Roundtable I Meeting Notes
September 29, 2022

Notes begin at 20:00 minutes in the meeting on Slide 9. For previous comments refer to PowerPoint notes slides:

John D- The dialysis system has exploded, especially in the last 7 years. With improved technology, dialysis patients are living longer, which a good thing but does create a greater burden on the system. As more dialysis centers continue to crop up, the primary focus for Tam is providing the Transit systems assistance to address the need. While the need can vary based on the number of centers available, at least 50% is focused on on-demand, curb to curb service. In 2021, TAM's effort focused on assisting this need by working with the centers. In 2021, there was budget language in MDOT to study NEMT and there was a study completed. In summary, the study indicates a great need with little. SB 838 by TAM. To increase the STAP funding. The fund is available across the state. Funding has been flat for the past 2 decades. Beginning in 2025, the funding would increase. Tam also focuses that our transits need resources including drivers. He noted much could be done in coordination.

Noelle- There was a discussion about HB1243, Noelle and John H gave testimony. Noelle pointed out there was a case management component which was very good since it allowed the case managers to participate.

John Hartline- John gave a little background on HB 1243. At the RMC summit, a year ago, he advocated for NEMT funding and he met with Seth Howard who inquired about this topic. Working with Delegate Howard's office by providing bullet points, the bill was submitted to benefit all 5 TCC. The main problem was that the bill was not supported by any Democrats. The bill was a great idea for rural health and through additional discussion, the urban partners became interested. The Bill included a provision that Governor provided contingency money of $1 million to be distributed to the 5 TCC. Unfortunately, the bill failed

Sara- Sara provided a broad description of her office. There are 50 Rural offices of Health in the country. There are 18 offices in Maryland. The ACA made healthcare available across the US. The Act influenced the state to adopt the Total Cost of Care model program. This approach helped transition the industry from volume based to value-based healthcare. In this regard both rural areas and Baltimore City are very similar when in this context. They see some funding for Medicare in SB295. Our "All payer model" is unique throughout the country. We have a hospital global rate system and we focus on preventative care. This could include non-emergency. The HSCRC is focused on keeping people out of the hospital and allows a higher quality of life to keep people out of hospitals. It is now growing in the primary care program. The more we

treat people out of hospital, the better for the patient as well as the healthcare system. Some programs that support TCC includes the Maryland Heartcare program to help people for transportation. But there are gaps, still. We have a variety of ways to address including our local Health depart transportation program. But we need to break down the silos.

Usually, peoples with disabilities have services but dental services are not available. This is a tragedy. Sara responded the approach should be "Non-emergency Health medications for opioid use. There was a discussion of the Western Maryland program about their Tooth Fairy program.

It was noted that some people view Oral health differently than medical health. There is a fear of the procedures. It is important to equalize oral health with health care. Delegate Robyn Lewis entered a link in the chat about HB 6 that passed that expand access for dental coverage for all adults in Medicaid. We hope will address the unmet need.

Our MDOT MTA OLTS is very active serving our transportation representatives. Tanya stated they manage all of the formula funds for the State. Section 5310 is administered by OLTS mostly to non-profits and they also support the LOTS for operating and Capital funds. IIJA (Infrastructure Investment Jobs Act) is a very large potential funding source. The IIJA initiated a larger pot of money of formula funds and MDOT MTA OLTS is restructuring the methodology for distribution. All LOTS will be able to review the formulas. There is also Section 5310 funding and Nancy Huggins is the OLTS expert. Tanya also mentioned discretionary funds that are available. For example, there was a grant that was delivered today, called Strengthening Mobility and Revolutionizing Transportation (SMART) Grants Program. This is a planning grant, and the grant can be used a support a system integration component.
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**After the Roundtable, Tanya forwarded on the SMART grant and noted the following portions of the application can be used for increasing Equity and Access specifically to:*

1. ***Get reduced-fare transit to people who need it by streamlining income-based transit fare programs by integrating back-end databases with other social service programs.***
2. ***Improve infrastructure for all by using technology to assess infrastructure that supports mobility, including sidewalks, bus shelters, bike lanes, and curb cuts.***
3. ***Improve equity with the integration of climate, public health, and socioeconomic data into transportation operations.***
4. ***Improve responsiveness, flexibility, and efficiency of paratransit services with booking, scheduling, and routing systems.***
5. ***Enhance transportation for passengers in wheelchairs by integrating an automated wheelchair securement system into transit, paratransit, or local mobility vehicles.***

Tanya noted that many of these grants have no or little matches. This is a direct and efficient way to fund the LOTS.

Nancy Huggins- The Section 5310 grant is now available to non-profits and throughout the state except for Montgomery and Prince George. There was a meeting at the TAM conference on this grant. A recording of the meeting is available on the TAM website. This grant permits funding for both operating and capital funding. There is a 50% match and 20% for capital funding. The application can be found on the TAM site and available for non-profits.

Senior Rides is another program that Nancy discussed and manages. It is available to fund rides for seniors and will include all types of services (shopping, friends, as well as medical). This grant is Statewide including Montgomery and Prince Georges (unlike the 5310). The round will open in January. There was a discussion about the current low funding level and there is a strong effort to increase funding. John noted that the Senior Rides program increased funding is a TAM priority because it is such a very small amount and it generally relies on volunteers and the program is very efficient.

