



Characterizing Medication Transportation

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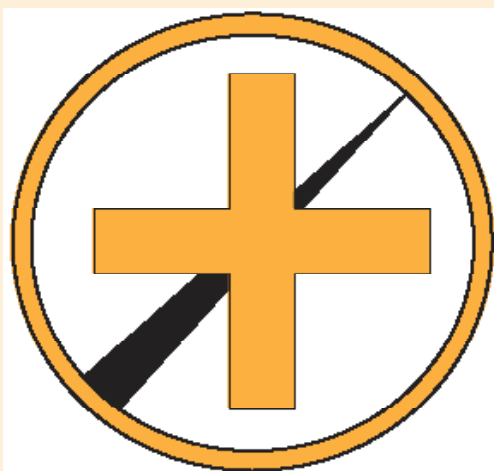


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A New Symbol:



Outpatient & Non-Emergency Medical Transportation

Throughout the medical and healthcare industries, there are many symbols that express the type and urgency of care provided. A red cross indicates extreme and potentially life-threatening conditions and situations while a blue version of a cross has been adopted by the largest provider of health insurance. The symbol indicating access for people with disabilities is well-known, while the yellow exclamation mark urges caution and poison warnings often correspond with a green graphic.

Recent years have produced the most sweeping restructuring of how we provide healthcare in our nation's history. More medical care is provided on an outpatient basis than ever before, in line with the growth of chronic conditions such as cancer, diabetes, end-stage renal disease and behavioral health diagnoses that require ongoing treatments like dialysis, chemotherapy and emotional counseling on a weekly – if not daily – basis. Legislative changes – most notably those affected by the Affordable Care Act – have likewise reshaped how we administer and pay for healthcare.


These seismic shifts impact how community and public transportation provides access to doctors offices, regional medical centers and treatment facilities. Non-emergency medical transportation is to outpatient care as ambulances are to emergency rooms: a fundamental – and in many ways, life-sustaining – element in the continuum of care. Our *Orange Cross* logo is a recognition of the profound role non-emergency medical transportation plays in supporting current health care practices so heavily dependent on outpatient care for chronic conditions. You'll notice the *Orange Cross* appear throughout this edition of *DigitalCT* and elsewhere as we continue this important discussion on the future of non-emergency medical transportation.

Charting Medical Transportation



*DigitalCT Editor-in-Chief Scott Bogren highlights the articles and stories that comprise this edition of DigitalCT.
Click anywhere on the image above to view the video.*



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In this edition of DigitalCT, The CTPodcast page features two important conversations. To subscribe to the CTPodcast, go to <http://ctpodcast.blogspot.com/> or search “The CTPodcast” in iTunes. Click on the microphone beside each entry to listen!

Clark Harder, Director of the Michigan Public Transit Association

The Michigan Public Transit Association's Clark Harder discusses key transit issues for MPTA, including how his previous career as a member of the Michigan State Legislature informs his work with the Association, his thoughts on the impact of term limits, and the Association's recent foray into non-emergency medical transportation (NEMT) at the state level.

Julie Wilcke of Portland's Ride Connection on Improving Transportation for Dialysis Patients

Ride Connection's Julie Wilcke discusses the agency's recent research on Improving Transportation for Patients Receiving Dialysis Treatments. The research, funded by the Administration for Community Living's Inclusive Coordinated Transportation Planning Project, involved direct feedback from dialysis patients, their caregivers, family members and more. Here, Wilcke talks about potential solutions gleaned from a more patient-centric approach to dialysis transportation.

Dr. Marsha Simon on Transit's Vital Role in Managing Chronic Illnesses

Dr. Marsha Simon, President of MJ Simon & Co., recently authored Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) To Coordinated Care for Chronically Ill Patients, a report that 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. This edition of the CT Podcast expands on that report, looking at the key trends and impacts its research reveals.



The CT Podcast

Insightful community and public transit discussion on timely issues. Brought to you by the Community Transportation Association of America.



Medical Transportation in an Era of Change

By Dale J. Marsico, CCTM

"It's been a long a long time comin but I know a change is goin' to come...oh yes it will."

— Sam Cooke

Earlier this year I had a chance to spend some time with Charla Sloan — a colleague from Oklahoma, the Transit Director of [Ki Bois Area Transit](#) — discussing what we were calling the good old days. We both agreed that in the good old days, when we both first started out in the transportation business, things seemed to be so much less complicated than they are today. What we knew as a call center back then was simply one person with a phone and a note pad listing transportation trips a week or 10 days in advance. When someone called looking for a ride to a doctor it was just that, a ride to a doctor that could take place any time in the morning or afternoon without much worry about the time you went or returned. The good old days were a less hectic time when not just transportation seemed simpler, but health care, too.

Mobility Management = Health Care Management

The provision of health care has changed dramatically in the past 20 years and the impact of these changes challenges the ways and means of providing transportation to-and-from an expanded concept of health care. No doubt, we are fortunate to live in a time when technology has significantly altered the course of what have long been considered deadly diseases. It wasn't long ago that a diagnosis of cancer, heart disease or kidney disease was considered a death sentence. Today, these particular diseases and many others can be managed in ways that were unthinkable in the good old days.

It's the concept of managing serious illnesses that is the key to understanding the changing role of transportation in the health care field. Managed health care requires many visits to outpatient health care facilities as part of how a patient's illnesses are controlled. I'm sure most of you recognize this trend most immediately in the form of your experience transporting dialysis patients. However there would be no benefit to this life-sustaining technological advance if a patient failed to ob-

tain — that is, actually get to — these dialysis treatments. Health care facilities providing dialysis often look to public and community transportation providers as the link to get patients to and from these treatments.

From the transportation side of the mobility management issue, the challenges these rides create for transportation providers are often difficult and complex. These patients may exhibit frailties and other symptoms related to their treatment. They may not fit well into the shared-ride approach that has characterized community transportation, causing financial challenges for transportation providers with limited financing. Sometimes there is difficulty with picking up patients for their trip home because treatment may cause complications that limit scheduled returns.

Over the last decade, dialysis transportation services have grown significantly as kidney disease has risen dramatically across the nation. The numbers for dialysis transportation alone are a significant challenge — but even more challenging is the trend that this level of outpatient services represents for our collective futures. If serious diseases like [End Stage Renal Disease](#) can be effectively

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managed, clearly other serious illnesses will be managed in similar fashion. For example, we're already seeing similar technological advances in cancer treatment and in the provision of therapies treating those dealing with the aftermath of cardiovascular disease and stroke. I wonder, what time of mobility demands will these advances necessitate?

A Different Kind of Transportation

Community and public transit professionals tend to think of medical transportation as an access issue. And it once was. Today, the services that are so demanding — like dialysis — are more than just access, they are an intrinsic part of what's now known as disease management. Effective disease management requires ongoing, regular transportation that serves as far more than mere access. This kind of transportation fills the space between ambulance services and traditional demand-response community and public transportation models. It requires something more than curb-to-curb service and often requires escorts and companions. It requires a flexibility that is hard to manage on scheduled service and often creates financial problems for organizations sharing costs.

Indeed, the history of financing these transportation services may not be a guide to the current and future need and costs of these trips. It is very difficult to provide

cost sharing when patients need individual trips and the health care reporting system is designed to be patient-specific. Sustained transportation on a one-to-one basis complicated by the needs for scheduling for high demand health care services can present an insurmountable challenge. Many community and public transit providers refer to these services as taxi-like for good reason.

Some providers of these mobility services receive compensation through our nation's various health care efforts — especially the NEMT effort created under Medicaid. Today's transportation and health care operating environments, however, are especially complicated as it relates to these demanding services. Through the [Affordable Care Act](#) (ACA), Medicaid coverage is at the heart of expanding medical care for a significant number of Americans. In the process of using it to fill an important coverage option for low-income working families, Medicaid is becoming more and more of a traditional insurance program with benefits managed by intermediaries and not governments. In several states adapting their benefits to conform with the ACA, the transportation benefit is moving to the managed care plan or insurance program that is replacing traditional Medicaid. All these efforts — designed to expand coverage — often do so by looking for significant discounts in the cost of health-related services. Outpatient care is

designed to bend the curve on health care costs, including mobility — whether done in an ambulance or in a non-emergency form of service similar to NEMT.

A Different Kind of Health Care

Two trends are driving the new bottom line in health care delivery: Expanding coverage and lowering costs. Insurance companies demand deep discounts in health care services. Ask any doctor or health care provider and a similar re-frame is constant. Of course as taxpayers and as employers, we want health care services discounted as a means of cost controls. It shouldn't be a surprise that this lowering bottom line costs impacts health care transportation, as well.

No one in the health care field wants to pay the full costs of any services and providers are often forced to make up these differences by increasing the volume of their work. Once again, if you ask any doctor they'll tell you they see more patients than ever, and they spend less time with each of them. Medical facilities without large volumes are unsustainable in the current environment — that's one of the reasons we see health care centered in large-urban areas where the volume resides and why those providing transportation in rural areas must often go further and further from home for all kinds of health care service.

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Where Do We Go From Here?

In this critical time of challenge we must be knowledgeable about the demographics of our communities and how much we spend on our current services. We must carefully decide the range of the services we offer, and search for the most cost-effective delivery maintaining quality that we can possibly create. Some of these factors include:

Demographics: We must familiarize ourselves with the specific health conditions in our communities, including the rates of illnesses like kidney disease, cancer, stroke and behavioral health since they are centers of transit demand. We also need to know the locations and places where treatment can be obtained. Finally, we must draw on our experiences to-date to understand what percent of those people look to community and public transportation for access. As those illnesses grow in our community, we can expect similar transportation demand growth.

Costs: Nothing is more important than understanding the costs of current health care transportation services being delivered by community and public transit. Although we tend to view our costs collectively across all passengers, we must look for individual costs for services that aren't necessarily access services but services that are part of the treatment process. These services are most likely much higher than the average costs and an

important indicator of future needs.

Beyond the limit: Demand for NEMT services often exceeds availability. When it comes to medical transportation there are no empty buses. There are many transportation providers already at capacity. We know that various forms of capital assistance from federal and state sources are limited. Those in the mobility field need to look for other tools to help them expand services.

To address the issue, there is a need for lower-cost alternatives and incorporating other kinds of services into the mobility mix. Some transit providers I have spoken with have revitalized their voluntary transportation efforts, some have created working relationships with other providers like taxis, some have developed unique coordination with health care providers and institutions, some have partnered with stretcher carriers and some have purchased hybrid cars as a cost-effective alternative to traditional vehicles. Those who have successfully faced this challenge have done so by defining their roles and limits in the transportation field. Not every community or public transit provider can provide every service needed in a community. However, they can join with others to create a network that can create broader solutions. No solution is possible unless we clearly know where we are as transportation providers at this critical moment in time.

Knowledge is Power

President Kennedy often cited the old Chinese proverb that, "the journey of a thousand miles begins with a single step." We created a basic effort we call the [Competitive Edge](#) to assist community and public transit organizations organize their efforts and information to address the issues surrounding medical transportation. This training effort includes looking at current costs and services designed to assist local transportation providers develop the means and methods to address future needs in medical transportation. This course can assist you by teaching important negotiating skills and health care terminology. And in the spirit of the time, its' discounted as well.

As well, the Mid-Atlantic Dialysis Summit (described in detail on p. 42) highlights CTAA's considerable ability to convene groups of transit officials, managers, advocates and even riders and develop vital next steps that move toward solutions.

Community and public transit has always been engaged in matching resources to the roles it fills in the communities it serves. The health care transportation needs of our communities are the latest in a series of challenges that have always been part of our history. They can be mastered by knowledge and determination. It's time for that "first step."

CT

Medicaid Non-Emergency Medical Transportation (NEMT) Saves Lives and Money

By Dr. Marsha Simon

Barriers To Accessing Healthcare

Each year, millions of Americans miss or delay preventative medical care due to their inability to access transportation services. Research has consistently shown that transportation is one of the most common barriers faced by low-income populations in accessing timely and necessary medical care because many low-income recipients simply lack the disposable income needed to have a working automobile or have access to affordable public transit in order to get to or from medical services.

The Medicaid non-emergency medical transportation (NEMT) benefit fills these various access gaps by providing the least costly but appropriate method of transportation services, such as taxis, vans and public transit for Medicaid beneficiaries with no means to get to and from their necessary medical appointments.

By way of background, the [Center for Medicaid and Medicare Services](#) (CMS) established transportation as a mandatory

benefit in order to provide consistent and efficient access to early intervention/preventative medical care for disadvantaged Medicaid recipients who would otherwise have no means of accessing healthcare services. As a result, providing access to preventative treatment prior to escalating healthcare needs has proven to be a less costly and more effective means of keeping low-income, elderly, and disabled recipients out of hospitals and nursing homes; allowing such individuals to remain viable members of the community and live healthier and independent lives while lowering overall health care costs.

Return on Investment

The federal requirement concerning medical transportation assurance is based upon recognition from past experience in Medicaid that unless needy individuals can actually get to and from providers of services, the entire goal of a state Medicaid program is compromised. Healthcare costs would escalate rapidly with low-income individuals ending up in high-cost emergency rooms via ambulance services at 15 times the cost of routine transportation.

3.6 Million

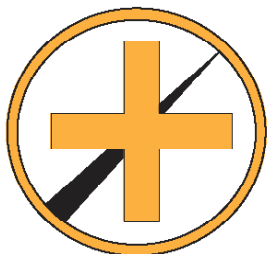
Approximate number of Americans who miss or delay medical care because of transportation issues

On average, NEMT is utilized by only 10 percent of the total Medicaid population and represents approximately one percent of total Medicaid expenditures. That said, measuring the benefits of providing access to transportation is far more difficult than measuring its costs. Nonetheless, studies have consistently shown that treatment programs that include transportation to increase attendance at appointments reported positive results, including fewer missed appointments, reduced length of stay and fewer emergency room visits. 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 percent, or about \$11.08 for each dollar the State invested in its medical transportation program.

NEMT and the Affordable Care Act

When viewed in the broader context of comprehensive healthcare reform, the assurance of such access to medical transportation is consistent with the law's intent to provide Medicaid coverage for all low-income American citizens and is considered to be a primary component of an efficient and effective health care delivery system. This, in turn, is key to the effective management of escalating medical costs as well as addressing general health care inefficiencies for this population.

