserved areas such as rural communities. The law provides financial incentives for multiple types of health care providers to practice in underserved areas. In aggregate, these provisions may allow underserved communities to retain the providers they have and may encourage additional providers to locate there. The ACA will also improve access to health care in underserved areas by providing $11 billion over five years to expand the number and capacity of federally supported community health centers. The research team was not able to estimate the aggregate impact of these provisions on public transportation providers. However, these provisions are noted so that rural transit providers and those serving community health centers can be aware of possible changes in the health care network in their communities.

Reducing the Incidence of Health Care Fraud. The ACA contains numerous provisions intended to reduce fraud by service providers and suppliers seeking payment from Medicaid, Medicare, or the Children's Health Insurance Program (CHIP). Although providers of Medicaid NEMT (including public transit agencies) are not explicitly addressed in these sections of the ACA, it is likely that implementation of these provisions will lead to additional compliance and reporting requirements for all Medicaid providers and suppliers, including transit agencies. Because these provisions have not yet been fully implemented, it is not possible at this time to assess how transit agencies in aggregate will be affected. However, during the development of the case studies featured in this report, the research team did investigate current reporting requirements for the transit agencies and their ability to collect and report additional information if necessary.

Pre-Existing Legal Requirements for Public Transit

Federal laws and regulations governing the participation of public transit in the management and delivery of Medicaid NEMT service will influence how implementation of the ACA affects transit agencies. In addition, requirements for transit agencies stemming from the ADA will also affect the extent to which transit agencies are required to provide (and pay for) trips for disabled individuals who are Medicaid participants.

Laws and Regulations Governing Transit Participation in Medicaid NEMT. Under federal Medicaid regulations, each state's Medicaid plan must specify that the administering state agency will ensure necessary transportation for recipients to and from Medicaid-covered health services. State Medicaid plans must also describe the methods that the state will use to meet this requirement. With the discretion afforded them by federal Medicaid regulations, states have chosen different models for managing and delivering NEMT. These models have presented different opportunities for the participation of public transit agencies.

One role available to transit agencies (and other types of organizations) in some states is that of NEMT broker. These brokers take on some or all of the following tasks: fielding trip requests, checking the eligibility of those requesting trips, selecting a transportation provider, scheduling trips, paying transportation providers, and monitoring the quality of service provided. As one would expect, public transit agencies can also serve as NEMT service providers, although federal Medicaid regulations intended to prevent fraud can make it challenging for transit agencies to participate as NEMT providers.

Americans with Disabilities Act. Public entities that operate fixed-route transportation services for the general public are required by U.S.DOT regulations implementing the ADA also to provide complementary paratransit service for persons who, because of their disability, are unable to use the fixed-route system. The ADA requirements are relevant to federal health care reform because, for particular trips, some individuals are dually eligible for both Medicaid NEMT and ADA paratransit (the eligibility standards for both programs are shown in Table 3 in Section 3 of this digest). For cases of dual eligibility, stakeholders may have different opinions about how the cost of the trip should be allocated between Medicaid and the transit agency. As the Medicaid population increases, the interplay between these two types of transportation service will become more important for transit operators and NEMT coordinators alike.

Case Studies

As shown in Table 1, five case studies were prepared to illustrate the disparate impacts the ACA could have on transit agencies or brokers of human services

Table 1 Comparison of case study subjects.

City/Agency	State	Type of Organization	Transit Service Setting	NEMT Service Delivery Geography	NEMT Broker	Expected Increase in State Medicaid Population*
Montachusett Regional Transit Authority (Fitchburg/Boston)	MA	Transit agency/ broker of human services transportation	Rural, small urban, and urban	Regional	Transit agency	Low
Jackson Transit Authority (Jackson)	MS	Transit agency	Urban	Statewide	Private-sector broker	High
Southwest Georgia Regional Commission (Camilla)	GA	Broker of human services transportation	Rural	Regional	Public-sector broker (recently replaced by private-sector broker)	High
Bis-Man Transit (Bismarck)	ND	Transit agency	Rural	County	No broker	High
Whatcom Transportation Authority (Bellingham)	WA	Transit agency	Rural, small urban	Regional	Public-sector broker	Medium

* Low = <25%, Medium = 25%–49%, High = ≥50%

transportation operating in different geographical settings and under different NEMT delivery frameworks. Specific findings or lessons learned from each case study can be found in Section 4 of the digest.

Monitoring and Communicating the Effects of the ACA on Public Transit

Transit operators and others who wish to monitor and communicate the impacts of the ACA on public transit face the difficult challenge of sorting out the effects of the law from other forces currently buffeting transit systems or looming on the horizon, such as the aging of the U.S. population and possible statutory changes to federal transit programs. However, the first step in discerning the impacts of the ACA is to document health care–related trends accurately. With this trend data in hand, transit operators or policy analysts can begin to determine ways to isolate the impacts of the ACA.

Current Data Collection by State Medicaid Programs. Federal Medicaid regulations currently require state Medicaid programs to collect extensive amounts of data from service providers, including NEMT providers. These data are collected to justify requests for reimbursement and to help identify cases of waste, fraud, or abuse. Therefore, data should be available on the overall number of NEMT trips by Medicaid population (such as the population made newly eligible by the ACA), as well as on the trip provider, mode of transport, and cost per trip. These data will likely be easier to access in states where NEMT administration has been centralized into regional or statewide brokerages. However, every state that bills the federal Medicaid program for NEMT trips must be able to document those trips to the satisfaction of federal and state auditors.

Current Data Collection by Transit Agencies. Transit agencies also collect considerable information about their services, so they will be the most likely source of data on the impacts of the ACA's non-Medicaid provisions. Transit agencies receiving federal funds must report financial and operating data to the National Transit Database (NTD), and state departments of transportation (DOTs) may require transit agencies to report additional data. In addition, for planning purposes, most transit agencies collect information on the number of passengers using the system and the overall cost of their services, plus some cost breakdowns to measure different service types and geographic service areas. Depending on the technology available, transit operators may also collect detailed ridership information by stop and time of day. Many transit agencies also collect information on pass usage.

Transit agency data for fixed-route services are primarily collected at the system level. Therefore, monitoring the impact of the ACA on fixed-route operations will most likely be limited to tracking changes in ridership to and from stops at or near major medical facilities. Transit agencies may also track use of different pass types, such as half-fare passes issued to older adults and individuals with disabilities, to see how usage is changing. Transit data on ADA complementary paratransit service and other demand-response services are extensive and more specific to individual riders and trips. Each trip is recorded individually, including passenger name, pick-up location, drop-off location, and time of day. For ADA paratransit and other demand-response services, transit agencies should be able to more easily measure the demand for services overall and the number of trips to and from medical facilities. If trips on a transit system's demand-response services are being paid for by Medicaid, transit agencies can also easily track that information, as well as all data points required by the state Medicaid program.

Emerging Monitoring Tools. New technologies relating to transit fare media are emerging constantly. It is conceivable that a "smart" Medicaid ID card or transit fare card could be electronically linked to both Medicaid and transit information systems so that it would only allow payment of transit trips that have been approved by the Medicaid agency. In addition to addressing many of the challenges of tracking the use of fixed-route transit for NEMT trips, this type of technology would facilitate the capture of data that would be useful in monitoring the impacts of the ACA.

Conclusions

The provision of the ACA that will have the most direct and discernible impacts on public transportation is the broadening of eligibility of the Medicaid program, a change that is expected to bring 11 million new participants into the program by 2018. This particular provision is significant to public transit because many Medicaid participants are entitled to transportation assistance if they have no other means

of traveling to Medicaid-funded medical services. Public transit agencies have historically participated in the provision of this transportation assistance, known as NEMT. However, changes made in the last decade to federal Medicaid rules have effectively pushed many state Medicaid programs away from partnerships with public transportation agencies and toward the use of private brokers and private transportation providers. This is the backdrop for the roll-out of the Medicaid expansion that is a key component of the ACA.

The research and case studies conducted for this report have generated the following conclusions about the potential impacts of the ACA on public transit agencies and operations:

- Stakeholders have varying expectations about how much the ACA will affect Medicaid NEMT programs and the way transit agencies interact with NEMT programs.
- Transit agency concerns about implementation of the ACA are focused around:
  - Capacity,
  - ADA paratransit,
  - Reimbursement rates for services provided, and
  - Documenting and reporting on NEMT rides.
- How NEMT programs are organized and structured makes a difference in how effectively and equitably transit agencies are incorporated into the NEMT network.
- Monitoring the impacts of the ACA on NEMT and public transit can be done with existing data, but it will be challenging to separate the effects of the ACA from the other trends affecting NEMT and human services transportation.

1 INTRODUCTION

In March 2010, President Barack Obama signed into law the most dramatic overhaul of the American health care system since the creation of Medicare in 1965. The Patient Protection and Affordable Care Act[1] (also known as the Affordable Care Act or ACA) has already changed some aspects of health care in the United States, although many provisions of the law will not be phased in until 2014 or later. The provisions yet to be fully implemented include those mandating that Americans purchase health insurance; creating insurance marketplaces called "health benefits exchanges," which will significantly broaden the eligibility requirements for Medicaid; and providing subsidies for the purchase of health insurance. The complicated business of implementing the ACA has accelerated since the Supreme Court's June 2012 ruling on the ACA and President Obama's reelection in November 2012. Together, these events make invalidation or repeal of the law more unlikely in the near future.

CBO has estimated that by 2022, the ACA will reduce the number of non-elderly people who are uninsured by about 30 million, thus increasing the percentage of legal, non-elderly residents with health insurance from 82 percent in 2012 to 92 percent by 2022 (*1*). With that many previously uninsured Americans gaining access to health care coverage, it is reasonable to expect some changes in the demand for transit services and in the opportunities for transit systems to provide health care–related transportation.

Project Purpose

The purpose of this report is to highlight for the transit community the provisions of the ACA that are likely to have the largest and most direct impacts on public transit agencies and operations, particularly those in rural and small urban areas. So that the reader can better understand the potential impact, the report also describes pre-existing legal requirements that govern the roles of public transit in health care–related transportation. The report then uses five case studies to illustrate how the ACA could affect particular transit systems operating in different geographic and policy environments. Finally, the report assesses ways in which transit agencies and government agencies can monitor and communicate the effects of federal health care reform on public transit as the ACA is implemented in the coming years.

Research Approach

To isolate the provisions of the ACA that are likely to have the largest and most direct impacts on transit service and providers, particularly those in

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (2010).

rural and small urban areas, the research team consulted existing summaries and analyses of the ACA by health policy organizations such as the Kaiser Family Foundation. The team also searched the websites of public transportation organizations such as the Community Transportation Association of America and organizations interested in rural health care to determine which provisions of the ACA were of special interest. Based on the findings of this initial task, the research team then researched and summarized the pre-existing legal requirements for public transportation agencies that will influence how public transportation agencies are affected by the ACA.

With this information in hand, the research team then selected five transit agencies to serve as subjects for case studies illustrating the potential impacts of the ACA on particular public transportation providers in different geographic and operating environments. The case studies were prepared by combining publicly available information and interviews with various stakeholders. For each case study, the following stakeholders were contacted: transit agency, state Medicaid program, Medicaid NEMT broker (if that state is using a broker model), and state DOT.

To assess ways in which transit agencies or other government agencies can monitor and communicate the effects of federal health care reform on public transit, the research team assessed the types of data currently collected by transit agencies and state Medicaid programs and selected the types of data most likely to capture the impacts of the ACA.

2 PROVISIONS OF FEDERAL HEALTH CARE REFORM THAT ARE MOST RELEVANT TO PUBLIC TRANSIT

To isolate the provisions of the ACA that are likely to have the largest and most direct impacts on transit service and providers, particularly those in rural and small urban areas, the research team consulted existing summaries and analyses of the ACA, such as the detailed analyses available from the Kaiser Family Foundation's Health Reform Source website (http://healthreform.kff.org/). The research team also searched the websites of public transportation organizations such as the Community Transportation Association of America and organizations interested in rural health care to find out which provisions of the ACA were of special interest to them.

Based on these efforts, the research team concluded that the provisions of the ACA that will likely have the largest and most direct impacts on public transit services and providers are those provisions intended to improve access to health care by (1) increasing the number of Americans with health care coverage, and (2) improving the availability of health care services in underserved areas. In addition, the provisions of the ACA intended to reduce the incidence of health care fraud are likely to affect transit agencies that provide transportation services to Medicaid participants. The major provisions of the ACA that are aimed at achieving these objectives are described in greater detail here and summarized in Table 2.

Provisions to Increase the Number of Americans with Health Insurance Coverage

Past health care policy research has shown that providing health insurance to the previously uninsured results in increased use of health care services (*2*). Greater use of health care services could increase the use of public transit by newly insured individuals who are transit-dependent. Because of the large number of previously uninsured people who are expected to obtain health insurance coverage, the number of added trips could have significant impacts on transit service and providers, particularly those in rural and small urban areas.

Medicaid Expansion

One of the primary means by which the ACA expands health insurance coverage is through expansion of Medicaid eligibility. As enacted, the ACA would have required participating states, beginning in January 2014, to cover nearly all people under age 65 with household incomes at or below 133 percent of the federal poverty line ($14,856 for an individual and $30,657 for a family of four in 2012). The ACA provided that the federal government could potentially withhold all of a state's existing federal Medicaid funds if it did not expand Medicaid eligibility as specified in the law.

Shortly after the ACA became law, the state of Florida (joined by 25 other states) sued the U.S. Department of Health and Human Services (HHS), challenging several aspects of the new law. Unlike the other court challenges to the ACA, the *Florida v. HHS* case was the only one that challenged the Medicaid expansion. Florida argued that the law's Medicaid expansion was an unconstitutional exer-

cise of Congress's spending clause power because it improperly coerced the states into participating in the expansion. The Supreme Court accepted the case of *Florida v. HHS* for its 2012 session, along with another case challenging the constitutionality of the ACA's individual mandate.

In its June 2012 ruling, a majority of the Court found the ACA's Medicaid expansion unconstitutionally coercive of states, because all of a state's existing federal Medicaid funds potentially were at risk for non-compliance. The majority also said that the law did not give states adequate notice to voluntarily consent to this change in the Medicaid program. The Court ruled that the federal government cannot withhold all or part of a state's matching funds for the existing Medicaid program if a state does not implement the expansion. The practical effect of the Court's decision was to make the ACA's Medicaid expansion optional for states.

Shortly after the ACA's enactment, CBO estimated that the ACA would result in 13 million new Medicaid participants in 2014 and 17 million new participants by 2022 (*1*). Those projections assumed that every state would expand eligibility for its Medicaid program as specified in the ACA. A similar 2010 analysis prepared for the Kaiser Commission on Medicaid and the Uninsured projected that the ACA would increase the national Medicaid population by 16–23 million in 2019. This analysis, the results of which are shown in the Appendix, provides growth projections for each state. The Kaiser Commission analysis shows that states with more restrictive Medicaid eligibility rules currently would see their Medicaid population grow by more than 50 percent (*3*).

In response to the Supreme Court ruling, CBO lowered its estimates downward by 6 million (7 million new participants in 2014 and 11 million by 2022) (*1*). The downward revision was based on the expectation that at least some states will choose to opt out or will decide to expand program eligibility at some point after 2014. Although many governors have made statements regarding whether their state should participate, definitive decisions will be made by state legislatures during their 2013 sessions.

Because most Medicaid participants are entitled to NEMT service, states that choose to participate in the ACA's Medicaid expansion can expect to experience increased demand for Medicaid NEMT as their Medicaid population grows. As described in Section 3, many public transit agencies play roles in the management and delivery of Medicaid NEMT service, and thus will be affected by the expansion of Medicaid eligibility.

Health Insurance Exchanges

The other principal means by which the ACA expands health insurance coverage is through the establishment of state-based health benefit exchanges, as well as subsidies and tax breaks to help low-income individuals and small businesses buy health insurance coverage through them. CBO has estimated that approximately 25 million people will obtain private coverage through these insurance exchanges by 2017 (although about 7 million of these will have had previous insurance coverage via other means) (*1*). Underlying these provisions is the ACA's controversial "individual mandate," the requirement that U.S. citizens and legal residents obtain qualifying health coverage or else incur tax penalties. The effect of the individual mandate is incorporated into CBO's estimates of the number of people expected to gain health insurance coverage through Medicaid and the other avenues created by the ACA.

Provisions to Increase the Availability of Health Care Services in Underserved Areas

In addition to the provisions aimed at increasing health care coverage, the ACA also contains numerous provisions intended to improve access to health care services in underserved areas. For example, the law provides a 10-percent incentive payment under Medicare for primary care physicians, nurse practitioners, and other professionals meeting certain conditions who practice in areas experiencing a shortage of health professionals. The law provides additional bonus payments for Medicare services by general surgeons in underserved areas and for home health providers in rural areas. The ACA also contains provisions boosting specific payment provisions for rural hospitals. In aggregate, these provisions may allow underserved communities to retain the providers they have and will provide some additional incentive to those considering practicing in underserved areas (*2*).