Another area for discussion is the NEMT Medicaid program. It was pointed out that many consider NEMT funding is for Medicaid only. There are only 4 transit systems in Maryland that use the Medicaid transportation funding in Maryland. The rest are not connected to a Transit but operate under non-profits. It was pointed out that most NEMT is through these other programs not just Medicaid. IN summary, NEMT is a combination that include a public area, for profit area, nonprofit area and private (family) area.

To put in context, Tanya told a story of a 17 year old girl whose mother had a massive stroke. She was just above the poverty line and was not eligible for Medicaid. Suddenly, there was no one who could take her to the follow up appointments and she had to rely on a 17 year old child. Even the MTA bus system was challenging due to physical disabilities and ailments. The line item is very small and most of us must still rely on family. But can someone do if they have no family who can drive them?

There was a question about volunteers. Nancy commented that she must develop a report each yar to the Legislation. Some questions were asked such as “How many miles have been used by Senior Rides do we have?” Note: After the meeting Nancy provided a summary of the rides which is attached to this report. They are transporting more people. Many of the Senior Rides program had to transition due to COVID to call people and deliver food.

From Nancy Huggins (after the meeting)

The following information is from a DRAFT report to the Governor on the FY2022 Senior Rides Program.

FY2022 Senior Rides Report (excerpts)

	FY2022
One-Way Trips	32,854
Senior-Ride Miles	323,584
Senior-Ride Hours	27,113

The grantees (8 in FY22) provided transportation and/or services for 1,765 individual seniors during FY2022. These were seniors with needs for access to medical appointments, trips for shopping and/or religious services, frail or vision-impaired seniors who need an escort to travel, and seniors with needs for ongoing therapy or medical treatment. Many of these seniors are not able to rely on family, friends, or neighbors for their rides. The SRP provides an alternative transporation service that allows the participating seniors to access needed services and to remain connected to their communities.

In FY2022, the grantee began seeing an uptick in service by providing more trips, traveled more miles and accumulated more hours as compared to FY2021. Also, in FY2022, there were 1,765 seniors transported: 191 more than FY2021. This is due to the increases of services following the height of the COVID-19 Pandemic. Several agencies that had switched from driving seniors to delivering food and supplies to those seniors in FY2020 and FY2021 continued the practice into FY2022, along with transporting passengers.

Sharon from PIC- works with keeping people engaged. Transportation is a high demand to the doctor, grocery store and hairstylist. Covid was a huge setback. Many volunteers had to stop due to health. The office stopped driving for 2-week s and they also set up rules to safety (masks, keep windows down, etc.) They get phone call saying this is their only opportunity for transportation. They don't have a close-knit family or anybody to help them. Appointments and outpatient services require that someone needs to be there all the time for the care and drive them home. This is very hard for someone. There was question about pay. PIC offers gas reimbursement but many will turn it down. When the gas prices went up, they went to the county to get more funding. Sharon noted that 98% of their volunteers will reject the payment. There are some programs that have paid drivers, but the bulk are voluntary. There is quite a bit for training, is the car in good shape, sexual harassment, etc. There was a question clarifying the number of senior ridership and drivers.

There was a question when the Senior Rides program seen an increase. In 2014 and it has not raised for %. The legislation allowed up to 500,000 but the program is funded less than $300,000.

Would anyone want to comment on the bridging the gaps. There was a discussion of Veteran transportation. They have been concerned about health transportation and they have asked us to include transportation. When we began W2W, we were getting requests for veteran calls. J. Hartline described how he received a call from a veteran who had a brain operation scheduled in Walter Reed but he had no transportation. When he completed their forms, the patient was able to drive but, a few years later, he was not. When he requested the VA provide transportation, they pointed out that he completed the form stating he did not need the transportation and if he needs to change that, he will have re-fill the forms and wait until they are approved (=/- 90-120 days). They have the money but it takes a lot of time to qualify.
There is a particular insanity that there is a medical operation that is very expensive but the operation must stop because of the cost of transportation. It was pointed out that paratransit serves mostly dialysis but it is supposed to help many others.

PIC reached out to dialysis centers about transportation to see if they would be interested in some type of financial arrangement to provide transportation. Sometimes it is a need for coordination or even intervention. They were not amendable

There was a discussion about the VA transportation service in Cambridge. They will only drop off patients on Route 50 and they will not go to the door. They will not leave Route 50. There needs to be something that make sure the patient is at their house to their door. They will just leave them on the side of the road.

Sara mentioned this is connected to work force development.

It was pointed out that dialysis centers are not willing to coordinate to support transportation for their patients. This is something that should be evaluated and particularly for dialysis, this is a life and death. For the non-profits and transportation, they have no money, no drivers, and this is an emergency. There was a brief discussion that matching hospitals with patients is very helpful to coordinate transportation. Specifically, Wheels to Wellness in Southern Maryland works with local hospitals to match the patients. Noelle described the program further. The case managers are interested in the program to help people.