In essence, Medicaid's transportation benefit serves as the life blood of our nation's publicly funded health care system, allowing our country's most vulnerable families to access critical medical services. It also lessens the financial burden on state governments by avoiding unnecessary emergency room visits, ambulance transportation and extended hospital stays. The assurance of such access to transportation has consistently proven to provide a positive impact on health care management from both an access and cost-containment perspective. **CT**



950,000

Approximate number of children who missed or delayed medical care because of transportation issues

\$367

The amount of money saved per person when providing NEMT for prenatal care



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CDL Medical Requirements and the Role of Predictive Modeling in Safety and Health Care

By DigitalCT Staff

“The value of predictive modeling in health care is that it allows us to identify those who are at the highest risk and will most benefit from disease management programs. The goal, of course, is to improve health for those patients and to lower costs for health care.”

Dr. Ogian Asparouha, Chief Scientist, MEDai

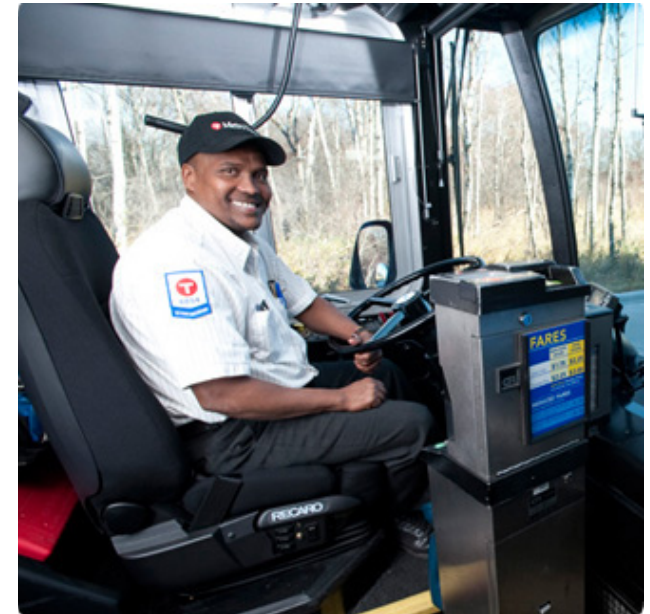
The technological advances associated with medical care have dramatically changed the way we provide health care and treatment. Predictive modeling is an analytical process that helps identify and target health care challenges in a way that can vastly improve a patient's health and their general living situation. One of the most common of these predictive models is the relationship between early identification of high cholesterol and reductions in heart disease. Testing identifies those in high-risk groups and points them into a treatment protocol based upon diet, exercise and medication. Besides improving the quality of life, this approach saves untold number of dollars when you consider treatment for a heart attack as opposed to preventive care. As the old adage says, “an ounce of prevention is worth a pound of cure.”

Linking testing and risk factors is not without controversy and accepting these kind of linkages is sometimes difficult. There was a steady debate on the cholesterol issue for some time before this approach linking predictive factors became acceptable.

In the last several weeks an issue has arisen in the community and public transportation field over a similar use of predictive health analysis. This case involves the link between risk factors measured using the Body Mass Index (BMI), and its relationship to the sleep disorder known as Sleep Apnea. There is concern that factors such as increased BMI, among others, create potential safety issues for those operating motor vehicles, including those driving in the community and public transportation field.

Heightened Concerns

Much of the heightened concern and awareness of this issue relates to proposed rules that go into affect in May of this year that affect the medical certification necessary for a Commercial Drivers License. If a driver is required to obtain a CDL, in almost all cases they must also receive a corresponding medical certification, officially known as a Medical Examiner's Certificate or informally as a DOT Medical Card. A medical exam is



required to obtain the certificate, which includes testing for a number of impairments, which might place a driver at a greater risk for accidents.

SAFETEA-LU required FMCSA to replace the previous system of physicians' certifications of drivers' medical fitness with a new regime, as follows (this language is from Section 4116(a) of SAFETEA-LU):

The Federal Motor Carrier Safety Administration shall: Establish and maintain a current national registry of medical examiners who are qualified to perform examinations and issue

medical certificates; remove from the registry the name of any medical examiner that fails to meet or maintain the qualifications established by the Secretary for being listed in the registry or otherwise does not meet the requirements of this section or regulation issued under this section; and, accept as valid only medical certificates issued by persons on the national registry of medical examiners. Further FMCSA may make participation of medical examiners in the national registry voluntary if such a change will enhance the safety of operators of commercial motor vehicles.

FMCSA published a proposed rule concerning this requirement in December 2008. The Final Rule implementing this requirement was published April 20, 2012. The requirement for state driver licensing agencies to comply with this rule takes effect May 21, 2014.

In other words, as part of these changes, exams must be performed by medical examiners certified through the FMCSA's National Registry of Certified Medical Examiners. The registry is can be found [here](#). Failure to comply with this requirement would be a downgrade of a CDL to a regular drivers' license.

In order for medical examiners to be qualified for the National Registry, they must first undergo specific training on the physical requirements for CDL medical certification and then pass an exam. In almost all cases, medical certificates had to be supplied to the states as part of the CDL issuing process — but the new feature under this rule is

that only medical professionals on FMCSA's national registry can issue these certificates — which raises a concern among some that there may not be enough certified doctors in a given state or community. CTAA will follow this concern in the coming months.

Previously, FMCSA had advised that public transportation drivers for systems that are units of federal, state or local government had been excepted from the Medical Certification. Today, they acknowledge that many states do require the Medical Card for any CDL holder, so we urge all community and public transit systems to review their mandates with the appropriate state licensing agency.

Although there is concern about the number of certified physicians there is nothing in this regulation that alters the previous issues of how predictive modeling affects drivers who have a high BMI or related conditions. Nothing in this proposal changes the existing requirements. CT Magazine staff spoke directly with FMCA officials about this specific concern. They were clear that neither the BMI or sleep apnea disqualify a person from receiving a CDL, rather it triggers a requirement that an operator is being properly treated from a medical perspective to manage this condition. The key factor here as in other areas is to identify and manage.

Preventive Maintenance for Machines and Preventive Care for Operators

Those who provide community and public transportation fully understand the relation-

ship of reducing risk when it comes to putting quality service on the street. That's why we invest in good maintenance and good training. The health of our operators is also part of our safety culture. The term *safety sensitive* positions is clearly linked to the positive outcomes that are measured in safe and reliable transportation services.

Because of the way predictive medicine has evolved we can help guarantee that safety sensitive staff are fully ready to engage their work in the best possible medical condition. Employee medical insurance like those provided through [CTAA's Insurance Store](#), are part of the solution because they create a path for treatment of conditions that are possible risks to the health of operators. A range of testing and preventative health care services is part of almost every kind of health coverage we offer. For those older operators covered by Medicare, preventive care is also high on the list of priorities. The Affordable Care Act also makes prevention a priority both to improve patient quality of life and cost.

Everyday there are advances in health care, especially in preventive medicine. Today's testing represents a foundation for continuing change where more and more illnesses and diseases can be identified and treated early. Since people are such an essential element to the delivery of community and public transportation services, this linkage will only become more important. In the end, it gives us a new kind of competitive edge.



The Big Question: Have the Medical Requirements Changed?

While many medical examiners are becoming more aware of the existing requirements and thereby disqualifying some drivers who were previously certified by examiners unaware of the CDL medical requirements, nothing has specifically changed with the May 21, 2014 date.

As FMCSA states on their website:

Question: *Are there new regulations regarding a driver's body mass index (BMI), body fat ratio, weight, neck size, and sleep apnea?*

Answer: *Despite rumors to the contrary, no. While research was recently released stating that a driver's BMI is a risk factor for identifying sleep apnea, neither the Federal Motor Carrier Safety Administration (FMCSA) nor the Compliance, Safety, Accountability program currently has any rules that restrict who can be a commercial motor vehicle driver based on BMI or weight, or neck size.*

According to FMCSA officials we spoke with, it is true that Sleep Apnea is a growing safety concern at the agency and that they

want to ensure that DOT-certified doctors are identifying sleep-apnea risk factors and ensure that CDL drivers at-risk are getting proper treatment. Sleep Apnea will not be, accord-

ing to the agency, an automatic failure of the medical exam. Rather, it will trigger (expensive) sleep studies and then treatment before a driver successfully passes the exam. **CT**

A CDL Refresher

Since the adoption of the Commercial Motor Vehicle Safety Act of 1986, drivers operating a passenger vehicle of 16 or more passengers (including the driver) must obtain a Class C Commercial Driver's License (CDL). Additionally, many states require drivers operating vehicles carrying between eight and 15 passengers to obtain a CDL.

Here is a quick refresher on when a CDL is required:

- If they operate a motor vehicle with a gross vehicle weight rating (GVWR), gross combination weight rating (GCWR), gross vehicle weight (GCW), or gross combination weight (GCW) of 4,536 kilograms or more in interstate commerce.
- If they operate a motor vehicle designed or used to transport more than 15 passengers (including the driver) in interstate commerce.
- If they operate a motor vehicle designed or used to transport between 9 and 15 passengers, for direct compensation, beyond 75 air miles from the driver's normal work-reporting location, in interstate commerce
- If they transport hazardous materials, in a quantity requiring placards, in interstate commerce.

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

Forward by Dale J. Marsico, CCTM

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 patient 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.

By MJS & Company

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

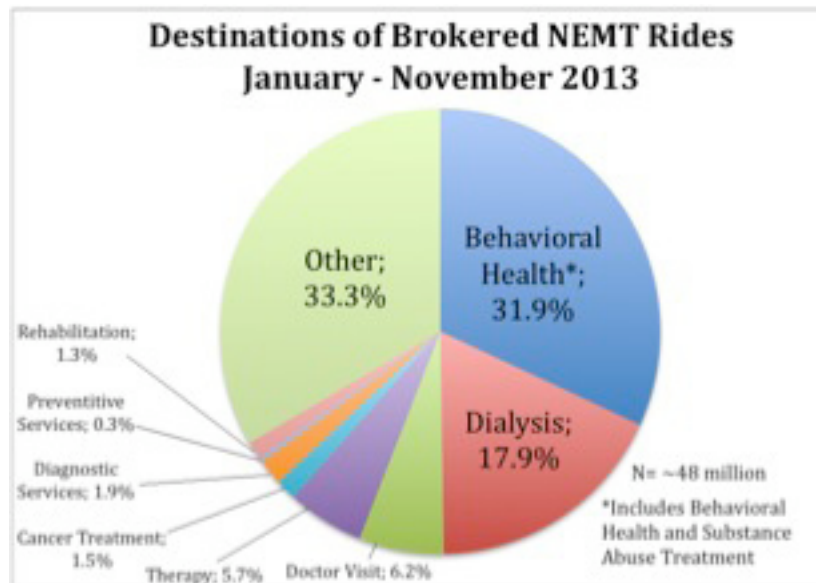
coverage alone does not guarantee access to healthcare services. A previous analysis of National Health Interview Survey data (1999 to 2009) found that 7 percent of Medicaid beneficiaries reported transportation as a barrier to accessing timely primary care treatment and even 0.6 percent of those with 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 life-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 in the report 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. Mil-

lions 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. They will need NEMT to access life sustaining health care services and treatments.

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*. 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*, 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.



Many states contract with transportation brokers 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 below uses national data from the nation's largest intermediary, managing an estimated 48 million rides in 2013 in 39 states. *Note: the chart includes data from states that have already expanded Medicaid to include individuals with incomes up to 138 percent 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 percent) and Pennsylvania (56.8 percent) were behavioral health services for substance abuse. By comparison, rides for dialysis ser-

vices were the most prevalent in Mississippi (46 percent) and Hawaii (42 percent) while rides to behavioral health services were highest in Florida (24.2 percent) and New Jersey (26.8 percent).

The *other* category in the chart 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 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 percent of health care costs are due to chronic conditions 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 (\$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 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. According to CMS: “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.” 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 percent (22,500) will be deemed medically frail. In Iowa, the state waiver request estimates that 15.8 percent of the 93,968 newly eligible individuals will default to the traditional Medicaid plan due to medical frailty. It is unclear to what extent 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, 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. 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. 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.

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. 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.

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 expanded Medicaid report having seen a mental health professional in the last year. However, according to the Kaiser Commission on Medicaid and the Uninsured, 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 percent of those with mental illness and 54 percent of those without) reported that they had not had a check-up in the past two years. 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.

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 percent 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:

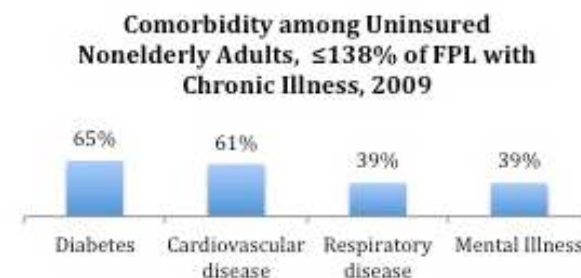
Because people on hemodialysis must receive treatment two to three times a week, reliable transportation is essential to ensure

that hemodialysis patients have access to their treatment centers.

According to the United States Renal Data System, the majority of hemodialysis patients rely on others to transport them to and from the dialysis clinic, with 66.8 percent of patients being driven by others, including by ambulance. Nearly 8 percent relied on public transportation such as bus, subway, train or taxi while only 25.3 percent drove themselves or walked.

Additionally, a 2005 survey 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.

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 each category were:

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 chart below.

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 an 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 percent, or about \$11.08 for each dollar the State invested in its medical transportation program. A NEMT benefit for this population would ensure these Members

receive the preventive care needed to avoid unnecessary and more costly treatment.

