STATEMENT OF
BARBARA K. CLINE
PRESIDENT – BOARD OF DIRECTORS
COMMUNITY TRANSPORTATION ASSOCIATION OF AMERICA

BEFORE THE COMMITTEE ON BANKING, HOUSING AND URBAN AFFAIRS
U.S. SENATE

MARCH 6, 2014

Mr. Chairman, Ranking Member Crapo, and Members of the Committee:

Thank you for inviting me to appear before you today to discuss reauthorization of the nation's surface transportation legislation – Moving Ahead for Progress in the 21st Century Act, known as MAP-21 – and the federal role and current challenges to public transportation.

I appear before you today as the President of the Community Transportation Association of America's (CTAA) Board of Directors, a national nonprofit, membership association committed to removing barriers to isolation and improving mobility for all people. The Association – founded in 1989 – provides informational resources, technical assistance, training and certification, and many additional resources to communities, transportation providers, and other groups to increase mobility and improve the quality of community and public transportation.

I am also the Executive Director of Prairie Hills Transit, located in Spearfish, S.D. Prairie Hills Transit serves a 12,000 square-mile service area and grew from an operation that started with a single van to one today comprised of 38 vehicles and 50 employees in six

South Dakota counties. I believe I am well-qualified to represent the more than 4,000 members of CTAA, as well as other rural transit providers like Prairie Hills Transit.

CTAA's Core Mobility Values

Over the past two years, CTAA – through extensive outreach and engagement with its members and the larger community and public transportation industry across the nation – has identified a series of core mobility values and specific policy recommendations to address the nation's mobility future. These values have been consistently codified and strengthened throughout the history of federal surface transportation legislation – including their current embodiment in MAP-21 – and must be continually reinforced and expanded upon in any subsequent reauthorization.

As an association, we believe that mobility is a basic right for all Americans that requires federal investment paired with support from state, county and local governments, as well as the means to encourage partnerships with the private sector and non-governmental interests. This need is triggered by a rising national population, increasing rural isolation, growing congestion and escalating climate change that demands greater community and public transportation options at the same time as regulations and policies place barriers to the development of new services while also making maintenance of existing systems more challenging.

This national mobility need requires a strategy that increases investment by responding to growing demand while enhancing productivity in all communities, regardless of location or size. The same level of investment is necessary to support riders of

community and public transportation, whether they are compelled to travel by need – ranging from older Americans and people with disabilities to veterans, tribal members and low-income workers – or choice. The investments we make now in improved options will return immense value for our entire society – both today and in years to come. For it is true that the greatest nation in the world should also be the world's leader in community and public transportation.

The effects of Congressional failure to reauthorize the nation's surface transportation legislation (MAP-21) would have devastating impacts not only on the members of CTAA, but – more importantly – the communities and passengers they serve. The current framework for our nation's entire community and public transportation network depends on continued, reliable and sufficient federal investment, which has largely been provided through the Mass Transit Account of the Highway Trust Fund. In recent years, routine shortfalls in the Highway Trust Fund have left Congressional leaders scrambling to cover the gap in revenue.

Recent proposals from both the Obama Administration and House of Representatives' Ways and Means Committee Chair Dave Camp offer encouraging signs that sufficient sources of revenue may be made available to support a meaningful reauthorization of MAP-21. Congress must act to ensure the nation's community and public transportation network is able to continue to meet the nation's current mobility needs and also respond to emerging needs, as well.

Policy Recommendations Overview

While CTAA and its members are open to a wide range of potential revenue sources to support the Trust Fund and its Mass Transit Account, make no mistake: if Congress fails to act, there will be staggering consequences to the millions of people who depend on community and public transportation every day to access jobs, health care, community services, youth education and training, shopping and retail outlets, child care and all the other elements of our communities that sustain our quality of life. Most immediately, service will be cut – often dramatically – at a time when more Americans than ever rely on these vital mobility options and fares will rise, often at the same time. Maintenance will suffer and vehicles will be further operated well beyond their recommended lifespan, all of which will impact reliability and on-time performance. Passengers will be the hardest hit, arriving to work late (or not at all), missing life-sustaining medical appointments and children will wait longer to be picked up from child care. In short, riders will pay more for less service that is also less reliable.

In rural communities and small urban areas, the impacts of a lack of continued investment in mobility options will be felt even more acutely. These communities depend on the support of federal programs to a greater degree than their counterparts in larger urbanized regions, as state investment is often inconsistent and local resources are often strained. There are no rainy day funds for the majority of rural and small urban transportation providers. At the same time, people in rural America and smaller cities typically have lower incomes and fewer mobility options at their disposal than those living in larger urban communities, magnifying the impacts of service cuts, disruptions

and fare increases. The ramifications of a failure to reauthorize our nation's surface transportation legislation will be disproportionately borne by rural and small urban Americans.

Moreover, these startling outcomes only presuppose maintenance of currently available service, not those of which are also required to meet the steadily climbing need for new mobility options. In communities of all sizes and locations, people need expanded transit service – new buses, trains and vans; vanpools and bike routes – to reach vital destinations in their neighborhoods and regions. MAP-21 represented a tepid response to this growing demand. Its successor must do far better in providing mobility operators the resources necessary to best serve their communities.

As Congress undertakes the process to reauthorize our nation's surface transportation legislation, CTAA and its members believe a series of structural foundations are necessary to maintain current mobility options and add new ones.

Overall, the federal transit program must receive growing investment to sustain all current community and public transportation operations – including both their capital and operating needs – along with a special focus on the growing demand for service in rural and small urban America. To this end, a renewed bus capital program that not only restores investment to pre-MAP-21 levels, but responds to the past two years of chronic underfunding is essential. No single issue is of greater concern to CTAA and its members.

Additionally, new legislation must be stable and support long-term funding whereby the most responsive and efficient decisions are made. This requires a reauthorization period

of at least five (5) years. The legislation's timeframe must be paired with dedicated, diversified revenue derived from sources beyond current levels of the federal gas tax. Those sources could include increasing and/or indexing the federal gas tax, or implementation of alternative revenue streams.

CTAA and its members recommend that Congress renew its leadership role in the selection process of needed transit projects while also increasing investment levels to correspond with the costs of new federal mandates imposed on transportation providers. We also recommend incentives for investment from the private sector and increased investment in growing non-traditional responses to mobility demands and in meeting the growing mobility needs of America's most vulnerable populations.

These, among other more detailed recommendations and priorities for MAP-21 reauthorization from CTAA and its members relating to rural and small urban transit, operating and capital investment, the Section 5310 and coordination / mobility management programs, nonprofit transit providers, mobility management, federal regulations and planning can be found in the attachment that follows this statement.