There was an interest in increasing the technology. Opening the dialysis center may help this. It seems we have the tools but we need to keep up with one shared solution rather than county to county. This may help with coordinating different types of rides. However, there was a comment that local agencies are supportive due to HPPA

requirements. For example, the W2W program needed to sign MOU's and BAAs with each hospital. Must keep patient information separate from the transportation information so that we can know the patient needs with the rides. As we move towards more urban areas, this may be very challenging if dealing with multiple hospitals.

If there is dialysis center, they need to be pulled in into the strategy. There needs to be buy in through technology and the State is working towards more social determinants of health and Crisp is getting pulled into this.

Tanya mentioned there discretionary spending. SMART is a potential grant to provide support. This is a planning grant and may be a great tool. Must be a government entity or transit authority. Partnerships are a great opportunity.

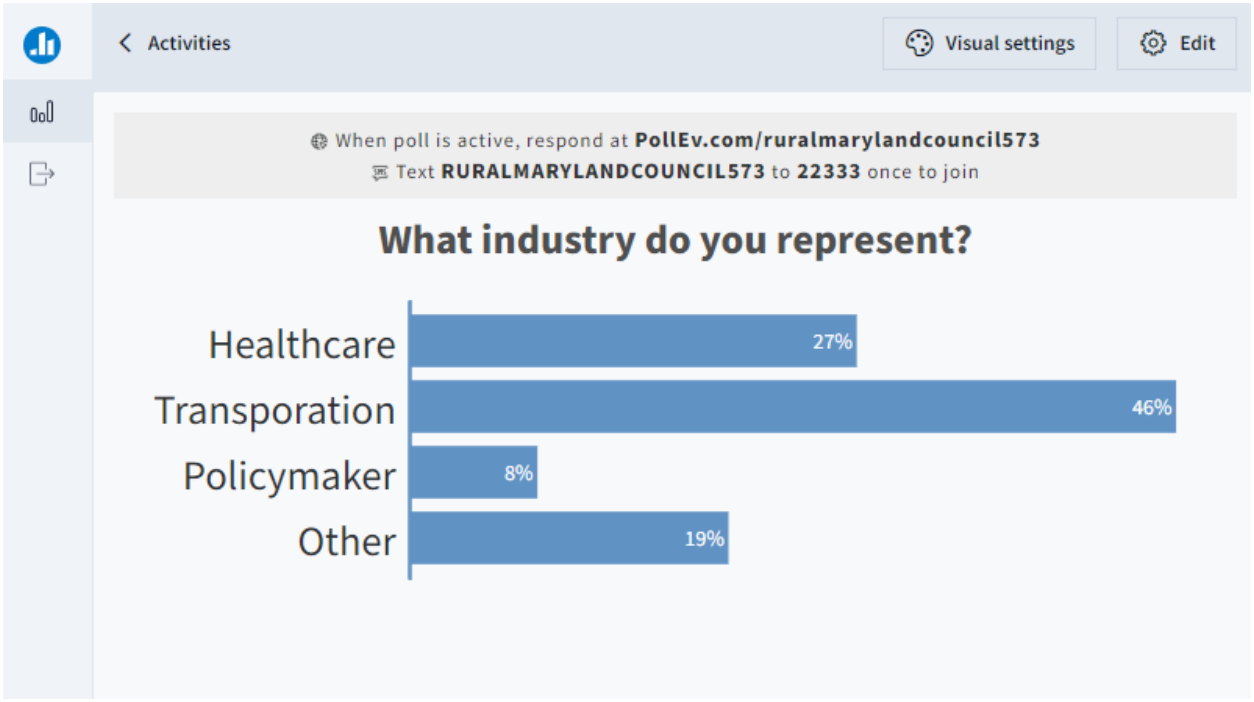
Question From Ms. Valentine. Are there any transportation programs? In Washington County, the CAC completes a program. But the current program cannot extend to the major regional areas. Nancy commented there are no programs in Washington County for outside of region program. There was an opportunity to apply for the Senior Rides program opened in January. The 5310 program is open now.

Dr Lorena de Leon-MPC works in the western part of the state and she described that most of their patients have transportation issues and they don't qualify. It is a nightmare to coordinate transportation across the state. They spend countless hours to download forms and many times they will hear stories of patients who are left on the curb. s. They are looking for to consider opportunities to use technology to centralize resources. Tripspark with is used by MDPT to coordinate with Medicaid. She works with four medical facilities. Anything

