Medicaid Bus Pass System

Ashley Clark, Brad Luck, Jessica Ricketson, Juan Zhang

I. Introduction & Problem Statement

In the state of Vermont, there are 182,045 people who receive medical care benefits through Medicaid. One of those benefits is non-emergency medical transportation (NEMT) - to help beneficiaries who do not have a vehicle in the home get to and from their medical appointments. The Department of Vermont Health Access (DVHA) manages this benefit through transportation brokers around the state. In Chittenden County, the Chittenden County Transportation Authority (CCTA) is the broker. CCTA has an extensive bus network throughout the county and Medicaid recipients who qualify for non-emergency medical transportation benefits and live along the bus route are eligible to receive a 10-punch buss pass. Prior to using their pass, a beneficiary must contact Maximus, the contracted Medicaid assistance office, and inform them of the date, time, and location of their medical appointment. Maximus verifies the appointment with the medical provider and then the use of the bus pass is authorized. When a beneficiary is down to just 2-punches left, they can call for a new 10-punch pass. This system was put in place in October 2012, in order to ensure that DVHA was following federal guidelines, which require them to verify that all transportation costs are directly associated with medical travel only. Prior to October, beneficiaries who qualified for the benefit received an unlimited 30-day bus pass. This change has had an adverse effect on one specific population, the New Americans who have been relocated to Chittenden County.

The Vermont Refugee Resettlement Program (VRRP) is located in Colchester, in Chittenden County, and oversees the arrival of 300 refugees annually to the state. More information about what it means to be a refugee and more detail about the resettlement process may be found in Appendix A. All refugees reside in Chittenden County upon arrival and receive a variety of services and benefits, including Medicaid. The recent change in the bus pass system presents some challenges to the refugee population. Some complications these people encounter while using the new system include but are not limited to, language barriers that make understanding and navigating the new process difficult, and families who are effected by chronic illnesses that require frequent medical care. The purpose of this paper is to investigate how the Medicaid bus pass system in Chittenden County for is working for refugees and to explore potential solutions to ensure that refugees have a system that provides safe access to transportation for their medical appointments.

II. Methodology

To gain a clear understanding of the old Medicaid bus pass acquisition and use process as compared to the newly implemented process, we did some reading and background research.

This included looking at documentation and handbooks published by the Department of Vermont Health Access (DVHA), the Vermont Department of Children and Families (DCF), Green Mountain Care (GMC), the Vermont Refugee Resettlement Program (VRRP) and Chittenden County Transportation Authority (CCTA). These are all key players in the creation and implementation of the new policy and process for obtaining and using bus passes for medically related transportation by Medicaid recipients. This background information gave us insight into why the change came about, what populations were effected the most, and perhaps most importantly, how these organizations work together to make the new process work. In addition, State and National Representatives were contacted in order to explore how Medicaid and transportation are handled in Vermont. We also called the Medicaid transportation phone hotline in order to experience the process firsthand. Document analysis and background research of refugee resettlement policy, Medicaid eligibility, Non-Emergency Medical Transportation policy was also conducted.

Before October 1, 2012, the Medicaid bus pass system was relatively simple. Medicaid recipients were issued unlimited use 30-day bus passes to be used on any CCTA route. Although this process had been working for Vermonters receiving Medicaid benefits, it was necessary that the State change the process to be in compliance with Federal Medicaid Regulations which state that all medically related transportation under Medicaid needs to be accounted for reporting purposes. Under the previous system, Vermont Medicaid patients could have used their bus passes for much more than getting to medical appointments making tracking and reporting bus pass use nearly impossible. Because Vermont was not able to provide this data (if required by the federal government), the state could have faced large fines.

The new process, implemented on October 1, 2012, requires each trip to a medical appointment to be accounted for through a long and complicated process. Individual Medicaid recipients are required to apply for a 10-pass bus card, make their medical appointment, call Maximus to verify that they will be using a bus pass to get to that specific appointment (and provide the date, location, and time), and have the trip verified on the date of the appointment by the medical provider. More information on the old and new Medicaid bus pass process may be found in Appendix C.

After gaining in-depth knowledge of the new and old processes and the populations the changes affect most, we were able to start digging deeper. We did this by conducting a series of interviews with key stakeholders in the Medicaid and Refugee / New American system. Each interviewee was asked the same set of questions (see Appendix B); most of the interviews were audio recorded, reviewed and significant statements transcribed. Notes on the conversations that took place during these interviews may be found in Appendix B. It is important to note that there was no interview with CCTA; they did however issue a broad statement on ridership via email. After all the interviews had been completed, evidence and common themes from the transcripts and notes were synthesized (see Appendix B). This gave a clear picture of what the real problems are that have come as a result of the changes in the Medicaid bus pass system. Unintended consequences include added difficulty for non-native English speakers to navigate and use the system, complications for those who require frequent trips to the doctor, barriers for

women who need to bring their children to medical appointments with them and a loss of transportation for non-medically related, yet essential life tasks such as grocery shopping, helping at local schools, getting to non-medical appointments, or visiting with family & friends.