Conclusion

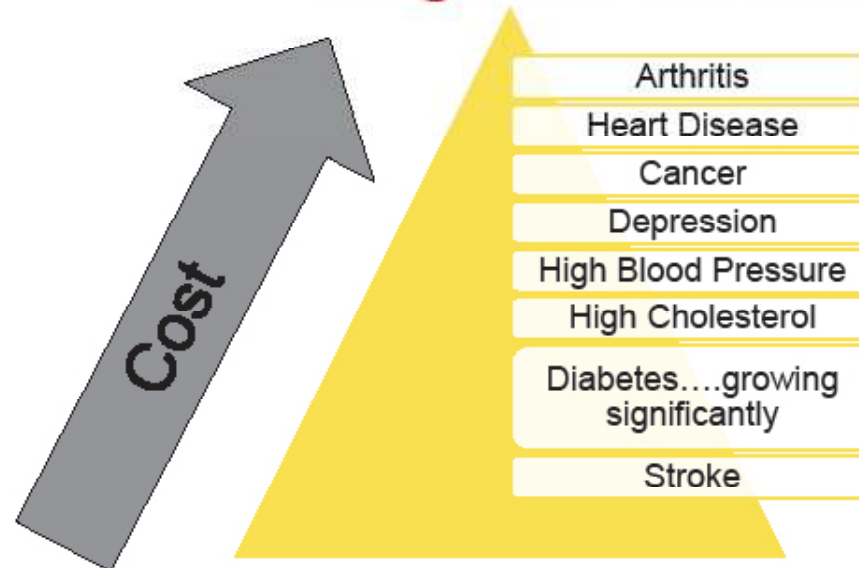
Allowing states to waive the requirement to provide NEMT to the expansion population enrolled in Medicaid runs counter to the overall goal of the Affordable Care Act to increase access to health care services for all. Eliminating NEMT will increase transportation barriers to life sustaining services 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* 40 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. **CT**

Health & Transportation: Partners in Wellness & Affordable Healthcare

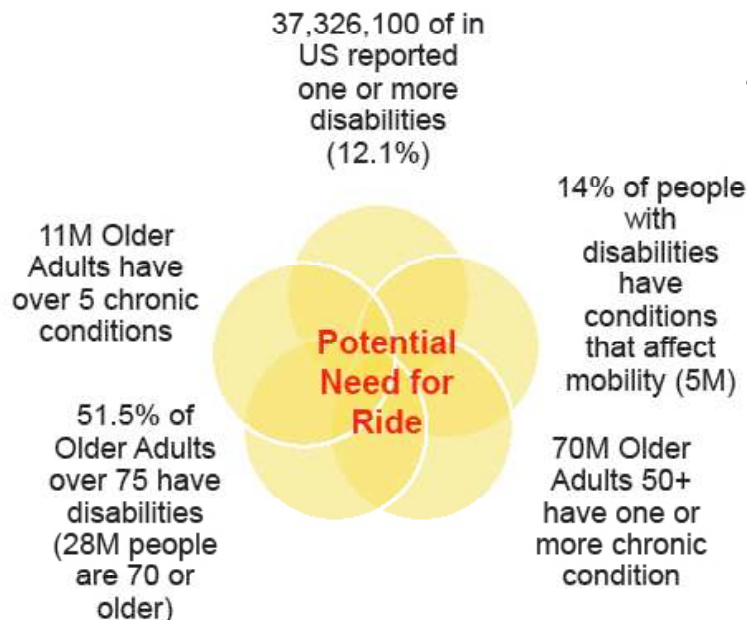
By Mary Leary, Easter Seals

Recent statistics have underscored the growing needs for human services populations to get healthcare rides. The increasing occurrence of chronic conditions are driving increased levels of disability and cost. Fortunately, accessible communities can help reduce the impact of these trends. Here, Easter Seals' Mary Leary outlines some key concepts for building bridges with healthcare systems and discusses the value proposition for the intersection of health and transportation.

**Greater the number of Chronic Conditions
the greater the cost**



This information comes from a National Center for Mobility Management-sponsored webinar entitled "Non-Emergency Medical Transportation: Emerging Research and Trends." Listen and view a [recording of the webinar here](#).



Livable Communities with Accessible Transportation Options Can Mitigate Chronic Conditions



Provides access to preventive care



Helps people convalesce at home



Reduces unnecessary hospital readmission



Helps people self-manage their chronic conditions

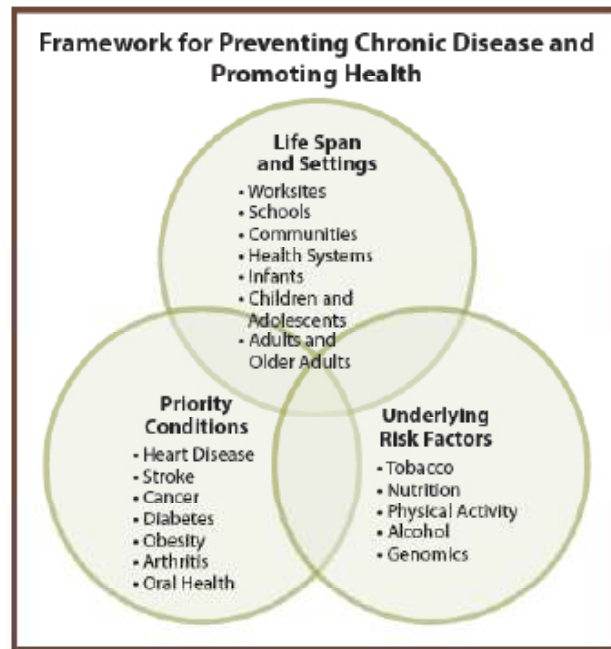


For those who are mobile, safe and accessible streets and transit increase and maintain fitness



Less cars reduce harmful emissions

Centers for Disease Control Framework



Centers for Medicare and Medicaid Innovation Healthcare Transformation AIMS



Personal Health Mobility (PHM) Measure

Quantify estimates for individuals' health access needs - number of appointments they require per year

- How many can they get to today
- How many do they really need
- Example, need 4/month today only have 2 or 50% PHM, add one more we increase PHM by 25%

Reduce Unnecessary Hospital Readmission

First suggested in 2008 by Florida State University

- 1% of trips help clients avoid a hospital stay saving on average \$ 7,900/stay



Partner with local hospital systems to quantify costs

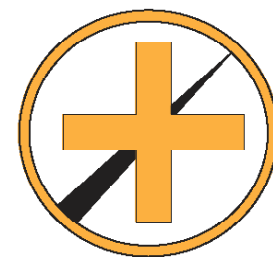
- to find their re-admissions rates and average cost per re-admission
- apply recent research suggesting that 11% of these are preventable
- apply an agreed upon average for what % of these were related to lack of transportation



Example: Local Hospital has 11% unnecessary re-admissions associated with approximately 2000 patients (220 patients) costing them an average of \$ 5,000 per re-admission or \$ 1.1M

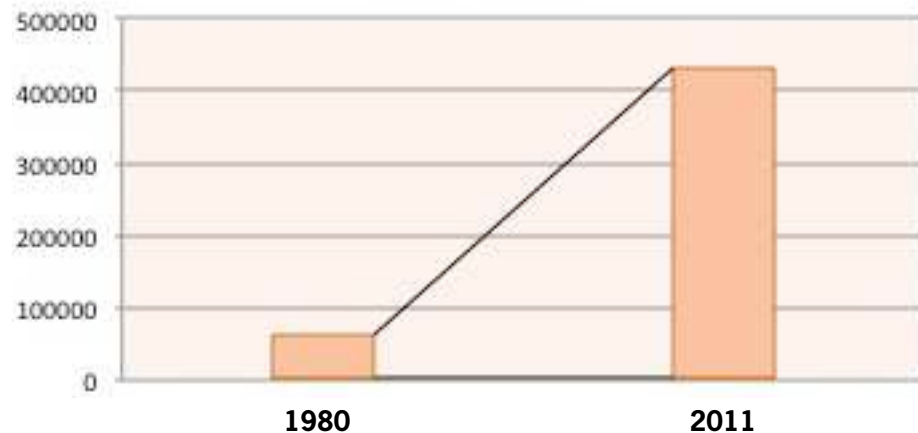
Summary – Mobility Managers Can Be Key in Improving Health and Wellness for their communities

- Learn about the health/wellness needs and stakeholders in your community
 - Connect with people with disabilities and older adults to understand their preferences and concerns regarding healthcare access
 - Build relationships with public health, mental health, long term services/supports, medical care and other healthcare services providers to identify issues and cost pressures
 - Apply your expertise and teach them about multi-modal resources, help them connect into your coordinated transportation work
- Much more information is available on healthy behaviors and health indicators at the county level
- For more assistance or help with quantifying need, just call the NCMM - **866-846-6400**
- **Also, check out the Easter Seals Project ACTION Brochure on planning for transportation after a medical procedures are:**
<http://www.projectaction.org/Initiatives/HealthTransportation.aspx> CT

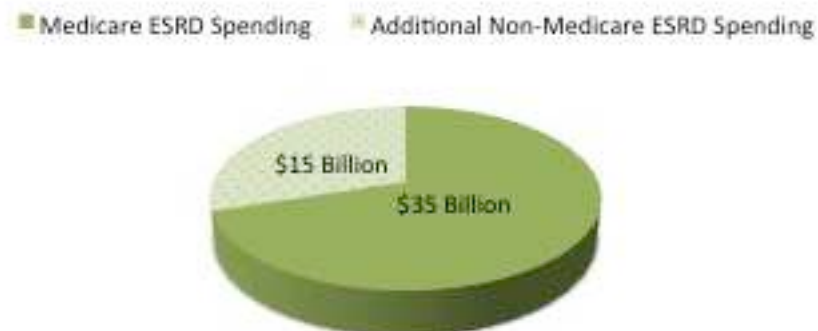


Dialysis Transportation: Behind the Numbers

**Number of Hemodialysis Patients:
1980 - 2011**



**Who Pays?
ESRD Spending in 2013**



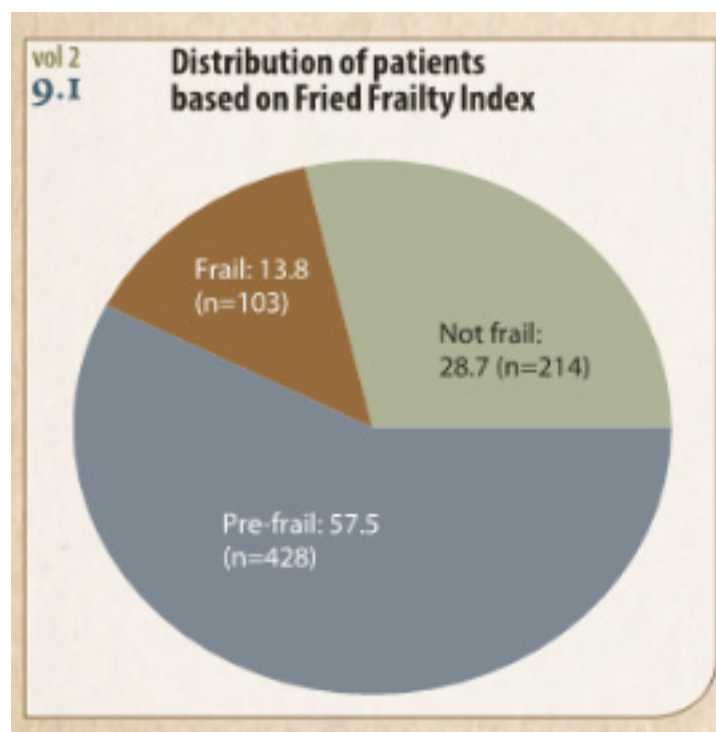
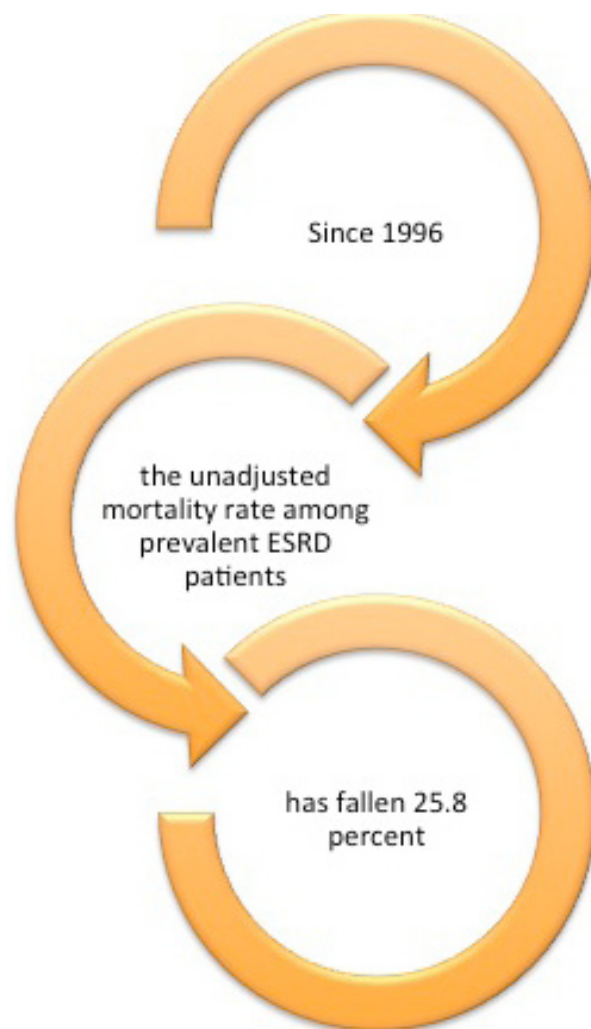
Annual Medicare
Cost per
Hemodialysis
Patient: \$85,000

In 2011, 119,000
patients started or re-
started hemodialysis

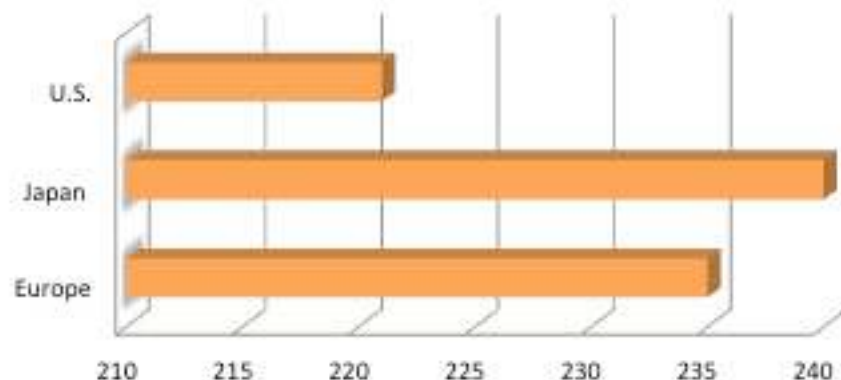
In 2013, a woman aged 50-54 without ESRD can expect to live another 28.7 years

In 2013, a woman aged 50-54 on dialysis could expect to live another 7.1 years

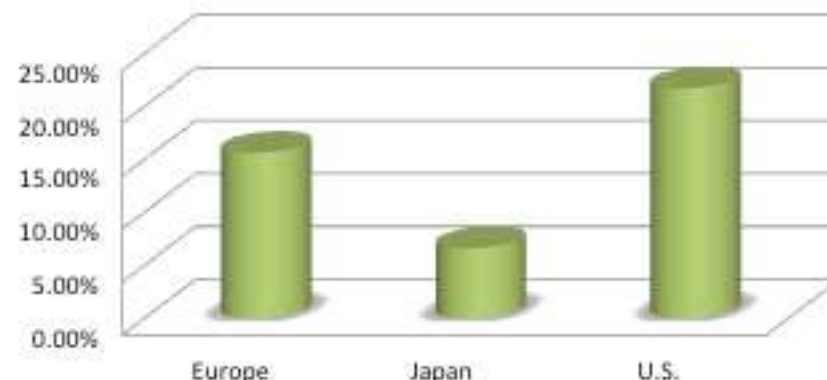
In 2007, a woman aged 50-54 on dialysis could expect to live another 6.2 years



