

JOINT COMMISSION ON HEALTH CARE

STRATEGIES TO ADDRESS TRANSPORTATION RELATED BARRIERS TO HEALTH CARE

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA



REPORT DOCUMENT #958

COMMONWEALTH OF VIRGINIA
RICHMOND
2025

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Strategies to Address Transportation Related Barriers to Health Care

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Strategies to Address Transportation Related Barriers to Health Care

POLICY OPTIONS IN BRIEF

Option: Direct DMAS to amend contracts with the MCOs to adopt performance metrics for Medicaid NEMT brokers consistent with the FFS NEMT program. (Option 1, page 16)

Option: Direct DMAS to develop guidance to the MCOs regarding NEMT mileage pre-authorization requirements. (Option 2, page 17)

Option: Increase the portion of the CMTF dedicated to supporting human service transportation programs to 0.0045%. (Option 3, page 23)

Option: Add \$500,000 per year to the CMTF for DRPT to provide technical assistance on program financial management to Section 5310 Program grantees. (Option 4, page 24)

Option: Provide up to \$8 million per year for DRPT to establish a grant program for mobility management services and regional transportation hubs. (Option 5, page 26)

Option: Provide up to \$5 million per year for DRPT to establish a grant program for microtransit services in rural areas of Virginia. (Option 6, page 29)

FINDINGS IN BRIEF

The Virginia NEMT Program has improved in recent years, but data collection could be enhanced

The NEMT program has improved on-time performance and unfilled trips. DMAS collects performance data for the FFS NEMT program on several metrics, however they do not specify performance metrics for MCOs to include in contracts with transportation brokers. As a result, Virginia's Medicaid MCOs are tracking and collecting performance metric data differently.

Fixed funding hinders expansion of transportation services for Section 5310 program recipients

Rising capital costs and costs of program operations without an increase in funding makes it impossible to expand services. The fixed allocation formula for Section 5310 Program funds limits the funding available for transportation programs in small urban and rural areas of the Commonwealth.

Transportation services in Virginia are siloed, limiting access and making coordination across programs difficult

The complexity of the siloed transportation system makes it difficult for patients to find appropriate services and frustrated when they have to interpret different eligibility requirements, service areas, and other service guidelines on their own. A solution to this issue is to increase agency level and individual level coordination of transportation services.

Rural areas of Virginia need additional transportation options and resources

National estimates indicate that rural residents live an average of 10.5 miles from the nearest hospital, compared to 4.4 miles in urban areas. When public transportation is available in rural areas, it may not serve the entire population. Microtransit could be a solution to increase transportation to health care in rural areas.

Strategies to Address Transportation Related Barriers to Health Care

Reliable transportation is an essential part of accessing health care services. Inadequate transportation can result in health burdens such as increased emergency department visits, poor chronic condition management, and poor health outcomes. In 2020, the Virginia Department of Rail and Public Transit (DRPT) reported that approximately six percent of households statewide did not have a vehicle available to them. In the Southwest region, seven percent of households lacked access to a vehicle, and in some pockets of Virginia, more than half of households lived without a car. Lack of available public transportation, inability to navigate complex transportation services, and programmatic barriers may also prevent individuals from accessing transportation to health care services. Both federal- and state-level programs exist to increase access to transportation services, particularly for high-needs populations. However, these programs are challenged to provide services to all eligible populations.

In 2025, the Joint Commission on Health Care directed staff to study transportation related barriers to health care. Specifically, staff shall:

- (i) Describe the types of transportation barriers to health care that exist in Virginia, the factors that contribute to the existence of such barriers, and the populations that are most affected by such barriers;
- (ii) Identify and evaluate existing interventions and programs that address transportation barriers to health care in Virginia;
- (iii) Identify strategies Virginia could implement to address transportation barriers, including strategies that have been implemented by other states; and
- (iv) Recommend policy options through which the state may reduce transportation barriers to health care for patients in Virginia.