III. Policy Options & Analysis

No Further Action

This policy option would mean maintaining the system as it is currently running. There would be no change to how bus passes are applied for, distributed, or how their usage is verified. This system is currently functional; however, it poses some level of difficulty for New Americans on Medicaid.

Create a Feedback Loop to Identify Opportunities for Success

Creating a feedback loop through an assessment or survey given to Medicaid recipients, medical care providers, as well as advocacy groups and case managers will gather opinions and criticisms of the bus pass program that may not otherwise be captured. Through designating one specific opportunity and location to give feedback, and publicizing it well, aspects of the program that are not working may be identified and altered based on the needs of the populations the policy serves.

Medical Provider Distributes Bus Passes in Addition to the Current System

Giving the medical providers discretion to distribute bus passes would be another option to modify the policy. This change would allow providers to give out bus passes for follow-up treatment, or a series of passes for those with chronic illness that may require frequent visits to the health care provider. Furthermore, distributing bus passes at the same time as the medical appointments are scheduled will simplify the process of appointment verification that currently exists. This policy option also maintains the current policy for patients who do not require frequent visits to their health care provider.

Create a Web-Based Scheduling Portal for Medicaid Transportation

This policy option provides for an alternative mechanism for scheduling Medicaid medical treatment transportation. This would give clients the opportunity to request bus passes and provide necessary appointment information in an online format. This form would be accessible at any time of day, and in the client's chosen language.

Market & Educate Case Managers on Face-to-Face Options to Obtain Bus Passes and Resolve Related Issues

Marketing and educating case managers on the different avenues for obtaining bus passes and resolving issues associated with Medicaid transportation will give clients more options to navigate the Medicaid system.

Vermont Agency of Human Services & Vermont Public Transportation Association Partner to Address Quality of Life for Medicaid Patients

Since moving away from the practice of distributing unlimited monthly bus passes to Medicaid recipients, the identified population has had other aspects of their lives negatively affected. Under the current policy there is no alternative provided for transportation that is not for a

medical purpose that impacts overall quality of life. Destinations that are important to quality of life but are not for medical treatment include but are not limited to: grocery shopping, visiting family, attending school functions or classes, and participating in community events. This policy recommendation would consist of the Vermont Agency of Human Services partnering with the Vermont Public Transportation Association to identify and fund a mechanism that could provide transportation for these reasons that impact overall quality of life. This would be done by conducting a survey of RISP Net members.

Policy Options Analysis

	No Further Action
Advantages	• System is currently functional • Vermont is in compliance with Federal Medicaid policy
Disadvantages	• Current system is difficult for non-native English speakers to navigate • There isn't a mechanism for travel outside of medically related business • There isn't a mechanism to track missed appointments or other unintended consequences • No feedback loop to improve the system over time
	Create a Feedback Loop to Identify Opportunities for Success
Advantages	• Continual feedback will inform authorities on how to improve the system to meet client & provider needs • Improve the relationship between the provider, advocacy groups, VRRP, and New Americans through improved communication channels
Disadvantages	• The costs associated with administration and upkeep of this mechanism may be high • Has the possibility to create frustration within surveyed populations if action isn't taken
	Medical Provider Distributes Bus Passes in Addition to the Current System
Advantages	• Patients with ongoing treatment for chronic illnesses or reoccurring medical needs can easily obtain passes when they set up their future/follow-up medical appointments • Provides a more holistic process for treating patients by considering all aspects of their personal lives • Simplifies some of the challenges of oral communication required in the traditional process for non-native English speakers • Actively responds to needs identified by families and elderly Medicaid