The Case for Increased Investment

CTAA and its members are committed to a growth strategy for all forms of surface transportation. Investment in our nation's surface transportation infrastructure — particularly public and community transportation in rural and small-urban areas — has lagged behind demand. The continuing impact of aging in place, regionalizing rural employment and health care, as well as the bus capital crisis and rising community and

passenger demand, make investments in rural and small urban transit in MAP-21's successor critical.

In the third quarter of 2013, ridership on transit systems in communities with populations under 100,000 grew by 2.89 percent compared with the prior year — the fastest growing segment of the community and public transportation industry. Ridership in these smaller communities has, in fact, grown every year for the past five years. Employment and medical trips make up the bulk of these growing trips, creating the type of positive outcomes that are the foundations of rural and small-urban transit.

In rural and small-city community and public transportation, the lack of adequate federal investment manifests itself in aging rolling stock and limited operations. Regulatory burdens have more dire consequences and finding local share to match federal investment is more challenging. As stated above, the threat of no MAP-21 reauthorization and the looming shortfall in the Mass Transit Account of the Highway Trust Fund has a vastly disproportionate impact on rural and small-urban transit operations, which rely more heavily on federal investment.

The Looming Bus Capital Crisis

The single greatest example of the lack of federal investment in rural and small-urban transit is in the bus capital program. MAP-21 cut by half the traditional federal program which rural and small-urban transit used exclusively to purchase buses. MAP-21's Section 5339 Bus and Bus Facilities Formula program provides only $1.25 million per

state for rural bus replacement needs and allocates similarly meager amounts through a formula for small-urban areas. The result is a looming bus capital crisis.

For example, in my home state of South Dakota, out of 377 total public and community transportation vehicles in service, 358 - more than 95 percent - exceed recommended useful life standards (5 years or more than 150,000 miles). Of those, 187 vehicles have been operating for more than 10 years! In 2013, 10 systems applied to receive investment for 24 new vehicles, but enough funding was awarded to purchase only eight of those 24 required vehicles. At current levels of investment, it would take nearly 20 years to replace all transit vehicles operating past their retirement age. For reference, in 2013, those systems carried more than 1.4 million riders and traveled more than 4.8 million miles.

Small urban communities face similar challenges. In West Virginia, two small-urban transit systems are operating fleets where greater than 51 percent of their vehicles exceed FTA's recommended retirement date, while another nine rural operators find that anywhere from 26 to 50 percent of their vehicles are operating beyond recommended retirement.

And, finally in New Jersey, more than 30 percent of the state's countywide community transit vehicles – service transporting that state’s most vulnerable population – are at least seven years old and have operated at least 175,000 miles, a total of 313 out of 995 vehicles.

The lack of adequate bus capital funding has an equally dire consequence to rural and small-urban operating investment. As vehicles age, they become significantly more expensive to maintain, resulting in rising operating costs. Older buses tend to be less fuel efficient than newer ones, also increasing operating expenses. Smaller buses — widely in use in rural and small-urban systems — often have recommended five-year service lives. The crisis in bus replacement at these agencies is no doubt exacerbated by the fact that these systems purchased many buses through the 2009 American Recovery and Reinvestment Act, vehicles which are now reaching the end of their useful lives.

CTAA and its members support both formula and discretionary solutions to this bus capital crisis, and hope to work with members of the Senate Banking Committee as well as other members of Congress to find solutions in this reauthorization to ensure rural and small-urban bus operators access to the capital they need to continue to serve their communities and passengers.

Regulatory Relief

The fact that this crisis coincides with the impending arrival of federal transit safety regulations even further adds to the challenge facing rural and small-urban transit operators. These new regulations specifically cover a state of good repair and transit asset management. Yet, there is no specific state of good repair capital program for bus operators of any size as there is for traditional rail systems (Section 5337), nor is there any additional federal investment to help these smaller systems acquire the rolling stock assets needed to ensure system safety. CTAA and its members fully support transit safety efforts and initiatives and continue to cooperate with the Federal Transit

Administration in its development of these important transit safety regulations. MAP-21 reauthorization is the time to ensure that the needed capital investment for rural and small-urban bus operators is available to fully meet the forthcoming safety regulations and requirements.

In fact, CTAA and its members recommend that no new or additional federal regulations be developed for rural and small-urban transit members without first developing a cost analysis. Further, these operators recommend that adequate federal investment to implement new and additional regulations be part of the next surface transportation reauthorization bill.

Supporting Vulnerable Populations

In MAP-21, the New Freedom program was combined with the Section 5310 program, along with a subsequent new set of program guidance. CTAA and its members support both increasing Section 5310 investment as well as the ability of states to select programs within the Section 5310 program — as was the case prior to MAP-21. Nonprofit agencies play a vital role in efficiently and cost-effectively serving vulnerable populations in rural and urban areas alike. Therefore, we support adding a Job Access and Reverse Commute (JARC) maintenance goal or percentage set-aside in the Section 5307 program, as well as developing language to incentivize and maintain the role of nonprofits in local procurements.

Mobility Management strategies promote transit innovations that meet the growing and changing needs of all sized communities and offer right-sized approaches to serving

vulnerable populations. CTAA and its members support investing in mobility management strategies to ensure cost-effective and efficient coordination of all human service transportation programs with community and public transportation and private operators into a full-fledged family of transportation services.

Population demographics and health care policies and trends are the two most prominent factors driving transportation demand in rural and small-urban America. Rural communities are increasingly aging, just as the services designed for older Americans in rural communities become more dispersed and regional in nature. Longer, more expensive trips are the result of these trends.