Patients require transportation to access health care

Even when health care services are available, they may not be accessible to patients who lack transportation to reach them. While new modalities for delivering health care services, such as telehealth, may offer some patients the ability to access particular health care services, certain treatments and health care services still require in-person presence of both the patient and the provider, such as dialysis or cancer treatment. When patients do not have access to transportation, they cannot be physically present to receive necessary health care services and treatments. In these cases, obtaining access to reliable transportation is the only solution that adequately addresses a patient's needs.

Patients may choose different modes of transportation to access health care

To access health care services, some patients can use *personal vehicles* by either driving themselves or relying on family and friends with vehicles. Patients may also use mass transit options like rail systems or bus transit systems. Bus transit systems can be a *fixed-route* that follow established routes or *deviated fixed-route* that allows vehicles to deviate from established routes by up to $\frac{3}{4}$ of a mile to collect and deliver riders. And finally, patients may access *demand response programs* that collect riders at their home and transport them directly to their destination. These programs can be *hand-to-hand*, meaning the drivers physically assist riders to or from the vehicle, or *curb-to-curb*, meaning that the driver picks the rider up at their home and drops them off at their appointment without physical assistance. Each of these modes of transportation may be more or less appropriate for patients depending on their needs, but in some cases, these modes may not be available to all patients.

Different types of transportation providers offer transportation services

Jewish Family Services of Tidewater is an example of a non-profit transportation provider. They provide rides to medical appointments for participants enrolled with Jewish Family Services Monday through Friday, from 9:00am to 2:00pm.

Transportation services can be offered by several different types of transportation providers including: (1) human service transportation providers, such as area agencies on aging, (2) non-profit organizations, such as hospitals or community centers (SIDEBAR), (3) public transit agencies, such as the Greater Richmond Transit Company or the Charlottesville Area Transit, or (4) private transportation providers, such as transportation network companies like Uber or Lyft or private taxi services. Each type of transportation provider may offer one or more different modes of transportation. For example, human service

transportation providers typically offer demand response transit, while public transit agencies typically offer fixed-route or deviated fixed-route transit. However, this is not always the case. Some public transit agencies in Virginia offer demand response transit services and some human service agencies offer mileage reimbursement programs that allow patients to reimburse their friends or family for driving them to medical appointments using their personal vehicle.

Transportation barriers to health care exist at different access points for patients

Transportation is a vital aspect of obtaining health care services; however, barriers to accessing adequate transportation exist for some patients. Barriers to transportation can manifest at different points of access, such as a patient not being able to access a vehicle, a lack of available public transportation, excessive cost of public transportation fares, diverse and rural geography resulting in long travel times and distances, or transportation service program eligibility requirements.

Availability of transportation services does not mean transportation is truly accessible for patients

A 2013 study by Levesque and colleagues created a framework that organizes individual, community, and health system variables influencing health care access into five interdependent dimensions. Applying these dimensions to transportation services and understanding how the dimensions intersect with each other can illuminate barriers people may face to accessing transportation services (TABLE 1). For a transportation service to be truly accessible for patients, it must meet each of these dimensions of access. For example, if a patient is financially eligible for a transportation program but the program does not serve the area in which the patient lives or receives health care services, the patient cannot access the program in a way that is meaningful for them. Similarly, if a transportation service is appropriate for a patient's medical needs but the patient is unaware that the program exists, the transportation service is not accessible for the patient. It is important for states to consider each dimension of access as they develop transportation programs and contemplate ways to increase access to transportation services for patients.

TABLE 1. Transportation dimensions of access

Dimensions of Access	Definition	Application to Transportation
Approachability	How well health care services can be identified and reached	Patient awareness of transportation programs
Acceptability	Extent to which individuals accept aspects of health care services	Patient willingness to use available transportation services
Availability and Accommodations	Health care services can be reached in a timely manner	Transportation service area reaches necessary destinations
Affordability	Extent to which people have resources and time to spend on health care services	Patient can afford to use transportation services
Appropriateness	Alignment between the health care services provided and the patients' needs	Transportation is a good fit for individuals' unique medical and other needs

SOURCE: JCHC staff analysis of Levesque, J. F., Harris, M. F., & Russell, G. (2013).