	recipients
Disadvantages	• Creates added work for the provider to manage and account for all of the distributed bus passes • May complicate tracking bus passes (for Federal reporting purposes) by adding additional distribution channels
	Create a Web-Based Scheduling Portal for Medicaid Transportation
Advantages	• Would offer an alternative for Medicaid patients who have access to the internet • Alternative language options could make the process easier for non-native English speakers to navigate • Simplifies the process for advocates or case managers to assist in scheduling appointments with or for clients • Could streamline the process for providers through maximizing efficiency via technology • Maximus could continue to be retained as the service provider • Utilizing the existing web presence on the Department for Children and Families website to host this service to minimize costs (www.dcf.vermont.gov/mybenefits)
Disadvantages	• Could be difficult for those would do not have access to the internet or lack computer skills • Setting up this new process could be costly
	Market & Educate Case Managers on Face-to-Face Options to Obtain Bus Passes and Resolve Related Issues
Advantages	• Would attract more traffic to the Cherry Street CCTA location where Medicaid bus passes can be obtained in person • Would be more effective system for refugee population to have in person communication • May expedite the bus pass acquisition process
Disadvantages	• Getting to the office may be challenging for some Medicaid patients • Hiring and retaining high quality customer service staff at CCTA would increase overall costs • Finding multi-lingual and well-trained staff to provide positive interactions may be difficult
	Vermont Agency of Human Services & Vermont Public Transportation Association Partner to Address Quality of Life for Medicaid Patients

Advantages	• Would address the need of Medicaid recipients' for transportation unrelated to medical treatment • Would increase communication between transportation agencies and VRRP to identify and actively problem solve other issues
Disadvantages	• Implementation could be complicated and costly • Identifying and tracking what would be deemed proper use could be difficult especially with respect to higher level policy discussion, creation, and implementation • Possible political tensions under a new partnership could strain monetary and human resources dedicated to this project

IV. Policy Recommendations & Future Outlook

It is the conclusion of our research group that there are many different policies that could be implemented to improve the quality of life of Medicaid recipients. Although the current system is operable, it was brought to our attention that there are many Medicaid recipients within the New American sub-population that do not use the new system because of the difficulty they encounter navigating it with limited English language skills. It is because of this and the other themes that came out of our interviews and research that we have decided upon the following sequenced action plan.

Immediate Action

Immediate action that can be taken to alleviate some frustration over the current system would be to create a web portal for Medicaid bus pass use scheduling. This web system could be hosted on the same website that Medicaid recipients currently find their benefit material and documents. This web based scheduling portal could be translated into different languages much like the current Medicaid resource website. In doing this, New Americans would be able to better navigate and utilize the new process in their native language resulting in fewer complications and better understanding of the procedure. Furthermore, if this is done via the web, providers could have an easier time confirming medical appointments and validating bus passes post use. Maximus (if available) could continue to be the vendor for this additional scheduling mechanism, allowing for one central location to record and report Medicaid medical transportation statistics.

Another item for immediate action is to educate case workers and market the existence of the CCTA customer service location on Cherry Street in Burlington. This location is underutilized currently, but does provide face-to-face service for those who need to apply for or resolve issues with Medicaid bus passes. It is suggested that as a part of increasing use of this office that multi-lingual customer service agents be recruited to more effectively assist the quickly growing New American population who often have difficulty with the English Language.

Short Term Action

Two short term action items were identified within our policy analysis. The first is to allow medical treatment providers to distribute bus passes for Medicaid recipients while they schedule follow-up appointments. This will specifically aid those who have acute illnesses that require frequent visits for medical care like physical therapy, and pregnant women or families with small children who need to have regularly scheduled visits to monitor regular growth and development. By allowing providers to distribute passes, it eliminates the step for the patient to call to schedule/coordinate/reapply for medical travel. If implemented after the web based portal system, data could still be stored and coordinated through Maximus. It is important to note that this will be in addition to maintaining the current application and renewal process as there will be instances where passes are required for immediate or unpredicted medical treatment.

The second recommendation for short term action is to create a feedback mechanism for those who utilize or coordinate Medicaid transportation. This could come in the form of a survey or feedback form to be made available to Medicaid recipients, VRRP case managers, medical care providers, and Medicaid bus pass coordinators. This would create one central location for positive and negative feedback to be collected, collated, and interpreted to make changes to the system over time. Currently, no such feedback loop exists making collecting opinions and criticisms of the new procedure extremely difficult. It is important to note that the new Medicaid bus pass acquisition and use process is still very new, so getting a feedback mechanism put together will be an important part of its development. It is hoped that collecting feedback from clients and providers will also increase communication between organizations.

Long Term Action

Finally, a suggestion for long term action is that the Vermont Agency of Human Services work with the Vermont Public Transportation Association and the Chittenden County Transportation Authority to assess the impact that the change in the bus pass system has had on the overall quality of life of Medicaid recipients. Since switching to the new bus pass structure, Medicaid recipients, especially New Americans have not had a mechanism for other kinds of travel besides walking. Walking, though appropriate in many metropolitan settings, isn't appropriate in Chittenden County. There simply isn't the infrastructure to support walking to all of the places necessary to maintain a quality of life that is expected while receiving Medicaid benefits. Furthermore, Vermont often has inhospitable weather conditions during the winter months which are not conducive to walking long distances. This is problematic because the lack of safe and reliable transportation to complete necessary tasks such as grocery shopping, or visiting their child's school has a negative impact on overall quality of life. It is hoped that through this partnership that additional means of transportation could be made available to the Medicaid population.