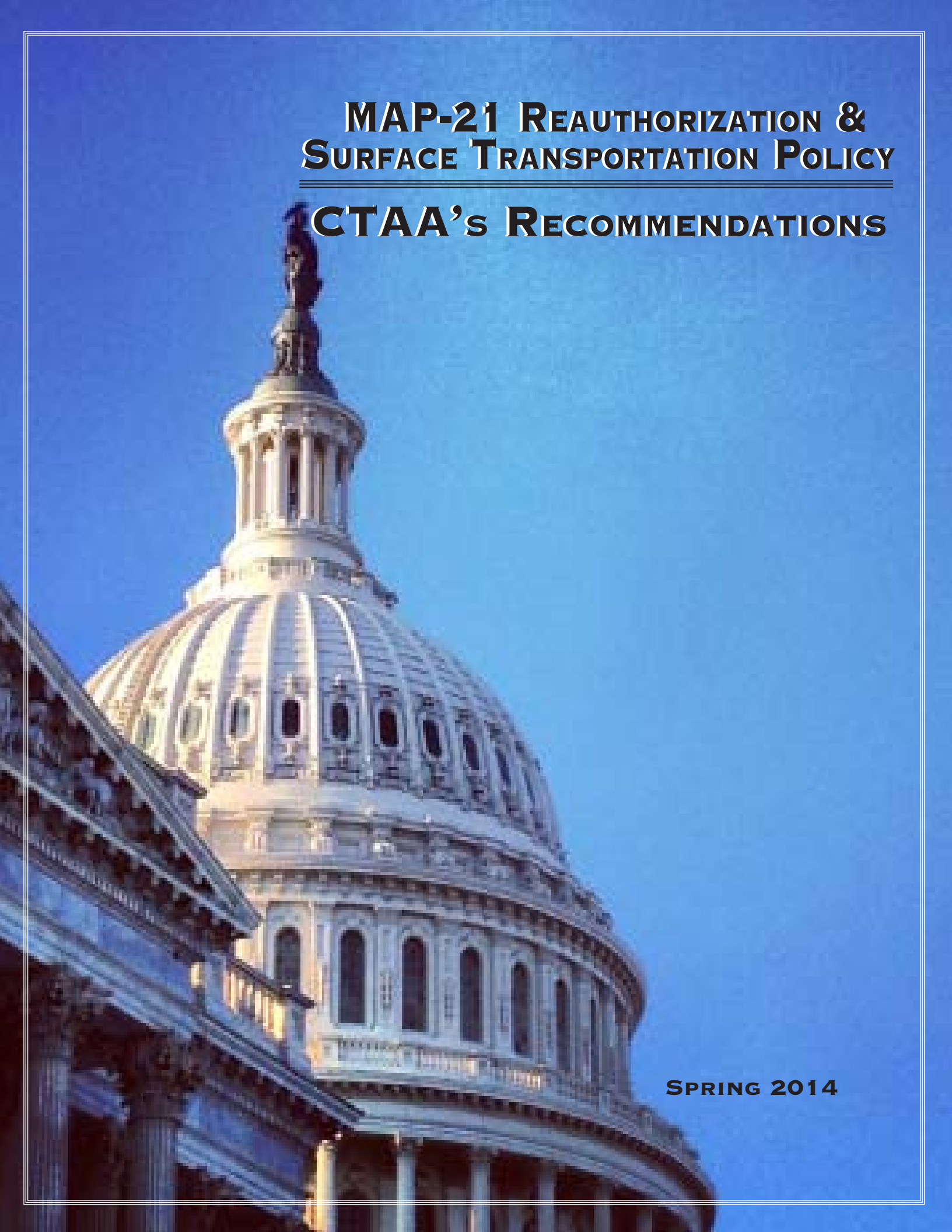
Health care trips in smaller communities and larger ones alike, have become inundated by demand for regular transportation to manage chronic conditions like dialysis, cancer treatments, physical/occupational therapies and even behavioral health services. The traditional service models deployed by community and public transportation systems are being strained by the burgeoning demand for these trips — many of which come from outside the Medicaid arena where non-emergency transportation is not covered. Further, the expansion of Medicaid program enrollment through the Affordable Care Act will assuredly add to this already overwhelming transportation demand (see our recently-released study on non-emergency medical transportation included in the attachment section).

A Time to Act

It is vital that Congress acts decisively to reauthorize the nation's surface transportation legislation by shoring up the Mass Transit Account of the Trust Fund and delivering crucial investment to America's community and public transportation systems and the millions of people they serve every day.

MAP-21 Reauthorization & Surface Transportation Policy

CTAA's Recommendations



Spring 2014

CTAA's Core Mobility Values

We recognize that many parts of the federal government play important and vital roles in addressing our nation's mobility future. Among the most important of these efforts are those included under legislation first developed more than 50 years ago and continued by legislation passed in 2012 titled Moving Ahead for Progress in the 21st Century (MAP-21).

+ We believe that mobility is a national need requiring investment by all Americans through our federal government and one that requires support of our states, cities, counties and other public and private institutions and interests.

+ We believe the increasing population of our country creates demand for expanding community and public transportation services, and that policies and practices that prevent the integration of the varied transportation resources and assets to support community mobility networks remain a barrier to maintaining existing services.

+ We are committed to an investment growth strategy for community and public transportation that responds to growing demand and enhances productivity.

+ We believe that community and public transportation is needed in all communities regardless of size or location.

+ We believe the increasing population of our country creates demand for expanding community and public transportation services as well as maintaining existing ones.

+ We believe that a growing number of people choose community and public transit as a mobility option. But we also recognize that choice is not an option for many of our fellow Americans — seniors, people with disabilities, veterans, low-income populations, Tribal members, etc. — for whom community and public transit is a necessity.

+ We believe that investments made today return value in years to come.

+ We expect the greatest nation in the world to be the world's leader in community and public transportation.

About This Document

Our Association's priorities build on a series of meetings, discussions and deliberations over the last year that have identified ways MAP-21 reauthorization can help our nation meet its mobility challenges and make sure our nation is the world leader in community and public transportation and in the industries required to strengthen our economy and create opportunity. The following document — though focused around MAP-21 reauthorization — includes additional, over-arching surface transportation policy priorities that fall outside the scope of MAP-21.

CTAA's MAP-21 Reauthorization Structural Recommendations

We Support:

+ For stability and planning, a five (5) year minimum Reauthorization

+ Dedicated, diversified revenue beyond the current federal gas tax

+ increasing and indexing the current Federal gas tax

+ using both formula and discretionary funding distribution

+ Incentivizing opportunity for more private-sector investment

+ Increasing investment to cover the costs of new Federal mandates

+ The renewed role of Congress in selecting needed transit projects

+ Growth in Overall Federal Transit Program to Sustain All Current Operations, Both in Capital and Operating

+ Equitably distributing all community and public transit investment

+ Increasing Funding to Meet Growing Demand in Rural and Small-Urban America

+ Increasing investment in Bus Capital that not only returns investment to pre-Map-21 levels, but that makes up for past two years of significant bus capital underfunding

+ Increasing investment to manage growing non-traditional mobility demands

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CTAA's MAP-21 Reauthorization

Recommendations for Rural Transit

We Support:

+ A five (5) year minimum Reauthorization with growing, stable investment in the Section 5311 program

+ Increasing Section 5311 investments to offset the rise in operating costs due to wage and health care costs

+ Increasing investment in the Section 5339 program that not only returns investment to pre-Map-21 levels, but that makes up for past two years of significant bus capital underfunding

+ Developing federal government performance measure on transit capital replacement Levels sufficient to maintain current service levels

+ Provide additional revenue into Section 5337 State of Good Repair Program to Allow for Bus Capital State of Good Repair Investment for rural transit

+ Continuing the land-mass adjusters in the Section 5311 formula

+ Developing rural-centric performance measures in cooperation with rural transit operators

+ Promoting cooperative arrangements around rural/urban boundary lines that recognize regional operations

+ Ensuring that safety regulations for rural transit minimize additional record-keeping, data collection and reporting