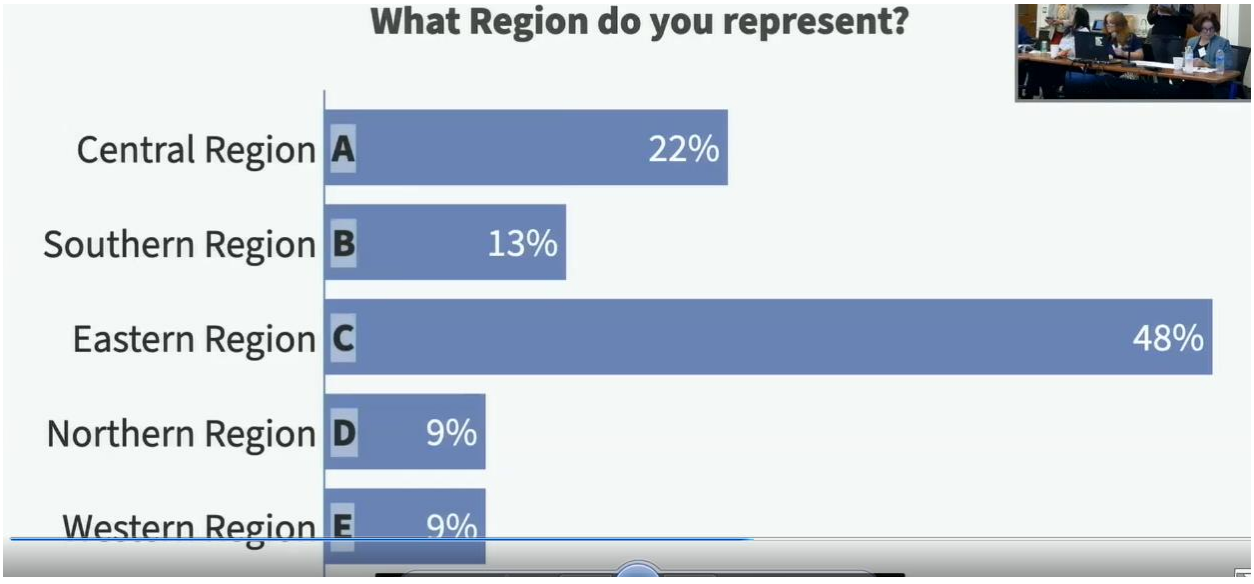
Lunch.

Vignette with Erin Farley

Poll Question 1:

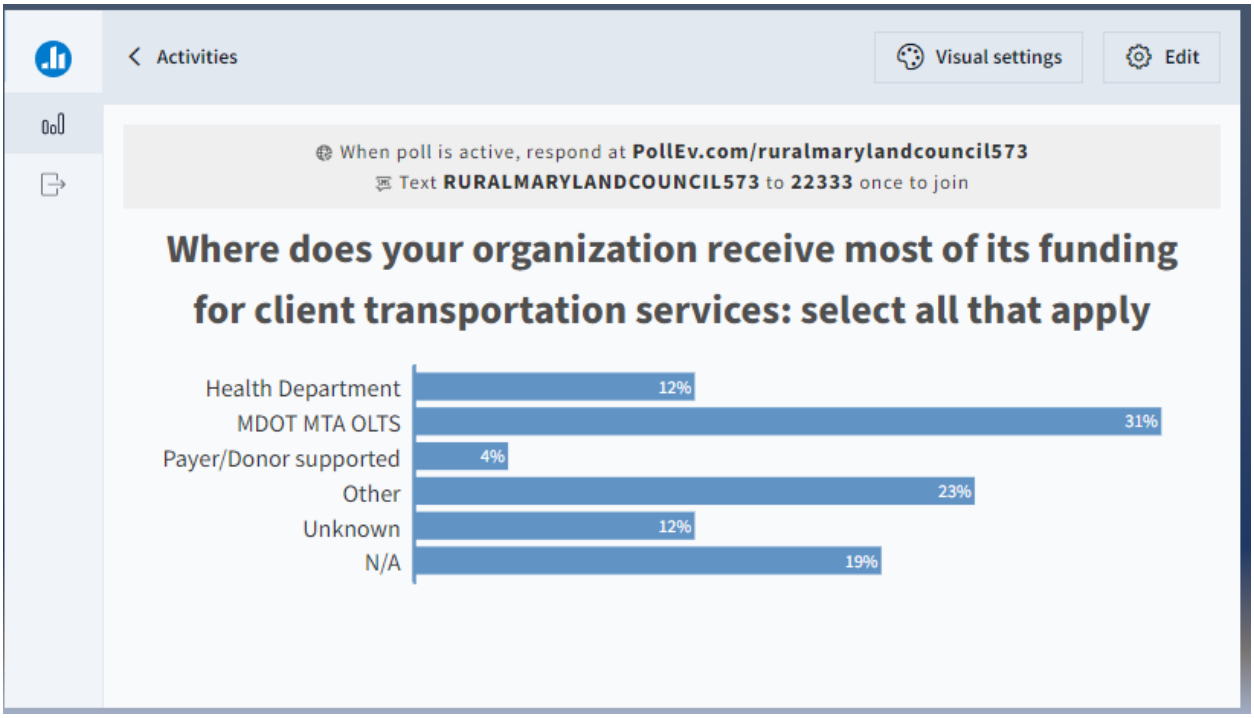


Strong transportation representation. 27% healthcare and 19% other. 8% policymaker.



Eastern Region had the strongest response at almost half of the responses followed by central and southern.

Poll Question 2:



It was noted this is a multiple type of response.

Observations:

- There was about 80% who are receiving funding for transportation service.
- About 1/3 of the funding is from MDOT. The second largest group was "other"
- Only 12% of the participants received funding from the Health Department. The smallest group was payor/donor supported
- Almost ¼ of the group indicated they get their funding from other sources" If it is not health department or MDOT MTA, does anyone know where they get this funding?