This partnership could also act as a regional transportation board and perhaps work to expand CCTAs reach across Chittenden County. This would allow for Medicaid recipients and New Americans in general to have a wider network of potential employers, medical provider options, access to different food retailers, and the ability to visit more family and friends. By increasing

the span of their operation in this way, CCTA could also increase net revenue by marketing to a whole new ridership population.

References

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3. "Medicaid in Vermont | Green Mountain Care." *Medicaid in Vermont | Green Mountain Care*. N.p., n.d. Web. 18 Apr. 2013.

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Appendix A: Background

What is a Refugee?

A refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group. Refugees differ from other immigrants in that they do not have the choice to remain in their home country. Refugees flee their countries to save their lives. They run from war and persecution, often losing beloved family members along the way. Many refugees then spend years and sometimes decades in substandard refugee camps. Less than one percent of the world's refugees get the chance to leave a camp and resettle in the United States, Canada, Europe, Australia, or other countries that resettle refugees.

Refugee Resettlement Program

The Refugee Resettlement Program is established to help newly arriving population of refugees become self-sufficient in the shortest timeframe following their arrival in the United States. The Federal Office of Refugee Resettlement (ORR) provides funds, policy and over-site; but services are administered by the state. The agencies responsible for managing the U.S. Refugee Resettlement Program are the following: Bureau of Population, Refugees, and Migration (PRM), Department of State US Citizenship and Immigration Services (USCIS), Department of Homeland Security (DHS), Office of Refugee Resettlement (ORR), Department of Health and Human Services (HHS). The Refugee Resettlement Program consists of the following services:

Refugee Cash Assistance (RCA) – Refugee cash assistance allows refugees that do not meet Family Independence guidelines to receive financial assistance for up to eight months after arrival in the USA. The benefit amount is the same as the benefit level for FI. Eligibility criteria for this service parallel the state's TANF (FI) programs.

Refugee Medical Assistance (RMA) – Refugee medical assistance provides a health screening within 90 days after arrival, as well as other medical assistance, for up to eight months after arrival in the US. Eligibility criteria for this service parallel the state's Medicaid programs.

Refugee Social Services (RSS) – Refugee social services include employability services which include job preparation training, job seeking and keeping skills, vocational skills training, case management and other services such as English Language Training, translation and interpreter services, citizenship preparation and social adjustment services.

In order to qualify under the U.S. resettlement program a refugee normally must (a) be of a designated nationality and fall within the priority categories for that nationality in that region; or, (b) be referred by a U.S. embassy, UNHCR or a non-governmental organization (NGO); and (c) meet the U.S. definition of refugee as determined by the DHS/USCIS; and (d) not be excludable under INA Section 212(a). A practical consideration is (e) that the refugee must have access to a U.S. refugee processing post or DHS/USCIS officer and (f) not be firmly resettled in any foreign country.

According to Refugee Council USA, since 1975, the U.S. has resettled over 3 million refugees, with annual admissions figures ranging from a high of 207,000 in 1980 to a low of 27,110 in 2002. The average number admitted annually since 1980 is 98,000.

Vermont Refugee Resettlement Program

As a local field office of the U.S. Committee for Refugees and Immigrants (USCRI), the Vermont Refugee Resettlement Program (VRRP) serves as the only resettlement program in the state of Vermont. Through the efforts of the VRRP, in conjunction with the DCF and other State entities, refugees receive cash and medical assistance, social services and preventive health services. Like Vermont, most States do not provide direct social services with their federal ORR funds. A number of States award funds to more than one agency to provide refugee services.

Since its establishment in 1980, VRRP has been bringing hope and opportunity to the lives of refugees and immigrants by defending human rights, promoting self-sufficiency, and forging community partnerships. VRRP provides refugees with their first home in the United States and acculturation services. It plays two roles: to offer short-term intensive services with the goal of helping refugees achieve self-sufficiency within eight months; to provide English Language Training and employment services for up to five years after arrival.

VRRP's award-winning volunteer program offers crucial community connections to newly arrived refugees. In addition, VRRP's Interpreting and Translating Services (VITS) provides the region with professional services in more than twenty-five languages. Through a wide range of direct and collaborative programs, VRRP helps refugees to successfully adapt to life in the United States.

Refugees in Vermont

Nearly 5,538 refugees have resettled in Vermont since 1980. Based on more reliable data, since 1990, the number who arrived annually in Vermont had been between 233 and 345. Refugees that have been resettled in Vermont include groups from Eastern Europe, Africa, Asia, and South America (Bogre, 2010).