+ Creating financial incentives for private-sector investment in rural transit

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CTAA's MAP-21 Reauthorization

Recommendations for Small-Urban Transit

We Support:

+ A five (5) year minimum Reauthorization with growing, stable investment in the Section 5307 program

+ Increasing Section 5307 investments to offset the rise in operating costs due to wage and health care costs

+ Increasing investment in the Section 5339 program that not only returns investment to pre-Map-21 levels, but that makes up for past two years of significant bus capital underfunding

+ Developing federal government performance measures on transit capital replacement Levels sufficient to maintain current service levels

+ Provide additional revenue into Section 5337 to Allow for Bus Capital State of Good Repair Investment

+ Rewarding performance and productivity by increasing Small Transit Intensive Cities (STIC) set-aside in Section 5307 program

+ Providing additional flexibility to small-urban transit providers by allowing them to choose designated recipient status and thus receive Section 5307 and 5339 funds directly

+ Ensuring that Safety Regulations for Small-Urban Transit Minimize Additional Record-Keeping, Data Collection and Reporting

+ Promoting cooperative arrangements Around rural/urban boundary lines That recognize regional operations

+ Creating financial incentives for private-sector investment in small-urban transit

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CTAA's MAP-21 Reauthorization

Recommendations for

Transit Operating

We Support:

+ Allowing farebox revenues to be used as local share

+ Allowing demand-response systems in urban Areas the same flexibility as fixed-route systems in the ability to Use Section 5307 funding for operating

+ Continuing operating flexibility in Congestion Mitigation and Air Quality (CMAQ) funding beyond the previous three-year limit

+ Increasing flexibility in Operating Investment Throughout the Transit Program, allowing local transit agency decision-making on the use of formula investment for capital and operating

+ Increasing operating investments to offset the rise in operating costs due to wage and health care costs

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CTAA's MAP-21 Reauthorization

Recommendations for Transit Capital

We Support:

+ Increasing investment in the Section 5339 program that not only returns investment to pre-Map-21 levels, but that makes up for past two years of significant bus capital underfunding

+ Flexible capital investment to suite local priorities and populations

+ Developing federal government performance measure on transit capital replacement Levels sufficient to maintain current service levels

+ Maintaining the capital infrastructure community and public transportation systems are currently operating before building new systems

+ Providing additional revenue into the Section 5337 Program to Allow for Bus Capital State of Good Repair Investment

+ Providing investment for rural and small-urban transit systems to implement Transit Asset Management Regulations

+ Fostering increased and reasonably priced rolling stock options for all forms of transit through the Buy America program

+ Developing a model transit procurement process for rural and small-urban operators that incorporates regional and multi-state arrangements and is in cooperation with states and transit operators

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CTAA's MAP-21 Reauthorization Recommendations for Section 5310, Coordination & JARC

We Support:

+ Studying MAP-21's consolidation of the Section 5310, JARC and New freedom programs through TRB/TCRP, determining the impact of these changes

+ Adding a JARC Maintenance Goal or Percentage Set-Aside Into Section 5307

+ Increasing Investment in Section 5310 Program to Deal with Growing Population of Older Americans and People with Disabilities

+ Allowing States the ability to manage Section 5310 programs as they did prior to MAP-21 and allow states full discretion on program selection

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CTAA's MAP-21 Reauthorization Recommendations for Nonprofit Transit Providers

We Support:

+ Recognizing the vital role of nonprofit transit providers in America's mobility network

+ Providing incentives to maintain nonprofit transit providers through special treatment in local procurements

+ Studying MAP-21's consolidation of the Section 5310, JARC and New freedom programs through TRB/TCRP, determining the impact of these changes

+ Adding a JARC Maintenance Goal or Percentage Set-Aside Into Section 5307

+ Increasing Investment in Section 5310 Program to Deal with Growing Population of Older Americans and People with Disabilities

+ Allowing States the ability to manage Section 5310 programs as they did prior to MAP-21 and allow states full discretion on program selection

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CTAA's MAP-21 Reauthorization
Recommendations for Mobility Management

We Support:

+ Investing in mobility management strategies to ensure cost-effective, efficient coordination of All Human Service Transportation programs with community and public transportation programs and private operators into a family of mobility services

+Recognizing mobility Management strategies to promote transit innovations that meet the growing and changing needs of communities and that offer mobility solutions to vulnerable populations

+ Studying the return on investment, through TRB/TCRP, in all forms of community and public transportation in the Continuum of Care and Relationship Between Mobility, Positive Health Care Outcomes and Reduced hospital Re-admissions and improved discharge management

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CTAA's MAP-21 Reauthorization

Recommendations for Regulations

We Support:

+ Nothing about us without us — All new federal regulations should be developed with the consent and cooperation of the community and public transit industry

+ No Additional Regulations Without Requisite Investment and a cost analysis to be completed along with all new regulations

+ Sufficient investment to implement State of Good Repair requirements

+ Consistent and timely decision-making, communications and processes from the Federal Transit Administration

+ Reviewing Safety Regulations for all Transit Operators That Minimize Additional Record-Keeping, Data Collection and Additional Reporting

+ Performance Measures that are incentives, Community-Specific and Realistic

+ Developing federal government performance measure on transit capital replacement Levels sufficient to maintain current service levels

+ Expanding Flexibility and consistency for Local Match and in-kind contributions in all FTA titles, Including use of Farebox Revenues

+ Fostering increased and reasonably priced rolling stock options for all forms of transit through the Buy America program

+ Developing a model transit procurement process for rural and small-urban operators in cooperation with states and grantees

+ Bringing Common Sense to Charter Bus Regulations by Solidify the Rural Exemption, eliminating nation-wide bidding and enforcing good-faith bidding standards

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CTAA's MAP-21 Reauthorization

Recommendations for Planning

We Support:

+ Including persons with disabilities, older individuals, persons from low-income households, Veterans and persons representing an urbanized area's predominant racial or ethnic minority populations in all state and local transportation planning activities

+ Including rural transit providers and major constituencies served by these rural transit providers in Metropolitan Planning Organization (MPO) processes

+ Ensuring that states consult with providers of rural and intercity public transportation services in the development of statewide and non metropolitan plans and transportation programs

+ Urging State Departments of Transportation to coordinate plans, programs and activities with the planning activities carried out by other state agencies that use transportation

+ Including and accounting for major public and private health care and employment trip generators in all transit planning activities

+ Developing a real role for community and public transit providers and planners in defining census designations that impact these operations

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Community Transportation Association

This year marks the 40th anniversary of *Smith vs. Vowell*, a federal court case dealing with transportation for those receiving health care benefits under Title XIX of the Social Security Act — what we know today as Medicaid. Many people believe this case created the non-emergency medical transportation program (NEMT) that provides access to health care for millions across America, in communities of all shapes and sizes. In making its decision about the merits of transportation in health care for Medicaid patients in the 1970s, the court grasped fundamental health care concepts that few understood at the time of its ruling but that dominate medical transportation issues today.

