North Carolina Department of Transportation
James H. Trogdon III, Secretary

Public Transportation Division
Debbie Collins, Director
919-707-4684
dgcollins1@ncdot.gov

Managed Care Organizations and Coordinated Transportation

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This is an exploration of the potential impacts of Medicaid Non Emergency Medical Transportation's (NEMT) conversion to a Managed Care Organization (MCO) model on coordinated community transportation providers.

Coordinated Transportation Model

North Carolina has been a leader in developing coordinated transportation systems, with all counties having some form of coordinated service for both the general public and human services agency passengers. Coordinated transportation systems are umbrella organizations that provide service to multiple human services agencies and, in many cases, the general public. By coordinating their efforts, human services agencies share the expense of capital and operating costs and therefore reduce the cost of individual trips (Burkhardt, 2012). Coordination also makes federal Section 5311 funds available to subsidize capital and operating costs in non-urbanized areas (FTA 2014).

Section 5311 funds were designed to combine federal transportation money previously split into different programs and to improve general public transportation in rural areas. Accessing these funds was the impetus for developing coordinated community transportation systems and serving the general public. North Carolina receives more than $30 million is Section 5311 funds every year. Before these services were coordinated, human services transportation was provided by individual agencies operating separate fleets of vehicles for serving senior centers, nutrition sites, Medicaid customers, and other federally funded program recipients.

Medicaid is the largest funder of human services agency transportation in the coordinated transportation model in North Carolina. It also serves as local match for other funding programs. In Fiscal Year 2017, coordinated transportation systems provided more than 1.5 million Medicaid-related trips, representing 23 percent of the total trips provided. In this year, Medicaid contracts resulted in $18.5 million in revenues, 19 percent of total state, federal and local revenues for coordinated providers. The table below categorizes transit systems by the percent of Medicaid trips provided out of the total number of trips. Nine transit systems reported zero Medicaid services. For six transit systems, Medicaid represents more than half of the service they provided.

Percent Medicaid Trips	Count of Coordinated Transportation Systems	Percent Medicaid Revenue (average)
0%	9	0%
1-25%	40	14%
26-50%	22	32%
51-75%	4	34%
>75%	2	73%

Providing Medicaid transportation tends to be more costly than most human services agency contracts because of the service characteristics. Nutrition trips, for instance, typically involve providing regularly scheduled service to customers living near nutrition sites and going to the same destination at the same time. Thus, it is easy to group nutrition trips to provide more efficient and cost-effective service. On the other hand, Medicaid trips tend to not follow patterns, have both origins and destinations dispersed throughout the service area, and have times dispersed throughout the day. As such, it is difficult to group Medicaid trips into efficient and cost-effective service.

Managed Care Scenarios

The August 9, 2018, Request for Proposals issued by the N.C. Department of Health and Human Services seeks to award contracts to four Managed Care Organizations (MCOs) at the statewide level and one or two additional contracts in each of the six regions. At least three potential Managed Care Organization models may be introduced with changes in Medicaid transportation:

1. ***MCO is the transportation broker.*** The MCO would manage the health services and contract with local service providers for transportation services. The coordinated transportation system might be the sole transportation provider, might share transportation responsibilities with other providers, or might not be utilized for transportation.
2. ***MCO contracts with a transportation broker***. The MCO would contract with a firm specializing in transportation to arrange all trips. The firm might be the coordinated transportation provider or a private firm. The private firm might partner with the coordinated transportation provider or with other providers, or bring in its own transportation solution.
3. ***MCO operates its own transportation***. The MCO would offer a turnkey solution by providing its own transportation. The coordinated transportation provider would not provide any Medicaid service.

Impacts on the Coordinated Model

If the coordinated transportation system is utilized to provide transportation in an MCO environment, it is expected the MCO will require changes in how transportation is provided. This section explores some potential changes and their impacts on the coordinated transportation model.

- ***Service Policies:*** MCOs are expected to establish stringent service policies. To be able to coordinate trips among multiple agencies, many coordinated transportation systems require at least a one-day advance reservation. MCOs may reduce the reservation period or require real-time, on-demand service. Reducing the advance reservation period could decrease efficiency and increase costs, although customer convenience would improve. In addition, on-time performance standards will likely be introduced. The MCO could refuse to reimburse providers for missed pickups and late arrivals.
- ***Cost Reimbursement:*** Coordinated transportation providers currently bill human services agencies for services a number of different ways; most use shared miles or hours, which is effective for recouping all expenses. The MCOs' proposed billing model is expected to

establish the reimbursement rates before the trip is carried, based on the distance between origin and destination. Coordinated providers will need to understand how changes in the cost reimbursement structure impact other services. Transportation providers will also need to be able to determine, on a trip-by-trip basis, whether the reimbursement rate is adequate to cover its costs – a calculation that will be based on the ability to group services, the distances to the origin and from the destination, and other service requirements. If the coordinated transportation provider is not judicious in only providing service where the reimbursement rate meets or exceeds the cost, then Medicaid transportation will be subsidized by other human services agencies, grant programs or local funds, reducing the ability of non-Medicaid passengers to access needed services.

- ***Scheduling/Billing Software:*** NCDOT has invested substantial funds and effort into ensuring that coordinated transportation providers have sophisticated scheduling and billing software packages, with many providers also utilizing on-vehicle technology such as tablets for digitally managing schedules. An MCO or transportation broker may require all providers to use proprietary technologies. With at least five MCOs active in each transportation jurisdiction and potentially eight for regional transportation providers, using proprietary technology will become an administrative burden. Medicaid trips will be isolated from other trips served by the coordinated transit provider, making it difficult to group trips. The administrative difficulties of managing multiple systems could result in coordinated transportation providers dedicating vehicles to Medicaid service, completely removing Medicaid from the coordinated model.
- ***Coordinated Providers Excluded from Medicaid Service:*** If the coordinated transportation system is not selected to participate in Medicaid service, the service being provided to the community will change. For 28 providers, Medicaid transportation represents more than 25 percent of the trips. These providers will be forced to rethink their service delivery models to constrain costs and increase efficiency. For instance, rather than providing pure demand-response services, zone-based or fixed services might be established. The coordinated providers will likely need assistance in redesigning these services. Their technology applications will also need to be re-evaluated to determine whether they are adequate for supporting these new service structures. Also, it is likely that the loss of Medicaid transportation will result in many coordinated providers being over-capitalized with vehicles, at least until new services are established.
- ***Cross-Jurisdictional Service:*** Regardless of which organizations provide Medicaid transportation in the future, it is likely that future Medicaid transportation providers will be required to operate beyond the traditional service area boundaries that currently exist. Rather than dealing with a single transportation agency for each service area, the MCO or its broker will likely assign trips to the most cost-effective provider – which could be an operator from a different service area. This dissolving of traditional service area boundaries may force coordinated transportation systems to consolidate or at least develop regional partnerships in order to remain competitive for Medicaid transportation.

1. Burkhardt, Jon E. and Richard Garrity. "Sharing the Costs of Human Services Transportation." *Transportation Research Record* 4, no. 2277 (2012): 57-64.
2. Federal Transit Administration. "FTA c 9040.1g Formula Grants for Rural Areas: Program Guidance and Application Instructions." (October 24, 2014, 2014): November 11, 2014.