Vermont has a diverse refugee population. According to statistics from the Vermont Agency of Human Services, Vermont saw an influx of immigrants from Africa and Asia in 2011. Refugees from the small Himalayan country of Bhutan and the Southeast Asian country of Burma have arrived in Vermont in large numbers. Since 2008, roughly 870 Bhutanese and 220 Burmese have made the Green Mountain State their new home. Within the past 10 years, Vermont has also seen refugees arrive from Eastern Europe and the Middle East, along with several small African countries including Togo, Burundi, and Rwanda, and many more from Somalia and Sudan. It should come as no surprise that there may be more than 80 different languages and dialects spoken in the state by foreign-born residents. Somalian refugees speak many different languages, including Somali, Bantu and Arabic dialects among others. It can be hard to find interpreters that have a strong background in certain dialects that are only spoken by a small population of people. While most refugees arrive and stay in Chittenden County, thanks in part to better job access with public transportation, some individuals do end up moving to other parts of Vermont. For

instance, central Vermont—including Waterbury, Montpelier, and Barre—has a large population of Bosnian-born residents and Russian-speaking Meskhetian Turks. There are pockets of refugees outside of Chittenden County, and there are certainly groups of non-English speaking people in other parts of the state, but certainly the vast majority live in Chittenden County (Simard, 2012).

Appendix B: Interviews

The Interviews

Medicaid Bus Pass Interview Questions:

- What is your role at your organization?
- Can you describe any knowledge you have of the Medicaid bus pass/transportation process?
- What was the process like in the past?
- Can you explain the change that has occurred?
- If you arrange or set up people for Medicaid transportation, how do you get them the information they need in order to be successful?
- Which population demographic do you think experiences the most challenges with Medicaid transportation and why?
- What do you think is working well with this system?
- What are some of the challenges with this system?
- What are your suggestions for ways to improve this system?
- How do you think the system is affecting new Americans?
- What are some of the barriers to access to medical transportation from your perspective?
- How has this affected your work and organization's tasks? Is it improved? More difficult? How and why?
- Are there other people we should talk to about this process?

Interview with Medicaid Bus Program Clerk

In a phone interview with a Vermont Medicaid Bus Program Clerk, we were informed that when someone enrolls in Medicaid they are mailed a benefits handbook, which contains information about transportation benefits. If they are on Medicaid, do not have a vehicle in their household, and do not have a medical exemption that prevents them from riding a bus, then they qualify for non-emergency medical transportation services. If there is a vehicle in the household then all members of the household are automatically disqualified for this service. If they live in Chittenden County and live on the bus route, then they qualify for the 10-pass bus pass benefit with CCTA. If they do not live in Chittenden County, then they are referred to their local transportation broker.

Community Health Centers of Burlington Interview

Through interviewing Guylaine Daoust, LEP Specialist at the Community Health Centers of Burlington, we were able to gain a better understanding of the impact of changing the Mediaid bus pass system on CHCB patients. Guylaine is new in her position which began at the same

time that the bus pass system was transitioning to the new methods. She was in attendance at many meetings between their organization and Maximus to discuss how the new system would work and to identify possible challenges that may come as a result. One of the major problems the staff at CHCB identified was complications that could surface due to the verbal communication component of the new process. This would specifically put a majority of the new Americans they serve at a disadvantage as many of them have limited English language proficiency.

After the initial implementation phase, Community Health Centers of Burlington did not see a change in cancelled appointments or patients that didn't show up for Medicaid appointments. The staff at CHCB attributed this to the fact that the majority of their Medicaid patients live within walking distance to the center on Riverside Avenue. Guylaine mentioned that even patients from Winooski walk to the clinic if they do not have a ride; even in the winter months. She also suggested that since Maximus simplified the process (shortly after implementation), there was less of a barrier to getting to appointments for those with limited ability to communicate verbally in English. The changes that were made to the Medicaid bus pass system just after implementation included the following:

- The client didn't need to call Maximus directly to inform them of the appointment; this information could be relayed by a case manager from VRRP
- The first month of Medicaid transportation could be through an alternate method coordinated through VRRP as a "back-up plan" in the event that the client couldn't navigate the bus pass system.
- Details of the appointment required to validate the trip were lessened to the appointment date, time, and location.

One interesting piece of information uncovered during this interview was that upon initial enrollment in the Medicaid system, there is an option to request letters that outline all pertinent information regarding the program to be translated in the client's native language. Guylaine shared with us that when she had personally gone through this process, she had requested the letters in French, her primary language, to gain a better understanding of the system. She never received these translated documents. She did note that this may have been an error, however, it was frustrating and could be a part of why this system is not operating as expected.