Patients who brought this litigation had the need for multiple trips to-and-from outpatient services, often weekly or monthly. At the time of their lawsuit, the state of Texas only provided ambulance transportation for Medicaid recipients to the "nearest emergency facility." Yet, these patients needed services to non-emergency treatment facilities, like physical and occupational therapy, gastroenterology clinics and urology treatments by specialists. The court found that these patients' complex medical needs were, "of such a magnitude that no single doctor or clinic" was capable of meeting their needs, and that the absence of this service in the state Medicaid plan was "preposterous." When the state raised costs as a concern the court responded by ruling, "the deprivation of medically necessary transportation is disadvantageous to the state" and "a kind of false economy that only results, in the end, in higher medical costs."

Today's medical environment has only increased the complexity observed by the court 40 years ago, and the failure to take appropriate steps to maintain outpatient connections costs considerably more. That's why NEMT was a good idea then and today.

The paper prepared by MJS & Co., recognizes the complexity of today's medical environment by highlighting the important role that behavioral health and other complex medical conditions play in transportation to today's medical services. These new challenges in patient management include the scheduling of transportation services. The court addressed this, as well, when it stated that the patent cannot be expected "to assume the administrative as well as the fiscal burden of arranging" their own transportation. To ask the patient to do that, especially those with complex health issues, according to the Court was "neither therapeutic, practical, nor legal." The need for skilled intermediaries in the transportation process was viewed as important for 40 years, not for financial reasons, but as an essential element in a plan of care.

The expanding Medicaid population, especially those with chronic care and special health care needs, needs the same transportation benefit. If the federal government permits states to drop the NEMT benefit, it will not take many patients to repeat the mistakes found by the judge writing in *Smith vs. Vowell*, who found that limitations on transportation are a "false sense of economy." That is why past experience is key and this paper by MJS & Co., so relevant.

Medicaid Expansion and Premium Assistance:
The Importance of Non-Emergency Medical Transportation (NEMT)
To Coordinated Care for Chronically Ill Patients

February 2014

New data shows that, last year, millions of chronically ill Americans relied on the Medicaid program for transportation to life sustaining medical care such as kidney dialysis and treatment for severe mental illnesses, such as schizophrenia. Lack of health insurance is often equated with lack of access to health services. However, the experience of millions of low-income Medicaid beneficiaries makes clear that health insurance coverage alone does not guarantee access to healthcare services. A previous analysis[1] of National Health Interview Survey data (1999 to 2009) found that 7% of Medicaid beneficiaries reported transportation as a barrier to accessing timely primary care treatment and even 0.6% of those with private coverage reported struggles with similar transportation barriers. As many states propose to scale back the Medicaid transportation benefit, it is important to note that no other barrier varied so greatly in prevalence between individuals with commercial insurance and those with Medicaid.

Transportation is a major barrier for a number of vulnerable individuals --whom a new data set shows are chronically ill Medicaid beneficiaries that need recurring access to live-saving health services. The Medicaid non-emergency medical transportation (NEMT) benefit removes this barrier by providing the least costly, but appropriate, method of transportation service, including taxis, vans and public transit for Medicaid beneficiaries unable to get to and from their medically necessary appointments. The data presented below shows the vital importance that transportation plays in the lives of those patients with chronic health conditions who require recurring visits to dialysis centers or behavioral health services. Millions of beneficiaries with chronic conditions will enter the Medicaid program through the Affordable Care Act. For instance, "in the District of Columbia and the 25 states where the expansion is under way, nearly 1.2 million uninsured adults newly eligible for coverage will have substance abuse problems, according to federal estimates, and more than 1.2 million are projected to have some sort of mental illness. An estimated 550,000 of those will have serious mental disorders that impair their everyday functioning."[2,3] They will need NEMT to access life sustaining health care services and treatments.

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[1] Cheung PT, Wiler JL, Lowe RA, Ginde AA. "National study of barriers to timely primary care and emergency department utilization among Medicaid beneficiaries." Annals of Emergency Medicine. 2012 Jul;60(1):4-10.e2.
[2] Pugh, Tony. "Medicaid expansion is expected to strain mental health services." McClatchy Washington Bureau. 2/13/2014. www.sacbee.com/2014/02/13/6151677/medicaid-expansion-is-expected.html. Article estimates are compiled from Substance Abuse and Mental Health Services Administration data in "National and State Estimates of the Prevalence of Behavioral Health Conditions Among the Uninsured." July 2013. http://store.samhsa.gov/product/National-and-State-Estimates-of-the-Prevalence-of-Behavioral-Health-Conditions-Among-the-Uninsured/PEP13-BHPREV-ACA

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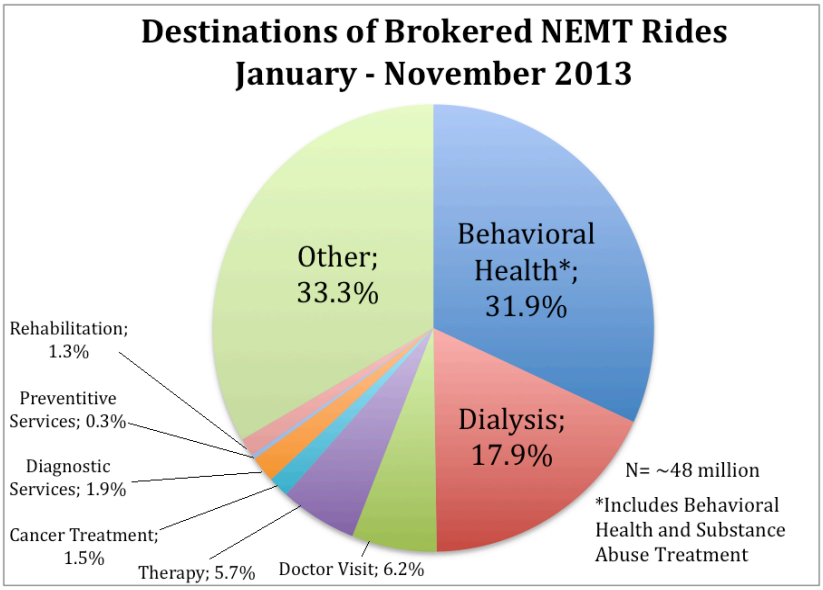
Medicaid Non-Emergency Medical Transportation

Since the Medicaid program's inception, the federal government has required states to assure access to medically necessary health services. Accordingly, Medicaid state plans are required to "Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers." (Federal Code of Regulations, 42 C.F.R. §431.53). Although many state Medicaid agencies have tried to eliminate the NEMT benefit, federal agency guidance and numerous court cases have affirmed the requirement for transportation. In *Smith v. Vowell*[4], the first case to test the enforceability of the transportation assurance, a federal district court found the Medicaid NEMT regulations "unequivocal" and that transportation was essential to the proper administration of Medicaid as an entitlement to critical health services.[5]

Many states contract with transportation brokers[6] to administer NEMT services and typically compensate these managers on a capitated, per-Medicaid beneficiary basis. This intermediary confirms the beneficiary's Medical eligibility, assures the destination is for a Medicaid-approved covered, medically necessary service, contracts with transportation providers, verifies transportation providers' licensing and safety inspections, and coordinates and schedules beneficiary transportation.