(For percentage breakdown details, refer to the slides. The following is a summary of the discussion and notes should be reviewed together with the slides) The meeting returned back to reviewing the survey results. The survey was released in early to mid-July and we received over 300 responses

Demographics:
Land use: Rural was about 2/3 and clearly the largest group; suburban was almost a third and urban was about 7%. This is a good mix maybe heavy on rural.

Region: Based on MDOT map. There is an emphasis on rural areas which patterns the land use. The Eastern shore was the largest region represented.
Organization classification: Government represented almost half with non-profits representing about 44% There was some interest from private sector but remained at less than 10%Of the government group, almost half were local representatives with about 1/3 was State government.

At this stage Leslie Coker facilitated the remaining survey polling questions.

How do you define NEMT: There was a clear tier level.
What non-emergency was available: The largest group was "I don't know" which seems that we need to work on defining the service.
What is your community's most urgent need? Although there is less understanding of the services, there is a better understanding of what are the needs.
Problem with current services: demand exceeds service, and funding. Patient non-compliance was not seen as a problem.

It was noted that the demand exceeds services is connected to funding. It was also pointed out that we were asked to identify what was the greatest problem.

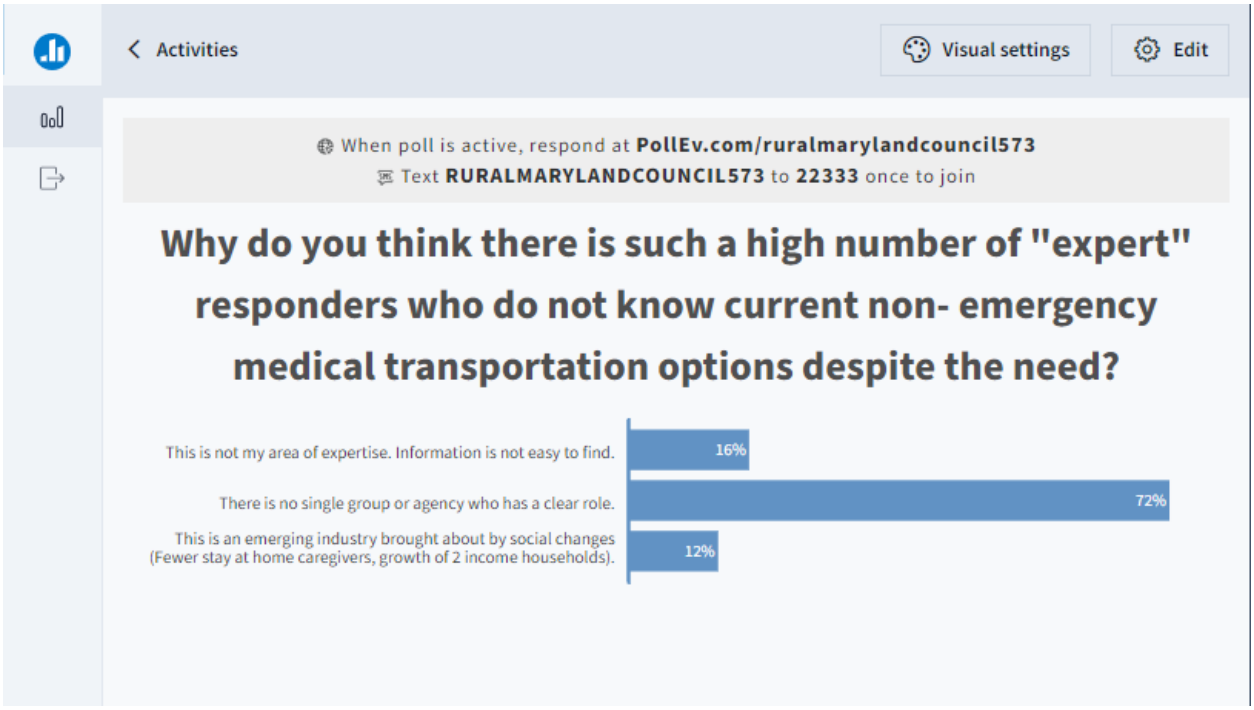
Demand could also include available appointment times.

Who is eligible? It was noted that the most needy may be identified

Who should be considered for providing NEMT? By far, non-profits were identified as the preferred group. This was preferred over other groups. Then Government and then hospitals.

Comments: Alex Handy of Upper shore Transit. Met with local hospitals suggested they promote ride to contact DCT or Queen Annes and put in their advertisement "If you need a ride". This seems logical but they did not get far.

It was noted that rural was the largest followed by suburban area.



One of the primary problems is that there is not clear group or leader.