Finally Guylaine informed us of a change that Community Health Centers of Burlington underwent not too long ago that may inform our research a little better. Recently, CHCB had transitioned from allowing translators to attend appointments with patients to now only allowing interpretation services over the phone. There wasn't much negative feedback over this change (though there was some). After some research, it was determined that many groups that were affected by this change had a cultural similarity that complaining (what American's often view as constructive criticism) was not an acceptable opinion to voice. The complaints they did receive came from communications with either VRRP case managers, or advocates from other agencies that worked with these populations.

We attempted to identify possible solutions to the complicated issue of Medicaid bus passes as a means to get patients to medical appointments. Guylaine agreed with us that the system is in its infancy and could possibly still going through an "organizational culture change". The best solution that we could come up with while brainstorming with her given her experience and point of view from the provider side of this process was to institute a formal mechanism for feedback on set intervals. This could take the form of a survey for providers, patients, and advocates that could be given every couple of months, or at the end of each fiscal year. This would allow for feedback, both positive and negative to get back to the proper institutions for action. By creating a feedback loop, not only is there communication happening (that isn't currently taking place), but also an organized system to better inform changes to the system as they are needed. This survey could be either verbal or written, and could be taken by individual patients or with the assistance of a VRRP case manager. It would also be preferable if these surveys could be administered with the option of alternate languages. Guylaine also provided us with an interesting document that breaks down CHCB's activities and case load over 2012 including Medicaid patients.

Interview with staff person at Vermont Refugee Resettlement Program (VRRP)

In an interview with a staff person at the Vermont Refugee Resettlement Program (VRRP), we were told that as soon as the new Medicaid buss pass system requirements were released they knew it was going to be a mess. The staffer communicated that the system was confusing to them (the staff) and so they knew it was going to be a challenge for the 300 refugees that move to Chittenden County each year. The staffer reported anecdotally that the system in general is too complicated for refugees and the individual questions whether or not refugees are using the system or just avoiding it by using a regular bus pass or other means of transportation. The staffer indicated that the notice regarding the change in Medicaid transportation from the state was relatively short and did not give ample time for those on the ground to prepare nor give recipients themselves time to adjust. The staffer said that refugees are often not comfortable on the phone and prefer face-to-face communication so that they can see body language and tone. Additionally, spelling names and street addresses over the phone can be extra burdensome. It was suggested that there be a face to face opportunity for people to schedule their bus transportation for medical appointments – somewhere near major bus stops (Cherry Street, Champlain Mill), a place that they already know and trust.

Interview with staff person at Department of Vermont Health Access (DVHA)

In an interview with a staff person at the Department of Vermont Health Access (DVHA), we were told the Vermont Public Transit Authority ran all non-emergency medical transportation arrangements and took payment for 23 years until VDHA took the program in-house four or five years ago. Taking it in-house produced a significant savings. Today there are 11-transportation brokers in the state, managed through contracts with DVHA. The underlying premise is that people who receive Medicaid benefits need to get to their appointments. Since the program was taken in-house, there has been greater attention to federal standards. There are four people in the state who work solely on non-emergency medical transportation. Last year, there

was attention given to the federal requirement that anything billed to Medicaid must be verifiable as being for a medical appointment or service. Prior to October 2012, if someone was on Medicaid, had no vehicle in their household, and lived in the Burlington district, they were eligible for a 30-day unlimited bus pass. A list of these people was faxed to Chittenden County Transportation Authority (CCTA) each month and the passes were mailed out. CCTA would bill Medicaid based on use per month. However, there was no system to monitor what the bus trips were being taken for. While some customers were using the passes scarcely, others were using them multiple times daily – clearly not just for medical appointments. The federal requirement of having a verifiable system of all Medicaid expenses was not being adhered to.

In July 2012, VDHA began to develop a new system for non-emergency medical transportation for Medicaid customers. Provider groups, refugee resettlement, Maximus, Vermont Center for Independent Living, and the Economic Services Division, were all involved in identifying the ultimate solution, which resulted in beneficiaries who qualified receiving a 10-punch bus pass. Each time they needed to use the bus to get to a medical appointment, they would need to call ahead to inform VDHA of their medical appointment. VDHA would call the provider and verify, thus satisfying the requirement of verifiable related medical expenses.