The ACA will also improve access to health care in underserved areas by investing in federally supported community health centers. These health centers currently serve the primary health care needs of more than 20 million patients in over 8,000 locations across the country. They provide affordable health services to low-income (and often uninsured)

patients. Community health centers will play a role in implementing many provisions of the ACA and in providing access to care for millions of Americans who will gain health insurance coverage under the law. To meet this new demand for services, particularly in underserved areas, the ACA provides $11 billion over five years to expand the number and capacity of community health centers. It is possible that this expansion in the network of community health centers will change demand for transit to and from these centers.

Provisions to Reduce Health Care Fraud

Title VI of the ACA contains numerous provisions to reduce fraud by service providers and suppliers seeking payment from Medicaid, Medicare, or CHIP. Among these provisions are those that require state Medicaid programs to implement new or enhanced procedures for screening and overseeing providers and suppliers. Although providers of Medicaid NEMT (including public transit agencies) are not explicitly addressed in these sections of the ACA, it is likely that implementation of these provisions will lead to increased compliance and reporting requirements for all Medicaid providers and suppliers, including transit agencies that are NEMT providers.

Table 2 summarizes the provisions of the ACA that the research team identified as likely to have the largest and most direct impacts on transit service and providers. The table describes whether each provision is required or allowed (i.e., mandatory or optional) and highlights the provision's relevance to public transit agencies, particularly those in rural or small urban areas.

Table 2 Federal health care reform provisions most relevant to public transportation.

Provision	Summary	Implementation Timeline	Nature of Provision (Required vs. Allowed)	Relevance to Public Transportation
Provisions to Expand Health Care Coverage				
Expansion of Medicaid Eligibility	Establishes a new category of Medicaid eligibility (beginning in 2014) for persons with income at or below 133% of the federal poverty line who are not otherwise eligible for Medicaid or Medicare. Federal cost-share (FMAP) for this category will be 100% in 2014, with no state financial participation until 2017. Federal cost-share will fall to 90% by 2020.	States had the option to expand coverage beginning April 2010. As initially enacted, the ACA required states to provide this coverage by January 2014 or risk losing existing Medicaid funding.	Optional to expand coverage before January 2014. Supreme Court ruling allows states to forego Medicaid expansion without losing existing Medicaid funding.	Projected to increase the Medicaid population by 11 million by 2018. New participants will be eligible for Medicaid non-emergency medical transportation (NEMT).
Health Benefit Exchanges	Creates state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.	Enrollment in exchanges begins January 1, 2014	Required	24 million people are expected to obtain coverage through exchanges by 2019. Increase likely in the number of medical-related trips via transit.
Premium Subsidies for Individuals	Premium subsidies will be provided on a sliding scale basis to families with incomes up to 400% of the poverty level who do not have access to other coverage to help them purchase insurance through the exchanges.	Effective January 1, 2014	Required	Will contribute to the number of people purchasing insurance through the exchanges.

Table 2 (Continued)

Provision	Summary	Implementation Timeline	Nature of Provision (Required vs. Allowed)	Relevance to Public Transportation
Provisions to Expand Health Care Coverage				
Small Business Tax Credits	Provides tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees. Phase I (2010-2013): tax credit up to 35% (25% for nonprofits) of employer cost; Phase II (2014 and later): tax credit up to 50% (35% for nonprofits) of employer cost if purchased through an insurance exchange for 2 years.	January 1, 2010	Allowed	Will contribute to the number of people purchasing insurance through the exchanges.
Individual Mandate to Have Health Insurance	Requires U.S. citizens and legal residents to have qualifying health coverage, or else incur tax penalties.	January 1, 2014	Required	Will contribute to the increase in the population with health insurance, which could increase the number of medical-related trips on transit.
Provisions to Improve Access to Health Care Services in Underserved Areas				
Incentives for Rural Health Care Providers	Provides various financial incentives to encourage health care providers to practice in rural areas.	Various	Various	Taken in aggregate, these provisions could change transit travel patterns in rural areas.
Increased Funding for Community Health Centers	Authorizes and appropriates $11 billion over 5 years to expand the operational capacity of Community Health Centers and to address capital needs.	Fiscal years 2011 to 2015	Required	Will allow Community Health Centers to serve 20 million new patients. Could change transit travel patterns near centers in both urban and rural areas.
Provisions to Reduce Fraud in Medicaid				
New Anti-Fraud Requirements for States	Requires states to implement new or enhanced procedures for screening, overseeing, and reporting on activities of providers and suppliers that participate in Medicaid. Also increases funding for states' anti-fraud activities.	Various	Required	Could increase the administrative requirements associated with being a provider of non-emergency transportation for Medicaid.

3 REVIEW OF RELEVANT LEGAL REQUIREMENTS FOR PUBLIC TRANSPORTATION

This section provides an overview of the pre-existing legal requirements for public transportation providers and services that are most relevant to federal health care reform. First described are the federal rules for Medicaid NEMT and how they affect the participation of public transit operators in providing or coordinating (i.e., brokering) NEMT services. The reason for focusing on Medicaid's NEMT rules is because, as described above, the ACA significantly broadens the eligibility criteria for Medicaid. As with existing Medicaid participants, many new participants will be entitled to NEMT service as part of their Medicaid benefits. This section also summarizes how state Medicaid programs have traditionally worked with transit agencies and current trends that could affect future collaboration. It also presents an overview of NEMT brokerage services, a role sometimes played by public transportation agencies, and the role of brokers in the delivery of Medicaid NEMT service.

Following the discussion of NEMT is a summary of U.S.DOT's requirements for complementary paratransit service in accordance with the ADA. These requirements are relevant to federal health care reform because there are some trips that are technically eligible for funding under either Medicaid NEMT or ADA paratransit. As the Medicaid population increases, the interplay between these two types of transportation service will become more important for transit operators and NEMT coordinators alike.

Medicaid Non-Emergency Medical Transportation (NEMT)

Title XIX of the Social Security Act of 1965 established the Medicaid program as a joint effort of the federal and state governments to ensure health care services for individuals and families who meet certain income and resource requirements, or who belong to other needy groups. The federal Medicaid program, administered by the Centers for Medicare and Medicaid Services (CMS), issues program guidelines and requirements, but each state is responsible for the design of its own Medicaid program, including such components as: eligibility standards; the type, amount, duration, and scope of services to be provided; rates of payment for services; and administrative procedures.

Under federal Medicaid regulations, each state's Medicaid plan must specify that the administering state agency will ensure necessary transportation for recipients to and from providers. Federal regulations (42 CFR 431.53) also require that each state's Medicaid plan describe the methods the state will use to meet this requirement. These transportation services are known as non-emergency medical transportation (NEMT). NEMT services include routine trips to medical appointments, as well as trips that are urgent (i.e., requiring same-day service) but not emergency in nature.

Under Medicaid, transportation is defined as scheduled, shared-ride service that may be provided as curb-to-curb or door-to-door, depending on medical necessity. NEMT services require 24-hour advance notice, except when medical circumstances require otherwise (e.g., sick child). Transportation services are available to eligible persons for a Medicaid-covered service performed by a participating Medicaid provider. States can cap the number of trips allowed per eligible individual on a monthly or annual basis.

Funding for Medicaid is allocated to states on a formula basis, following federal approval of a state's Medicaid plan. The federal funding allocation formula considers such factors as the state's medical assistance expenditures and a 3-year average of per-capita income. States are allowed to categorize some Medicaid services (including NEMT) as either an optional medical service or an administrative expense. Each option has its own advantages and disadvantages:

- **Optional Medical Service.** If a state opts to fund NEMT as an optional medical service, the federal rate of participation (i.e., funding match) will depend on the state's federal medical assistance percentage (FMAP). FMAP rates range from about 50 to 83 percent and are re-calculated annually. For most states, treating NEMT as an optional medical service would provide for a higher reimbursement rate than treating it as an administrative expense. However, there are additional requirements associated with claiming transportation as a medical service. For example, states must assure that the service is available throughout the state at comparable quality, that a system is in place to pay the service provider directly, and that Medicaid clients are provided freedom of choice in selecting a service provider.

- **Administrative Expense.** If a state opts to claim NEMT as an administrative expense, the federal share in the expense is 50 percent, usually less than a state's FMAP rate. However, this option provides states with additional flexibility, largely by eliminating the freedom-of-choice requirement.

Under the ACA, all states will initially receive an FMAP of 100 percent for the newly eligible Medicaid population. The 100-percent match will be in effect for three years, after which it will fall to 95 percent in 2017 and to 90 percent in 2020. Although falling to 90 percent, the FMAP rate for newly eligible Medicaid participants will remain much higher than the FMAP rates for the rest of the Medicaid population. This higher FMAP rate could influence how states choose to claim reimbursement for NEMT service.

NEMT Brokerages

NEMT brokerages refer to the practice of hiring a manager or broker to assume partial or full responsibility for providing Medicaid NEMT service. A broker's duties can include eligibility screening, fielding trip requests with a call center, assigning trips, managing transportation providers, and reporting. Usually, NEMT brokers manage transportation services but are not transportation providers themselves. The public transit agencies serving as both NEMT brokers and providers are the exceptions to this rule.

Across the country, Medicaid NEMT brokers are currently working at local, regional, and statewide levels. They can be a private for-profit entity, a private nonprofit organization, or a government agency (including a public transit agency). Federal Medicaid regulations governing the acquisition and management of each type of broker vary slightly, and there are benefits and drawbacks associated with each type. Almost all brokers require an administrative fee to provide their services; this fee is in addition to the cost of providing transportation. The assumption behind choosing a brokerage model is that the operating efficiencies achieved by using a broker will outweigh the administrative fee charged.

Delegating the complexities of coordinating Medicaid NEMT service to a private broker has many advantages. Private brokers are often "full-risk" brokers, meaning that the contracting agency and the broker agree upon a capitated rate for transportation service (e.g., a fixed amount per eligible Medicaid client per month). Any cost overruns are the broker's responsibility, enabling the contracting agency to predict costs with more accuracy. Private, for-profit brokers also tend to be more technologically sophisticated and more likely to have access to software programs to schedule and assign trips. Furthermore, some private, for-profit brokers back up local operations with large national call centers that take calls from clients across the country.

Public and nonprofit brokers are typically local agencies or organizations with closer ties to public transit agencies and other local services. Many of these brokerages pre-date the development of transit coordination programs and the changes to NEMT regulations of the last five years. For instance, Vermont's public transit agencies have been serving as NEMT brokers since the 1980s. This is largely because cooperation is required by state law, but also because over time, the public transit agencies have developed effective working relationships with human service and medical agencies. Some state Medicaid programs value their relationships with these public or nonprofit partners, as well as their local knowledge. Another advantage of public and nonprofit brokers is that they don't earn a profit for their services; thus, administrative fees are typically less, sometimes significantly so.

Historically, federal rules governing NEMT brokerages made implementing a brokerage challenging for states that chose to treat NEMT as an optional medical service rather than an administrative expense. In other words, if states chose not to participate in the waiver process, they saw their options as either to work with a broker or to receive the higher FMAP rate, but not both. Consequently, most states, regions, or counties with brokerages chose to bill NEMT as an administrative expense or operated under a Medicaid waiver. This changed with the Deficit Reduction Act (DRA) of 2005. That law created a new option for states to amend their Medicaid plans in order to limit the freedom-of-choice requirement associated with NEMT as an optional medical service, while at the same time maintaining federal reimbursement at the higher FMAP levels. This change better enabled states to use the least costly medically appropriate mode of travel instead of relying solely on a participant's choice of transportation provider, which could be a more expensive option. Additionally, the DRA did away with a state's need to justify the cost-effectiveness of the proposed freedom-of-choice waiver and the need to re-apply for a waiver every two years. However, at

the same time, the DRA added several conditions that make using public brokers more challenging:

- The broker must be a wholly separate governmental "unit";
- The broker must be able to prove that it is the "most appropriate, effective, and lowest cost" mode choice for every trip that it awards to itself; and
- The broker must be able to document that, for each individual transportation service, the rate charged is no more than that charged to the general public.

Additional requirements in the DRA for competitive bidding processes and avoidance of conflict-of-interest have further restricted the ability of states to use public brokers such as public transit agencies. However, by establishing proper oversight and monitoring procedures, some states have been able to maintain their public brokerages and receive reimbursements at their FMAP rate. These states include Florida, Massachusetts, Oregon, and Vermont. Other states, such as Texas, Maine, and Kentucky, have opted to reevaluate their systems and, in some cases, have switched to private brokerages or chosen to use the old waiver system (which has considerable administrative requirements) in order to comply with federal regulations.

State Options for NEMT Service Delivery

States can choose to structure NEMT services in a number of ways—locally (e.g., by county), regionally, or statewide. Typically, but not always, a state's administrative structure for NEMT mirrors how it manages and delivers Medicaid services. The largest and fastest-growing model of NEMT administration is a statewide brokerage, which is almost always managed by a private brokerage company.

Local Service Delivery. A handful of states, including Florida, Maryland, New York, North Dakota, and North Carolina, designate local entities, such as county-based departments of social services, as the managers of NEMT service delivery. These states often require coordination with other transportation programs in the county or local area. Under this structure, NEMT programs range from single-person operations to large, automated systems managing hundreds of trips per day. Service delivery models are the most diverse at this level. For example, in Wake County, North Carolina (home of the state capital Raleigh), the county's transportation coordinator manages nearly 30 different transportation programs for a variety of county departments and nonprofits, including Medicaid. As another example, Florida uses a very successful county-based delivery structure for NEMT service.

Regional Service Delivery. Other states use a regional (i.e., multi-county) model for NEMT service, grouping counties with similar characteristics into a unified NEMT service district. These regions use brokers to manage the larger population of participants and typically work with a variety of regional transportation providers. Like county-based systems, regional service delivery models are diverse; some are managed by public transit authorities, others by nonprofits, and still others by private for-profit brokerages.

Hawaii, South Carolina, and Virginia are states that use private brokers for their NEMT regions. Arkansas, Georgia, and Kentucky use a mix of private and nonprofit brokers in their regions. Oregon and Washington State use a mix of nonprofits and public transit providers as brokers for the designated regions. In Oregon, NEMT is provided through eight regional brokerages. Of these, five are transit agencies and three are councils of government. Some brokers, such as Lane Transit District, are responsible for only one county, while others, such as that sponsored by the Mid-Columbia Council of Governments, span a service area of multiple (up to seven) counties. The Oregon Department of Human Services uses interagency agreements with the brokers and does not competitively procure them. Massachusetts, Maine, and Vermont have historically relied solely on public transit operators as their regional NEMT brokers.

Some states combine regional and local service delivery structures. Colorado, Pennsylvania, Minnesota, and Michigan (to be joined by Texas) hire private brokers to manage NEMT in their major metropolitan areas while maintaining county-based service delivery in the remainder of the state.

Statewide Service Delivery. As described above, by relaxing brokerage regulations, the DRA effectively encouraged many states to create statewide brokerages. However, the DRA's restrictions on how brokers are procured have also led to an increasing use of private, for-profit firms as statewide brokers. More recently, economic pressures and input from CMS have further encouraged states to transition to statewide brokerages. Due to increasingly tight state budgets and diminishing federal aid, states are considering using private brokers as a way to save money.

CMS also appears to be actively encouraging statewide, private brokerages as a way to combat fraud.

As a result of these trends, a handful of private entities have emerged that specialize in operating Medicaid NEMT brokerages, and a majority of statewide broker contracts are with these two or three large companies. These firms typically can set up brokerages quickly and use a network of local service providers to fulfill trip requests. Many state contracts require the broker to have a local call center, but the companies are also able to offer off-hours services through call centers in other areas that are open longer or in different time zones. At least 15 states use a private, statewide broker, and more are transitioning to this model from the localized models discussed above.

As discussed, many statewide brokers are contracted as "full-risk" brokers and, as such, are compensated using a capitated rate (e.g., per client per month). This approach fixes the cost of NEMT service to the state and ensures service will be provided. If costs to transport clients run over this payment from the state Medicaid program, the private broker is responsible for covering the expenses. In the past two years alone, at least eight states have transitioned or are in the process of transitioning their NEMT service delivery models to statewide brokerages. In nearly every case, the states have competitively bid the contract and selected a private broker. These services are typically not coordinated with any other transportation service in the state. The brokers are usually paid capitated rates, and most of these states bill NEMT as an administrative expense.