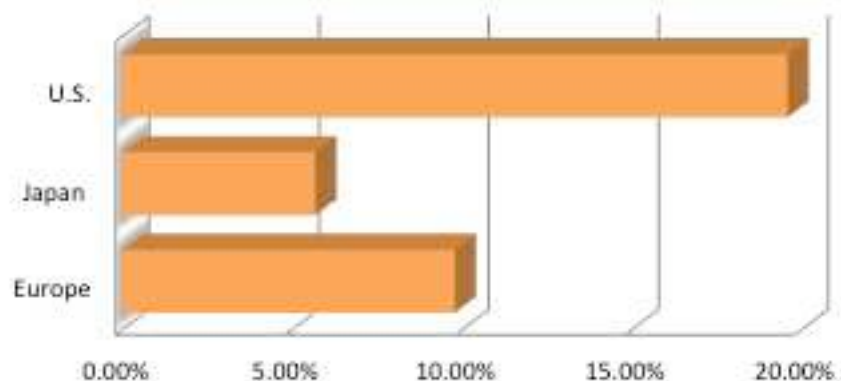
Average Dialysis Treatment Times (minutes)



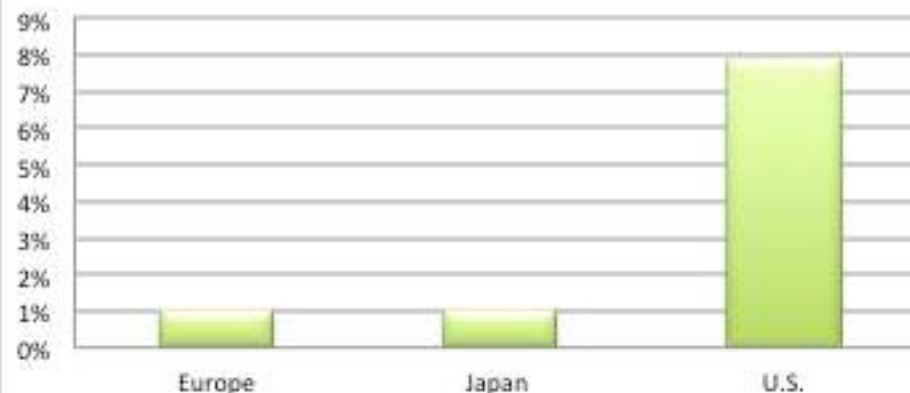
1-Year Mortality Rates (Adjusted) for Dialysis Patients



Percentage of Dialysis Treatments Shortened by ≥ 20 Minutes



Percentage of Missed Dialysis Treatments (per month)



Maryland Study of Paratransit Services for Dialysis

This vital research was performed by [KFH Group, Inc.](#), at the behest of the Maryland State Legislature and is excerpted here with permission.

Background

In the most recent session of the Maryland General Assembly, a bill was introduced regarding funding for public transit services to meet the growing demand for door-to-door transportation to dialysis centers. The Joint Committee expressed concern about the adequacy of funding for public transit services to meet this growing need. In lieu of legislation, the legislature's Joint Committee requested the Maryland Department of Transportation, Maryland Transit Administration (MTA), conduct the study in consultation with the Department of Health and Mental Hygiene, the Maryland Association of Counties, and the Transportation Association of Maryland. The purpose of this study was to estimate both 1) the demand for paratransit to dialysis centers, and 2) the funding that would be required if public transit agencies were to meet that demand.

Dialysis Transportation – The Need

United States

Nationwide, it is estimated that the number of people needing kidney dialysis is growing at a rate of 10 percent annually. Usually dialysis treatments are required three times a week, Monday through Saturday. Thus, access to reliable transportation to and from treatment centers is essential to the health of these persons. The National Institute of Health estimated that, at the end of 2009, over 870,000 people had end-stage renal disease (ESRD) in the United States. From 1980 – 2009, the prevalent rate for ESRD increased nearly 600 percent.¹ At the end of 2009, almost 400,000 ESRD patients were being treated with some form of dialysis, mostly in clinic settings.

Maryland

It appears that approximately 8,800 Marylanders have ESRD and could require dialysis treatment. Of these, it is estimated that approximately 8,300 people receive dialysis at one of the 114 dialysis centers in the State. Further, it is estimated that this num-

ber is growing at a rate of 3-4 percent annually.

According to the 2011 annual report by the Mid-Atlantic Renal Coalition (MARC), on December 30, 2011, 8,834 Maryland residents had ESRD.² Table 1 (*see next page*) presents the prevalence of ESRD by jurisdiction using zip code data (slightly lower).

Kidney dialysis is provided at a variety of locations including local hospitals and independent dialysis centers. Table 2 (*see next page*) lists the number of dialysis centers by jurisdiction in the State. It is interesting to note that there are dialysis centers in all jurisdictions except Caroline and Queen Anne's counties.

Currently, many Maryland residents that require dialysis treatments rely on public transit to access those services. These dialysis patients rely on general demand response services, fixed routes, and ADA complementary paratransit services provided by public transit operators throughout the State. For the purposes of this report, the research team considered as "paratransit" as a broad term that encompasses the demand response

Table 1: ESRD PREVALENCE RATE BY JURISDICTION (2011)

County	Number of Dialysis Patients	Jurisdiction Population	Prevalence Rate	Jurisdiction Pop. as % of State	Dialysis Patients as % of State Patient Pop.
Allegany	89	74,012	0.12%	1.3%	1.0%
Anne Arundel	587	550,488	0.11%	9.4%	6.7%
Baltimore City	1,137	817,455	0.14%	13.9%	13.0%
Baltimore County	2,092	621,342	0.34%	10.6%	24.0%
Calvert	93	89,628	0.10%	1.5%	1.1%
Caroline	35	32,718	0.11%	0.6%	0.4%
Carroll	84	167,217	0.05%	2.8%	1.0%
Cecil	67	101,696	0.07%	1.7%	0.8%
Charles	200	150,592	0.13%	2.6%	2.3%
Dorchester	58	32,551	0.18%	0.6%	0.7%
Frederick	170	239,582	0.07%	4.1%	1.9%
Garrett	26	29,854	0.09%	0.5%	0.3%
Harford	227	248,622	0.09%	4.2%	2.6%
Howard	204	299,430	0.07%	5.1%	2.3%
Kent	17	20,191	0.08%	0.3%	0.2%
Montgomery	792	1,004,709	0.08%	17.1%	9.1%
Prince George's	2,167	881,138	0.25%	15.0%	24.8%
Queen Anne's	36	48,595	0.07%	0.8%	0.4%
Saint Mary's	126	108,987	0.12%	1.9%	1.4%
Somerset	33	26,253	0.13%	0.4%	0.4%
Talbot	44	38,098	0.12%	0.6%	0.5%
Washington	160	149,180	0.11%	2.5%	1.8%
Wicomico	203	100,647	0.20%	1.7%	2.3%
Worcester	87	51,578	0.17%	0.9%	1.0%
Statewide	8,734	5,884,563	0.15%	100.0%	100.0%

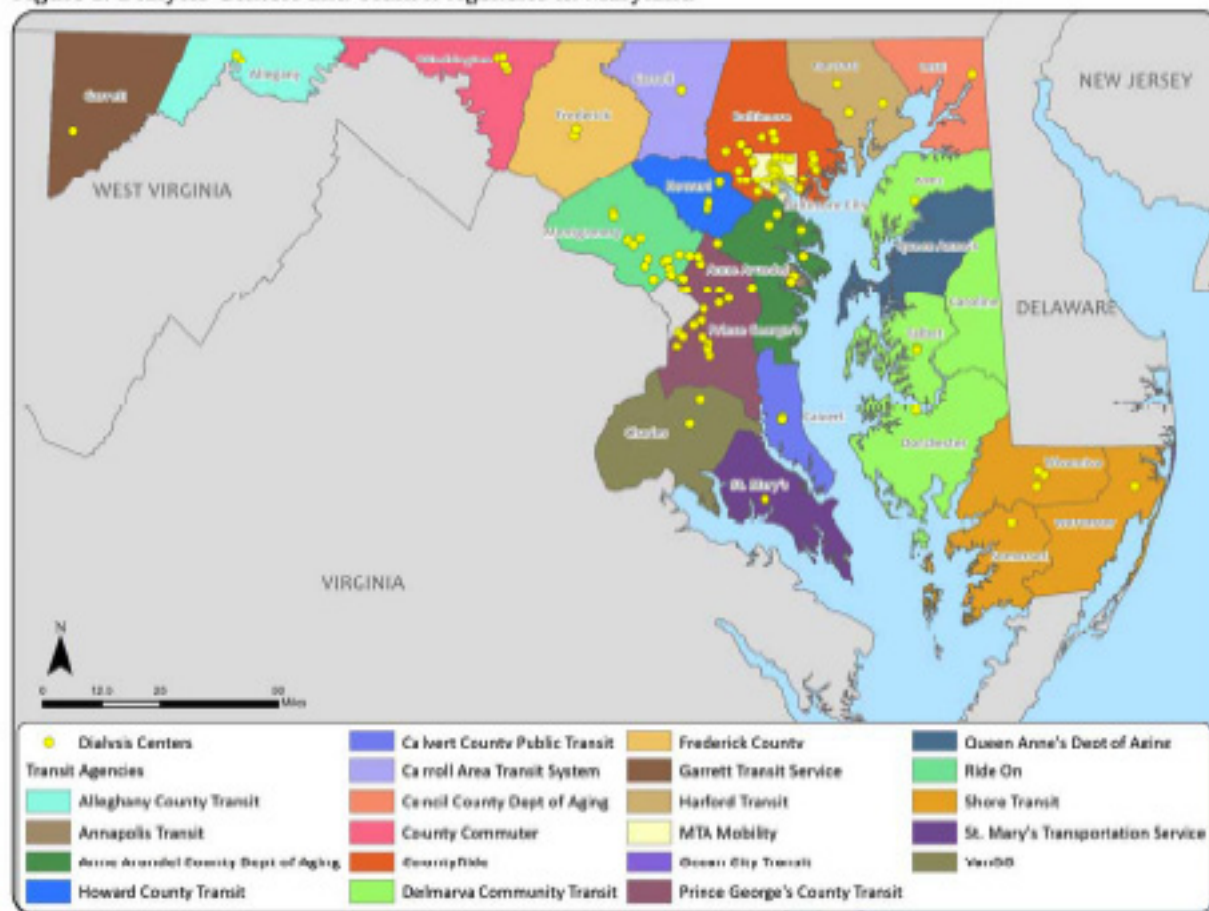
Source: 2011 Annual Report, Mid Atlantic Renal Coalition (MARC)

Table 2: DIALYSIS CENTERS

Jurisdiction	Number of Centers
Allegany County	2
Anne Arundel County	6
Baltimore City	19
Baltimore County	18
Calvert County	2
Caroline County *	0
Carroll County	1
Cecil County	1
Charles County	2
Dorchester County	1
Frederick County	2
Garrett County	1
Harford County	3
Howard County	3
Kent County	1
Montgomery County	15
Prince George's County	25
Queen Anne's County *	0
Somerset County	1
St. Mary's County	1
Talbot County	2
Washington County	4
Wicomico County	3
Worcester County	1
TOTAL	114

* No dialysis center within jurisdiction.

Figure 1: Dialysis Centers and Transit Agencies in Maryland



and ADA complementary paratransit services provided by public transit agencies and human service agencies in the State. These services are funded by a combination of State, federal transit and local funds, all of which are being stretched to meet the needs of residents of the State.

Figure 1 (*see above*) presents the location of dialysis centers in the State along with the transit systems that provide paratransit

services in each jurisdiction.

Study Objectives

The objective of this study was to 1) estimate the demand for paratransit trips for dialysis patients in each jurisdiction and, 2) project the funding required to ensure the local public transit agencies are able to meet that demand.

Research Tasks

The research involved gathering data on current dialysis patients and trips. This included surveying the 114 dialysis centers in the State to determine:

- Current number of dialysis patients,
- Whether the staff knows how patients currently travel to and from the center, and
- Whether (and how) the center facili-

Table 3 - DIALYSIS CENTERS SURVEYED

	Number of Centers	Number of Centers that Responded	Survey Response Rate
Allegany County	2	2	100%
Anne Arundel County	6	5	83%
Baltimore City	19	17	89%
Baltimore County	18	18	100%
Calvert County	2	2	100%
Caroline County *	0	0	0%
Carroll County	1	1	100%
Cecil County	1	1	100%
Charles County	2	2	100%
Dorchester County	1	1	100%
Frederick County	2	2	100%
Garrett County	1	1	100%
Harford County	3	3	100%
Howard County	3	3	100%
Kent County	1	1	100%
Montgomery County	15	9	60%
Prince George's County	25	23	92%
Queen Anne's County *	0	0	0%
Somerset County	1	0	0%
St. Mary's County	1	1	100%
Talbot County	2	2	100%
Washington County	4	4	100%
Wicomico County	3	3	100%
Worcester County	1	1	100%
TOTAL	114	102	89%

* No dialysis center within jurisdiction.

tates or assists in arranging transportation services for its patients, either through scheduling assistance, courtesy phone, or other means.

After calling to determine the most appropriate person to contact at each center, the research team conducted telephone interviews with staff at each center. The team was able to gather information from 102 or 90 percent of the centers, which was used to estimate the number of dialysis patients traveling to the centers daily along with their mode of transportation. Table 3 (*see previous page*) presents the center response rate by jurisdiction.

The data gathering effort also included collecting information on the paratransit services provided by the Locally Operated Transit Systems (LOTS) as well as the ADA Complementary paratransit services provided directly by MTA (Mobility) in the Baltimore Region and by WMATA (Metro Access) in the Washington suburbs of Maryland.

Information from the public transit operators included:

- number of paratransit dialysis trips currently provided,
- current cost of those trips,
- constraints on those trips (do they have to turn down trip requests to dialysis? If so, how many?), and
- average cost per paratransit trip.

The research team sent a paper survey to the LOTS and made follow-up calls where needed. Additional ADA paratransit data was collected directly from Mobility and MetroAccess.