Patients with limited financial resources or who travel long distances to access health care face more significant transportation related barriers

For individuals with low household incomes or limited financial resources, the cost of transportation can be a barrier to accessing transportation services and, as a result, health care. An Urban Institute report found that 14 percent of adults with low family incomes and 12 percent of adults with public health insurance were more likely to forgo needed care due to difficulty finding transportation. Lower income patients may not be able to purchase or maintain personal vehicles and the costs of public transportation may be more than lower income patients can afford.

Patients who must travel long distances to access health care services face significant transportation-related barriers. The demands of longer travel times and distances may create additional barriers to use of personal vehicles, particularly for patients who rely on friends or family members who must take time away from work or other priorities to provide transportation. Patients located further from health care services may also face more barriers to using public transportation to reach services. Longer travel distances and travel times can increase the cost of public transportation, as providers may charge higher fees or riders may be required to utilize multiple forms of transportation to reach their destination. Longer travel distances and times can also limit the availability of transportation as the duration of individual trips ties up vehicles and drivers, rendering them unavailable for other trips.

In rural areas of Virginia including Southwest Virginia, the Northern Neck, and the Eastern Shore low population density, dispersed settlement patterns, and long distances between population centers make operation of fixed-route public transportation inefficient. One provider reported, “When people are so spread out it's really tough to develop a route. We do have some people we take to dialysis appointments that are 50 to 60 miles away.” A lack of access to transportation to health care in rural communities only widens the gap between health disparities for rural and urban patients. A 2023 Urban Institute study found that seven percent of rural adults missed a healthcare appointment within a 12-month timeframe due to transportation difficulties, compared to five percent of urban adults. In some areas of the Commonwealth, mountainous terrain or rivers and other bodies of water further contribute to the problem of long travel distances and times, creating physical barriers that require long routes and significant travel time to navigate around.

Medical facility closures create additional transportation related barriers to care. Longer travel distances and times resulting from closure of medical facilities can also make a transportation program that was once appropriate for the patient, no longer appropriate. Programs that impose time or distance limitations on travel services may become unavailable when closure of medical facilities forces patients to travel longer distances to access health care services.

The burden of transportation related barriers to health care is magnified for patients who require more frequent health care services

Patients who require frequent health care services or those who require recurring medical appointments like older patients or patients receiving cancer treatment, wound care, or dialysis, must navigate barriers to accessing transportation more often than other patients. Patients who require regular transportation to distant services may not have access to or be able to use personal vehicles and may face challenges obtaining consistent transportation from family or friends. Cost burdens of public transportation are multiplied for patients who must travel frequently for health care, creating significant challenges for these patients, particularly those with limited financial resources.

Frequent travel for health care services also creates burdens on transportation providers. The frequency of need, the distances traveled, and the duration of appointments can create significant demands for transportation services, driving up the cost of providing transportation and reducing provider capacity. One stakeholder reported, “part of the challenge with [recurring trips] is that it is expensive for a small provider to be able to provide that service multiple times a week for one individual. And some places will, by necessity because of their available funding, put a cap on how many trips per month you can take. So, they might be able to go to their first six appointments, but then the rest of the month they have to find something else.” This forces patients who need frequent transportation to piecemeal their transportation options together throughout the month to access necessary health care services or to skip health care services when transportation is not available.