Relationship of Medicaid NEMT to Public Transit

There are several reasons why Medicaid NEMT programs are interested in working with public transportation operators, first and foremost of which is cost. Transit is the least expensive and often the most effective transportation mode available to able-bodied NEMT clients. Second, public transportation systems are required by law to be fully accessible, and most transit systems provide service to hospitals and medical centers. Third, creating a completely separate transportation system to provide Medicaid NEMT is seen by many as redundant and inefficient, even if public transportation may not be appropriate for all medical trips.

However, using public transportation to provide Medicaid NEMT service also creates challenges for brokers. All trips paid for by Medicaid must be approved prior to travel and must be documented. In addition, Medicaid will not pay for transportation to any non-Medicaid services. Several years ago, Rhode Island began purchasing bus passes for Medicaid clients, which had the advantages of streamlining service delivery and eliminating the time-consuming, trip-by-trip approval process. Medicaid clients received a monthly bus pass, and this program earned praise for its partnership with the Rhode Island Public Transit Authority.

However, in 2008, CMS released an audit of the program and deemed it non-compliant with federal regulations. CMS had several concerns about how the program was managed and how transit passes were distributed to clients. These concerns ultimately led to a ruling that the potential for Medicaid clients to use bus passes for trips other than Medicaid-approved medical trips meant Medicaid was subsidizing the transit system (*3*). CMS did not re-approve the program. As a result of the audit, Rhode Island stopped distributing bus passes to Medicaid clients and instead, for specific programs, initiated a bus ticket program. The bus ticket program continues to be a cost-effective part of Rhode Island's NEMT program.

The regulations resulting from the enactment of the DRA clarified that Medicaid will not reimburse states for fixed-route transit rides for more than the fare charged to the public. Federal regulations also state that a governmental NEMT broker for Medicaid should pay "no more for fixed-route public transportation than the rate charged to the general public and no more for public paratransit services than the rate charged to other state human services agencies for comparable services" [42 CFR 440.170(4)(ii)(B)(4)(iii)]. For nonprofit NEMT brokers, however, there are no restrictions on negotiating rates with public transit agencies, and "it is appropriate and consistent with current practice for Medicaid to pay more than the rate charged to disabled individuals for a comparable ride" [42 CFR 433.139 Title 42 (b-f)].

Several states do use public transit agencies as NEMT brokers or primary service providers for NEMT. Massachusetts, Maine, and Vermont have historically engaged public transit providers as regional brokers for all of their NEMT service regions, and these brokers will sometimes assign NEMT passengers to themselves. How often they do so depends on the circumstances within each region. Similarly, both Kentucky and Oregon use public transportation providers as brokers in some of their NEMT service regions. The State of Delaware contracts with a private for-profit transportation broker, but this broker

is required to work with the statewide public transportation operator to assign as many trips to transit as possible.

Recently, however, several states have come under CMS scrutiny based on federal regulations prohibiting self-referrals. For example, to avoid conflicts of interest, federal law prohibits physicians from referring patients to other facilities owned by the physician. When applied to transportation providers, this law makes it challenging to execute a model in which a public transportation provider serving as an NEMT broker assigns trips to itself. This has led some states to consider alternative models, while others have managed to continue using public transit providers as brokers. Massachusetts, for example, competitively bids its regional brokerages among regional transit authorities that also provide NEMT trips. The regional transit authorities serving as brokers have established strict rules for lowest qualified bidding to select providers. This process is well documented and monitored by the Massachusetts Office of Human Service Transportation. Furthermore, Massachusetts bills NEMT as an administrative expense, meaning that the rules governing its brokerages are fewer and less strict.

ADA Complementary Paratransit

Public entities that operate fixed-route transportation services for the general public are required by U.S.DOT regulations on implementing the ADA also to provide complementary paratransit service for persons who, because of their disability, are unable to use the fixed-route system. These regulations include a variety of service criteria that must be met by complementary paratransit service programs. FTA is responsible for ensuring compliance with the ADA and U.S.DOT implementing regulations. As part of its compliance efforts, FTA, through its Office of Civil Rights, conducts periodic assessments of fixed-route transit and complementary paratransit services operated by its grantees.

The following requirements govern the delivery of ADA paratransit service:

- **Types of Service.** Complementary paratransit service for ADA paratransit-eligible persons is defined as origin-to-destination service. In some cases, individuals in certain eligibility categories may receive a feeder service trip to and/or from an accessible fixed-route station.
- **Service Area.** ADA service is required when origins and destinations are within ¾ mile of fixed-route corridors. Small areas surrounded by corridors also fall into the service area, as well as areas within ¾ mile of rail stations. ADA service is not required in cases in which an agency does not have legal authority to operate across a jurisdictional border.
- **Service Hours.** Service hours are the same as fixed-route service hours for the accompanying fixed route.
- **Response Time.** Agencies are required to schedule a trip for the day following the request (next-day requests). An agency is required to have staff or an automated system that allows for trip scheduling during typical business hours, on any day prior to the day that service is requested. An agency may allow reservations up to 14 days in advance, but this allowance is not required. Agencies must schedule trips within one hour on either side of the requested trip time, which can be negotiated with the individual.
- **Fares.** Agencies are allowed to charge a fare for ADA paratransit service that is up to twice the fare charged on fixed-route service. Personal care attendants are allowed to ride free of charge, but other companions of ADA-eligible individuals must pay the ADA fare. Trips provided through a contract to another government entity or any type of service organization may be charged at a higher fare. Often, the transit agency charges other agencies the full cost of the trip, sometimes including an administrative charge, instead of the public fare. In many cases, this difference is significant; for example, an ADA passenger fare may be $3, but the full cost of the trip may be $30. The allowance for transit agencies to charge more to organizations using their service is a significant benefit of ADA law.
- **Trip Purpose Restrictions.** Transit agencies can not restrict ADA paratransit service to certain trip types or prioritize any trip type over others (e.g., prioritizing a medical trip over a trip to the grocery store). This offers eligible individuals the same freedom as fixed-route riders.
- **Capacity Constraints.** In contrast to the rules governing Medicaid NEMT, transit agencies cannot limit the number of trips allowed to any eligible individual. Although many transit agencies struggle with capacity constraints on ADA service, they are not allowed to create waiting lists (except for subscription trips) and must

Table 3 Eligibility standards for Medicaid NEMT and ADA complementary paratransit.

Program Features	Medicaid NEMT	ADA Paratransit
Basis for client eligibility	Income	Disability; unable to use fixed-route transit
Eligible type of trip	Medicaid-eligible medical appointments (if no other transportation options are available). Additional restrictions may apply.	No restriction as to type or number of trips
Service area	Any	Within 3/4 mile of a fixed route
Time of day/days of week	Any	Same hours as fixed-route
Customer fare	Usually none	Up to twice the fixed-route fare
Responsible entity	State health agencies	Public transit operators providing fixed-route service

have standards for delivering service in a timely and fair fashion. Significantly late pick-ups, trip denials, missed trips, and excessively long trips must be tracked and kept to a strict minimum. Similarly, telephone wait times for reservations service must be kept to a minimum.

Other requirements govern the training of personnel, maintenance of equipment, presentation of information in accessible formats, and allowing passengers to ride with service animals. Table 3 summarizes eligibility standards for ADA paratransit and compares them to the eligibility standards for Medicaid NEMT service. As mentioned above, the requirement to provide ADA paratransit service applies to transit agencies providing fixed-route services. Some small or rural communities with limited or no fixed-route services provide other demand-response or dial-a-ride services, often for members of the public and not subject to any eligibility requirements. This kind of transit service is not required to meet ADA paratransit standards.

As noted above, some individuals are dually eligible for both Medicaid NEMT and ADA paratransit. For these cases, stakeholders may have different opinions about which program is the funder of last resort. Per federal statute, Medicaid funds are to be used after all third-party liability coverage for medical services has been exhausted. This "payer of last resort" rule has created differences in opinion about how transportation should be funded. Some NEMT brokers interpret the rule to mean that ADA paratransit is a third party available to provide NEMT services, and therefore, financially responsible for NEMT trips. Transit operators, on the other hand, tend to argue that ADA paratransit is not intended to meet specific specialized transportation needs, and that NEMT falls into this category of service.

As the Medicaid population increases, the interplay between these two types of transportation service will become more important for transit operators and NEMT coordinators alike. Some ADA paratransit providers have reported that local NEMT programs refuse trips or reimbursements to clients who are eligible for both ADA paratransit service and Medicaid NEMT. This results in ADA paratransit services transporting individuals at the public ADA fare, when they could otherwise be reimbursed for their actual cost to provide the trip, depending on the circumstances.

4 CASE STUDIES

The research team assessed the potential impacts of the ACA on public transportation through the development of five case studies. The five transit agencies were chosen from a list of potential case study candidates that included a diversity of operating models and a range of geographic and policy environments. The variables used to select these candidates included:

- Anticipated level of increase in the state's Medicaid population if the state chooses to participate in the expansion of the program as specified in the ACA;
- The state's Medicaid NEMT service delivery model;
- Whether the public transit agency is currently involved with the state's Medicaid NEMT system;
- Geographic setting (i.e., rural, small urban, or urban); and
- Geographic region of the country.

The first three criteria were used because of the ACA's significant expansion of Medicaid and the presumed accompanying impacts on Medicaid NEMT service. The next two criteria were used to help ensure that the project's results are relevant to a larger number of transit providers. The five case study subjects are:

- Montachusett Regional Transit Authority (Fitchburg/Boston, MA);
- Southwest Georgia Regional Commission (Camilla, GA);
- Jackson Transit Authority (Jackson, MS);
- Bis-Man Transit (Bismarck-Mandan, ND); and
- Whatcom Transportation Authority (Bellingham, WA).

These five case study agencies are compared in Table 4. With the exception of Massachusetts, the four other states in which case studies are located are anticipated to experience at least a 25-percent increase in their Medicaid populations if they opt in to the ACA's expansion of the program. A Massachusetts provider was included because that state's health care reform law served as a model for the federal ACA. It was therefore considered worthwhile to assess the impacts of the state's own version of health care reform on one of the state's transit agencies. The case studies also represent a range of rural, small urban, and urban settings and a national geographic spread. Perhaps most critically, they represent a number of service delivery models for transit and Medicaid NEMT services. In some cases, transit and Medicaid NEMT are closely linked; in others, the relationship is more distant.

The case studies were carried out by combining publicly available information and interviews with various stakeholders. The research team reviewed published reports and studies on state Medicaid programs, information on NEMT services, and relevant planning documents. This information was supplemented by interviews with stakeholders, including representatives from state Medicaid and transportation departments, staff at local transit agencies and social service agencies, and NEMT brokers. In some cases, interviews with stakeholders led to recommendations for interviews with additional stakeholders, such that in nearly every case, at least four interviews were conducted per case study.

Montachusett Regional Transit Authority

The Montachusett Regional Transit Authority (MART) is a public transportation provider operating in north-central Massachusetts. MART operates a variety of transportation services, including fixed-route transit, ADA complementary paratransit service, long-distance hospital shuttles, and town-based demand-response service. MART's service area covers some 63 square miles, includes 21 municipalities, and serves a population of 113,000 individuals.

In addition to operating public transportation, MART also functions as a transportation broker, managing and assigning medical and human service transportation for the Massachusetts Executive Office of Health and Human Services (EOHHS). MART is currently contracted to provide brokerage functions for its public transportation service area, as well as several other regions. MART currently provides 70 percent of the Commonwealth's medical transportation services, including the metropolitan Boston area; several medium-sized cities such as Springfield, Lowell, and parts of Worcester; and large tracts of suburban communities.

Significance as a Case Study

Massachusetts and MART offer an interesting case study, because:

- Massachusetts implemented its own version of health care reform in 2006, and the state served as a model for several aspects of the federal health care reform law.
- Massachusetts has a regional model for NEMT service delivery and contracts with public entities to serve as brokers for NEMT service.
- MART is one of only a handful of nonprofit organizations serving as Medicaid transportation brokers in the nation. It has one of the largest nonprofit brokerages in the country, providing 3.9 million trips annually and managing a budget of over $68 million.
- MART's service area includes urban, rural, and suburban areas.
- MART manages a sophisticated software system that it has developed over the past decade, working closely with the software provider to build custom modules tailored to MART's particular needs.

Expected Statewide Impacts of Federal Health Care Reform

The Massachusetts health care reform law, enacted in 2006, has been cited as a model for the federal ACA, and, as shown in Table 5, it includes

Table 4 Comparison of transit agencies highlighted in case studies.

Case Study	NEMT Management Model	Service Area	Other Programs Included in Brokerage	Method for Paying NEMT Broker	Statewide NEMT Program Costs (millions)	NEMT Trips Provided Statewide	Statewide Average Cost per Trip	Statewide Trips on Transit	Integration with Transit
Montachusett Regional Transit Authority Boston/ Fitchburg, MA	Regional brokerage – public-sector broker	Varied – includes four regions (rural, suburban, and urban)	Department of Developmental Services (DDS) Department of Public Health	Management fee plus flat cost per trip (by program category)	$34.1m	2.2m	$15.59	About 4% (156,000 trips)	Broker is a transit agency, but use of transit for trips is minimal.
Southwest Georgia Regional Commission Camilla, GA	Regional brokerage – public-sector broker	Rural	Various human service programs. Coordinates funding for public transit.	Per member per month	$80.9	3.1m	$26.10	About 8% (251,000 trips)	Varies by NEMT region
Jackson Transit Authority Jackson, MS	Statewide brokerage – private for-profit broker	Urban	NEMT only	Per member per month	$31.5	818,000	$38.50	Minimal	Minimal
Bis-Man Transit Bismarck, ND	No broker – administered by county social service agencies	Small urban/rural	No broker	No broker	$0.6	21,600	$28.70	58% (12,500 trips)	Approximately 1/3 of state's transit agencies provide NEMT trips.
Whatcom Transportation Authority Bellingham, WA	Regional brokerage – public-sector broker	Small urban/rural	NEMT only	Actual costs plus set administrative fee ($3/trip)	$74	3.4m	$21.76	46% (1.5m trips)	High level of cooperation/ integration with transit

Table 5 Comparison of Massachusetts and federal health care reform laws.

Feature	Massachusetts health care reform law (2006)	Federal Patient Protection & Affordable Care Act (2010)
Individual mandate	Yes. Or pay up to a $1,200 a year penalty.	Yes. Or pay a penalty of $95 a year in 2014, then $695 a year in 2016, when penalty is fully implemented.
Individual subsidies	Yes. For people earning up to 300% of poverty level.	Yes. For people earning up to 400% of poverty level.
Employer mandate	Yes. Companies with 11 or more employees must make "fair and reasonable" contribution toward health insurance or pay a $295 penalty per employee.	Yes. Companies with 50 or more employees that do not offer coverage must pay up to a $2,000 penalty per employee. No penalties for smaller companies.
Employer subsidies	Yes. Subsidies up to 15% if employees participate in a wellness program.	Yes. Tax credits up to 50% of the employer's contribution for companies with up to 25 employees and average wages below $50,000.
Health insurance exchanges	Yes	Yes
Coverage for young adults	Yes. Can stay on parents' plan for two years after no longer claimed as dependent for tax purposes or age 26, whichever comes first.	Yes. Can stay on parents' plan until age 26.
Long-term care	No	No. Included in original law as Community Living Assistance Services and Support Act (CLASS) but program was eliminated because it was deemed financially unsustainable.
Prohibition on rescinding coverage	Yes	Yes
Coverage for pre-existing conditions	Yes, but plans can limit coverage for a condition for six months in certain circumstances.	Yes
Lifetime limits on insurance coverage	Yes, technically allowed, but few plans have them.	No
Annual limits on insurance coverage	Yes (in limited cases)	No
Free preventive care	No, but plans must allow doctor visits for preventive care without a deductible.	Yes
Cost control measures in original legislation	No	Yes

many of the same provisions as the ACA, including expanded access to publicly funded or subsidized health care. Because Massachusetts has already implemented many of the health care reforms required by the ACA, the federal law is not expected to have a large impact on the number of Massachusetts residents enrolled in Medicaid. Assuming Massachusetts participates in the ACA's Medicaid expansion, the state's Medicaid enrollment is expected to increase by only 2 to 5 percent by 2019, relative to projections without federal health care reform. This projected increase translates to approximately 30,000 to 75,000 individuals (*4*).

Summary of Transit Service in the Region

MART is the local transit provider for the Fitchburg metropolitan area within the North Central brokerage region, serving 21 communities. As part of its role as a regional transit authority, MART operates 11 fixed routes in the Fitchburg-Leominster area, seven fixed routes in Gardner, and two medical center shuttles to Boston and Worcester. MART also provides complementary ADA services and Dial-A-Ride services for older adults and persons with disabilities. Subscription demand-response service is also available to members of the general public for a premium fare. The agency maintains a fleet of 27 buses, 177 vans, and two trolley buses.