Research Results

As outlined above, the research was conducted to answer three main questions:

1. Number of Dialysis Patients/Trips - How many dialysis patients travel to Maryland dialysis centers? How is this likely to increase in the future?

2. Number of Dialysis Trips on Public Paratransit - How many dialysis patients rely on public transit currently? How many paratransit trips are provided by public transit agencies? How many additional trips would be provided now and in the future if additional funding/resources were available (latent demand)?

3. Cost of Additional Trips - What would it cost to provide these additional trips?

Number of Dialysis Patients/Trips

Research Question - How many patients travel to Maryland dialysis centers? How is this likely to increase in the future?

Based on the interviews with the dialysis centers, it is estimated that 8,300 patients

Table 4: NUMBER OF PATIENTS REPORTED BY DIALYSIS CENTERS (2013)

County	Number of Patients Reported by Dialysis Centers Located in Jurisdiction
Allegany	93
Anne Arundel**	319
Baltimore City**	1,268
Baltimore County	1,274
Calvert	157
Caroline*	0
Carroll	200
Cecil	94
Charles	113
Dorchester	105
Frederick	164
Garrett	75
Harford	188
Howard	90
Kent	60
Montgomery**	590
Prince George's**	1,945
Queen Anne's*	0
Somerset	122
St. Mary's**	0
Talbot	94
Washington	262
Wicomico	132
Worcester	88
Total Reported by Centers Interviewed	7,433
Estimated Patients at All Centers	8,307

Source: Dialysis Centers

*No dialysis center within the County

** No response from some dialysis centers

currently travel to dialysis centers in Maryland. Table 4 (*see above*) presents the num-

Table 5: ESRD PREVALANCE BY JURIDICATION

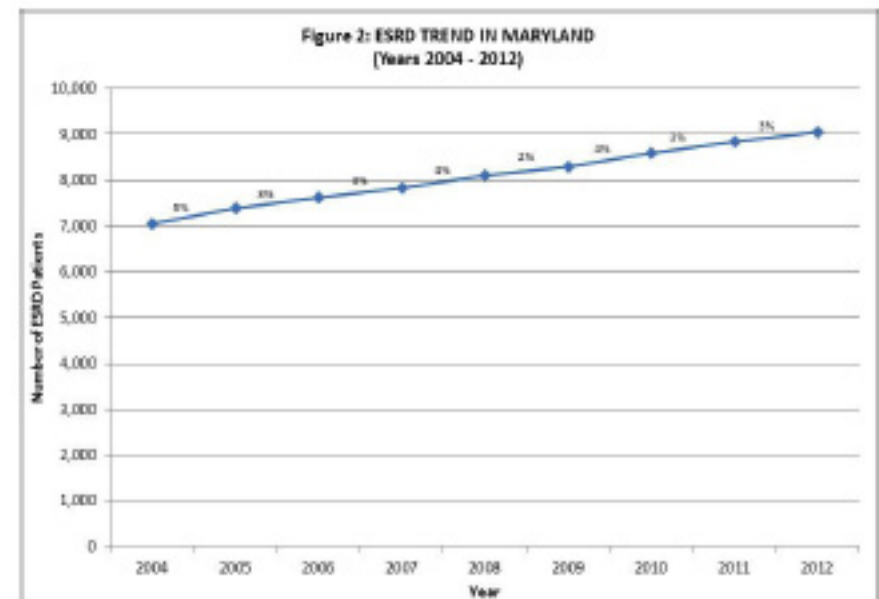
County	ESRD PREVALANCE BY MONTH			
	April 2012	July 2011	July 2010	April 2009
Allegany	89	87	96	89
Anne Arundel	587	591	553	542
Baltimore City	1,137	1,112	1,056	985
Baltimore County	2,092	2,062	1,957	1,920
Calvert	93	91	95	84
Caroline	35	31	27	27
Carroll	84	93	100	80
Cecil	67	74	82	80
Charles	200	196	199	187
Dorchester	58	66	62	62
Frederick	170	165	150	156
Garrett	26	24	28	28
Harford	227	241	230	212
Howard	204	191	181	150
Kent	17	17	20	17
Montgomery	792	772	786	741
Prince George's	2,167	2,129	2,044	2,025
Queen Anne's	30	39	36	30
Somerset	33	29	21	34
St. Mary's	126	112	123	115
Talbot	44	40	43	40
Washington	160	138	144	137
Wicomico	203	197	120	159
Worcester	87	89	88	92
TOTAL	8,728	8,586	8,241	7,992

Source: 2011 Annual Report, Mid Atlantic Renal Coalition (MARC) Zip Code Reports

ber of dialysis patients by jurisdiction as reported by the centers along with an estimate of the number of dialysis patients in all centers (including those that declined to be interviewed). It is noted that Table 4 includes patients treated at centers located in each jurisdiction and not the number of dialysis patients that reside in the in the jurisdiction (patients living in one jurisdiction can travel to another dialysis center for treatment).

To help answer the question about how the number of dialysis trips is growing, Table 5 (*see chart at left*) presents the ESRD prevalence rates from April 2009 to April 2012.⁴ The table shows that persons with ESRD in Maryland increased from 7,992 in April 2009 to 8,728 in April 2012; a three year growth rate of 9 percent and an annual growth rate of 3.6 percent.

The graphic in Figure 2 (*see below*) shows a broader timeframe - the increase in ESRD prevalence from 2004 to 2012. Figure 3 (*see next page*) presents the location of dialysis patients in the State along with the transit systems providing paratransit services in each jurisdiction.



Based on the trends presented above, it is estimated that the need for dialysis services will grow 2-4 percent annually or 28 percent from 8,300 patients in 2012 to over 10,600 patients in 2020. Table 6 (*see below right*) presents a projection of the number of 2020 patients by jurisdiction.

Number of Potential Dialysis Trips on Public Transit

Research Questions - How many dialysis patients rely on public transit currently? How many additional trips would be provided now, and in the future, if additional funding/resources were available (latent demand)?

Estimating the number of current and future dialysis trips on public transit required a two-pronged approach. First, responses from the dialysis center survey were used to determine how patients currently travel to/from their dialysis

appointments - self, family, and friends, public transportation (including ADA paratransit), cabs, and Medicaid transportation. Specifically, we looked at how many currently ride public transit paratransit services to dialysis. Second, the study team used the information gathered from the LOTS and ADA paratransit providers on how many trips they currently provide to dialysis to reconcile the two estimates and estimate the demand for dialysis trips in the future.

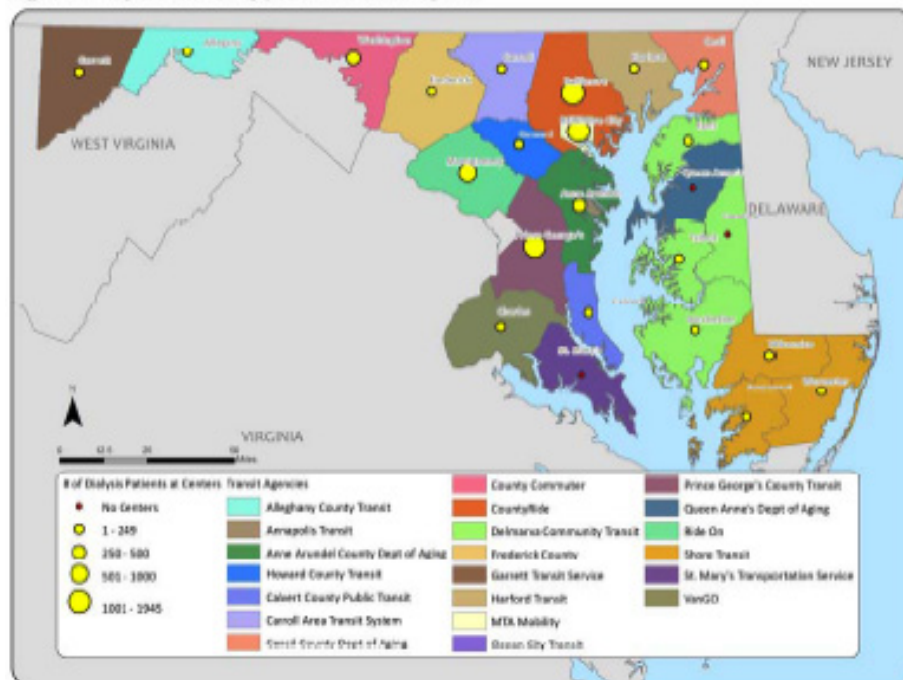
Table 6: ESTIMATED NUMBER OF DIALYSIS PATIENTS (2012 and 2020)

County	Number of Persons with ESRD ¹	Estimated Number of Dialysis Patients 2012	Estimated Number of Dialysis Patients 2020
Allegany	89	86	110
Anne Arundel	587	565	723
Baltimore City	1,137	1,094	1400
Baltimore County	2,092	2,012	2575
Calvert	93	89	114
Caroline*	35	34	43
Carroll	84	81	103
Cecil	67	64	82
Charles	200	192	246
Dorchester	58	56	71
Frederick	170	163	209
Garrett	26	25	32
Harford	227	218	279
Howard	204	196	251
Kent	17	16	21
Montgomery	792	762	975
Prince George's	2,167	2,084	2668
Queen Anne's*	36	35	44
St. Mary's	126	121	155
Somerset	33	32	41
Talbot	44	42	54
Washington	160	154	197
Wicomico	203	195	250
Worcester	87	84	107
Total	8,734	8,300	10,624

* No dialysis center within the County

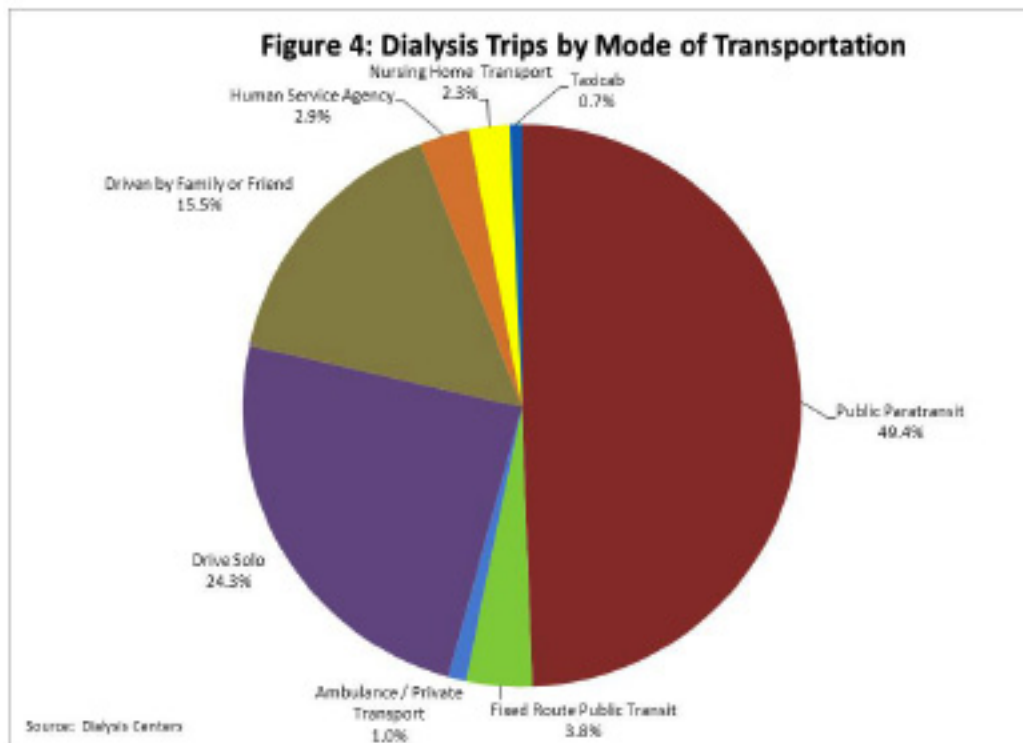
¹Mid Atlantic Renal Coalition (MARC) data by zip code

Figure 3: Dialysis Patients, by Jurisdiction, in Maryland



The number of annual trips to dialysis centers is 2.6 million trips (8,300 patients taking 312 annual trips). When asked about the mode of transportation used by their patients (*see below*), the dialysis centers report that 49 percent of the trips to their centers, almost 1.3 million trips annually, are taken on public paratransit. Clearly, these trips include both paratransit provided by transit systems and trips provided by other paratransit operators, most notably the vendors operating Medical Assistance transportation (Non-Emergency Medicaid Transportation - NEMT).

The current number of paratransit trips provided to dialysis by the public transit operators in the State is estimated at over 443,000 annual trips. Table 7 (*see below right*) presents this data by jurisdiction. Other human service paratransit services provide the remaining 836,000 annual trips.



Cost of Public Transit Paratransit Dialysis Trips

Research Questions - What does it cost to provide the additional public transit paratransit trips to dialysis now? What would it cost in the future?

Table 7: DIALYSIS PARATRANSIT TRIPS AND COST BY JURISDICTION

Jurisdiction	FY13		Total Cost
	Dialysis Paratransit	Cost per Trip	
Allegany County	2,144	\$41.31	\$88,569
Anne Arundel County *	31,978	\$25.34	\$892,058
Baltimore City **	165,316	\$35.82	\$8,108,961
Baltimore County	2,317	\$45.00	\$104,265
Calvert County	2,750	\$30.15	\$82,913
Caroline County	1,456	\$18.49	\$26,921
Carroll County	797	\$11.85	\$9,444
Cecil County	857	\$13.19	\$11,304
Charles County	17,160	\$52.66	\$903,646
Dorchester County	5,616	\$18.49	\$103,840
Frederick County	9,742	\$29.58	\$288,168
Garrett County	2,343	\$12.43	\$29,123
Harford County	4,040	\$25.55	\$103,222
Howard County	4,738	\$34.27	\$162,371
Kent County	1,248	\$18.49	\$23,076
Montgomery County	37,950	\$52.02	\$1,974,159
Prince George's County***	119,253	\$35.39	\$5,640,879
Queen Anne's County	2,300	\$40.00	\$92,000
Somerset County	3,927	\$21.64	\$84,976
St. Mary's County	8,376	\$17.83	\$149,344
Talbot County	4,368	\$18.49	\$80,764
Washington County Transit	3,279	\$17.53	\$57,481
Wicomico County	7,552	\$21.64	\$163,414
Worcester County	3,625	\$21.64	\$78,439
TOTAL	443,131		\$19,259,337

Source: LOTS and MetroAccess and MTA Mobility

* Includes both Annapolis Transit and Anne Arundel County Department of Aging & Disabilities. Cost per trip represents an average of both agencies.