Transportation disadvantaged populations are more likely to have poor health outcomes

Transportation disadvantaged populations are more likely to experience health-related burdens such as foregoing needed treatment, medication nonadherence, increased emergency department visits and hospitalizations, poor health outcomes, poor quality of life, and increased risk of mortality. In one study, patients with liver disease who experienced transportation insecurity were more likely to demonstrate medication nonadherence, experience worsening self-reported health status over the past year, not work due to poor health over the past year, and be in a higher-risk category for number of hospitalizations annually. Other studies have found that patients facing transportation barriers miss preventative care, rely disproportionately on emergency department services for medical care, and experience preventable hospitalizations.

Federal and state programs attempt to reduce barriers to transportation, particularly for at-risk populations

Various federal and state programs provide funding for transportation in Virginia, including programs that fund public mass transit systems. This study focused on two transportation

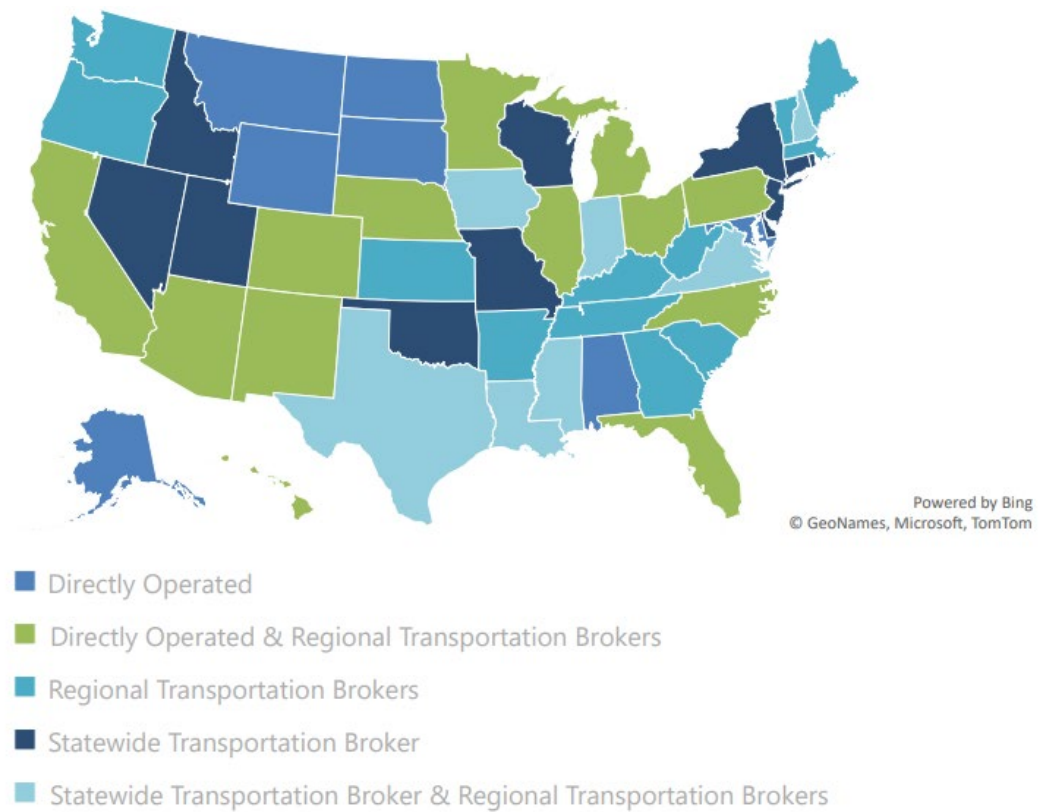
programs that receive state funding to provide services to populations with the greatest need for transportation to health care. These programs include (1) the Medicaid Non-Emergency Transportation (NEMT) Program administered by the Department of Medical Assistance Services (DMAS) and (2) the Enhanced Mobility of Seniors and Individuals with Disabilities Section 5310 program (referred to as the Section 5310 Program) administered by the Department of Rail and Public Transportation (DRPT).

The Virginia Department of Medical Assistance Services must ensure that members have access to medical transportation

Federal regulations require DMAS to ensure that Medicaid members have access to transportation for non-emergency medical services through the Medicaid NEMT Program. Federal regulations do not specify how a state's Medicaid transportation program should operate. As a result, states have flexibility in determining how to provide NEMT services and NEMT programs vary by state.