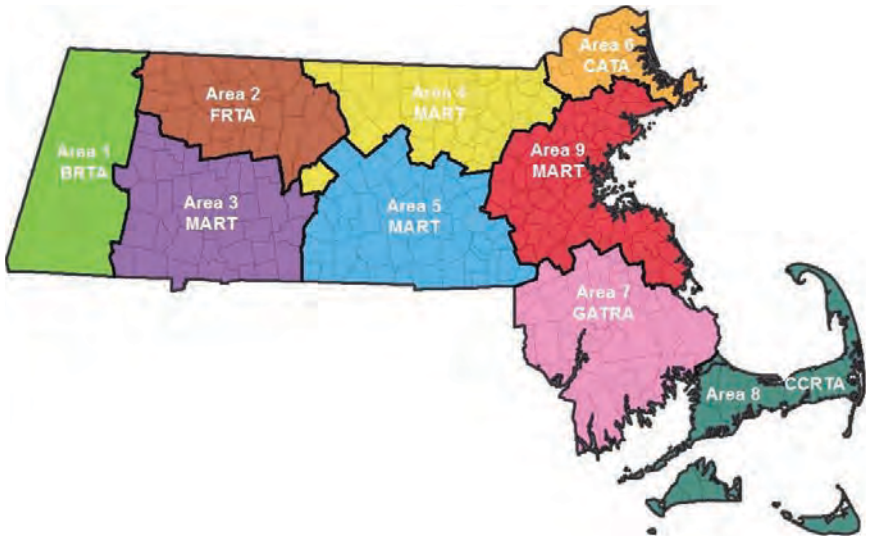
MART is the NEMT broker for four of the state's nine human service transportation (HST) brokerage regions, serving the Pioneer Valley, North Central, South Central, and Greater Boston regions. In 2010, MART brokered approximately 3.7 million trips across its four regions, comprising 70 percent of the trips provided by the state's HST network. Of these, approximately 1.2 million were Medicaid trips, 2.4 million were DDS trips, and 100,000 were Department of Public Health (DPH) trips.

Summary of NEMT Brokerage System in Massachusetts

The Commonwealth of Massachusetts manages its coordinated HST network through its Office of Human Service Transportation, which is part of the state's EOHHS. The HST Office has a director plus approximately 10 full-time-equivalent (FTE) staff responsible for managing and coordinating transportation services associated with four human services programs administered by EOHHS:

- MassHealth (Medicaid) NEMT;
- MassHealth-funded Day Habilitation programs;
- Department of Developmental Services–supported employment workshops and residential supports; and
- DPH's early intervention programs for children and families.

The HST Office has divided the state into nine service areas and competitively awards brokerage contracts for each region (see Figure 1). Regional transit authorities (RTAs) are the only entities that



Source: Massachusetts Executive Office of Health & Human Services.

Figure 1 Massachusetts Human Service Transportation regions.

can respond to the requests for proposals, but RTAs can hold contracts for HST regions that are not part of their RTA service area. The RTA brokers subcontract with qualified, local transportation service providers to provide the NEMT trips. The brokerage contracts set performance standards and specific outcome measures that are established and monitored by the HST Office. The primary responsibilities of the brokers include:

- Arranging consumer trips and contracting for services with local providers;
- Monitoring and ensuring service quality (on-site inspections, consumer surveys, etc.);
- Developing routing and other strategies to increase system efficiency and cost-effectiveness; and
- Tracking and reporting system usage and costs and monitoring performance benchmarks.

HST brokers are reimbursed based on a per-trip rate that is set annually by the HST Office based on the average trip costs recorded in the previous year. Trip rates are set for each program. The HST Office, not the regional broker, establishes the contracted per-trip rate for each sponsoring agency, and the rates are the same in all nine regions across the state. MART sends biweekly invoices to agency sponsors that include total cost for the two-week period, total number of trips, and average trip cost. Under this system, the actual costs for trip provision are calculated monthly and reported to the HST Office, but sponsoring agencies are billed at the contracted rate (not at the actual cost of the trips). Both the HST Office and brokers compare costs throughout the year; if actual costs exceed billed costs, brokers can ask for a rate increase and invoice at the actual trip costs for the remainder of the year. In this way, there are no downside risks for the brokers.

A unique aspect of the HST contracts is an incentive program that allows brokers to share cost savings with the HST Office. As discussed, MART begins the year by charging state agencies the contracted trip rate set by the HST Office. If MART is able to provide service for less than the contracted rate, MART is allowed to keep savings (or profits) up to 3 percent of the annual projected program costs. In other words, if MART is able to broker trips below the contracted trip rate, they can keep the difference until they have realized 3 percent of the total program costs. For example, if the program cost is $1 million, MART would be allowed to keep up to $30,000 in profits earned by brokering trips for less than the contracted amount.

If MART achieves this 3-percent savings, it recalculates the average trip cost for the fiscal year up to that point in time (which is less than the contracted rate) and begins billing agency sponsors using the average trip cost as the new, lower per-trip rate. Brokers are allowed to keep the savings or "profit" but must use these funds for HST-related activities. In MART's case, much of the profits have been used to update and expand its software system. This incentive program is fairly unique among state brokerage models, in part because in this case all brokers are public, nonprofit entities.

MART works with the transportation providers extensively to address two primary concerns: trip reimbursements and monitoring of service quality. Reimbursing trip costs emerged as a major issue, largely because of the delays involved with large government agencies. In response to this, MART agreed to pay vendors upfront for most (60 to 80 percent) of the trip costs and reconcile with them at the end of the month. This helps the transportation providers manage their cash flow more easily, reduces the need to borrow money, and effectively means many small service providers can stay in business.

MART also has an extensive system to monitor service quality. To participate as a vendor, transportation providers must agree to a series of performance standards that include penalties for non-compliance. They also agree to on-site inspections and review of their services. MART has a large staff (nearly 70 FTEs) and thus is able carry out these duties.

Perspective of State Human Service Transportation Office

The HST Office does not anticipate that the ACA will have a significant impact in how it manages, delivers, or organizes its NEMT program. Because Massachusetts has already implemented its own version of health care reform, the federal ACA is not expected to significantly increase Medicaid enrollment in Massachusetts. In addition, Massachusetts is well-equipped to handle changes to its NEMT programs. The state has an effective human service transportation infrastructure, consisting of extensive software systems, an effective broker system, and a robust network of transportation providers. This infrastructure allows the HST Office to manage an influx of enrollees, ramp up capacity as needed, and

provide expanded reports and data according to new requirements.

As a case study for how the ACA could affect demand for NEMT services, Massachusetts's experience with its health care reform is inconclusive. Although the annual growth rates for MassHealth trips were highest during the two years following the passage of universal healthcare (FY 2007 and FY 2008), it is not clear if the growth is directly attributable to the implementation of health care reform. Other states experienced similar increases in NEMT trips during this same time period, and, as shown in Figure 2, other human services programs for which the HST Office coordinates transportation experienced higher growth in trip numbers than MassHealth did in every year except 2007.

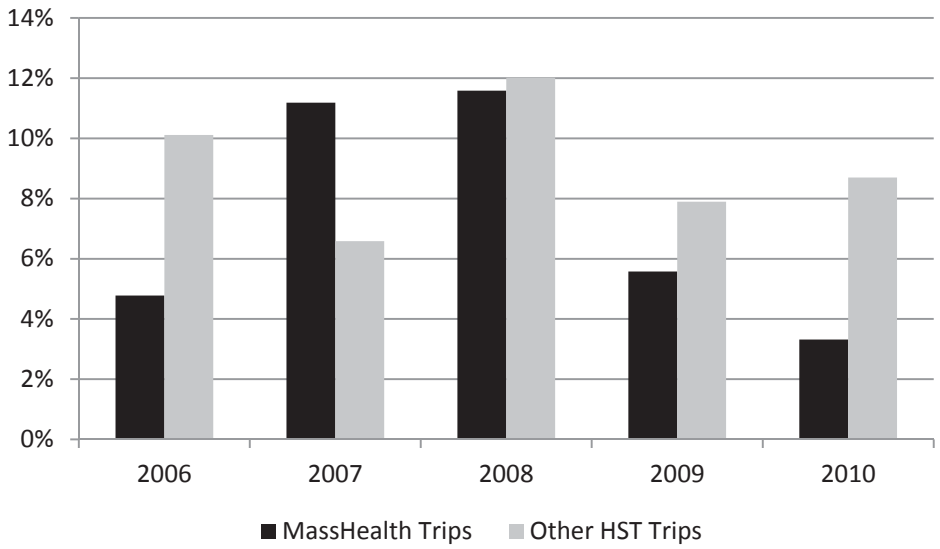
The HST Office is very focused on collecting and tracking hard data and sets clear requirements as part of its contracting with brokers. The data required from brokers is fairly simple—requirements are mostly focused on number of trips, number of consumers, and costs—but brokers are required to report regularly according to specified formats. The HST Office, in turn, summarizes data quarterly, compares costs with negotiated trips rates, and reports on the statewide network annually. Because their reporting system is so comprehensive, the HST Office believes that it can accommodate any additional Medicaid reporting requirements stemming from the ACA with little disruption or increased expense.

Despite its commitment to working with public transit agencies as brokers, the HST Office does not encourage use of fixed-route services. The office does not allow brokers to purchase transit tickets for Medicaid clients. Instead, it requires Medicaid clients to purchase transit tickets themselves and to submit reimbursement forms afterwards. As a result, HST expenditures on fixed-route transit are fairly low, just $106,594 in FY 2010, or 4.3 percent of the total expenditures of $2.5 million.

Perspective of NEMT Broker

MART has emerged as a highly successful and effective HST broker. According to MART officials, much of this success is attributable to the agency's software system, which they said enables the agency to efficiently collect the necessary data to conduct a wide range of analyses and assessments on the agency's brokerage operations. MART officials believe that this software will enable the agency to manage the anticipated effects of the ACA while minimizing disruption to its operations and existing reporting structure.

As both the local transit provider for Fitchburg and the broker for the region, MART can place brokered trips onto its own vehicles. MART is allowed to do this when its services are identified as the lowest cost mode, a selection process that is conducted electronically. MART's software automatically selects



Source: Massachusetts Office of Human Service Transportation.

Figure 2 Annual growth rates in MassHealth (Medicaid) trips and other HST trips before and after implementation of health care reform in Massachusetts.

the provider that can provide the trip for the least cost; this automated process is intended to eliminate any human bias and dispel concerns about self-referrals. Even with these assurances, the HST Office monitors trips referred to MART closely.

Potential Increased Reporting Requirements. The provisions of the ACA that target waste, fraud, and abuse could result in increased reporting requirements for all Medicaid providers, including transportation providers. If reporting requirements change or increase as anticipated, MART officials believe that the agency can alter its software to extract additional information from its database and submit it in the format required by the federal government. Any need for new or different metrics, therefore, should be easily incorporated into the existing system.

Billing Rates and Potential Cost Increases. MART is paid a flat per-trip rate by MassHealth; this rate is negotiated every year and varies by service region. As discussed, the reimbursement system is designed to be dynamic and adjust to increases or decreases in trip costs. MART is also reimbursed for every trip provided, so there are no risks associated with changes in trip volume. MART contracts with over 150 providers to fulfill its trip requests. Low-cost trip provision is a factor in MART's trip assignment process, so vendors set their rates in order to remain competitive. Vendors may change their rates monthly. MART does not anticipate that any rate changes will affect its provider network because of the competitive bidding process.

Ability to Increase Capacity. As for the other transportation providers in its network, MART acknowledges that many may be anticipating growth in trip volume due to the ACA. However, MART's trip assignment process is market-driven. Trip assignments are released to all service providers in good standing and assignments are made purely based on costs. Currently, the supply of transportation service providers exceeds the demand for service (trips). MART has the ability to increase the supply of providers at any time by merely requesting more service. If there are no bidders for a particular trip, providers can increase their price.

In addition, MART continually monitors staff levels, call volume, phone system capabilities, and other equipment and software to ensure there is enough capacity to support operations. These analyses look at efficiency, effectiveness, service quality, and growth capabilities. This allows MART to look ahead and anticipate upgrades in advance of need. MART officials believe that these monitoring devices will assist MART in knowing when and if changes and upgrades are necessary as a result of increased call or trip volume due to the ACA.

Tracking and Monitoring Systems. Because of its sophisticated software capabilities, MART officials believe that the agency will be able to make adjustments quickly to accommodate new reporting requirements and tracking systems. Currently, MART tracks the number of clients by program and costs in its electronic billing records and archival data. As additional reports are required by changes to existing regulations, MART has the capacity to upgrade its software or add modules to accommodate the new requirements.

Conclusions and Lessons

The Commonwealth of Massachusetts has established a well-planned and effective system for providing medical and human service transportation. This network is built around carefully executed broker contracts that ensure the HST Office has adequate information to assess, track, and evaluate the supply, demand, and costs of its transportation services. Under this system, MART has emerged as a dynamic, effective, and responsive broker for a variety of reasons, including the development of a sophisticated software system that allows them to monitor supply and demand and control costs. Several lessons can be taken from this case study:

- Massachusetts has set up an HST Office within its EOHHS with dedicated resources to understand and manage the medical transportation programs effectively.
- The HST Office uses contracts to set expectations for public-sector transportation brokers, but also includes incentives for brokers to reduce costs, while protecting itself against cost increases.
- The HST Office also collects important data, which it uses to track program performance. It also publishes clear, easy-to-read reports on this information. This data-driven approach helps to protect the program against anecdotal information about fraud or abuse.

- MART uses a combination of qualitative and quantitative techniques to manage the program. The staff uses data and customer feedback and site visits to monitor service providers and service quality. The agency also relies on an extensive software system to assign trips based on costs to approved vendors. The software also ensures MART is able to efficiently collect required data, monitor the service network, and report back to the Commonwealth.
- Resources to support this system are derived, in part, through the cost-sharing arrangement that allows MART to keep a portion of savings achieved.

Jackson Transit Authority

Jackson is the largest city in Mississippi, with a population of about 175,000; the entire metropolitan area contains close to 540,000 residents. Transit service in the City of Jackson is provided by the Jackson Transit Authority (JATRAN). Mississippi manages its non-emergency medical transportation program through a statewide contract with a private Medicaid NEMT broker.

Significance as a Case Study

Jackson was selected as a case study for several reasons:

- More than 21 percent of Mississippi's population lives below the federal poverty line, compared to 13.8 percent nationwide.
- Mississippi's Medicaid enrollment has been projected to increase by at least 40 percent when the ACA is fully implemented.
- It offers an example of a state that utilizes a private, statewide broker to manage its Medicaid NEMT services.

Expected Statewide Impacts of Federal Health Care Reform

If Mississippi chooses to participate in the ACA's Medicaid expansion, the state's Medicaid enrollment has been projected to grow by 41 to 54 percent by 2019, relative to projections without federal health care reform. This percentage increase translates to roughly 320,000 to 420,000 individuals compared to the baseline enrollment of approximately 779,000 (*4*).

Summary of Transit Service in Region

JATRAN's services include ten fixed-route bus routes within the City of Jackson and ADA complementary paratransit service called HandiLift. JATRAN also operates demand-response service for the general public (Reserve-A-Ride), which is available to all of Jackson County. The agency is managed by a city department and operates with a fleet of 27 buses and 8 vans.

Through the Reserve-A-Ride program, JATRAN works with several educational and human service partners to provide transportation in support of specific programs. These programs include Head Start, Paratransit for Employment and Training (i.e., transportation for persons with a disability traveling to and from work), School Rides, Medical Shuttles, and Transportation to Work/Project Zero. Fares on Reserve-A-Ride are set based on distance; adult cash fares range from $4.00 to $7.50 per one-way trip.

Summary of NEMT Service Delivery System in Mississippi

As mentioned, Mississippi manages its NEMT services through a statewide contract with a private-sector broker. This broker was awarded the NEMT brokerage contract in 2006 and continues to hold this contract. Its contract responsibilities include eligibility screening, trip scheduling, and third-party contracting with local transportation companies. It maintains a pool of NEMT providers and distributes trips according to the least costly most appropriate mode available. The company does not own the vehicles used in the provision of NEMT, but does credential the drivers. It also handles provider reimbursement and quality assurance. The broker is paid on a per-member-per-month basis (i.e., capitated rate).

In 2011, 818,000 NEMT trips were provided through the state's Medicaid program, of which 619,000 were for ambulatory trips and 198,000 for wheelchair users. The state does not track data by mode, so no data indicating transit usage were available at the time of this report. The total cost of the program was $31.1 million in 2010 and $31.5 million in 2011. In 2011, the average cost per trip was $38.50.