** Includes both Mobility and CAR. Cost per trip represents an average of both Mobility and CAR. □

*** Includes both MetroAccess and Prince George's County paratransit

Based on available data on the number of paratransit dialysis trips provided by the State's public transit systems and the average cost of a paratransit trip at each transit system, it is estimated that public transit operators in the State currently spend \$19M annually to provide paratransit services to dialysis centers. (Table 7 – *see previous page* – provided this information by jurisdiction). This estimate does not include expenses incurred by other public agencies/programs to provide paratransit services to dialysis, such as those provided by Medical Assistance (Medicaid) and other human service agencies.

Latent and Future Demand

The public transit operators in the State are not able to provide all trips currently needed or requested by patients going to dialysis centers. The study estimates the future need for paratransit to dialysis in two pieces:

- Current Latent Demand - The trips (and related costs) that are not being met because transit systems do not currently have the funding or resources available to meet all dialysis trip needs;
- Future Demand – The increase in paratransit trips required to meet the travel needs of the increased number of dialysis patients expected by 2020.

Table 8: LATENT DEMAND FOR PARATRANSIT BY PUBLIC TRANSIT PROVIDERS

Jurisdiction	Estimated Latent Demand (2013)				
	Trips Infeasible on Public Paratransit due to Service Constraints*	Denied Trips*	Total Unmet Trips	Total Additional Trips on Paratransit	Total Cost of Additional Paratransit Trips
Allegany	5,884	107	5,992	2,991	\$123,538
Anne Arundel	20,339	1,599	21,938	11,565	\$293,061
Baltimore City	0	0	0	0	\$0
Baltimore County	0	8,382	8,382	8,382	\$377,174
Calvert	1,279	138	1,417	764	\$23,044
Caroline**	0	73	73	73	\$1,346
Carroll	12,664	40	12,704	6,245	\$74,006
Cecil	6,140	43	6,183	3,052	\$40,250
Charles	1,279	858	2,137	1,485	\$78,190
Dorchester	6,524	281	6,805	3,478	\$64,299
Frederick	11,513	487	12,000	6,128	\$181,277
Garrett	4,605	117	4,722	2,374	\$29,505
Harford	9,978	202	10,180	5,091	\$130,078
Howard	6,524	237	6,761	3,434	\$117,670
Kent	3,838	62	3,900	1,943	\$35,923
Montgomery	0	1,898	1,898	1,898	\$98,708
Prince George's	0	5,963	5,963	5,963	\$211,018
Queen Anne's**	0	115	115	115	\$4,600
Saint Mary's***	0	196	196	196	\$3,501
Somerset	0	419	419	419	\$9,063
Talbot	0	218	218	218	\$4,038
Washington	8,826	164	8,990	4,489	\$78,691
Wicomico	4,861	378	5,239	2,759	\$59,714
Worcester	4,093	181	4,275	2,187	\$47,327
Statewide	108,348	22,157	130,505	75,247	\$2,086,021

*According to Dialysis Centers or Transit Systems

**Counties don't have dialysis centers

***Dialysis center in county did not respond

Latent Demand and Cost

The latent demand for paratransit services resulting from public paratransit capacity and funding constraints is estimated at 75,000 trips. Latent demand (unmet needs) includes:

- The transit systems report that they have to deny about 22,000 trips annually (assumes all of these would be on paratransit);
- Some transit systems do not operate services at the hours, or days of the week when patients need to go to dialysis (e.g., on Saturdays). It is estimated that an additional 53,000 dialysis trips are not possible on public transit because of service span/days issues (108,000 trips but assuming only 49 percent would be on paratransit).

An additional \$2.1M will be needed annually (in 2013 dollars) to provide these trips. Table 8 (*see previous page*) presents an estimate of the latent demand and cost of providing these services by jurisdiction.

Increase in Demand to 2020

By 2020, the number of Marylanders receiving dialysis is projected to grow by 2,300 dialysis patients to over 10,600; these new patients will require over 718,000 additional trips to dialysis centers. It is estimated that

half these trips would be on paratransit (352,000 annual trips). Assuming that other human service agency paratransit services continue to increase their services proportionately, public transit operators will need to provide approximately 145,000 additional paratransit trips annually. In the event that other public agencies are unable to serve additional clients, public transit agencies could be expected to provide their share of the 352,000 new trips needed – or an additional 207,000 annual trips.

The estimated incremental cost to public transit agencies of providing all current latent and future paratransit trips to dialysis is estimated at \$6M annually (in 2013 dollars). Table 9 (*see chart at right*) presents the estimated number of future paratransit trips by jurisdiction and the additional cost (in 2013 dollars) by

Table 9: ESTIMATED ADDITIONAL DIALYSIS PARATRANSIT DEMAND ON PUBLIC TRANSIT (2020)

Jurisdiction	Additional Public Paratransit in 2020	
	Paratransit Dialysis Trips	Dialysis Paratransit Trips
Allegany County	1,438	\$59,390
Anne Arundel County *	12,192	\$340,114
Baltimore City **	46,288	\$2,278,195
Baltimore County	2,996	\$134,807
Calvert County	984	\$29,668
Caroline County	428	\$7,915
Carroll County	1,972	\$23,366
Cecil County	1,094	\$14,435
Charles County	5,221	\$274,914
Dorchester County	2,546	\$47,079
Frederick County	4,444	\$131,445
Garrett County	1,321	\$16,416
Harford County	2,557	\$65,324
Howard County	2,288	\$78,412
Kent County	893	\$16,520
Montgomery County	11,157	\$580,403
Prince George's County***	35,060	\$1,667,742
Queen Anne's County	676	\$27,048
St. Mary's County	2,400	\$42,797
Somerset County	1,217	\$26,331
Talbot County	1,284	\$23,745
Washington County Transit	2,175	\$38,128
Wicomico County	2,887	\$62,476
Worcester County	1,627	\$35,215
TOTAL	145,146	\$6,021,882

* Includes both Annapolis Transit and Anne Arundel County Department of Aging & Disabilities.

** Includes both Mobility and CAR. Cost per trip represents an average of both agencies.

*** Includes both Prince George's County Transit and MetroAccess. Cost per trip represents an average of both agencies.

Table 10: TOTAL ESTIMATED DIALYSIS PARATRANSIT DEMAND IN 2020

Jurisdiction	Current Paratransit Dialysis Trips Needed on Public Transit		Total Estimated Future Trips/Cost (2020)	
	Total Dialysis Paratransit Trips	Total Cost of Dialysis Paratransit Trips	Total Dialysis Paratransit Trips	Total Cost of Dialysis Paratransit Trips
Allegany County	5,135	\$212,107	6,572	\$271,497
Anne Arundel County *	43,543	\$1,214,680	55,735	\$1,554,794
Baltimore City **	165,316	\$8,108,961	211,604	\$10,387,156
Baltimore County	10,699	\$481,455	13,695	\$616,262
Calvert County	3,514	\$105,956	4,498	\$135,624
Caroline County	1,529	\$28,268	1,957	\$36,182
Carroll County	7,042	\$83,451	9,014	\$106,817
Cecil County	3,909	\$51,553	5,003	\$65,988
Charles County	18,645	\$981,836	23,865	\$1,256,750
Dorchester County	9,094	\$168,139	11,640	\$215,218
Frederick County	15,870	\$469,446	20,314	\$600,890
Garrett County	4,717	\$58,628	6,037	\$75,044
Harford County	9,131	\$233,300	11,688	\$298,624
Howard County	8,172	\$280,041	10,460	\$358,453
Kent County	3,191	\$58,998	4,084	\$75,518
Montgomery County	39,848	\$2,072,867	51,005	\$2,653,270
Prince George's County***	125,216	\$5,923,283	160,276	\$7,591,025
Queen Anne's County	2,415	\$96,600	3,091	\$123,648
St. Mary's County	8,572	\$152,845	10,973	\$195,641
Somerset County	4,346	\$94,038	5,562	\$120,369
Talbot County	4,586	\$84,803	5,871	\$108,547
Washington County Transit	7,768	\$136,172	9,943	\$174,300
Wicomico County	10,311	\$223,129	13,198	\$285,605
Worcester County	5,812	\$125,766	7,439	\$160,981
TOTAL	518,379	21,446,321	663,525	\$27,468,203

* Includes both Annapolis Transit and Anne Arundel County Department of Aging & Disabilities.

Cost per trip represents an average of both agencies.

** Includes both Mobility and CAR. Cost per trip represents an average of both agencies. □

*** Includes both Prince George's County Transit and MetroAccess. Cost per trip represents an average of both agencies.

jurisdiction. Again, these estimates assume that other human service agencies continue services at commensurate levels and are able to provide a similar share of the trips needed.

Total Demand and Cost

The total cost to public transit agencies of providing all current, latent and future paratransit dialysis trips in 2020 is estimated at \$27M; an increase of \$8M annually. It is anticipated that this will require providing an additional 663,000 trips annually. Table 10 (*see chart at left*) presents a summary of all unmet trip needs. This represents a 42 percent increase in current funding used by public transit operators for paratransit trips to dialysis (from \$19M to \$27M).

In the event that other paratransit services in the State are unable to serve any additional new clients, the increase for public transit operators could be as great as \$14M for a total of \$33M annually (in 2013 dollars). This represents almost a 75 percent increase over the current \$19M spend by public transit operators to provide paratransit dialysis centers in the State.

Study Limitations and Implications

These demand and cost projections are based on a number of assumptions:

1. Prevalence rates and incidence rates for new people needing dialysis services will con-

tinue to increase at approximately 3 percent annually in future years.

2. Current standard of health care for dialysis patients will continue into the future.
3. Current utilization patterns at dialysis centers will remain the same.
4. Trip patterns (trip length and the related cost per trip) will remain the same.

These assumptions may or may not reflect future conditions and limit somewhat the demand and cost projections provided in the report. The actual demand and costs will vary up or down depending on the accuracy of these assumptions.

The incidence rates for new patients may be affected by changes to health care and lifestyle in future years. For example, better primary/preventive care may prevent or delay the progression of kidney disease/diabetes/hypertension before dialysis is required.

The current utilization of center-based dialysis may not continue as the standard of care for dialysis patients. For example, it may be possible to provide more home-based dialysis in future years, particularly if the cost of more expensive home-based dialysis can be offset by the additional cost of paratransit costs.

Summary of Results

Table 11 provides a summary of the estimated dialysis paratransit trips needed on public transit systems in Maryland and the cost to provide those services. As shown, the current 443,000 dialysis paratransit trips by public transit agencies would increase to 518,000 annual trips if the transit systems had the resources (funding/vehicles) to expand their capacity to meet these needs. This number would increase further in 2020 to 664,000 annual trips as the number of dialysis patients grows over time.

to \$21M in order to expand to meet current demand. In order to meet the needs of new dialysis patients in 2020, the cost would increase to over \$27M annually (an increase over existing funding of \$8M or 43 percent). In the event that other human service programs in the State are unable to provide their clients with additional paratransit services, the additional cost to public transit operators could be as high as \$14M (in 2013 dollars) bringing their total to over \$35M annually. This represents an increase of 83 percent increase over the current \$19M currently spent by public transit operators. **CT**

Table 11: SUMMARY OF PARATRANSIT DIALYSIS TRIP NEEDS AND COST

	Year	
	2013	2020
Number of Persons on Dialysis	8,800	11,300
Number of Dialysis Center Patients	8,300	10,600
Annual Paratransit Trips to Dialysis Centers (all patients)	2,600,000	3,300,000
Estimated Trips to Dialysis Centers (all providers)	1,274,000	1,617,000
Current Trips on Public Transit	443,000	
Estimated Public Transit Trips to Meet Unmet Needs	518,000	
Projected Paratransit Trips by Public Transit Operators*		664,000
Projected Paratransit Trips by Public Transit Operators if Other Agencies Do Not Increase Services*		870,000
Annual Paratransit Cost by Public Transit Operators (2013 dollars)		
Current Public Transit Operator Cost for Paratransit to Dialysis	\$19,259,000	
Estimated Public Transit Operator Paratransit Cost to Service Unmet Needs	\$21,446,000	
Projected Public Transit Operator Cost for Paratransit*		\$27,468,000
Projected Public Transit Operator Cost for Paratransit if Other Agencies Do Not Increase Services*		\$35,300,000

* To meet unmet needs and future increases in number of patients

The Mid-Atlantic Dialysis Summit

By Scott Bogren

In early April, a number of transit providers, state association leaders, mobility managers and advocates from around the mid-Atlantic region came together at CTAA's headquarters in Washington, D.C., to participate in the Mid-Atlantic Dialysis Summit. The group's goal was simple: to get a better handle on the impact of the growing demand for dialysis transportation across the region and to explore ways to cost-effectively meet the demand and develop new partners.

CTAA staff members Carolyn Jeskey, Amy Conrick, Rich Sampson and Scott Bogren led the committed group through a design-thinking-based process, with an eye toward avoiding simply complaining about the current situation and, rather, to focus on innovation and solutions. Importantly, the process led participants to view the entirety of End Stage Renal Disease and the transportation it demands through the eyes of patients, dialysis centers, insurers, elected officials and more.

What follows is a series of key points, thoughts and notes from each of the Summit's sections, designed to provide a glimpse of the day's activities and, hopefully, to in-

spire additional regions to follow suit. We are fully aware that some points are repetitive, opting to provide a full account of the day's outcome.

We can bring this type of session — and its outcomes — to your system, your state or your region. Should you be interested in launching a similar summit, please contact Scott Bogren at bogren@ctaa.org or at 202.247.1921.

The Dialysis Transportation Challenge: Why We're Here

We began the summit with a quick discussion of why each participant attended and what each hoped to achieve.

- We are reaching the breaking point;
- Issue is epidemic;
- We have a problem, need to find a solution;
- Examine cost sharing for dialysis patients with public-private partnerships;
- The complexity of dialysis transportation;
- The second wave of dialysis patients broke our back;
- Learn about the challenges faced in other

Mid-Atlantic states. How are they comparable and how are they different? Any innovations we can import and can we assist in developing a national dialysis transportation message;

- To learn to respect the rider;
- To find possible solutions to the dialysis transportation demand and balancing trip purposes;
- It's a national issue;
- To break through the [Safe Harbor](#) issue;
- There is high demand and investment is decreasing. Dialysis centers are becoming more demanding;
- Better understand issue of dialysis transportation and potential future impacts on systems and their budgets;
- A need to better understand who is providing service now (public vs. private vs. ADA vs. Medicaid) and the capacity of each;
- To hear best practices and lessons learned from around the region from colleagues who are confronted with the same crisis I face: an expansion of dialysis that I'm incapable of meeting;

- Getting the complete picture of the issue would magnify the issue;
- Transportation is not part of the dialysis business model and it needs to be;
- To find the next steps towards a funding solution so public transit can meet projected demand;
- Public-private partnerships; and
- To see how we can address the needs of the traveling community and funding to provide the service.