The chart to the right uses national data from the nation's largest intermediary, managing an estimated 48 million rides in 2013 in 39 states.[7] (Note: the chart

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[4] SMITH v. VOWELL. Civ. A. No. SA-72-CA-285. 379 F.Supp. 139 (1974). Benjamin Edward SMITH et al. v. Raymond W. VOWELL et al. United States District Court, W. D. Texas, San Antonio Division. June 27, 1974.

[5] Sara Rosenbaum, Nancy Lopez, Marsha Simon, Melanie Morris. "Medicaid's Medical Transportation Assurance." George Washington University Department of Health Policy. July 2009.

[6] Note: The Medicaid and CHIP Payment and Access Commission (MACPAC) defines these arrangements as prepaid ambulatory health plans (PAHP) wherein an entity that does not have a comprehensive risk contract is paid on the basis of prepaid capitation payments or another payment arrangement that does not use state plan rates. The brokerage option was created in Section 6083 of the Deficit Reduction Act (Public Law 109-171), subsection (iv). T

The option allows states to work with a broker who "complies with such requirements related to prohibitions on referrals and conflict of interest " These entities have been called "brokers," "managers," "intermediaries" or "prime vendors". This paper will use the term "intermediaries" to illustrate their role as independent liaisons between the transportation providers and the Medicaid beneficiaries.

[7] AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, NC, NE, NJ, NM, NV, NY, OH, OK, PA, RI, SC, TN, TX, UT, VA, WA, WI

includes data from states that have already expanded Medicaid to include individuals with incomes up to 138% of FPL, the population covered by ACA.) It shows that about half of Medicaid NEMT services were provided to facilities providing dialysis treatment or behavioral health services (including mental health services and substance abuse treatment)**.** That is, the most rides were for individuals with chronic illness for whom the lack of treatment would be life threatening or would result in institutionalization in the criminal justice system or psychiatric hospital.

There is, however, variation from state-to-state, which reflects states' differing benefits and covered populations. For instance, most Medicaid NEMT rides in Connecticut (49.3%) and Pennsylvania (56.8%) were behavioral health services for substance abuse. By comparison, rides for dialysis services were the most prevalent in Mississippi (46%) and Hawaii (42%) while rides to behavioral health services were highest in Florida (24.2%) and New Jersey (26.8%).

The "Other" category in the chart above represents destinations such as: adult day care, federally qualified health centers, outpatient surgery facilities, pharmacies, or smoking cessation services. It also includes transportation to specialists such as gastroenterologists, dermatologists, neurologists, obstetricians and gynecologists, orthopedists, pulmonologists, or urologists. In most cases, NEMT rides to these facilities and providers are provided in standard vehicles or through the use of public transportation.

However, as the chart above illustrates, the majority of current NEMT services are for regularly scheduled, non-emergency medical trips for individuals requiring additional assistance with transportation to coordinated care for behavioral health services, substance abuse treatment and dialysis services. Thus, the majority of NEMT rides are more than a transportation subsidy to low-income patients. Most Medicaid subsidized rides transport chronically ill beneficiaries requiring a more robust, specialized transportation benefit to more intensive and recurring treatments and services. **The dominance of the chronically ill as users of the NEMT benefit underscores the danger of eliminating the NEMT benefit.** More than 75% of health care costs are due to chronic conditions[8] and therefore account for a growing share of Medicaid costs. The NEMT benefit is a key element of a coordinated care plan and if eliminated, could prevent the implementation of new strategies to coordinate care for the highest cost beneficiaries. Because, as the judge writing the *Smith v. Vowell* decision noted, there are concerns that a patient's transportation difficulties could have "a direct and causally injurious effect upon the course of his medical treatment."

NEMT in Medicaid Expansion Using Premium Assistance

The Affordable Care Act (ACA) permits states, as they determine, to expand Medicaid to nearly all individuals with incomes up to 138 percent of the federal poverty level (FPL) ($15,856 for an individual; $26,962 for a family of three in 2014). Some states have proposed to adopt an insurance model based on premium assistance in lieu of expanding their traditional Medicaid programs. Under this long available model, states use Medicaid funds to purchase Qualified

[8] Centers for Disease Control and Prevention. "Chronic Diseases: The Power to Prevent, The Call to Control: At A Glance 2009." www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm.

Health Plans (QHPs) in the Exchanges/Marketplaces for some or all newly eligible Medicaid beneficiaries under the ACA. In order to offer premium assistance, a state must first file either a state plan amendment or section 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) in order to be granted authority or approval by the federal government.

CMS has issued final regulations providing guidance to states on how to implement Medicaid expansion through premium assistance.[9] CMS explained: "Under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. Therefore, states must have mechanisms in place to "wrap-around" commercial [insurance] coverage to the extent that benefits are less than those in Medicaid."[10] These wrap-around benefits include NEMT that is rarely covered in commercial insurance health plans.

However, despite transportation's proven benefits, especially to the chronically ill, some states are proposing to waive the NEMT assurance requirement in premium assistance plans, arguing that the QHPs are commercial plans that do not traditionally offer NEMT services. In Iowa, CMS has agreed to temporarily "relieve the state from the responsibility to assure non-emergency transportation to and from providers" for its Medicaid expansion population. This waiver authority sunsets after one year during which the state is required to collect data in order to evaluate the impact of lack of access on care. Pennsylvania recently submitted a premium assistance proposal to CMS that requested to waive all wraparound services, including non-emergency transportation. Other states, including New Hampshire, are considering premium assistance options and may request to waive the assurance of NEMT services for this expansion population as well.