The broker currently does not have a contractual relationship with JATRAN, the transit agency in Jackson, but it does have contracts with transit agencies in smaller locations in Mississippi such as Natchez, and with human service agencies in rural

areas such as the counties northwest of Jackson. Public agencies entering into contracts with the broker receive a reimbursement per trip that is higher than the fare but lower than the actual cost per trip. The broker maintains that it is not interested in shifting trips onto the paratransit program so that transit agencies only receive fare revenues for those trips. The company has a stated hierarchy for allocation of trips, with the first choice always fixed-route transit where available.

Perspective of State Department of Transportation

Mississippi DOT's transit division has not developed a formal plan for addressing the anticipated increase in NEMT trips expected to result from implementation of the ACA, but the issue is regularly discussed in the regional groups that meet monthly as part of the regional planning process. One of the main topics of discussion has been the types of vehicles that should be purchased to serve a changing clientele. Whereas in the past larger vehicles were used to transport individuals to jobs, the newer clientele will likely be traveling in smaller groups and to medical appointments, which results in less clustering of trips and softer ridership peaks. The transit division anticipates that six- or seven-passenger vehicles will be utilized more efficiently than the larger ones used previously.

From the state DOT's perspective, the impacts of the ACA on public transportation represent both a challenge and an opportunity. The challenge will be providing more trips without a significant infusion of funding, especially if transit systems continue to provide service without being reimbursed by Medicaid for the trips. However, the state also views this trend as an opportunity to make a difference in the community and to convey to elected officials and others the important role played by these transportation providers.

Perspective of NEMT Broker

Regarding the broker's planning for the implementation of the ACA, a spokesperson said he does not anticipate any changes in the functions of the brokerage, but rather a need for increased staffing to handle the anticipated increases in NEMT trips. The company has already hired a Director of Transportation Operations to enhance working relationships with transit agencies and increase coordination on a national level, and this has yielded minor successes to date. For example, the company partnered with the Community Transportation Association of America to develop standardized national training for NEMT drivers. However, there have not been changes specific to Mississippi.

Perspective of Transit Agency

JATRAN is the fixed-route transit provider in the City of Jackson, and is also responsible for the provision of ADA paratransit service through its HandiLift program. In the past, JATRAN partnered with the broker and received reimbursement for Medicaid NEMT trips, but it is not currently under contract with the company. The transit agency offered that part of the reason why it (and presumably other transit agencies in the state) has chosen not to work with the private broker is because of the administrative burden involved, particularly with regard to billing procedures.

The federal Half-Fare program allows passengers to show their Medicaid card as proof of disability, thereby permitting any individual holding a Medicaid card to ride transit for half-fare. JATRAN has noticed an increase in the volume of fixed-route trips by HandiLift riders who receive discounted fixed-route fares, particularly in the area of Jackson where four medical centers are concentrated. JATRAN has also observed a significant increase in overall fixed-route ridership to this area. The area is served by the most heavily used bus route in the system, which operates on 15-minute headways.

Perspective of State Medicaid Program

Although Mississippi's Medicaid program has not embarked on specific plans to address an anticipated increase in trip volumes from implementation of the ACA, a state Medicaid official indicated that it is unlikely that the current statewide brokerage model would change. The statewide brokerage model was originally adopted due to the higher federal contribution allowed when billing transportation as a medical expense; receiving the FMAP rate with a private broker is far simpler than utilizing a nonprofit or governmental broker. The current capitated rate (per member per month) negotiated with the broker was based on a specific assumption of NEMT trips, with an allowance for renegotiation in the event of a 5-percent variance (a typical arrangement in other parts of the country). If new enrollees travel at a higher rate, the capitated rate may need to be reconsidered. State officials suggest, how-

ever, that if trip rates per person do increase due to implementation of the ACA, the state would likely renegotiate the capitated rate rather than consider a different service delivery model.

Conclusions and Lessons

Several key lessons can be learned from Jackson's current NEMT service delivery system:

- The State of Mississippi's NEMT service delivery model is less coordinated with public and human service networks than that of several other case study states, and there is significantly less interaction between public transportation authorities and either the State Medicaid office or the NEMT broker.
- Many transit agencies are not currently part of the NEMT service delivery system. Though reasons vary, one stated reason is the paperwork necessary for obtaining a contract with the broker. If this is the case now, any increased paperwork required under ACA for all providers could emerge as a deterrent for transit agencies to participate in NEMT.
- JATRAN receives no reimbursement for Medicaid trips. Although a missed opportunity for revenue, this is not uncommon. The federal Half-Fare program requires JATRAN to allow Medicaid recipients to ride fixed-route services (off-peak only) at a discount.
- Few public transportation agencies in Mississippi currently work with the broker. This creates a disadvantage for both the transit agencies and the broker; the broker could utilize a less expensive form of transportation, and agencies could gain additional revenue.
- Rural public transportation providers in Mississippi that do partner with the broker to provide NEMT are not reimbursed for the full cost of service.
- The state and regional transit agencies, especially nonprofit organizations operating in rural areas, are thinking ahead to the implementation of ACA and are planning for changes in vehicle type as well as other capital and infrastructural changes.

Southwest Georgia Regional Commission

The southwest Georgia region consists of 14 rural counties in the southwest corner of the state: Terrell, Lee, Worth, Colquitt, Thomas, Grady, Decatur, Seminole, Early, Miller, Baker, Mitchell, Dougherty, and Calhoun counties. Together, these counties had a population of about 356,000 in 2010. The largest metropolitan area in the region is the City of Albany, which had a 2010 population of approximately 76,000 people.

Under the guidance of the Southwest Georgia Regional Commission (SWGRC), the area's transportation providers and agencies work together to meet the basic transportation needs of residents. SWGRC coordinates funding from the Georgia Department of Human Services (DHS) transportation services and Georgia DOT public transportation services (FTA Section 5311) for the 14-county area. SWGRC also held a contract with the Georgia Department of Community Health (DCH) to broker NEMT service for a 40-county service area. However, in January 2012, the state awarded the contract to a private, for-profit company.

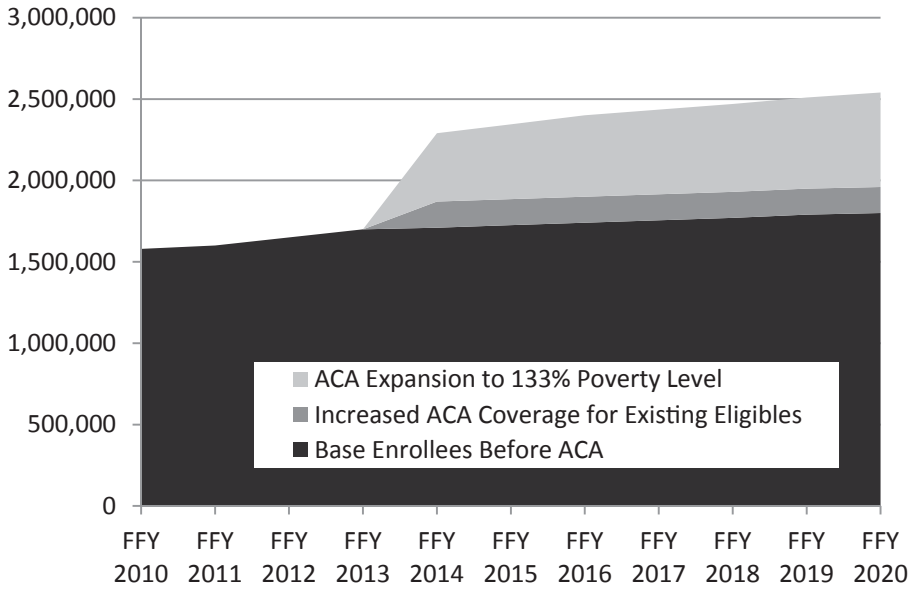
Significance as a Case Study

SWGRC and the State of Georgia present an interesting case study because:

- Georgia provides NEMT services through a regional brokerage model.
- Until it lost the NEMT contract in January 2012, SWGRC was one of only a handful of nonprofit organizations serving as NEMT transportation brokers in the nation, and was the only nonprofit broker for any of Georgia's NEMT service delivery regions.
- SWGRC managed the NEMT brokerage through a sophisticated call center that facilitated extensive data tracking.
- Georgia does not provide state assistance to rural and small urban transit operators.
- The 14-county SWGRC region is the most rural of the five case study areas.

Expected Statewide Impacts of Federal Health Care Reform

If Georgia chooses to participate in the ACA's Medicaid expansion, the state's Medicaid enrollment has been projected to increase by 40 to 57 percent, relative to projections without federal health care reform. This projected increase translates into 650,000 to 907,000 additional participants (*4*). Figure 3 shows Georgia DCH's year-by-year projections of its Medicaid population under the ACA. The requisite spending increase is estimated to be



Source: Georgia Department of Community Health. Note: ACA = Patient Protection and Affordable Care Act.

Figure 3 Projected increase in Georgia's Medicaid population under federal health care reform.

nearly 20 percent by 2019, according to a projection by Georgia DCH. Estimates mark the cumulative increase in state spending at $2.5 billion through 2019 (*6*).

Summary of Transit Service in Region

The SWGRC region has two public transportation providers, plus several private providers, many of which also provide human service transportation through contracts with SWGRC.

Albany Transit. Albany Transit System (ATS) is the only small urban transit operator in the region. ATS operates 10 general public bus routes and paratransit services for ADA-eligible riders. All 10 of the bus routes operate on a scheduled fixed-route system at least six days per week; four of the routes operate on Sundays. Albany Transit is funded through a combination of fares, federal funding, and the local general fund. Georgia DOT requires that fares cover at least 10 percent of transit operating costs. Under the SWGRC brokerage model, Albany Transit provided some NEMT trips, mostly through the sale of bus tickets.

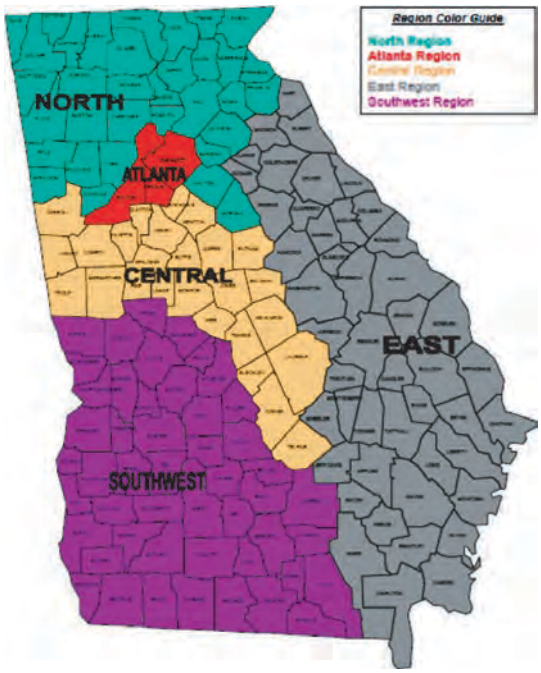
Thomas County Area Transit. Thomas County Area Transit (TCAT) is a public, county-wide operator for Thomas County. TCAT provides dial-a-ride services for the general public and also contracts with SWGRC to provide human service and medical transportation. TCAT is primarily funded through a combination of federal transportation programs (e.g., FTA Sections 5310 and 5311 funds), revenue received through contracts with Georgia DCH, and fares. (TCAT is subject to the same requirement for fares to cover at least 10 percent of operating costs as are urban and small urban operators.) Passengers are scheduled on the same vehicle, regardless of who funds their trip. TCAT owns 17 vehicles in total, 15 shuttles and two vans. When SWGRC was the NEMT broker, TCAT carried approximately 2.5 percent of the regional Medicaid trips; however, now that Logisticare has become the regional broker, TCAT is no longer an NEMT service provider.

Other Providers in the Region. Three private providers operated as contractors for the brokerage system in the SWGRC region. Under the SWGRC brokerage model, the private transportation providers were called upon to transport individuals for a number of human service and medical transportation programs, including Medicaid. Some providers also received FTA Sections 5310 and

5311 funds for either general public transportation in the rural areas, or to purchase vehicles to provide human service transportation. The private operators have fairly large vehicle fleets and provided the majority of Medicaid transportation in the region. SWGRC only receives information about its publicly funded vehicle operations and does not have data about the private operators' operational costs.

Summary of NEMT Brokerage System in Georgia

As shown in Figure 4, Georgia DCH uses five service regions for its Medicaid NEMT program, and the agency contracts with a broker for each of these regions. When it was one of the state's NEMT brokers, SWGRC operated a sophisticated call center that allowed the call taker to confirm eligibility and schedule a trip. Trips were assigned based on cost and availability and allocated to a range of providers including volunteer drivers, taxi services, and the providers described above. Although it no longer provides Medicaid NEMT service, SWGRC is still the broker for a number of human service transportation programs and some public transportation services.



Source: Georgia Department of Community Health.

Figure 4 Georgia NEMT brokerage regions.

When it was an NEMT broker, SWGRC negotiated a per-trip rate with providers annually. The NEMT brokerage contract, however, was based on a capitated or per-member-per-month rate. Thus, as the NEMT broker, SWGRC was required to provide transportation regardless of how much the service cost, or how much they were paid. As a result, they were incentivized to assign trips to the lowest cost provider to preserve funds. If SWGRC utilized services that caused them to exceed their total fee based on the capitated rate, they were solely responsible for the cost overrun.

According to SWGRC, its status as a nonprofit and its ability to operate as a broker for multiple human service, medical, and public transportation programs offered a significant advantage to the community. If SWGRC was able to provide NEMT services for less than the contracted rate, the agency as a nonprofit could not keep the unspent revenues as profits. Instead, SWGRC invested any savings in brokerage infrastructure, such as its call center, or used the funds to ensure other transportation programs kept operating. Furthermore, because the NEMT program was coordinated with other human service and public transportation programs, SWGRC was able to coordinate some funding programs, mingle trips, and stretch resources, either by scheduling joint trips or accessing low-cost modes, such as volunteer drivers. According to the State of Georgia NEMT program, brokers are contractually required to fulfill 92 percent of all trip requests. According to SWGRC, the organization consistently filled 98 percent of trip requests.

Perspective of Transit Agency

Most of the private transportation providers with whom SWGRC contracted for NEMT have remained with the current broker. However, with the switch of brokerages, TCAT is no longer an NEMT provider. According to TCAT, the negotiated trip rates were reduced and the new rate would not cover TCAT's costs. Prior to the new broker, TCAT had been preparing for increased ridership as a result of federal health care reform. As a public transit agency, TCAT receives funding for vehicles, largely through federal funding programs. To receive new vehicles, transit operators must document need and compete statewide for funding. Consequently, a primary concern for the agency was its ability to expand its fleet quickly enough to meet growing demand.

Perspective of NEMT Broker

In the past few years, the number of Medicaid NEMT trips has risen rapidly in Georgia's southwest region. SWGRC attributes this increase to an increase in the price of gas and to the difficult economy (i.e., more people qualifying for human and medical services). Regardless of the ACA, SWGRC expects that usage of NEMT services and costs of providing those services will continue to increase. The agency expects that any increases associated with the ACA will be in addition to growth stemming from existing factors affecting the NEMT program.

As discussed, SWGRC did not win the bid to renew its contract as NEMT broker for the southwest region. The private broker entered a lower bid and was awarded the contract. The private company began providing NEMT brokerage services in the southwest region as of April 1, 2012. Prior to the new bid award, SWGRC had been in discussions with DCH about potential changes resulting from the ACA and their impact on NEMT. SWGRC believed that the Medicaid enrollees resulting from the ACA might be more likely to access their transportation benefits than the current Medicaid population. Under a capitated or "per-member-per-month" contract, brokers are paid based on the number of individuals enrolled. DCH's policy is that the NEMT broker can renegotiate the capitated rate mid-contract if the Medicaid population changes by 5 percent or more, but there are no provisions for rate changes based on how much individual enrollees use the service.

The SWGRC representative discussed a concern unique to public transportation providers serving as Medicaid NEMT providers. In order to increase capacity, providers of all types may need to purchase new vehicles to ensure they can continue to manage all requests for NEMT trips. However, for public transportation providers, the time required to purchase a new vehicle can be up to 18 months. In contrast, private providers are typically able to acquire new vehicles in a matter of weeks. This difference in purchasing timelines presents a significant disadvantage for public transportation operators.