Dialysis Transportation Through Different Perspectives

After covering why everyone had made the time and effort to attend the Summit, the group examined dialysis transportation through the eyes of various constituents. Here's what we found:

Patient

- Taxpayer
- Caught in crossfire
- Me, me, me
- Call health commissioner
- Fear of death
- Feel helpless
- Voiceless



- No insurance
- Stress/anxiety
- Lack stamina
- Vulnerable
- Transit anxiety
- Wish to be seen as a full person

Dialysis Clinic

- Reimbursement rates down
- Demand exceeds capacity
- Answer to profit margin/shareholders
- Direction of profit growth
- Transportation = not my job
- I'm in the health business

- They'll get here somehow
- It's a county function
- We're good corporate citizens
- Go find another clinic
- Location siting done by state

Legislator

- Lack knowledge
- Think that it's a local issue
- Not our problem
- Dialysis is too expensive
- Lobbying pressure
- Pressure from competing interests
- Worried about re-election
- Delay action with request for more information/research

- Do dialysis patients vote?
- Is the patient a constituent?

Insurance

- Preferred providers
- Medicaid vs. private insurance vs. patients without coverage
- Impact of Affordable Care Act
- Doctors with relationships with clinics

Reframing the Question

A key component in the design thinking process is evaluation, are we asking the right question? During the Mid-Atlantic Dialysis Summit, the group tackled reframing the base line question once they'd both broadened their perspective and shared their reasons for participating in the summit. Here's what the attendees developed:

How can we meet the growing need for dialysis transportation when there is not enough money, partners and understanding to meet the growing demand for dialysis transportation?

Dialysis Summit: Exploring Various Opportunities

Participants in the Summit readily acknowledged that dialysis transportation afforded opportunities, as well as challenges. Here, they list what they viewed as those opportunities:

- Technology;
- Varied funding streams and partners, for example, foundations;
- Re-shape our conversation with clinics;
- Rider-based advocacy campaign;
- Convene constituent groups;
- Document/catalog successes;
- Find champion among local elected official;

- Splitting the trips: in-bound and home-bound;
- Avoid being adversarial and controversial;
- Select three ideas that were suggested at the Summit as funding methods and test a couple of them — copays or means test, line item for transportation, subsidy from a philanthropic partner;
- Form advocacy groups consisting of patients/families/elected officials/ dialysis clinics/transit/other;
- Improved technology;
- Collecting models where it's working;
- Find additional dialysis investments;
- Glad CTAA is taking a closer look at this epidemic, seems like a national issue;
- Get dialysis passengers involved;
- Catalog/document successes;
- Use Maryland study as example to try to document state-wide need elsewhere;
- Develop new partnerships with customers and health care providers;
- Increase awareness of crisis;
- Find methods to partner with dialysis centers;
- Convene constituent groups at state level;

- Be a better advocate;
- Revisit establishing relationships with dialysis center and staff;
- Approach local legislators;
- Be a resource to local, state and federal elected officials on the dialysis transportation issue;
- Survey my dialysis riders and gain a flavor for what their reliance on transportation;
- Find varied funding partners;
- Use marketing to educate and possibly increase public and corporate awareness and generate funding;
- Meet with local dialysis provider and brainstorm ways to improve situation;
- Reach out to dialysis centers for support, donation, advertising;
- Begin to cap dialysis ridership that is break even and not a loss and investigate alternative finance methods;
- My system will negotiate a higher rate for dialysis transport with broker;
- Look to technology to help provide solutions to transportation needs;
- Work on funding options;
- Work on scheduling opportunities;
- Expand interest in dialysis transportation

with other stakeholders;

- Share findings from conversation across the region;
- Establish center/customer cost sharing through hospital-based dialysis centers not subject to Safe Harbor;
- Explore taxi industry voucher for delayed return trips;
- Examine role of car share excess capacity to provide service; and
- Explore possibility of private dialysis center taking on vehicle ads to open dialogue.

There Are Successes

As we worked through the day-long Summit, all participants began to realize that though the issue continues to prove vexing, they have achieved some very real successes. Here, they recount those successes:

- They local clinic worked with us over the winter during storms to better schedule trips;
- A veteran needing dialysis moved to our community and used mobility management and travel training to not only get him rides to dialysis, but improve his overall mobility and quality of life;
- We've enacted a dialysis fare (\$6 roundtrip);
- We're working with local partners;

- We spoke with DaVita, sensed some willingness and agreement from the folks at this site;
- We've leveraged local assets;
- Local hospital negotiations; and
- CTAA's Competitive Edge training.

Emerging Innovations and Solutions

Once the group had taken a closer look at some of the recent research on dialysis transportation, population demographics and health care trends, a key group of innovations and solutions began to emerge. They are listed here:

- We need investment, understanding and partners;
- Need a fare for everyone;
- Not going to bypass centers, develop clearly defined service parameters;
- Break up dialysis trips into two, distinct trips;
- In-bound, first option should be transit (assuming local transit exists);
- Opportunity for ticketing/subsidy on in-bound trip;
- Dialysis centers need to be located logically and with transportation in mind;
- Means testing not only covers income, it

covers ability;

- Best solutions come from shared interests between potential partners;
- Schedule transit-dependent patients during transit service hours;
- Need to develop alternative modes to serve dialysis patients, particularly regarding the home-bound trip — patient car share, coupons, taxi vouchers, 5310 vehicles, volunteer drivers, family rideshare);
- Dialysis centers need to contribute to costs for low-income passengers;
- It's the return trip that's the tough solution;
- Potential partners include: Obviously, the dialysis centers; hospitals; social service agencies; referring doctors; clients/families; foundations, like National Kidney Foundation/American Kidney Foundation; elected officials at local, state and federal levels; the public through new marketing efforts; Medicaid brokers; state health agencies and officials;
- Health care should be better advocates;
- Would welcome contracts for service;
- The entire dialysis business model should be aware of the positive outcomes transit facilitates;
- Transit's compassion should be rewarded;
- Safe Harbor would be replaced with a cost-

effective, mutually beneficial partnership; and,

- Transit scheduling should be embedded in Dialysis clinics.

Dialysis Summit: The Next Steps

Before the day-long Summit concluded, participants and CTAA staff each recorded their ideal next steps. They are listed here:

- Question: How much are transportation systems putting in (financially) to the dialysis systems now? What is projected?;
- National Dialogue on Dialysis Transportation at EXPO with prior survey and drop-in discussion center;
- Question: Who is doing dialysis transportation cost-sharing with centers in spite of Safe Harbor?;
- Need a best practices document;
- Where can we get a definitive answer to the Safe Harbor question?;
- Must learn to understand the full dialysis business model and how various forms of community and public transit fit into it;
- Develop a model that helps educate Dialysis Clinics on transportation providers' issues and to share their business model;
- Play off the notion of Dialysis companies as good corporate citizens with projects for ESRD patients, to sponsor patient transpor-

tation, create a shared community event, dialysis clinic employees as volunteer drivers;

- Must learn how a dialysis system bills for services and analyze the billing trends;
- Learn from talking with drivers and dispatchers;
- Who is providing services now and their overall capacity, an analysis;
- Develop a legislative champion, preferably one with personal dialysis experience;
- Fully costing out dialysis trips to your agency;
- Where does kidney disease fit in public perception as compared with other chronic illnesses;
- What can we learn from other public health awareness campaigns;
- What is the average dialysis clinic reimbursement?;
- Develop a template with vocabulary to enhance provider/clinic discussions;
- Test ideas in pilots;
- Put patients in advocacy spotlight;
- Help build relationships on the issue on Capitol Hill;
- Can we use Sen. Finance Committee and other key committees to put pressure on

CMS, ie: dear colleague letter?;

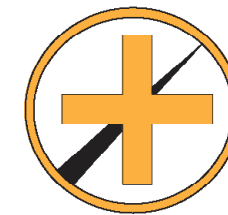
- What if article on what would happen if we stopped dialysis trips for a day;
- Meet with decision makers locally (legislators, local officials, staff) to explain the need for dialysis transportation;
- Work with dialysis providers on ways to partner for the benefit of their clients;
- Studies and surveys on cost analysis and myth vs. reality;
- Do a couple of different journey maps locally (rider/patient, dispatcher, drivers);
- Collect models;
- Meet again;
- Identify and develop broad coalitions;
- Develop messaging/campaign that spotlights the importance of our transportation, can be used to educate others;
- Try to establish working relationships with Dialysis Centers;
- Continue the dialogue and expand the panel to include invested partners;
- Collect data and publish findings;
- Use CTAA as a resource;
- Approach Dialysis units to: Determine their needs in the short-term; ascertain their plans to meet the predicted increase in patients;

share our experiences; and be sure to do all the above in a non-confrontational way;

- Imperative that this effort moves forward;
- This group should reconvene and be a model for other regions to emulate;
- Add a workshop to the EXPO on this topic;
- Educate the public and elected on issue, growing needs and tell the patients' stories;
- Work with dialysis clinics to learn each other's issues and find solutions;
- Work with CTAA to work with Congress;
- Find out if any states have cost-sharing with private dialysis centers;
- Create a dialogue with various stakeholders;
- Discuss with drivers and dispatch – find

ways to be more economical in the delivery of service;

- Awareness: get dialysis in the forethoughts of partners;
- Pursue alternative funding strategies/sources;
- Survey patients about their needs; and
- Approach corporate dialysis. CT



**Outpatient &
Non-Emergency
Medical Transportation**

CT Fast Mail



The perfect compliment to *Digital CT* is our bi-weekly E-Newsletter, *CT Fast Mail*. Delivering the latest news on transit policy from the nation's capitol, develop-

ments from across the country, research and analysis publications and information on resources and technical assistance from the Community Transportation Association and other partners, *CT Fast Mail* is the most direct location for the most relevant news and updates in the industry.

And it's free to sign-up! Simply send an email to fastmail@ctaa.org and you'll be connected with the next issue of *CT Fast Mail*. In the meantime, view the latest edition at www.ctaa.org.

Improving Transportation for Patients Receiving Dialysis Treatment

This report emerges from Portland, Oregon's [Ride Connection](#) and a Strengthening Inclusive Coordinated Transportation Planning project, and is excerpted here with permission.

Introduction

As a coordinator and provider of transportation, Ride Connection noted several indications of an existing need to address the difficulties associated with transportation for individuals who are receiving dialysis treatment. First, we heard feedback from our riders directly and from on-going rider surveys that current transportation options were not adequately serving the needs of these patients. Secondly, we heard from transportation partners that the specific needs of patients receiving dialysis treatment made transportation provision more challenging than for other riders. Finally, we saw an increase in trip requests for dialysis transportation, which resulted in a shift in capacity to accommodate the requests. Transportation of patients to and from dialysis appointments presented both a challenge and an opportunity.

The findings of this report contribute to a growing body of literature that holds transportation as serving a function that is much more than merely moving people from point



Improving Transportation for Patients Receiving Dialysis Treatments

Executive Report on Findings

January 2014



A to point B, but rather consider transportation to be intricately tied with greater quality of life and also for public health outcomes. Indeed, a 2005 study funded by the Transportation Research Board of the National Academies written by Hughes and Cromwell has shown that providing non-emergency medical transportation to those who are 'transportation disadvantaged' can significantly reduce emergency room and hospital expenditures, thereby leading to better health outcomes and a higher quality of life for patients, as well as reduced costs of medical services. This same report included a cost/benefit analysis and concluded that in the case of patients requiring kidney dialysis, providing transportation for disadvantaged would prove highly cost effective when we consider all of the improvements in the quality of life that result and cost savings that would result.

The findings in this report highlight numerous additional ways in which the health outcomes of patients are directly and indirectly impacted by barriers or inadequacies in their transportation options, thereby suggesting that improved transportation options would not only improve health outcomes, but could potentially reduce overall healthcare costs by reducing medical complications for patients down the road.

Approach

In the summer of 2013, Ride Connection launched a six-month participatory planning

process that identified existing challenges related to transportation for patients to dialysis treatment, and how these challenges impacted patient health. This process involved the creation of an advisory committee, focus groups, a patient survey, a caregiver/healthcare provider survey and a public workshop. Each of these steps helped to identify transportation challenges and informed specific changes that would not only improve the quality of transportation services, but ultimately would improve the health outcomes of patients receiving dialysis treatment. Prior to beginning this process, we obtained approval from the Human Subjects Research Review Committee of Portland State University to assure the ethical integrity of our practices. Further, our staff reviewed literature related to End Stage Renal Disease, dialysis and non-emergency transportation prior to engaging with patients, caregivers and healthcare providers in order to ensure that we had an adequate background understanding of the issues.

Involving Participants

We reached out to the dialysis community throughout this process to ensure input from many different perspectives: from those who work in the field to those who are affected by the disease. An advisory committee met monthly and was composed of five dialysis patients, a transportation provider, a caregiver and five healthcare providers. The committee provided input for the Project Team's methodology of data collection, identified

priority issues, developed survey and focus group questions, and helped develop solutions with next steps.

During the entire project, the Project Team worked to share decision making, interpretation of findings and development of recommendations with the dialysis community participating in the project.

Data Collection

Eighty-three patients and 26 caregivers, transportation providers and healthcare providers completed surveys. Two focus groups were held and were attended by eight patients and two caregivers, who provided details related to their challenges and experiences with transportation to and from dialysis treatment. These sessions were led by two facilitators trained in working with vulnerable populations.

Finally, 19 stakeholders participated in a public workshop to help develop workable solutions to these challenges. Stakeholders included patients from both focus groups, caregivers, healthcare providers, Advisory Committee Members, transportation providers, drivers, Non-emergency medical transportation Administrator and a Coordinated Care representative.

Results

Involving participants in the planning and decision making process ensured relevant outcomes were achieved. It also resulted in

new relationship development and shared understanding among participants. The advisory committee, patient survey, and focus groups helped us to identify numerous broad issues and areas of concern related to the impact of transportation on health outcomes for dialysis patients. Here are the main themes:

DEPENDABILITY: When a ride is late or does not show up, a patient may have to cut their dialysis treatment short, which could have deleterious impact on their health. Patients can also be stranded at the clinic if they miss their ride home.