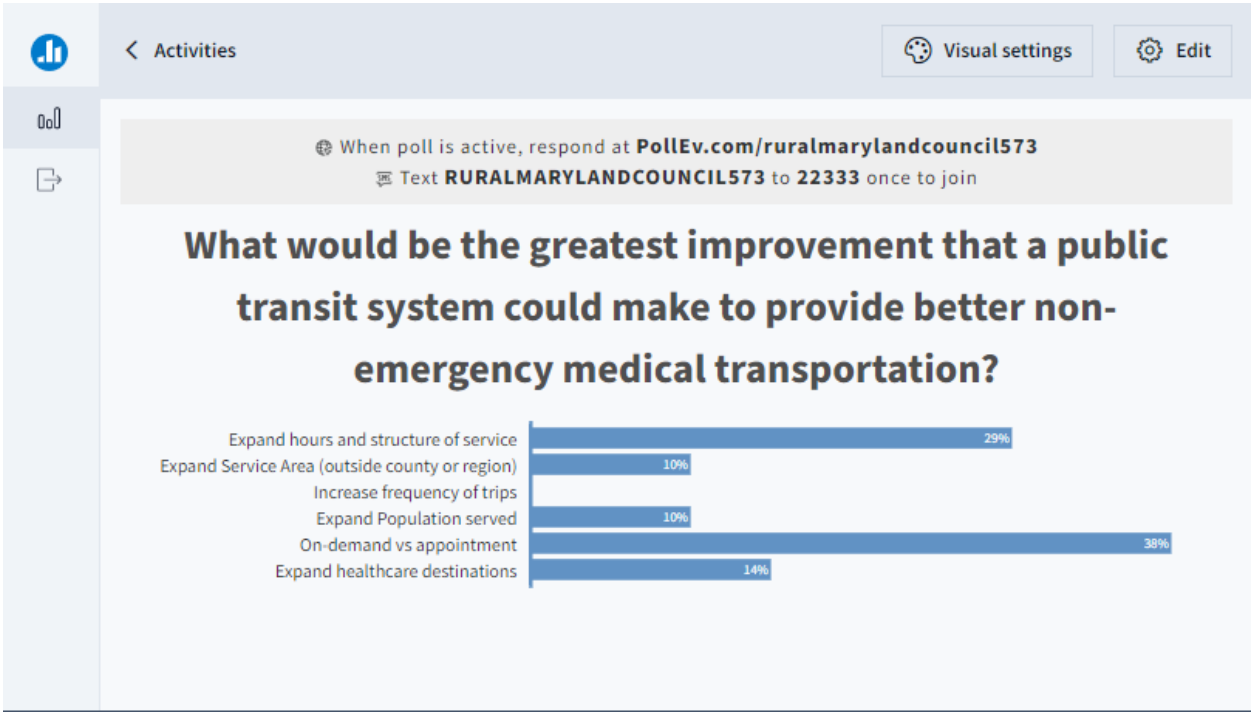
Comments: (Sara) There was a brief discussion on how all of the programs "braid together". We also braid organization together too (non-profit, hospital, non-profits). This is such a big part of life (transportation) There needs to be some parameters set to establish who does what and when. And there needs to be some mapping of that. Who does what best and how do we pull it all together. Hopefully, this roundtable and this group will help.

(Noelle) There are a lot of experts at the table and we end up thinking someone else is doing this or is responsible. Maybe Medicaid, etc. There is a belief that "someone" is doing this but we don't know if they really are

(Dr. Lorena Del Leon) commented that in other states, the managed care organizations can better control the funding or can direct it to other entities. In Maryland it is based on the County and this creates a challenge.

John H- In Southern Maryland and on the Eastern Shore, the healthcare system requires transportation out of the region to a specialist. There really is no one who needs long range transportation. This point was re-affirmed by Dr DeLeon who works in a large managed care program. She noted this is common and they recently had a similar situation. One community member had surgery in PG and needed follow up care in Baltimore. It was ridiculous to find transportation since it took three weeks to

coordinate and they paid out of pocket. So, it's just not the knowledge of what is available but the capacity of the area resources to find the transportation.



Expand hours and provide on-demand services. No one selected frequency of trips. (Yolanda) It is not a matter of number of hours but it is a matter of targeted trips. There was a question on what on-demand service is.