A small proportion of newly Medicaid eligible adults in states opting to use premium assistance may be considered "medically frail" (defined in 42 CFR 440 § 440.315) and given the choice whether to enroll in the Exchange, with, or perhaps without, a NEMT wrap-around benefit, or traditional Medicaid with an NEMT benefit. Each state defines medical frailty, but federal regulations require that the definition include at least include certain groups of children, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

The states that currently have CMS-approved premium assistance programs anticipate a small number of newly eligible Medicaid beneficiaries will be considered medically frail through self-attestation. The Arkansas waiver request projected, of the 225,000 newly eligible individuals, 10% (22,500) will be deemed medically frail. In Iowa, the state waiver request estimates that 15.8% of the 93,968 newly eligible individuals will default to the traditional Medicaid plan due

[9] CMS. Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment. Federal Register, 78 FR 42159. July 15, 2013.
[10] CMS. "Medicaid and the Affordable Care Act: Premium Assistance." March 2013.

to medical frailty. It is unclear to what extend the self-attested medically frail will overlap with the chronically ill and if this will be sufficient to ensure transportation of the most medically needy.

NEMT is Essential to Medicaid Beneficiaries

Non-emergency medical transportation is a vital element of healthcare delivery to low-income patients. As presented in the intermediary data above, beneficiaries utilizing behavioral health and dialysis services rely heavily on transportation to access health care. The studies below demonstrate the importance of Medicaid-supported NEMT to health and healthcare outcomes, continuity of care and hospital avoidance.

Lack of Transportation is a Barrier to Care: Studies have identified transportation as a barrier for low-income individuals in accessing timely, necessary and continuing medical care. Many low-income patients do not have automobiles and cannot afford public transportation.[11] The assurance of such medical transportation ensures access to physicians' offices and outpatient facilities to receive routine and preventive care, as well as care for chronic conditions, such as dialysis and cancer treatment. Additionally, persons with disabilities may have special transportation needs and barriers that require specialized vehicles and additional safety measures.

Missing preventive care or prescribed medication can lead to more costly, resource intensive care and hospitalization.[12] A 2006 study found a delay or failure to fill a prescription was more common among those under age 65, African Americans, those with reported incomes of less than $25,000, or those who reported transportation issues.[13] The researchers found that even after adjusting for socio-demographic characteristics, those who reported transportation problems were more likely to report medication non-adherence.

Additionally, many studies have documented the impact of poor transportation on lower use of preventive and primary care and increased use of emergency department services. The provision of-- and access to-- transportation increases the likelihood of primary care physician visits in the pediatric population, HIV-positive adults, and frequent emergency room users.[14] A 2010 study of low-income adults found that nearly one-quarter reported having transportation problems that had caused them to miss or reschedule a clinic appointment in the past.[15]

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[11] Rosenbaum, et al.
[12] MedPAC. *Report to the Congress: Aligning Incentives in Medicare*. June 2010. page 133.
[13] Wroth, T, Pathman, D., "Primary Medication Adherence in a Rural Population: The Role of the Patient-Physician Relationship and Satisfaction with Care," *Journal of the American Board of Family Medicine,* September-October 2006; Volume 19**:** No. 5.
[14] Kim, J, Norton, E, Stearns, S, "Transportation Brokerage Services and Medicaid Beneficiaries'' Access to Care," Health Services Research, 44:1, February 2009.
[15] Silver, Diana, Jan Blustein, and Beth C. Weitzman. 2012. Transportation to clinic: Findings from a pilot clinic-based survey of low-income suburbanites. *Journal of Immigrant and Minority Health* 14, (2) (04): 350-5.

Under the premium assistance option, the newly eligible Medicaid beneficiaries will have health insurance but without NEMT, their access to medical services could be limited, leading to delayed care and/or increased, avoidable hospitalizations.

New Demand for Recurring Behavioral Health Services: Only about 5.5 percent of the currently uninsured who are eligible for Medicaid under expansion report having seen a mental health professional in the last year. However, according to the Kaiser Commission on Medicaid and the Uninsured,[16] over 60 percent of adults with a diagnosable behavioral health disorder and 70 percent of children in need of treatment do not receive mental health services, and nearly 90 percent of people over age 12 with a substance use or dependence disorder did not receive specialty treatment for their illness. Further, a large number of uninsured adults (46% of those with mental illness and 54% of those without) reported that they had not had a check-up in the past two years[17]. Therefore, it has been suggested, "that there is some amount of unmet demand" and as this population gains Medicaid coverage there might be an increase in the use of mental health and substance abuse treatments.[18]

Treatments for behavioral health issues help patients to be productive members of society, maintain employment and care for themselves. However, the new data above shows that transportation is integral to treatment of behavioral health issues. Lack of transportation is a particular problem for beneficiaries with mental illness, as they may be adverse to their medical care and unlikely to seek a means of transportation independently. As noted above, 31.9% of the intermediary's Medicaid NEMT rides were to behavioral health services including substance abuse treatments. To ensure the new Medicaid beneficiaries with unmet behavioral health needs receive such life sustaining treatment, states must offer NEMT to the expansion population.

Transportation Key to Dialysis Treatments: Because people on hemodialysis must receive treatment two to three times a week, reliable transportation is essential to ensure that hemodialysis patients have access to their treatment centers.[19]

According to the United States Renal Data System,[20] the majority of hemodialysis patients rely on others to transport them to and from the dialysis clinic, with 66.8% of patients being

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[16] Kaiser Commission on Medicaid and the Uninsured. "Mental Health Financing in the United States: A Primer." April 2011.
[17] Kaiser Commission on Medicaid and the Uninsured. "The Role of Medicaid for People with Behavioral Health Conditions." November, 2012.
[18] Truven Health Analytics. "Medicaid Expansion: Profiling the Future Medicaid-Eligible Population". January 2012.
[19] Note: Nearly 84% of people receiving dialysis (hemodialysis or peritoneal) have Medicare coverage (through Medicare fee-for-service, Medicare-Medicaid dual coverage, a Medicare HMO, or Medicare Secondary Payer coverage). Medicare does not have a non-emergency medical transportation benefit. Medicare-Medicaid dual eligibles and Medicaid beneficiaries in the three-month waiting period for ESRD Medicare coverage (for beneficiaries that will be participating in hemodialysis treatment in a dialysis facility) are eligible to use Medicaid's NEMT service. In 2011, 14.4% of patients receiving hemodialysis and 11.6% of beneficiaries receiving peritoneal dialysis were Medicare-Medicaid dual eligibles. Data Source*:* U.S. Renal Data System, USRDS 2013 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. 2013*.*

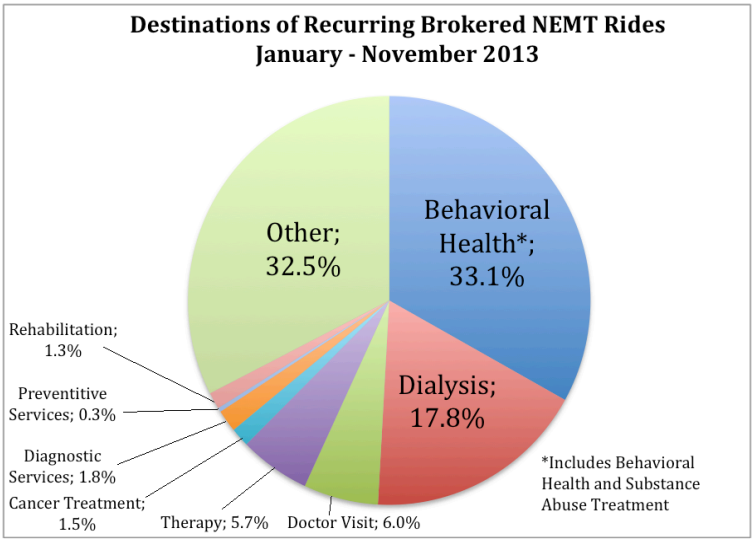
driven by others, including by ambulance. Nearly 8% relied on public transportation such as bus, subway, train or taxi while only 25.3% drove themselves or walked.