Perspective of State Medicaid Program

Georgia DCH recently undertook an extensive study of its Medicaid service delivery models, including its model for delivering NEMT services. The study recommends a number of redesigns of current service, including NEMT (*5*). The report states that the brokerage system has helped reduce fraud and abuse and has led to significant cost savings. The report also found that the brokerage system enhances coverage in rural areas. However, the report lists a number of concerns with the brokerage system:

- Capacity constraints exist, especially in rural areas, where some brokers have utilized non-NEMT services to take clients to appointments. These trips are not reimbursable by Medicaid.
- The brokerage system does not allow consumer choice of brokers since only one broker is designated in each region.
- DCH also perceives that having one regional broker limits its ability to negotiate contractual provisions and billing issues.
- In some regions, it can be difficult for brokers to find transportation providers due to costs associated with specific trips.

Although the report does not recommend a specific course of action, the report documents the benefits of a "carve-in" system, implying that such a model is under consideration. Under a carve-in model, NEMT would be included with managed-care contracts and would become the responsibility of the health plans as opposed to that of DCH. This structure would require a relationship between the brokers and the health plans, rather than between the brokers and DCH. Under this model, the involvement of transit systems in NEMT is unclear.

The report also mentions pending legislation in the Georgia legislature (Georgia House Bill 277), which calls for a study of coordinated rural and human service transportation systems. This type of study would likely investigate the relationships between transit systems and funding programs such as Medicaid. The report states that this potential coordination was not taken into account when making NEMT recommendations regarding the service delivery model. All of these changes show that Georgia, like a large number of other states, sees a need to consider major changes to its Medicaid NEMT program.

Georgia DCH, which manages the state's Medicaid program, is currently reviewing options for all aspects of the Medicaid program, including the NEMT program. As discussed, one model under consider-

ation is bundling NEMT services into managed-care contracts. Bundling NEMT would be a significant change in Georgia's model, and Georgia DCH believes that the current brokerage model has served the state well in terms of service and fraud control. The change is being reviewed as part of the Medicaid and PeachCare for Kids Design Strategy Report; preliminary findings were released to the public in January 2012.

In concert with the internal Medicaid program review process, Georgia DCH reviewed the ACA and is aware of the potential ramifications for Georgia. The agency has estimated an increase in Medicaid enrollment of about 650,000 and increased costs to the state of up to $2.5 billion. However, Georgia DCH did not make any definite plans for implementing the ACA prior to the Supreme Court's 2012 ruling on the constitutionality of the law. Because of this "wait-and-see" approach, DCH had not discussed the potential impacts of the ACA on NEMT or transit. After the Supreme Court's ruling made the ACA's Medicaid expansion voluntary, the Governor of Georgia announced that the state would not participate in it.

Conclusions and Lessons

Several important lessons for transit agencies are apparent from the Georgia case study. Namely:

- SWGRC offers an example of a multi-program, nonprofit broker and highlights aspects of this model which benefit the broader community. These benefits include the ability to access a variety of modes, including low-cost modes such as volunteer drivers, and the ability to coordinate or commingle passengers traveling under multiple funding sources. Both of these functions are especially important in rural areas.
- As a nonprofit broker, SWGRC was required to reinvest "profits" associated with NEMT back into the brokerage and the community transportation network.
- In rural areas, there is a strong incentive for public agencies and transportation providers to work together to ensure transportation is available. Many transportation providers, including public transportation operators, rely on several programs to remain viable.
- Public transportation programs have a limited ability to expand their vehicle fleets quickly. They must document existing need and compete for funds statewide.
- Brokerage contracts may need to allow additional flexibility to renegotiate contracts as the ACA is implemented. Current capitated or "per-member-per-month" contracts, as structured in Georgia, only allow for increases associated with increased enrollment. Changes in usage rates do not trigger renegotiation of the capitated payment amount.
- NEMT program cost increases, even without the projected impacts of the ACA, are encouraging states to consider different models for service delivery.

Bis-Man Transit

The Bismarck-Mandan metropolitan area is located in central North Dakota. In addition to being the state capital and county seat of Burleigh County, Bismarck is a regional center of health care, education, and retail for the south-central portion of the state. Bismarck itself is home to about 61,000 residents, while the town of Mandan, located across the Missouri River from Bismarck, has a population of about 18,000 residents. Including adjacent communities, the entire Bismarck-Mandan metropolitan statistical area has a population of roughly 109,000. Not surprisingly, the largest employers in the metropolitan area include the State of North Dakota, the federal government, and the Bismarck public school system. However, several health care entities in the metropolitan area are also major employers; these include the Medcenter One hospital and the St. Alexius Medical Center (*8*). Public transportation service in the Bismarck-Mandan metropolitan area is provided by Bis-Man Transit.

North Dakota is currently experiencing a boom in oil and gas production, and although the Bismarck-Mandan area is not close to the actual production sites, this boom has had indirect implications for Bismarck as the state capital. For instance, as a result of the surge in oil and gas production, North Dakota experienced the largest percentage increases in tax revenues among all states in both fiscal years 2010 and 2011. The increase for fiscal year 2011 was more than 44 percent, almost twice the percentage increase for the closest state (*9*). One ramification of the revenue windfall is that the state has not had to engage in the cost-cutting that other states have had to do to balance their budgets. For example, at

a time when other states have been freezing or cutting Medicaid provider reimbursement rates, North Dakota increased provider rates by 6 percent across the board in fiscal year 2011. Providers other than physicians received an additional rate increase of 3 percent in fiscal year 2012 (*6*).

Significance as a Case Study

Bismarck provides an interesting case study because:

- North Dakota is expected to see a large percentage increase in the number of individuals eligible for Medicaid; thus, the number of people eligible for NEMT service can be expected to increase commensurately.
- NEMT is currently managed by county social service agencies, and there is no NEMT brokerage system in place.
- The State of North Dakota is beginning the process of coordinating its human service transportation programs (including Medicaid NEMT) more closely, which will influence how federal health care reform affects the state's transit operators.

Expected Statewide Impacts of Federal Health Care Reform

If North Dakota chooses to participate in the ACA's Medicaid expansion, the state's Medicaid enrollment is expected to increase by 44 to 61 percent by 2019, relative to projections without federal health care reform (*4*). This projected increase is partly due to the fact that North Dakota does not currently offer Medicaid coverage to non-disabled adults other than pregnant women or the parents of children who are eligible for Medicaid. Although the projected percentage increase in North Dakota's Medicaid population is among the highest projected for any state, because of the state's small population, the projected increase in the number of Medicaid enrollees is relatively small (29,000 to 40,000 individuals).

Summary of Transit Service in Region

Bis-Man Paratransit and Capital Area Transit (CAT) provide local transit and ADA complementary paratransit service in the Bismarck-Mandan area. Bis-Man Paratransit began providing door-to-door service for persons with disabilities in 1990. Shortly thereafter, the service was expanded to serve senior citizens age 60 or older as well. Since its inception, Bis-Man Paratransit has offered around-the-clock service to eligible residents who live within two miles of the city limits of Bismarck and Mandan. It also serves the city of Lincoln less than 10 miles away. In 2010, the service provided approximately 172,000 annual passenger trips using 29 buses. An April 2010 analysis of trip origins and destinations for Bis-Man Paratransit showed that Medcenter One and St. Alexius Medical Center were among the top five origins or destinations (*11*).

CAT began offering fixed-route bus service in Bismarck and Mandan in 2004. The 12 bus routes are designed to operate primarily as community circulators, traveling throughout the Bismarck-Mandan urban area and providing service within and adjacent to most residential areas. In 2010, CAT provided about 128,000 annual passenger trips. From 2007 to 2011, monthly boardings averaged about 10,500.

Summary of Medicaid NEMT System in North Dakota

North Dakota does not currently use any brokers to administer Medicaid NEMT. Eligibility determinations for NEMT trips are made by the case workers in county social service agencies as part of their overall Medicaid responsibilities. The Medicaid recipient is required to contact his or her county eligibility worker, and that person is responsible for assessing whether the recipient has access to free transportation via family, friends, or a personal vehicle. If the worker determines that the recipient does not have access to free transportation, the eligibility worker makes arrangements to find a transportation provider for the recipient, taking into consideration any special conditions that may apply (e.g., recipient is wheelchair-bound). The state created a manual for county eligibility workers that includes all Medicaid-enrolled transportation providers. The worker uses that document and determines the most economical means to provide the transportation that meets the needs of the recipient.

Perspective of State Department of Transportation

According to an official in the public transportation office at the North Dakota DOT, only about one-third of the state's 35 transit agencies currently provide Medicaid NEMT service. The official said

that transit operators have cited several issues as discouraging them from providing NEMT trips for Medicaid. For example, some transit providers are discouraged by the lag time in receiving payment from the Medicaid program for trips provided, although this may be an issue only for those transit agencies that submit paper invoices instead of submitting bills online.

According to North Dakota DOT, some transit agencies have also found the operational requirements for the NEMT program to be problematic. For example, there is a toll-free number that NEMT providers are to call to verify the eligibility of Medicaid riders, but the transit operator cannot call the number until it has arrived at the point of origin and the potential rider provides his or her identification card. Thus, the transportation provider risks driving to the passenger's starting location only to find out that a trip is not eligible for reimbursement by Medicaid. Finally, transit providers have been frustrated by what they describe as disparities in how the county social service agencies administer NEMT. In some counties, the Medicaid participant can select the transportation provider, whereas in other counties, it is the social service agency that selects the transportation provider.

The North Dakota DOT official indicated that the agency has been meeting with the state's Medicaid office to discuss changes to the NEMT program that could result in increased participation of the state's transit providers. For example, North Dakota DOT is encouraging the Medicaid program to standardize NEMT payments for public transit agencies by establishing two statewide rates, one for in-town trips and one for out-of-town trips. These rates would apply to both for-profit and public NEMT transportation providers. North Dakota DOT is also advocating for more standardization in how NEMT is administered by the county social service agencies. Additionally, in a separate, longer-term initiative, North Dakota DOT is leading an interagency effort to establish five regional call centers that would assign trips for Medicaid NEMT and veterans transportation programs. The goal was to have two of these call centers in operation by the end of 2012, with the others to follow later. According to North Dakota DOT officials, the potential impacts of federal health care reform on the state's Medicaid population had not yet been factored into the planning for these call centers.

Perspective of State Medicaid Program

As shown in Table 6, North Dakota's Medicaid program provided about 21,600 trips in calendar year 2011. During that year, roughly 3,500 (5 percent) Medicaid enrollees utilized NEMT service. Annual funds spent on NEMT totaled about $620,000 in 2011, a tiny percentage (less than 0.1 percent) of the state's roughly $688 million Medicaid budget. The average cost per NEMT trip was about $29. Transit provided 58 percent of the NEMT trips in 2011. North Dakota Medicaid reimburses NEMT providers using a fee schedule that includes: flat rates, mileage-based rates, or a combination of both.

Officials from the North Dakota Medicaid program indicated that the program supports the concept of coordinated regional call centers (as described above) and would like to see the effort progress. They noted, however, that because North Dakota agencies operate under biennial budgets, changes that may have a significant budget impact are difficult to implement once the budget has been set for the biennium. Along those same lines, the officials indicated that states will have some discretion in

Table 6 Number of North Dakota NEMT trips by mode, calendar year 2011.

Mode	Number of Trips	Percent of Total
Ambulatory transit	10,000	46%
Wheelchair transit	2,500	12%
Private transportation providers	3,200	15%
Taxi	5,800	27%
Intercity bus, train, or air	100	<1%
Total	21,600	100%

Source: North Dakota Department of Human Services.

designing the benefits plan for the population made eligible for Medicaid by the ACA, and that North Dakota will be making decisions about the benefits plan during the 2013 biennial legislative session.

Perspective of Transit System

In 2011, Bis-Man Paratransit provided approximately 8,300 NEMT trips, an average rate of about 700 NEMT trips per month. These trips accounted for less than 5 percent of the roughly 172,000 paratransit trips that the agency provided that year. Bis-Man Paratransit was paid $10 for each NEMT trip, for a total of about $83,000 for the year, compared to total fare revenues of about $464,000 and a paratransit operating budget of roughly $1.7 million. Bis-Man Transit did not have any data on the extent to which its CAT fixed-route service is used by Medicaid participants, although a passenger survey conducted in 2011 as part of a transit development planning process indicated that only 5 percent of non-home origins or destinations for fixed-route trips were for medical or dental purposes (*8*).

Because every passenger on the Bis-Man Paratransit service must complete an application ahead of time, the transit agency usually already has the passenger's medical assistance identification number in its database. If not, the driver records the identification number at the time of customer pick-up. For reporting and recordkeeping purposes, the agency maintains the charge slips filled out by its drivers. Bis-Man Transit submits a monthly bill electronically to the state Medicaid program. If the Medicaid program declines to pay for a particular trip, the transit agency will seek payment from the passenger.

According to Bis-Man Transit's Executive Director, the transit agency has not encountered the obstacles to participation in the state's Medicaid NEMT program that other transit agencies in the state have cited. For one, because Bis-Man Transit submits its bills to the state Medicaid program electronically, it usually receives payment within as little as a week. Bis-Man Transit believes that even if federal health care reform does result in an increase in North Dakota's Medicaid population by as much as 60 percent, the impacts on the transit agency's paratransit service are likely to be manageable. First, the only newly enrolled Medicaid participants who could use the paratransit service would be those who meet the agency's current eligibility criterion of being age 60 or older. Second, because NEMT trips represent less than 5 percent of the paratransit trips currently provided, an increase of as much as 60 percent would not have a significant impact on the agency's total number of paratransit trips.

Regarding the role of its fixed-route operations in providing access to health care facilities for patients and workers, the transit agency has recently begun a partnership with one of Bismarck's hospitals to help alleviate a parking shortage at the facility. The hospital has begun purchasing monthly transit passes for employees. At present, only 15 employees have signed up for the program, but the program is still in its infancy.

Conclusions and Lessons

- For one of North Dakota's largest transit agencies, participating in the state's NEMT program has not been difficult, and the agency is confident that it could scale up its participation to meet any increased demand for NEMT trips resulting from implementation of the ACA.
- Only about one-third of the state's transit agencies are providing NEMT trips, although ND DOT is working with the state's Medicaid program to address some of the concerns of the transit agencies not yet participating but interested in doing so.
- The state is engaged in an effort to improve coordination of state-funded human service transportation by establishing regional call centers. This effort is not related to federal health care reform, but it could benefit the state as it begins to experience increases in its Medicaid population.

Whatcom Transportation Authority

Whatcom County (population 201,000) is located in northwestern Washington State approximately 90 miles north of Seattle. The county shares a border with Canada and contains coastline on the Puget Sound. Bellingham, the largest city in the county with a population of approximately 81,000, has the second-largest harbor in the Puget Sound and is the point of departure and arrival for passenger ferries to Alaska, Canada, and Washington's San Juan Islands.

Major employers in Whatcom County include government (City of Bellingham, Whatcom County), education (Western Washington University, local school districts), and health care (St. Joseph Hospital). Public transportation services in Bellingham and the rest of Whatcom County are provided by the Whatcom Transportation Authority (WTA). Wash-

ington's Medicaid NEMT services are managed by eight transportation brokers, which are a mix of public agencies and private nonprofit entities. The Northwest Regional Council (NWRC), an association of county governments, serves as the NEMT broker for Whatcom County and three adjoining counties.

Significance as a Case Study

Bellingham provides an interesting case study because:

- Public transit and Medicaid NEMT services are both organized regionally, although the boundaries of the two regions are not the same.
- WTA and NWRC are both public entities and have a long working relationship.
- The percentage of NEMT trips that the NWRC provides via public transit far exceeds the statewide average for NEMT brokers.

Expected Statewide Impacts of Federal Health Care Reform

If Washington State chooses to participate in the ACA's Medicaid expansion, the state's Medicaid enrollment is expected to increase by 25 to 34 percent by 2019, relative to projections without federal health care reform. This percentage increase represents an increase of roughly 300,000 to 400,000 individuals from the baseline enrollment of approximately 1.2 million (*3*).

Summary of Transit Service in Region

WTA operates fixed-route, deviated-route, ADA complementary paratransit, intercounty connector, and rural dial-a-ride service throughout Whatcom County. WTA's fleet includes 59 full-size buses, 39 mini-buses for paratransit service, and 39 vanpool vehicles. WTA operates 36 fixed routes, which had nearly 4.7 million linked boardings in 2011, an average of roughly 390,000 per month. Paratransit ridership in 2011 was about 175,000 boardings, an average of about 15,000 per month. The rural dial-a-ride service, called Safety Net, had 1,400 boardings in 2011 (*12*).