State Medicaid agencies may choose to deliver NEMT services directly - through contracts between the state agency and transportation providers that deliver transportation services to Medicaid enrollees - or through contracts with transportation brokers - private companies that manage contracts with transportation providers and coordinate rides for Medicaid members. State agencies opting to deliver NEMT services through transportation brokers may enter into agreements directly with brokers or may allow Medicaid managed care organizations (MCOs) to enter into agreements with transportation brokers of their choosing to provide services for Medicaid managed care plan enrollees. When NEMT is provided through contracts between the state agency or an MCO and a transportation broker, the transportation broker assumes the full risk of providing NEMT services. States may choose to implement a single model of NEMT delivery or implement a combination of the models (FIGURE 1).

FIGURE 1. NEMT models by state



SOURCE: Texas A&M Transportation Institute & RLS and Associates, Inc., 2025.

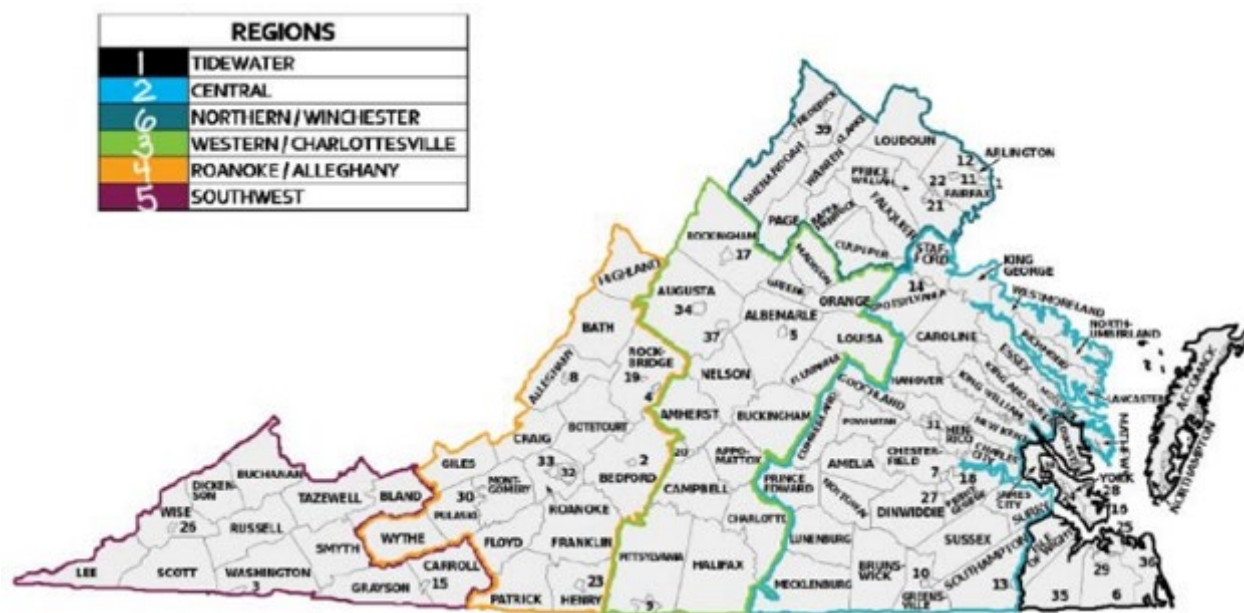
Virginia utilizes a mixed brokerage model to assure transportation for members