Additionally, a 2005 survey[21] of rural North Carolina dialysis patients found that primary transportation barriers include: (1) prohibitive costs; (2) riders being ineligible for transport services; (3) insufficient transportation provider operating hours; (4) depleted transportation provider funding.

Waiving the requirement to provide NEMT to the expansion population enrolled in Medicaid through premium assistance will increase transportation barriers to dialysis services leading to poor health outcomes, increased hospitalizations, and increased transplantations or even deaths. Moreover, waiving NEMT may lead to increased use of more expensive ambulance transportation. Medicare only covers ambulance services for medical emergencies or if alternate forms of transportation could endanger the patient's health. Nonetheless, Medicare has seen an increase in the use of ambulance transportation to non-emergency medical services, particularly to essential dialysis services, as vulnerable patients have few transportation alternatives and Medicare does not include an NEMT benefit.[22]

Transportation to Treatments for Chronic Illness Are a Majority of NEMT Rides

Chronic diseases are among the most prevalent, costly, and preventable of all health problems. Medical spending has grown rapidly in recent years and is placing a significant burden on state budgets. The data provided by the Medicaid NEMT intermediary to the right shows that the majority of rides provided are for recurring transportation, meaning they occur greater than twice per week.



As mentioned above, most Medicaid NEMT rides were to services for substance abuse, dialysis or behavioral health services. Reflecting the differences in benefits and populations, the destinations of recurring rides vary by state. According to the data provided by the transportation intermediary, the states with the highest percentage of recurring rides in

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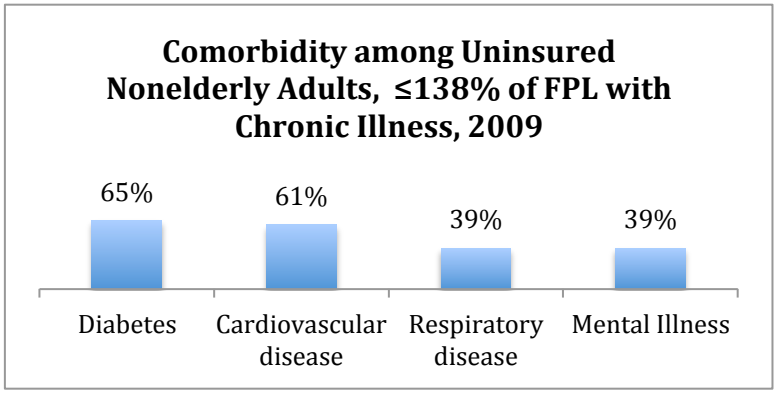
[20] CE Latham, Obstacles to achieving adequate dialysis dose: Compliance, education, transportation, and reimbursement, American Journal of Kidney Diseases, Volume 32, Issue 6, Supplement 4, December 1998, Pages S93-S95.
[21] Lind, M., Sulek, J. (2005). Assessing dialysis transportation needs in rural and small urban transit systems. Urban Transit Institute: North Carolina A & T State University.
[22] MedPAC. Report to the Congress; Medicare and the Health Care Delivery System. June 2013. Pages 167-193.

each category were:

Destination	State with Highest Recurring Rides	State with Second Highest Recurring Rides
Substance Abuse Treatment	Pennsylvania: 57%	Connecticut: 49.4%
Behavioral Health Services	Florida: 31.9%	New Jersey: 26.9%
Dialysis Services	Mississippi: 47.4%	Hawaii: 43.4%

Compounding the impact of the primary conditions on Medicaid beneficiaries, comorbidities are common among individuals with chronic conditions. The Kaiser Commission on Medicaid and the Uninsured found that many uninsured have physical and mental illness comorbidities as illustrated in the adjacent chart.[23]



In addition to expanding health insurance coverage, several provisions of the ACA expand access to health care services that help Medicaid beneficiaries prevent and manage chronic disease. Waiving the NEMT requirement for this population will exacerbate chronic disease, increase comorbidities and result in hospitalizations that would have been avoided if treated with timely and appropriate medical care.

Medicaid NEMT Ensures the Right Type of Transportation at Lowest Cost

Providing a NEMT benefit to Medicaid beneficiaries receiving coverage through premium assistance would reduce unnecessary visits to the emergency department and overutilization of ambulance services. When these new Medicaid beneficiaries need transportation to medical care, without an NEMT benefit they are likely to call an ambulance that is only permitted to transport them to the emergency department, where they will receive care at almost 15 times the cost of routine treatment. A study conducted by Florida State University concluded that if only one percent of the medical trips funded resulted in the avoidance of an emergency room hospital visit, the payback to the State would be 1108%, or about $11.08 for each dollar the State invested in its medical transportation program.[24] A NEMT benefit for this population would ensure these Members receive the preventive care needed to avoid unnecessary and more costly treatment.

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[23] Table adapted from Kaiser Commission. The Role of Medicaid for Adults with Chronic Illnesses. November 2012.

[24] Florida Transportation Disadvantaged Programs Return On Investment Study Prepared By The Marketing Institute / Florida State University's College of Business – Dr. J. Joseph Cronin, Jr.

Conclusion

Allowing states to waive the requirement to provide NEMT to the expansion population enrolled in Medicaid runs counter to the overall goal of the Affordable Care Act to increase access to health care services for all. Eliminating NEMT will increase transportation barriers to life sustaining services for chronic illness. Despite having health insurance, the newly eligible Medicaid beneficiaries will have poor health outcomes, increased hospitalization, or preventable deaths. Additionally, lack of an NEMT benefit will likely increase Medicaid spending through overuse of expensive ambulance services. As described in *Smith v. Vowell* forty years ago, "an untreated, minor medical problem becomes the major medical problem and…... the individual ….. becomes….. sick enough to qualify as an emergency case to be transported by ambulance and to be admitted as a hospital in-patient. It is the worst kind of false economy." The dominance of the chronically ill as users of the NEMT benefit underscores the danger of eliminating the NEMT benefit for any low-income patients, including the new Medicaid beneficiaries.