Summary of Medicaid NEMT Brokerage System in Washington State

Washington State's Health Care Authority (HCA) administers the state's Medicaid program, including NEMT service. Since 1989, Washington's NEMT services for the state's 13 transportation service regions have been managed by regional brokers. Currently, there are eight regional brokers, all chosen through a competitive procurement process. The transportation service regions and the NEMT brokers are shown in Figure 5. Washington State's

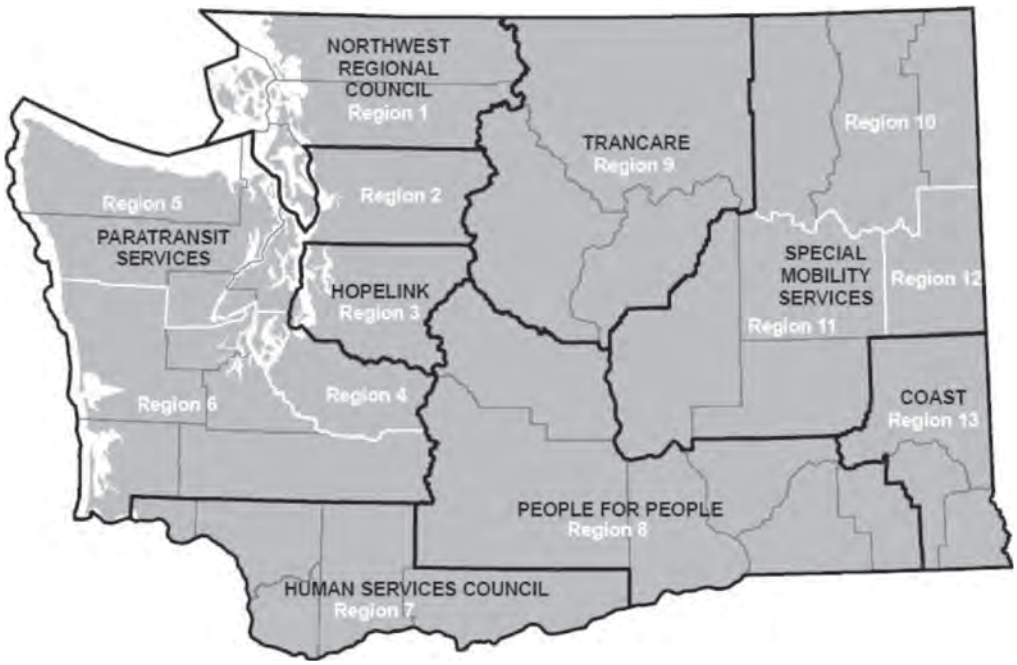


Figure 5 Washington State's regions and brokers for Medicaid NEMT.

broker organizations are a mix of public agencies and private nonprofit entities. The NWRC, an association of county governments, serves as the NEMT broker for Whatcom County and three adjoining counties (Island, San Juan, and Skagit).

The regional NEMT brokers perform all administrative functions of the NEMT program, including receiving transportation requests, verifying client eligibility, screening clients for mobility status and existing transportation resources, verifying eligibility and coverage of medical events, arranging for transport, and billing and payments. The state's contracting requirements with NEMT brokers also require them to do extensive quality monitoring and reporting. Brokers are required to arrange the least-costly appropriate method of transportation. Under the NEMT contracts, brokers receive an administrative fee plus reimbursement for the direct trip costs. The brokers receive an average of less than $3 per trip for administration, or about 15 percent of the total cost of the average trip (*13*).

Outside of their state Medicaid contracts, some brokers also contract with other agencies to coordinate other kinds of trips, such as senior citizen trips to meal sites, shopping, social outings, support groups, and adult day health centers.

Perspective of Transit Agency

NWRC has a standing monthly order with WTA for monthly transit passes, which are valid for unlimited travel on both the fixed-route and paratransit service. The broker is reimbursed for any unused passes that are returned to WTA. There is no other formal arrangement between NWRC and WTA, nor is there any additional reporting that WTA must do for the broker.

In 2011, NWRC purchased 8,000 WTA monthly passes, approximately 20 percent of all monthly passes sold that year. If all of these passes were purchased at the $25 price charged to members of the general public (versus $13 for ADA-eligible passengers and $15 for students), the revenues to WTA would be roughly $200,000. As a basis for comparison, total fare revenues for WTA in 2011 were about $2.3 million, and the transit agency's total operating budget in 2011 was nearly $22 million.

WTA staff indicated that they don't foresee federal health care reform having a discernible impact on the transit agency's paratransit service. They did not see how implementation of the ACA could result in a large number of additional ADA-eligible people suddenly asking for transit service, either through Medicaid or on their own. WTA staff acknowledged that having more paratransit riders referred to it by NWRC results in higher net costs for the transit agency, but they do not currently consider this to be an issue of great concern.

Perspective of State Medicaid Program

As shown in Table 7, in calendar year 2010, the state's NEMT program provided about 3.4 million trips at a cost of $74 million (*14*). According to HCA officials, the state's NEMT program currently serves 3 to 7 percent of the state's Medicaid population in a given month, which translates to about 33,000 to 77,000 of the state's roughly 1.1 million

Table 7 Washington State and NWRC NEMT trips, calendar year 2010.

Mode/Provider	NWRC		Statewide	
	# of trips	% of total	# of trips	% of total
Public transit	102,510	62.3%	1,552,505	45.7%
Private vendor	42,650	25.9%	1,421,967	41.9%
Gas voucher	14,652	8.9%	333,773	9.8%
Mileage reimbursement	1,271	0.8%	21,182	0.6%
Ferry	2,860	1.7%	7,189	0.2%
Volunteer	517	0.3%	58,858	1.7%
Other	16	--	970	--
Total	164,476	100%	3,396,474	100%

Numbers may not add due to rounding.

Source: Washington State DOT 2010 Summary of Public Transportation.

Medicaid participants. NEMT services comprise approximately 1 percent of the state's Medicaid budget. In 2010, transit systems provided almost 46 percent of Washington State's NEMT trips. The extent to which each of the state's regional brokers refers trips to public transit depends on the geography of its service region and the availability of transit service within that region, among other factors.

Despite the expected increase in the size of the state's Medicaid population under federal health care reform (projected at 26 to 30 percent), Washington State Department of Social and Health Services (DSHS) officials anticipate that the state's NEMT program will be able to accommodate any associated increase in NEMT trips. They said that because most of the new Medicaid enrollees will have higher incomes than current Medicaid participants, the new enrollees should have more of their own transportation resources and should therefore require less assistance from the NEMT program. In addition, they said that the regional NEMT brokers are supposed to be able to handle up to a 25-percent spike in the number of NEMT trips. DSHS officials think that this reserve capacity should help the NEMT program adjust to any increased demand resulting from federal health care reform.

Regarding any increased emphasis on the accountability and program integrity stemming from federal health care reform, DSHS officials said that the agency is continuing to take steps to prevent fraud in its NEMT program. For example, the agency has developed a database that allows it to match the dates of NEMT trips and medical appointments for individual Medicaid participants.

Perspective of NEMT Brokerage

In 2011, NWRC purchased 8,000 monthly passes from WTA. A Medicaid participant seeking a monthly transit pass must show NWRC his or her scheduled medical appointments for the upcoming month. NWRC then determines whether a monthly bus pass is the lowest cost, most appropriate way of providing transportation to the scheduled appointments. NWRC representatives said that as a broker, it considers public transit to be the mode of first choice. As shown in Table 7, NWRC used public transit for about 62 percent of its NEMT trips in 2010, higher than the statewide average of about 46 percent. NWRC representatives noted that this figure is more remarkable considering that of the four counties for which it is a broker, San Juan County has no transit, and Island County has fare-free transit. Although NWRC encourages use of Island County's fare-free transit when appropriate, those trips do not show up in its reported NEMT totals.

NWRC acknowledged that a broker's use of transit is partly determined by the availability of transit service in a particular area and the extent to which transit qualifies as the lowest cost, most appropriate mode in each situation. However, NWRC representatives said that its reliance on transit for NEMT trips could be partly attributed to the longstanding ties between NWRC and WTA, including staff who have moved from one agency to the other. They also cited the past efforts by a brokerage supervisor (herself a transit user) to encourage staff to direct Medicaid participants to transit when appropriate. Finally, NWRC also acknowledged the willingness of WTA and its other transit partner, Skagit Transit, to work collaboratively with it.

NWRC representatives said that federal health care reform has been "on their radar screen," but not with regard to its role as a Medicaid NEMT broker. NWRC also serves as northwest Washington's Area Agency on Aging, and as such, it plans and implements services for seniors and adults with disabilities who need assistance caring for themselves. It is in this role that NWRC has begun to consider how federal health care reform will affect its programs and services.

Regarding how it would respond to an increase in demand for NEMT trips, NWRC indicated that it has multiple NEMT vendors in place, none of which is working full-time for the NEMT program. Therefore, if needed, they should be able to commit more of their capacity to the NEMT program. If not, NWRC said that there are other vendors that would like to participate in the NEMT program but are not currently doing so. These vendors could be brought on board as needed. As far as fraud prevention and program integrity, NWRC said that it currently exceeds the state's minimum requirement for verification of NEMT trips. The agency also noted that as a governmental entity, its audit requirements are more stringent than those for private for-profit or nonprofit organizations.

Conclusions and Lessons

- Washington State is already providing nearly 46 percent of its Medicaid NEMT trips using public transit.

- Washington State Medicaid officials do not expect a sizable increase in the demand for NEMT services resulting from the implementation of health care reform, primarily because the new enrollees will have higher incomes and fewer debilitating disabilities than current Medicaid participants.
- A long, close working relationship between the Medicaid NEMT broker (NWRC) and the transit agency (WTA) has helped encourage the use of public transportation for NEMT trips.

5 MONITORING PROCESS FOR HEALTH CARE REFORM EFFECTS ON TRANSIT

Transit operators and others who wish to monitor and communicate the impacts of the ACA on public transit face the difficult challenge of sorting out the effects of the law from all of the other forces currently buffeting transit systems or looming on the horizon. The ACA is coming into effect during a period of considerable change in public and human service transportation. The economic downturn of 2008 and the slow recovery since then have meant that most states and local agencies continue to face budget pressures that are resulting in cuts or reforms to state Medicaid programs and local public transportation services, as well as to other human service and health programs. Some transit agencies have experienced increases in the demand for ADA paratransit services, and they attribute at least some of this growth to reduction or elimination of other community transportation services. Isolating the impacts of the ACA in such a turbulent environment will be very challenging.

Nonetheless, the first step in discerning the impacts of the ACA is to document health care–related trends accurately. With this trend data in hand, transit operators and policy analysts can begin to determine ways to isolate the impacts of the ACA. This section describes the types of data currently collected by state Medicaid programs and transit agencies and suggests which of these data types could help show the impacts of the ACA on public transit.

During the first three years of the ACA's Medicaid expansion (2014 to 2016), states will have a grace period during which the federal government will reimburse the full costs of providing services to Medicaid participants made eligible by the ACA, before transitioning in stages to a 90-percent federal reimbursement rate for that population. This transition period offers a unique opportunity for states and transit agencies to track costs and evaluate service delivery models as they gain experience with the new Medicaid population made eligible by the ACA.

Existing Medicaid NEMT Data Collection and Monitoring

Federal Medicaid regulations currently require extensive data to be collected, not just by providers of medical services but also by NEMT providers. Much of the data are collected to comply with federal regulations that require state Medicaid offices to establish methods for identifying and investigating suspected fraud and abuse cases (42 CFR 455.13). Methods for identifying and investigating suspected fraud and abuse are developed as part of the state Medicaid plan, which is approved by CMS. States, therefore, are primarily responsible for data collection requirements. Accordingly, specific data points collected by NEMT brokers and providers vary somewhat by state, but the following information is almost always required to be collected:

- Number of one-way trips by mode and by Medicaid population;
- Total cost of trips;
- Average cost per trip;
- Total direct service and administrative costs, and average cost per trip of each;
- Number of unduplicated clients;
- Percent of trip verifications performed;
- Call answering performance statistics;
- Trip denial statistics;
- Percentage of pick-ups/drop-offs within waiting time;
- Number of trips canceled/rescheduled; and
- Number of complaints.

This level of information means that for individual trips, NEMT brokers and providers must record:

- Date individual enrolled in Medicaid;
- Medicaid status (i.e., specific Medicaid program in which an individual is enrolled);
- Prior authorization that the individual requesting travel is Medicaid-eligible;
- Prior authorization for the trip requested;
- A trip manifest documenting the trip origin, destination, and name of the individual transported; and
- Confirmation that the trip was made by the individual authorized.

Depending on how transportation costs are reimbursed, NEMT brokers and providers collect additional information, including trip cost, mileage, mode, any shared rides, day of the week, and time of day. Such extensive data collection efforts mean that the number of trips by individual and the costs of those trips are well-documented. As a result, most states and NEMT brokers currently monitor, at a minimum, the volume of trips provided and the cost of the program. Most state agencies employing NEMT brokers require the brokers to keep extensive records on file, but unless they are conducting an audit, the states themselves typically only access summary reports. These summary reports omit much of the detail that could highlight changes in the use of public transit for NEMT trips.

Potential Monitoring Tools

Many state Medicaid programs have existing software that captures data that could be used to measure the effects of the ACA on NEMT services, and by extension on public transit. At a minimum, most states should be able to track changes in the following:

- Number of individuals eligible for NEMT by Medicaid program or category;
- Number and percent of eligible Medicaid participants actually using NEMT service;
- Number of NEMT trips;
- Cost of NEMT program (overall and per trip); and
- Operating and administrative costs by program and by trip.

Not included in this list are the mode of travel used and the cost of trips (including miles traveled and time in vehicle) by mode. The case study research suggests that most brokers are able to track NEMT trips by service provider and by mode of travel. This information may be tracked through software systems, or manually through contracts with providers to operate a set number of trips at a predetermined price. Consequently, brokers are also able to understand the cost per trip by service provided. Ultimately, however, one of the most important pieces of information will be to track Medicaid clients by program or eligibility class to ensure that those made eligible by the ACA are tracked separately from other Medicaid participants. This practice will almost certainly be included in any new reporting requirements so that states can receive the higher FMAP reimbursement rate associated with this set of Medicaid enrollees.

Transit Agency Data Collection and Monitoring

Transit agencies typically collect considerable information about their services. Therefore, they are the most likely source of data on the effects of the non-Medicaid provisions of the ACA on public transit. Broadly speaking, transit agencies receiving federal funds must report the following data to the NTD: funding and revenue sources, operating costs and expenses, capital costs and expenses, and ridership. A handful of transit agencies operating very small systems in rural areas are exempt from reporting to the NTD, but these agencies typically still collect some data on their systems. States may require additional data reporting by transit operators.

Data requirements vary by the type of funding received, but most transit agencies collect information on the number of passengers using the system and the overall cost of their services, plus some cost breakdowns to measure different service types and geographic service areas. Depending on the technology available at the agency, transit operators may also collect detailed ridership information such as boardings and alightings by stop and by time of day. This information is almost always exclusively used for operations and service planning. For the most part, with the exception of ADA complementary paratransit services, transit agencies collect very little information on individual riders.

Some transit agencies, however, also collect information on pass usage. Tracking information on pass usage is important to transit agencies because it influences how fare structures are set, and in many cases, pass usage is the primary means of billing high-volume clients (e.g., universities) for bulk pass sales. Transit authorities also typically offer discounted passes. For example, FTA requires that transit agencies allow older adults and persons with disabilities to pay half-fare during off-peak periods. Some systems extend a similar program to students and/or youths. Transit agencies can collect information on pass usage by hand (e.g., recorded by drivers on a clipboard) or with an electronic farebox. Advanced fare-collection technologies also allow the collection of detailed information about how a particular type of pass or individual card is used, such as time of day, location, and frequency. However, it is important to

point out that all information is about how the card is used; the card cannot easily and reliably (i.e., without requiring drivers to check photo identification) be traced to a particular individual.

Transit data on ADA complementary paratransit systems and other demand-response services, on the other hand, are extensive and more specific to individual trip. Each trip is recorded individually, including passenger name, pick-up location, drop-off location, and time of day. The information is usually collected when the trip is scheduled and, depending on the software that the transit agency uses, may also be recorded when the trip is provided. Some mobile information systems with GPS capabilities allow the driver to record that the vehicle arrived at a specific location at a specific time and then traveled to another specific location. However, the Health Insurance Portability and Accountability Act (HIPAA) prohibits transit agencies from asking passengers if they are Medicaid-eligible clients. As a result, transit agencies cannot readily determine whether the cost of the trip may be reimbursable through Medicaid.

Transit agency data collection efforts for fixed-route service, therefore, are primarily collected at the system level. Therefore, monitoring the impact of the ACA on fixed-route operations will be limited to observing changes in ridership to and from key health care locations and changes in pass usage. For ADA paratransit and other demand-response services, transit agencies should be able to more easily measure the demand for services overall and the number of trips to health care locations. If trips on a transit system's demand-response services are being paid for by Medicaid, transit agencies can also easily track that information, as well as all data points required by the state Medicaid program. Medicaid travelers using ADA services and paying a public fare, however, cannot be tracked, even when they are traveling for a Medicaid-eligible purpose, because they are not identified as such. Consequently, if the demand for ADA services increases, it may be difficult to know if the increased demand is attributable to the ACA.