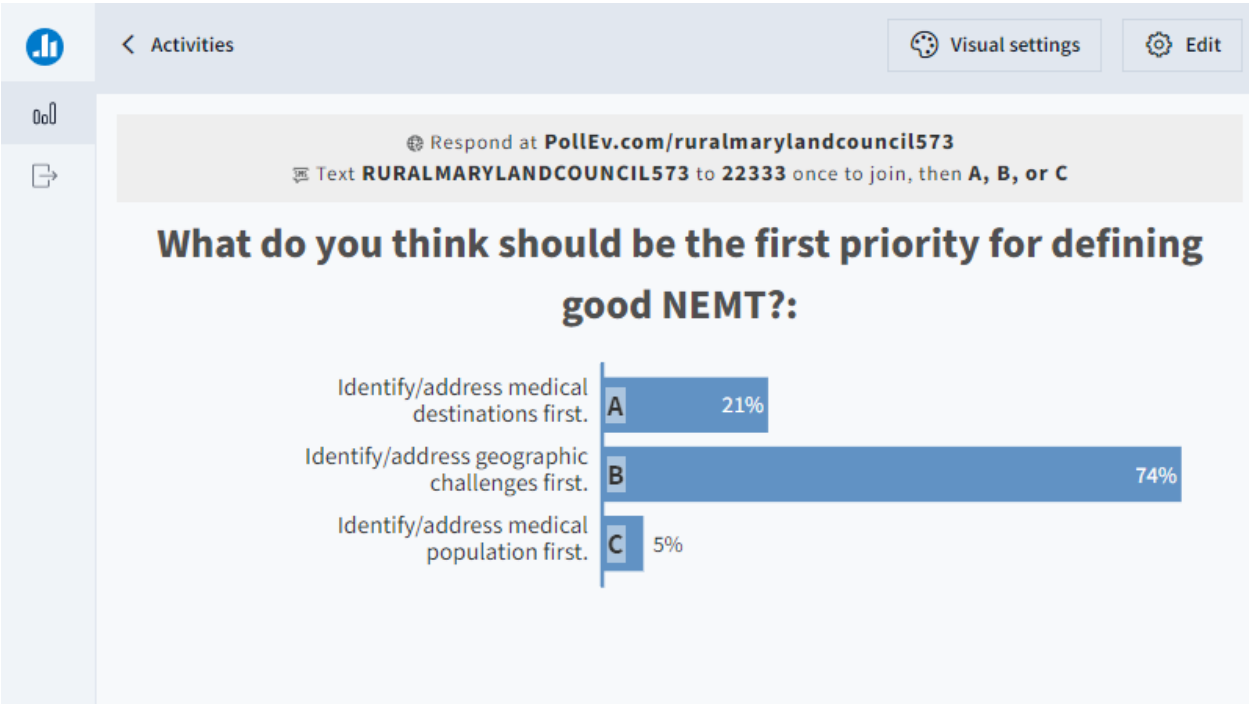
Suzanne from Cecil County– Described on-demand verse others. On demand is more similar to an uber or lyft but it is operated by a public transit system. Her demand response program is on ADA/paratransit and she relies on using "deviated routes" system instead. This allows her the ability to deny trips. For example, right now, she has only 3 drivers so if you have a trip and call at the last minute, you may not get a ride because there is no one available. She participated in an on-demand pilot project that was funded through IMI to assist citizens who were on active recovery and it was very successful. Very dynamic She discussed you can create zones where the trips occur so you do not duplicate services where you have a robust transit service. It also helps with the last mile and connections.

Chris (Carroll)- Public school system may be another example to consider. The sub system has changed to be more open. Previously you would get phone calls early in the morning. They switched to a model that any area that you can sub in and you can pick out a month worth of work. Might a model to take from public school to

Dr Lorena del Leon- They are working on a blueprint around this with a multi-modal company that can use the MTA platform and that can also include uber or lyft. This will allow a lot of options since you can have a centralized platform that can do multi model and that can help with full ambulance transport to ambulatory patients. Having that option helps.

Yolanda commented on W2W. She noted that uber and lyft are not available. This was affirmed by Dr Del Leon. She is building a business case with them to bring them to the table. Suzanne form Cecil affirmed this was their problem

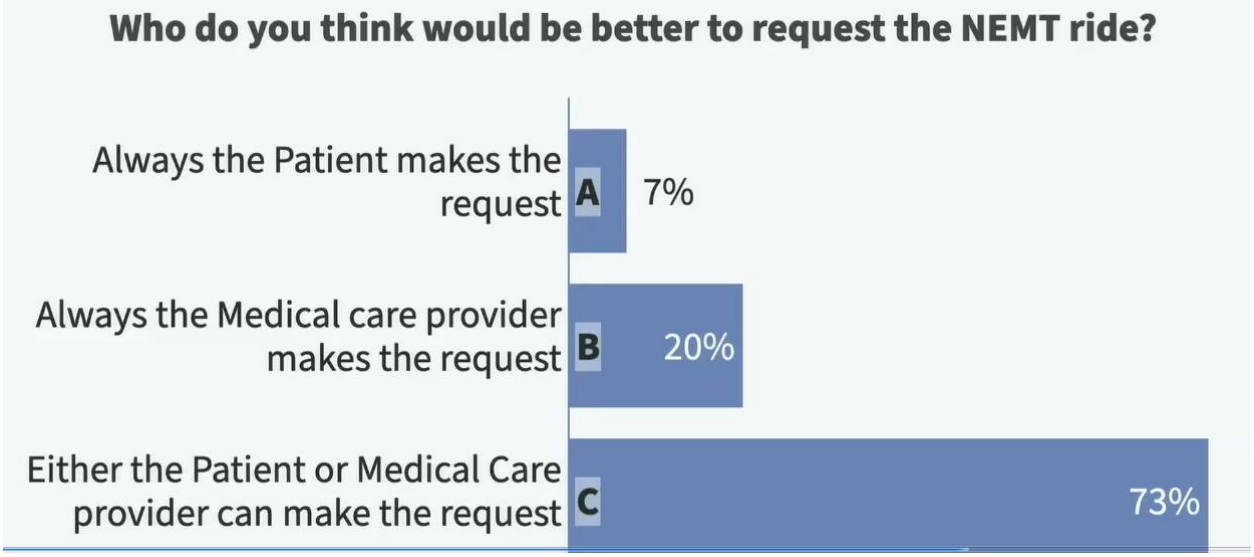
Sharon mentioned that elderly may not understand the technology. One patient discussed her son set up a n uber ride. She was willing to take a cab. Also, many uber and lyft may not have the wheelchair capacity. Dr del Leon commented that Lyft was trying to become wheelchair accessible. But having a centralize d platform was very helpful.