The VDHA staffer indicates that they were aware of the challenges of this system – in particular for refugees. They produced flyers and translated them into different languages. Caseworkers can call appointments in and appointments can be made in person at the Cherry Street office. Since implementation in October 2012, the overall transportation numbers are down, but there has been no feedback – good or bad. There were some provider issues early on, which have been resolved. And, they made the option to get to the transportation extension on the Medicaid phone line easier. To date, the system seems to be working. There are no indicators or reasons to do anything differently, though the Department is open to suggestions and feedback.

Interview with Staff at Association of Africans Living in Vermont

Association of Africans Living in Vermont case managers help with Medicaid bus voucher access. They are not aware of any problems with the system currently, but it used to be that you got a monthly bus pass at CCTA. Now you need to take a letter to the front desk at CCTA in order to get the 10-ride pass.

The impact of the change is that people now need to arrange for transportation to do other things which they used to be able to use the monthly bus pass for. In the past there was no distinction. Now, only some people who are on Reach Up can get bus passes for employment related activities. The demographic which this change affects the most is the elderly, and perhaps mothers with young children. ***We can't measure the impact of bus pass loss because people figure out ways to get things done.*** So far, they have heard no stories of people missing medical appointments after the bus pass change because they find rides thru family members, interpreters and other service providers.

The staff expressed the opinion that CCTA takes the wrong approach to solving the problem of ridership: they look at costs and benefits first, but building new lines encourages economic development. For instance, in Colchester, there are new developments and apartments which are

vacant because you need a car. You need to make routes available in the whole county, especially to industrial parks.

The impact on the elderly population is large: they are non-drivers, they need to get to medical appointments but are also now maybe staying at home and missing out on social opportunities and the health benefits of them. A suggestion for how to change the system would be to make exceptions for elderly and women with young children. CCTA should also do a survey to see who needs the bus, and determine who they want to serve. How effective is their relationship with Medicaid? What are they trying to do? What are the times that they need to be running, and to where? What is the town relationship to CCTA? How can towns improve the lives of older people?
Maybe instead of Medicaid/CCTA giving the bus pass out, the medical provider could. They know how many appointments their patients will need, and they could give them a pass for a certain amount of time.

An impact on AALV is that staff will go with clients to CCTA because it's faster than dealing with the phone- taking staff time and resources. They will provide their clients transportation because it's part of their work. CCTA and employers/medical providers should be surveyed to coordinate the needs of riders.

Interview with Vermont Department of Health Staff Person

In an interview with a staff person from the Vermont Department of Health who has had involvement in refugee health, we were made aware of the wide range of agencies and organizations that play a role in assisting refugees and new Americans in Vermont. She suggested we speak with VRPR, AALV, RISPNET, and Denise Lamaroux, the State Refugee Coordinator. She said that this is part of the confusion in general – that there are many different players and it is hard to figure out exactly who to talk to between all of the different agencies. We discussed the recent changes in the Medicaid bus pass system. The staff person offered some general observations. She said that generally refugees have more medical appointments than the average person due to the nature of their health condition and history prior to their arrival. She also said that many refugees have limited English proficiency and experience challenges reading, spelling, and speaking. She said that all of this makes phone conversation extremely challenging.

She mentioned other resources, including John Barber, Bill Clark, Maximus, Sita Luitel, and Guylain Doust. She said that overall the phone in system seems confusing from a design perspective for the people that are likely to need the bus passes – refugees. She said that while no one is complaining, as far as she is aware, she also was not aware of a way to measure if the system is working. She raised questions that would be interesting to know – like how many people have lost the access to the 10-punch pass system due to improper use, or how many calls have been dropped or lost because people hung up, and how many calls have required the services of an interpreter.

Themes Gleaned from Interviews

As a result of the interviews that we conducted, the following themes and key take aways arose:

- Verbal communication is extremely challenging for those with limited English proficiency – in particular phone conversation.
- There are no clear issues to date with the new bus pass system, but there is no formal mechanism to gather feedback about the system and the general culture of those who may be experiencing issues is to not complain.
- The system is complicated. There could be easier ways to administer it, which could include involving health care providers.
- While the changes in the bus pass system helped the Medicaid program ensure verifiable medical appointments, it may have had unintended consequences of making other travel more difficult for those affected by this change.

Appendix C: The Bus Pass System

Effective October 1, 2012

Medicaid and Transportation: How the System Works

Medicaid Bus Pass Changes (Effective: October 2012)

Medicaid is a benefit assistance program that was started in the mid-1960's to help those who were aged, blind, low-income, or disabled. New Americans and Refugees were added to this list later in the program's history. Funding comes from the federal and state governments but is administered by State agencies. One component of this program is the Medicaid Transportation Program which provides transportation services to and from medical services and appointments.