Potential Monitoring Tools

Within existing data collection practices, opportunities for tracking an increase in ridership resulting from the ACA include: passenger volumes overall, boarding and alighting at key locations, such as at stops near major medical facilities, and pass usage by type. Transit agencies could also easily incorporate questions about trip purpose into on-board surveys, but on-board surveys are typically not done frequently enough to provide ongoing trend information about the impacts of the ACA. Transit agencies may also wish to track use of different pass types, such as half-fare passes issued to older adults and individuals with disabilities, to understand how usage is changing. The ACA may increase or decrease the use of this program.

Paratransit systems, on the other hand, will easily be able to track use of their services, but not if any additional trips are a specific result of the ACA. Potential useful information will be changes in overall demand (service volume), the number of individuals enrolled, trips per capita, and demand for trips to and from health care destinations, such as medical facilities, doctor's offices, and pharmacies. By tracking and monitoring these metrics, agencies may be able to ascertain how the ACA is affecting their services.

Emerging Monitoring Tools

New technologies relating to fare media are emerging constantly. A large transit system with a strong Medicaid agency partner would be a good candidate site to pilot a new type of Medicaid ID or fare technology (smart card or other media) that would be activated based on an individual's Medicaid eligibility status and, if appropriate, programmed to work within a transit agency's fare box. The ID or fare card would only function if the trip had been approved by the Medicaid agency, thus eliminating the issue of using an unlimited pass for a non-Medicaid-approved trip. This type of ID or fare card would also allow tracking of the origin and destination of the trip, the time of day the trip was taken, and the cost of the trip. The transit agency could track usage of the card and provide the information to Medicaid as part of the reimbursement process.

6 CONCLUSIONS

The report examines how the ACA could affect public transportation providers. The provision of the ACA that will have the most direct and discernible impacts on public transportation is the broadening of eligibility of the Medicaid program, a change that is expected to bring 11 million new participants into the program by 2018. This particular provision is

significant to public transit because many Medicaid participants are entitled to transportation assistance if they have no other means of traveling to Medicaid-funded medical services. Public transit agencies have historically participated in the provision of this transportation assistance, known as nonemergency medical transportation (NEMT).

However, changes made in the last decade to federal Medicaid rules have effectively pushed state Medicaid programs away from partnerships with public transportation agencies and toward the use of private brokers and private transportation providers. As a result, only state Medicaid programs with clear directives (e.g., statutory mandates) have continued to give public transportation agencies a central role in the delivery of NEMT service. In addition, partly because of the adoption of private brokerage models, NEMT service delivery networks are becoming more isolated from, rather than more integrated with, other human service and public transportation programs. In cases in which state Medicaid programs work in partnership with public transportation agencies, these relationships have primarily involved transit agencies functioning as NEMT brokers rather than as transportation providers.

This study was conducted during a unique window of time because many states, including states in which case study research was conducted, were participating in a challenge to the constitutionality of the ACA. States had reacted differently to the ongoing legal challenge—some were actively preparing for the implementation of the ACA, while others were waiting for the Supreme Court's decision before taking actions. Despite the fact that the ACA has not yet been fully implemented, this research suggests a number of findings about how the ACA could affect transit agencies:

Stakeholders have varying expectations about how much the ACA will affect NEMT programs. This study found few points of universal agreement among stakeholders about how the ACA will affect NEMT programs and the way transit agencies interact with NEMT. This finding may reflect that case studies were selected in part because they have different NEMT service delivery models. Some stakeholders think that the ACA will significantly increase the demand for and cost of NEMT programs. These stakeholders tend to represent rural areas and/or come from states that expect a dramatic percentage increase in the state's Medicaid population. Others, however, expect that new Medicaid enrollees will not use NEMT as much as existing participants, largely because the new enrollees will be higher-income and have fewer disabilities and fewer chronic health conditions than existing Medicaid participants.

Transit agency concerns about implementation of the ACA are focused around: (1) service capacity; (2) ADA paratransit; (3) reimbursement rates for services provided; and (4) documenting and reporting on NEMT rides.

1. **Service Capacity.** Some stakeholders are concerned about the ability of their transportation service delivery networks (i.e., the number of providers and number of available vehicles) to quickly and efficiently expand in response to increasing demand associated with the ACA. This is especially true for stakeholders working in rural areas and stakeholders who work with public and nonprofit transportation providers that depend on federal funds to expand their fleet. Other stakeholders are less concerned with the ability to increase capacity. These stakeholders tend to have ample competition for trips, and thus capacity in their NEMT networks.
2. **ADA Paratransit.** Concern about ADA paratransit includes concern over increased demand for ADA paratransit services, as well as how transit agencies will be reimbursed for providing these services. Currently, transit agencies are challenged by their ability to ensure Medicaid clients pay the full cost of transportation services provided, rather than merely the public fare. Some transit agencies are fearful that their paratransit services will come under increased pressure if state Medicaid agencies put more Medicaid-eligible individuals traveling to a Medicaid service on ADA paratransit and pay the fare (as compared to the cost of the trip or another negotiated rate). Ensuring Medicaid pays the fully allocated cost for ADA trips is a critical concern among some (but not all) transit agencies.
3. **Reimbursement Rates.** Currently, there is significant disparity in terms of how transit agencies are reimbursed when they provide transportation services for NEMT brokers. Transit agencies do have different expectations about reimbursement rates. Although they are willing to provide fixed-route transit to NEMT riders for the published fare, most

transit agencies are less willing to provide demand-response services to NEMT riders for the published fare, because the cost per trip is so much higher. Some transit agencies are reimbursed by Medicaid for the fully allocated cost of providing paratransit service; some are reimbursed based on the public fare; and some are reimbursed for another amount in between the fare and the fully allocated cost. Many transit agencies appear to be willing to accept a reimbursement rate that is higher than the fare but lower than the actual cost of providing the services. Some stakeholders say transit operators accept a lower rate in part because some operators believe that serving these individuals is part of their mission; this is especially true of transit agencies in rural areas. Others accept a less-than-ideal reimbursement rate because it is still higher than the public fare.

4. **Documenting and Reporting on NEMT Rides.** Some transit agencies are also currently challenged to collect sufficient data required by their state Medicaid offices, especially for trips on fixed-route transit. Many transit agencies believe that they can offer low-cost NEMT service through their fixed-route services, but they are unable to collect the information needed to confirm, book, and document travel. If more flexibility were allowed in terms of how trips are documented on the fixed-route network, transit agencies would likely be more willing participants in the NEMT program.

How NEMT programs are organized and structured makes a difference in how effectively and equitably transit agencies are incorporated into the NEMT network. Public and nonprofit brokerages, for example, appear to be more closely integrated with public transportation services, with transit playing a larger role in the service delivery network and providing more NEMT trips. This finding appears to be true across several different operating environments, including rural and small urban areas. Private, for-profit brokers, on the other hand, tend to use fixed-route transit less often, even in cases when there are clear financial incentives to do so. Private, for-profit brokers also appear to be less likely to successfully negotiate agreeable terms with transit operators.

Monitoring the impacts of the ACA on NEMT and public transit can be done with existing data, but it will be challenging to separate the effects of the ACA from the other trends affecting NEMT and human services. In some ways, tracking the impact of the ACA on Medicaid NEMT (and by extension on public transit) will be straightforward. State NEMT programs track all trips individually, and by identifying the individual as a Medicaid enrollee made eligible by the ACA (which must be done to qualify expenses for the higher FMAP reimbursement rate), usage and cost can be measured. However, the participation rate for Medicaid and the associated demand for NEMT service will also be affected by other underlying trends, such as the unemployment rate and the price of gasoline. Interpretation of the data, therefore, needs to be conducted carefully.

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ACRONYMS

ACA	Patient Protection and Affordable Care Act
ADA	Americans with Disabilities Act
ATS	Albany Transit System (GA)
CAT	Capital Area Transit (ND)
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DCH	Georgia Department of Community Health
DDS	Massachusetts Department of Developmental Services
DHS	Georgia Department of Human Services
DPH	Massachusetts Department of Public Health
DRA	Deficit Reduction Act of 2005
EOHHS	Massachusetts Executive Office of Health and Human Services
FMAP	Federal medical assistance percentage
FTE	Full-time-equivalent
FY	Fiscal year
HCA	Washington State Health Care Authority
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HST	Human service transportation
HST Office	Massachusetts Human Service Transportation Office
JATRAN	Jackson Transit Authority (MS)
MART	Montachusett Regional Transit Authority
NEMT	Non-emergency medical transportation
NTD	National Transit Database
NWRC	Northwest Regional Council
RTA	Regional transit authority
SWGRC	Southwest Georgia Regional Commission
TCAT	Thomas County Area Transit (GA)
WTA	Whatcom Transportation Authority

APPENDIX: PROJECTED INCREASES IN 2019 STATE MEDICAID POPULATIONS UNDER FEDERAL HEALTH CARE REFORM

Table A shows state-by-state projections of increases in state Medicaid enrollment in 2019 compared to a baseline scenario without implementation of the Medicaid expansion in the ACA. These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in health benefit exchanges, or state or federal savings from reduced uncompensated care, or the transition of individuals from state-funded programs to Medicaid in 2014. The table shows projections using two sets of assumptions:

- **Standard Participation Scenario.** This scenario assumes that states will implement health reform and achieve levels of participation similar to current enrollment in Medicaid among those made newly eligible for coverage; however, this scenario assumes little additional participation among those currently eligible. These results attempt to approximate participation rates used by the CBO to estimate the national impact of the Medicaid expansion.
- **Enhanced Outreach Scenario.** This scenario assumes a more aggressive outreach and enrollment campaign at both the federal and state levels that would promote more robust participation in Medicaid and further reduce the number of uninsured in this low-income population compared to the standard scenario. The enhanced scenario also assumes that individuals respond favorably to the new requirement for coverage.

Table A Projected increases in 2019 state Medicaid populations under federal health care reform.

	Baseline Medicaid Enrollment	Standard Participation Scenario				Enhanced Outreach Scenario			
		Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	% Change in Enrollment	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	% Change in Enrollment
Nevada	221,412	136,563	100,813	47.0%	61.7%	196,168	156,025	72.70%	88.6%
Oregon	485,926	294,600	211,542	56.7%	60.6%	386,845	292,651	78.40%	79.6%
Utah	247,841	138,918	78,284	52.5%	56.1%	180,478	113,872	76.30%	72.8%
Montana	105,156	57,356	37,978	49.6%	54.5%	78,840	56,889	74.30%	75.0%
Oklahoma	697,357	357,150	261,157	53.1%	51.2%	470,358	367,541	74.80%	67.4%
Colorado	514,871	245,730	166,471	50.0%	47.7%	337,706	249,208	74.80%	65.6%
Texas	3,955,352	1,798,314	1,379,713	49.4%	45.5%	2,513,355	2,055,888	73.60%	63.5%
North Dakota	65,637	28,864	17,198	45.1%	44.0%	40,017	26,457	69.40%	61.0%
Kansas	341,840	143,445	89,265	50.9%	42.0%	192,006	131,528	75.10%	56.2%
Virginia	890,205	372,470	245,840	50.6%	41.8%	504,466	365,514	75.20%	56.7%
Mississippi	778,772	320,748	256,920	54.9%	41.2%	419,571	350,091	74.80%	53.9%
Georgia	1,598,648	646,557	479,138	49.4%	40.4%	907,203	721,558	74.40%	56.7%
Wyoming	74,760	29,899	19,099	53.0%	40.0%	40,041	27,488	76.20%	53.6%
Idaho	217,961	85,883	59,078	53.9%	39.4%	115,730	85,523	78.10%	53.1%
New Hampshire	144,072	55,918	34,625	48.7%	38.8%	76,744	52,146	73.40%	53.3%
Alaska	111,144	42,794	33,106	48.4%	38.5%	59,914	49,061	71.70%	53.9%
South Carolina	896,326	344,109	247,478	56.4%	38.4%	443,020	334,296	76.20%	49.4%
North Carolina	1,658,226	633,485	429,272	46.6%	38.2%	887,560	661,292	71.80%	53.5%
New Jersey	1,025,757	390,490	292,489	45.3%	38.1%	567,852	455,627	70.60%	55.4%
Hawaii	221,574	84,130	42,381	50.0%	38.0%	110,203	64,167	75.70%	49.7%
Kentucky	880,957	329,000	250,704	57.1%	37.3%	423,757	337,987	77.00%	48.1%
Alabama	952,205	351,567	244,804	53.2%	36.9%	455,952	335,547	72.90%	47.9%
Nebraska	231,612	83,898	50,364	53.9%	36.2%	110,820	71,053	76.00%	47.8%
Florida	2,741,705	951,622	683,477	44.4%	34.7%	1,376,753	1,073,391	69.70%	50.2%
Minnesota	764,717	251,783	132,511	44.2%	32.9%	348,684	211,781	70.70%	45.6%
Louisiana	1,130,318	366,318	277,746	50.7%	32.4%	507,952	409,869	74.80%	44.9%
Maryland	758,215	245,996	174,484	46.2%	32.4%	348,140	267,555	70.80%	45.9%
Ohio	2,088,824	667,376	462,024	50.0%	31.9%	901,023	670,992	72.60%	43.1%

Table A (Continued)

	Baseline Medicaid Enrollment	Standard Participation Scenario				Enhanced Outreach Scenario			
		Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	% Change in Enrollment	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Decrease in Uninsured Adults <133%FPL	% Change in Enrollment
Michigan	1,952,376	589,965	430,744	50.6%	30.2%	812,818	635,231	74.60%	41.6%
Missouri	1,031,437	307,872	207,678	45.5%	29.8%	437,735	324,276	71.00%	42.4%
West Virginia	412,987	121,635	95,675	56.7%	29.5%	156,582	129,185	76.50%	37.9%
Indiana	1,013,278	297,737	215,803	44.2%	29.4%	427,311	337,987	69.10%	42.2%
New Mexico	512,199	145,024	111,279	52.6%	28.3%	201,855	163,105	77.10%	39.4%
Arkansas	718,305	200,690	154,836	47.6%	27.9%	286,347	234,695	72.10%	39.9%
South Dakota	121,115	31,317	18,594	51.9%	25.9%	41,847	27,160	75.80%	34.6%
Illinois	2,449,446	631,024	429,258	42.5%	25.8%	911,830	694,012	68.80%	37.2%
Iowa	452,614	114,691	74,498	44.1%	25.3%	163,264	117,621	69.60%	36.1%
Washington State	1,175,565	295,662	189,463	52.2%	25.2%	395,577	276,096	76.10%	33.6%
Pennsylvania	2,219,363	482,366	282,014	41.4%	21.7%	682,880	458,200	67.20%	30.8%
Tennessee	1,584,178	330,932	245,691	43.3%	20.9%	474,240	372,894	65.70%	29.9%
Wisconsin	988,055	205,987	127,862	50.6%	20.8%	277,116	188,043	74.30%	28.0%
Connecticut	567,331	114,083	75,864	48.0%	20.1%	154,664	113,876	72.10%	27.3%
California	9,985,807	2,008,796	1,406,101	41.5%	20.1%	2,986,362	2,291,221	67.60%	29.9%
Rhode Island	205,565	41,185	29,147	50.6%	20.0%	53,841	40,850	70.90%	26.2%
District of Columbia	179,890	28,900	15,308	49.1%	16.1%	38,763	22,891	73.40%	21.5%
Maine	367,836	43,468	27,877	47.4%	11.8%	59,502	41,858	71.10%	16.2%
Arizona	1,364,237	105,428	81,095	13.6%	7.7%	305,634	273,008	45.60%	22.4%
Delaware	181,158	12,081	7,916	15.9%	6.7%	28,839	23,317	46.90%	15.9%
New York	5,136,867	305,945	223,175	14.8%	6.0%	820,623	706,575	46.70%	16.0%
Vermont	159,835	4,484	3,214	10.2%	2.8%	15,509	13,443	42.90%	9.7%
Massachusetts**	1,464,896	29,921	10,401	10.2%	2.0%	75,569	43,508	42.90%	5.2%
Total	*58,045,730*	*15,904,173*	*11,221,455*	*44.5%*	*27.4%*	*22,809,862*	*17,524,046*	*69.50%*	*39.3%*

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a lower share of uninsured within the newly enrolled due to low levels of uninsured residents in the baseline.

Source: John Holahan and Irene Headen, Urban Institute, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% Federal Poverty Line," prepared for Kaiser Commission on Medicaid and the Uninsured, May 2010.

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