Overwhelmingly, address the geographic challenges first was preferred. There was a question about the descriptions. Medical destinations would prioritize hospitals and medical centers for service; geographic rural/urban deserts challenges are to prioritize the areas where patients are not served because there is no service and the third is to target specific patients with chronic diseases such as dialysis patients to provide them

with transportation. It was noted that the more rural have a high geographic issue. Further, there is no "one size fits all"

Dr. Valentine-Western Maryland has several areas



There was a discussion that "always" is very hardline. You want the responsible party to be the one who makes the appointment (mom, dad, etc.) because you may not have any kind of negative thing you can give….. It's easier to find the pattern if it is one person being responsible. When asked, Keith Adkins noted that the survey results offered "no big surprises". Keith commented that sometimes they will get a request from the Health Department to pick someone up. They will go out pick up the patient only to find out they did not need the ride and that "they told them at the Health Department" and that information does not get communicated back. The DCS would then be stuck with the cost of the pick-up include in gas, wear and tear and driver time. If they had the software program that shared, they could collect that information they could keep track of the no shows and who is mismanaging the appointments. Keeping up with the addresses was also very difficult because people will move or change their phone number and they won't update the transportation provider at DCS. They currently do not have a dispatcher to make reminder calls to patients of their upcoming rides. They complete over 2,000 trips a month that would be difficult to keep up. It was noted that sometime

Darlene Valene-

John Hartline- W2W studied what was done by Mike Pennington. That is why we have the care coordinators to call the day before. Our no show is about 2-4 % because there was a focus by the care coordinator/doctor and a patient. If the patient would not come out, the driver would go to the door. At that stage, the driver would be responsible for collecting the patient.

Chris- We are going to be an iterative process anyway do we need to hire specialize driver to take the harder patients. If we complete this type of work at the State, that free up time for others.

Tanya -There is a need for a joint effort by both healthcare and transportation providers and do we have the capacity to keep this long term.

Darlene- they have their own patients. There will always be a high number of no shows.

Sharon- PIC asks patients to give a 5-day notice and the driver will call and introduced themselves to the patient. They have a low no show rate. The collaborative approach is huge. There is no way a dispatcher will call all the patients. The population is challenging and may be difficult due to their physical ailments. "How do you feed an elephant" one bite at a time. There is no one simple thing to do this.

There is a need to recognize there is no "one size fits all"

Sara- When appointment made in the medical clinics, there should be a conversation for expectations. Where do you get those expectations? Hopefully that will impact no show and build value.

A level of coordination puts scheduling as a gatekeeper with people who have skin in the game (budget). It becomes incumbent on them to use their resources well which will affect their service if not coordinated. As transit, we should be able to rely on information so that we can tell you when we can and can't complete a ride. The gatekeeper can manage it at granular patient level and maybe the organization and the State provides the overarching controls and sets up that coordination infrastructure and charges that with working with the providers and we don't lose the piece to get the patients to the need. This is very important in the more rural areas such as Eastern shore "to get the patients over the bridge".

Scott Warner- Question 5 was difficult. Concerned that the burden would fall on the Transit system. What is the healthcare system going to do? They tried this before. They came to the table because 30% failed to show up.

John- Many times, he hears that the health care industry will "dump" patients on the transit system. These are people. There is very little concern from the healthcare

industry to provide. Medicaid will send them to the transit system. More money is good but if the structure is not addressed, the system will continue to have the same inefficiencies that we have now. As the population ages, it will continue to be difficult to provide. Covid upended a lot of thigs for example, NEMT, is making transits to keep their head above water. This is a partnership with both sides to come to the table.

John H- We allocate funding/miles at the hospitals. We tell them a certain number of miles each month. They have a limited number of miles.

Darlene Valentine- works in medical field and wanted to comment on the relationship. For example, the medical team should work with the patient to outreach worker who works with transit and healthcare to make sure it works. They have outreach workers who reinforces the need that it is important to their appointments.

Dr del Leon – The transit system does the best they can and this is about coordination. This starts with the funding and the distribution and make sure the person in the middle gets their help

Nancy reinforced that coordination is the highest score item.

Elizabeth Beck- could not unmute her sound.

Several emphasized the need for partnership.

Could the healthcare be part of the funding of the solution.

Noelle- There is a total cost of care which they pay but the actual driving patients is not their area.

Suzanne (Cecil)- It's not just healthcare it is workforce, etc. Until everyone had transportation it would be a barrier.

Lenny (Dorchester) Maybe look into mobile integrated health to visit homes. Doing house calls may be good. He is in EMT.

There was a discussion about patients who do not need an ambulance but they need to get an appointment. They are also susceptible to scammers because they are simply lonely. There was a discussion about the types of ambulance patients. Tier I- patient needs immediate help at medical center (lights flashing, etc.) Tier II- patients needs some help at the medical center (no lights flashing) Tier III- patient does not need immediate help and that could have been an appointment Tier IV- patient is just lonely.

Noelle- patients who don't pay the ambulance, it comes out the hospital budget which affects their other projects. It was noted that one local EMT station 80% are not for emergencies.

It was also noted that we know who the "frequent flyers" are