The State of Vermont Agency of Human Services and the Office of Vermont Health Access transitioned from using unlimited monthly bus passes as the means of provided transportation to medical appointments for Medicaid patients. This change was made in order to comply with federal regulations that had been in violation not just in Vermont, but in many states across the US. Vermont was prompted to make this change after other states had been identified as not in compliance and fined heavily. As per federal law, transportation to medical appointments for Medicaid patients must be verified and accounted for. This was not the case in Vermont up until October 2012 because it was very hard to track and trips taken by Medicaid patients through the unlimited CCTA bus passes that were distributed. Furthermore, it could not be confirmed that the passes were *only* being used for transportation to medical appointments.

Effective October 1, 2012, the new policy states that: Chittenden County Medicaid beneficiaries will be issued a 10 trip bus voucher for verifiable medical appointments instead of a regular, unlimited 30-day bus pass through Chittenden County Transportation Authority. This change ensures that bus transportation is for valid medical appointments and that the benefit of bus transportation is no longer misused. This change affects approximately 1100 beneficiaries and has been vetted through the Vermont Legal Aid before implementation.

Under the new system, Medicaid patients must apply for bus passes (in sets of 10) through an application process that may either be completed in person at CCTA or over the phone. To use a pass for transportation to a medical appointment, the client must call Maximus (the provider that coordinates and verifies transportation) to inform them of the date, time, and location of their appointment. This call may be made with the assistance of a Vermont Refugee Resettlement Program Case Manager if the client has limited English language speaking skills. Once the client has checked in for their appointment, the provider must call and verify that the patient has indeed shown up for their appointment, thus verifying their bus pass was used appropriately. If the client does not have access to a CCTA bus line, they are able to arrange for transportation via either a cab service or through the Special Services Transportation Agency. Restrictions to this policy are as follows:

- Prior authorization is required. (Exceptions may be granted in a case of a medical emergency)
- Transportation is not otherwise available to the Medicaid recipient.
- Transportation is to and from necessary medical services.
- The medical service is generally abailable to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.
- Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.
- Reimbursement for the service is limited to enrolled transportation providers.
- Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
- Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

Income & Premium for Medicaid

# in Household	1	2	3	4	Your cost is
If you live outside of Chittenden County and your total monthly/yearly household income is less than:	$975 $11,700	$975 $11,700	$1,175 $14,100	$1,333 $15,996	**$0/mo**
If you live inside of Chittenden County and your total monthly/yearly household income is less than:	$1,058 $12,696	$1,058 $12,696	$1,250 $15,000	$1,408 $16,896	**$0/mo**

(Source: Medicaid in Vermont Website: *http://www.greenmountaincare.org/vermont-health-insurance-plans/medicaid)*

Non-Emergency Medical Transportation (NEMT) is a covered service for beneficiaries enrolled in traditional and Primary Care Plus (PC Plus) Medicaid and Dr. Dynasaur programs. NEMT is a statewide service for providing transports for eligible people to and from necessary, non-emergency medical services. It is provided through Personal Services Contracts between the State of Vermont, Department of Vermont Health Access (DVHA) and local public transit Brokers (NEMT Manual, 2012).

Per Federal Rule 42 CFR 440.170(a), "Transportation includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatments for a recipient."

Future Research Suggested Next Steps

This project was a great learning opportunity and provided a meaningful experience for us to apply the theories and practices of Public Administration to a real life problem our community members experience daily. Although this set of recommendations and associate research was intensive in itself, there are some suggested next steps our group could offer if someone else were to continue where we left off.

The first suggestion would be to attempt to open up a line of communication with CCTA. Creating a dialogue beyond a broad statement of their ridership would better inform the policy options we provide here. It would be interesting to know their level of involvement in this issue so far, their interest in working with a regional transportation agency, and any other thoughts they bring to the discussion. Unfortunately, this was not something we were able to capture in our research during the semester.

The second suggestion would be to conduct a cost – benefit analysis of the old system as compared to the new bus pass system. It would be interesting to see if there were in fact a cost savings that could support the implementation of and sustain some (ideally all) of the policy options we presented. It would also be interesting to get approximate cost projections for each policy option we came up with and try to identify funding streams that would support these initiatives.

A third recommendation would be to look into the different kinds of feedback mechanisms that would capture data on how the system is working at various levels. This would include finding a way to actively solicit comments on the current system, a way to collate that data and code it to identify reoccurring themes, and then propose action from this information.

Finally, it would be our recommendation that if work on this project is further considered that alternative policy options be considered. It is important to note that the options presented in this paper were limited not only by the amount of information we were able to collect, but ultimately by the time constraints we were operating under.

We would like to wish future students working on this project luck. We are open to assisting in getting you oriented to the problem definition as we understood it, and the issue evolution over time.