FLEXIBILITY: Participants identified a greater need for flexibility in scheduling so that when patients need more time to complete their treatment or to stabilize after dialysis, they can easily reschedule their rides home.

WAITING AND INDIRECT ROUTES: Participants identified frustrations with the service they use related to patients having to ride across town and sometimes right past their home or clinic to pick up another person before they are dropped off.

COST/AFFORDABILITY: Results of the data collection showed that the majority of patients surveyed are low income, therefore the cost of transportation to and from treatment cost provides a huge barrier.

DRIVER TRAINING: Participants noted a need for driver education and training so

that they can better understand the needs and rights of patients.

GEOGRAPHY: Participants noted that some patients are often assigned to clinics that are far away from their home even when closer options are available.

Solutions

Strategies, best practices, and community resource ideas that came from participants in this process were numerous and can be grouped into two categories. Some can be easily implemented now and others will take additional resources:

1. Develop education, advocacy, recruitment and outreach activities such as; regional transportation fact sheet specific to dialysis, dialysis education campaign, enhanced driver training beyond the Ride Connection network, recruitment program for volunteer drivers that will be on-call for flexible return trips, and a system to support patients that are newly diagnosed. Many more ideas emerged and will be documented in a report that will be made public.

2. Collaborative pilot to effect change: Work with a clinic and all transportation providers to create a more reliable, affordable, friendly and flexible dialysis transportation system.

Input from the advisory committee, from the workshop, and from discussions among Ride Connection staff and stakeholders then

helped to identify a set of operational protocols internal to our organization. These new protocols incorporated strategies and best practices and community resources that could address some of these issues and immediately improve the quality of our service to dialysis patients. There were five suggested protocol changes:

1. No-show/late cancel policy revised: no penalization for late cancels or no-shows due to medical emergencies or treatments that run long.

2. Guaranteed return trip: ensure all Ride Connection customers understand that they will not be stranded at a clinic without a ride home.

3. Driver training: Enhance training courses to include more in-depth information about conditions that affect patients receiving dialysis treatment.

4. Education: Develop fact sheets for riders, drivers, and clinics that outline service expectations and dialysis patients' rights and responsibilities

5. Scheduling protocol: When rides are being shared that include trips from dialysis clinics, those being transported from clinics will be taken home first.

Challenges

The health of individuals how receive dialysis treatment fluctuates daily. This has created challenges in attendance to meetings

and focus groups. As a result, we have offered over the phone or in-person interviews. Due to HIPPA rules, we have had to work with the social workers at clinics to have them recruit patients, making participant recruitment a bit more difficult. We worked diligently to identify social workers that understood the transportation challenges of those that they served to assist us with these efforts.

We experienced some resistance to participation from the corporate entities who own a group of the dialysis clinics. We are in the process of providing them information about the program and are enlisting our champion social workers' support to get them on board as we start the next phases of this project.

Plans for the Future

This process was unlike any inclusive planning project we have undertaken before. The level of commitment, the importance of this issue, the devotion and expertise in the Advisory Committee and level of engagement encouraged and motivated us to go beyond our thinking about internal processes. The project team brought up the content of this project in regular staff meetings, encouraged staff to attend the patient-delivered training on dialysis and we have embedded these efforts into our organization even before the project reached completion. We remain more committed than ever to involve our riders and the broader community of stakeholders in all of our organization's new initiatives

moving forward.

While this portion of our project is complete, we have no intention of stopping here. We have been asked to present information about our findings to TriMet's Committee on Accessible Transportation, Health Share's Citizens Advisory Council, Elders in Action's Transportation Sub-Committee and the Special Transportation Funds Advisory Committee who is responsible for the Coordinated Human Services Transportation Plan.

Additionally, we have applied for additional inclusive planning and implementations funds as well as operations money for a pilot project to better address the transportation needs of people receiving dialysis treatments. We will continue to keep stakeholders engaged in this topic as we move forward in addressing transportation needs for people who receive dialysis treatments.

This project was made possible by the outstanding work of the Advisory Committee and those that participated in the focus groups and completed surveys. Thank you to each of you for sharing your stories and knowledge with us.

This project was made possible with support from:

Administration for Community Living

Community Transportation Association of America

Health Share of Oregon

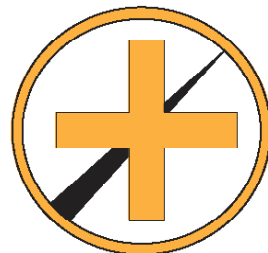
Oregon Department of Transportation

TriMet

Upstream Public Health

About Ride Connection:

*Ride Connection is a non-profit that has been providing transportation for people with disabilities and older adults for over 25 years. Our mission is to link accessible, responsive transportation with community needs. In coordination with over 30 community partners, Ride Connection provides customer-focused, safe, reliable transportation options for individuals in Clackamas, Multnomah, and Washington counties in Oregon. Recently, Ride Connection's Julie Wilcke discussed the agency's recent research on Improving Transportation for Patients Receiving Dialysis Treatments on the [CT Podcast](#). **CT***



New Benefits for Members! Join Today!

Becoming a member of the Community Transportation Association of America presents an ever-growing pool of benefits and services, including:

- New Certified Safety and Security Manager (CSSM) Training
- Access to the Insurance Store at CTAA
- The Latest Policy Analysis and an Effective Voice in Washington
- Technical Assistance Programs and Information Resources
- Discounted PASS Driver Training and Certification

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Transportation**
ASSOCIATION

ANNOUNCING

The Competitive Edge:

Making Community and Public Transit
the Best Alternative for Medical Transportation

Today there is never-before-seen complexity in the non-emergency medical transportation field. Limited funding combined with growing patient loads has states seeking intermediaries that can control costs through competition. Community and public transportation providers must become efficient, safe, cost-effective and accountable to maintain these important medical transportation services. The Community Transportation Association, in response to requests from its members, is introducing a new initiative this fall —the Competitive Edge — which will give community and public transit providers the tools, resources and benefits they need to make them central players in this new medical transportation environment. Here's what the Competitive Edge encompasses:

1

The Competitive Edge Training

CTAA has developed an all-new training course that combines and emphasizes the following topics:

- Value: Determining the true cost of service
- Pricing: Lowering your costs to be competitive
- Negotiation: Winning through persuasion
- Accountability: Building a recordkeeping and reporting process
- Training: Focusing on the patient

Access to the Transit Industry's Best Resources and Training

You don't need to have all the answers, you need to have access to them when you need them. Here's how the Competitive Edge helps:

- Peers and Information Sharing: CTAA will put you in contact with your industry peers, where you can learn from experience
- On-Line Library and Resource Holdings: The most timely resources, news and research, all housed on CTAA's medical transportation website
- CTAA staff: Our professional staff are always available to offer analysis and insight
- Important training and certification programs such as the Certified Safety and Security Manager, PASS Driver Certification, and the soon-to-be released Medi-PASS Driver Certification.

2

3

Valuable CTAA Member Benefits

As part of the Competitive Edge initiative, the Association has developed a cohesive set of benefits to ensure your operation is efficient and cost-effective:

- The Insurance Store: Through an exclusive agreement with Newtek, members can access the best coverage at the lowest price.
- Energy Program: CTAA members pay less for fuel and energy with our FleetCards program and other energy management initiatives

Please go to www.ctaa.org/competitiveedge to learn how you can bring the Competitive Edge to your state. As always, CTAA training staff are available to help tailor this new program to your precise needs. Please call Charles Dickson at 202.247.8356 or email dickson@ctaa.org for all the details on this unique opportunity!



LANTA Plans Implementation of Two New Routes

The [Lehigh and Northampton Transportation Authority](#) (LANTA) looks to implement two new enhanced routes that would decrease travel times in the Valley's intercity bus service. LANTA's director of planning, Owen O'Neil, presented the Enhanced Bus/Bus Rapid Transit study results with the Lehigh Valley Transportation Study's technical committee. Executive Director Armand Greco expects the board to adopt the study's result.

The first route would run from Wal-Mart in Whitehall Township, and up Sixth and Seventh Street in Allentown. The route would then run into Bethlehem via Hanover Avenue to West Broad Street in 20 minutes. The line will continue on to South Side Bethlehem and to Lehigh Valley Industrial Park VII along Route 412. The second route would follow the first stops of the first route with frequent bus services along the line. The route would then run from Muhlenberg

College into Bethlehem via Hanover Avenue to West Broad Street and into South Side Bethlehem.

It will take LANTA approximately six years to implement the entire plan as it will only implement pieces of the project each time funding becomes available.

"The eventual goal would be to have the buses coming so frequently – one every 10 minutes – that no one would need a schedule," O'Neil said. "It's supposed to mimic a light rail line."



McLennan County to Close Gaps in Services

Transit officials urged McLennan County leaders to close the service gaps created by the 2010 U.S. Census Bureau maps by creating a combined urban and rural transportation district. The census map reclassified certain counties from rural to urban that resulted in a lack of funding. Closing the gap

would allow the county's [Waco Transit System](#) to manage the county's transportation services and receive state money.

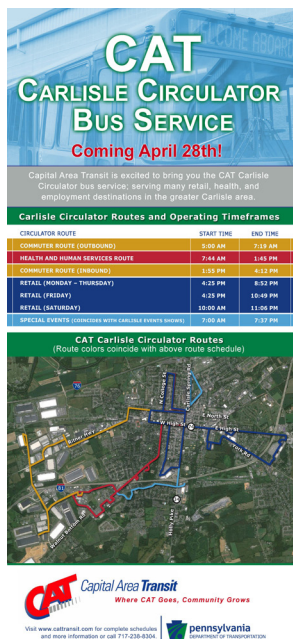
The current transit district acts as an on-demand service offering 5,100 hours of service each year. The new district is expected to increase to more than 20,000 hours of service each year. Waco Transit General Manager John Hendrickson explained that it would need to learn where most transit requests come from in order to develop "flex routes" for new on-demand services. This service would include vans that pick up people along specific routes.

"As ridership increases and the way we operate increases, we would see more money long term for this region," Hendrickson said.

Carlisle (Pa.) Bus Circulator Launches Trial

After years of discussions with the [Capital Area Transit](#) on how to maximize mass transit, the Capital Area Transit Carlisle bus circulator began its three-year trial in late April. Although it is expected that the new bus service will bring success, its ridership for the next three years determines its future.

The Carlisle bus circulator is estimated to cost more than \$428,000 annually. With the help of funding, federal investments will pay \$214,183 and state investments will pay \$186,246 while municipalities, and local businesses and organizations will pay



CAT
CARLISLE CIRCULATOR
BUS SERVICE
Coming April 28th!

Capital Area Transit is excited to bring you the CAT Carlisle Circulator bus service, serving many retail, health, and employment destinations in the greater Carlisle area.

Carlisle Circulator Routes and Operating Timeframes

CONCULATOR ROUTE	START TIME	END TIME
COMPUTER ROUTE (OUTBOUND)	9:00 AM	7:15 AM
HEALTH AND HUMAN SERVICES ROUTE	7:44 AM	1:45 PM
COMPUTER ROUTE (INBOUND)	1:05 PM	4:12 PM
RETAIL (WEDNESDAY - THURSDAY)	4:35 PM	8:00 PM
RETAIL (FRIDAY)	4:35 PM	10:40 PM
RETAIL (SATURDAY)	10:00 AM	11:00 PM
SPECIAL EVENTS (CONCULATOR WITH CARLISLE EVENTS SCHEDULE)	7:00 AM	7:37 PM

CAT Carlisle Circulator Routes
(Route colors coincide with above route schedule)

Capital Area Transit
Where CAT Goes, Community Grows

Visit www.cattatransit.com for complete schedules and more information or call 717-238-8304.

pennsylvania
Department of Transportation

\$28,000.

The Capital Area Transit will monitor the circulator's ridership every six months in order to adjust the bus routes. With employment around the area, commuters must decide if using the new circulator benefits themselves. The new circulator would also benefit students at Dickinson College who travel to nearby retail stores and fast

food restaurants.

Some of the Carlisle Bus Circulator stops are included on commuter routes such as North Bedford and East North streets, health and human services routes such as East North and North Pitt streets, and retail routes such as North and North College streets.

"The planning work is done. The trial is here," Cumberland County Commissioner Gary Eichelberger said Friday. "Now it is up to you ladies and gentlemen of the public to make this work."

Shawnee Transit Building New Headquarters

The [Shawnee Mass Transit District](#) (Ill.) broke new ground Wednesday, April 9 for their new headquarters in Vienna. The new bus service will provide transportation to Johnson, Union, Pulaski, Alexander and Massac Counties.

Although its first services began more than a decade ago, the transit district received a \$2.2 million grant for a new headquarters in 2009. The new headquarters will provide enough room for offices, dispatches and a garage for the new and growing service fleet.

The routes will run through small towns and into bigger cities, such as Marion, Carbondale, Cape Girardeau and Paducah. The transit district wants the public to know that they have access to available rides. As the district hopes to attract more customers, it received another \$4 million grant for three new depots and 20 additional buses. "We're growing pretty fast. We went from 2,000 trips a month to well over 10,000 trips a month," said Executive Director Maureen Mann. "A lot of people think that we only transport the sick, and the elderly, and the public aid clients, but we are a true mass transit district."

DeLand Transit Begins Votran Bus Service

The \$1.45 million, 3.5 acre Intermodal

Transportation Facility will begin this May four [Votran](#) bus services along four routes. One route is along route 20, which is the main north-south bus route through West Volusia. With the new [SunRail](#) service beginning May 1, two of the four routes will take commuters to the DeBary station that runs the SunRail commuter line.

The DeLand City Commission approved on April 7 an extra \$70,467 for quick improvements for enclosures for two bike racks at the facility and a security camera system. Before Votran's services, riders had to stop at the corner of Woodland Boulevard and International Speedway Boulevard to transfer between the north-south and east-west connectors, but Votran's efficient new bus service will integrate the two by integrating route 20 (north-south) with route 60 (east-west). "They'll be interlined, which means people won't have to transfer between the two anymore," said Steve Sherrer general manager at Votran. "Basically the route 20 going north-bound will turn into route 60 and go across to the east side of the county and vice-versa."



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As with everything we do at CTAA, we strive to ensure that our publications are fully accessible to everyone. In the production of this digital publication, we only employ widely used technology that comes standard with most computers. The pdf files we create are those most commonly used by readers of such files. That said, we know that we can always improve this publication's accessibility and we'd like your help. We want everyone to be able to make best use of this digital magazine. If we can provide any of the articles or content in a different format, please let us know at cteditor@ctaa.org.

Community
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