Initially, DMAS provided NEMT services for all Medicaid members directly, through contracts with NEMT providers. Then in 2009, DMAS switched to a brokerage model for its NEMT transportation program, contracting directly with a transportation broker for delivery of NEMT services. This change was implemented under the provisions of the Deficit Reduction Act of 2005, which allowed states to establish NEMT brokerage programs without the need for prior waivers. In 2017, the agency adopted a mixed brokerage model, maintaining a contract with a state-wide transportation broker for NEMT for the Fee-For-Service (FFS) population, while allowing the MCOs to contract with their own state-wide transportation brokers for NEMT services for the members served. DMAS reports that the primary reason for the change to the brokerage model was to reduce fraud, waste, and abuse in the NEMT program by improving management and oversight. At the time the brokerage model was adopted in 2005, Virginia reported a 32 percent reduction in the incidence of fraud with respect to NEMT claims. According to DMAS, the introduction of the brokerage model and additional program integrity and oversight measures have reduced these issues significantly.

DMAS provides NEMT services for members enrolled in the fee-for-service program through a contract with Modivcare

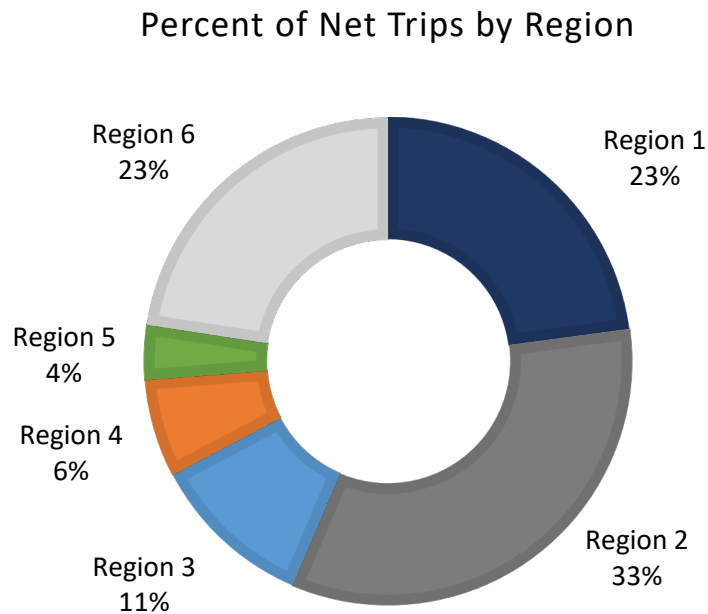
As of Fiscal Year (FY) 2025, DMAS provided NEMT services for the FFS program through a contract with Modivcare. Modivcare, in turn, contracts with private transportation companies or human service organizations to provide rides to Medicaid members enrolled in the FFS program throughout the state. Data provided by DMAS demonstrates that Modivcare is providing rides in each of the six regions (FIGURE 2); however, there is a large difference in the number of rides provided in regions 1, 2 and 6, compared to regions 3, 4, and 5 (FIGURE 3). This could be attributed to the smaller number of individuals living in regions 3 through 5 or could be due to a lack of transportation providers contracted with Modivcare in those regions. In FY24, DMAS spent \$71.1 million to provide NEMT services for members in the FFS program. State funding covered 46 percent of the cost of the FFS NEMT program, or \$32.7 million, and federal funding covered 54 percent, or \$38.4 million.

FIGURE 2. DMAS service regions



SOURCE: Department of Medical Assistance Services, 2025.

FIGURE 3. NEMT trips by DMAS service region



SOURCE: Department of Medical Assistance Services data, 2025.

Medicaid managed care organizations contract with different transportation brokers for NEMT services for enrolled members

Virginia's mixed brokerage model allows each Medicaid MCO to contract for NEMT services with a transportation broker of its choice. Because NEMT is a carved-in service, the MCOs use a portion of the capitated payment provided by DMAS to the MCO to cover the costs of transportation services provided by the transportation broker. As of FY24, United, Aetna, and Sentara entered into contracts with Modivcare, while Anthem and Molina contracted with Access2Care. Multiple MCOs that use Modivcare, the transportation broker providing services to Medicaid members enrolled in the FFS NEMT program, indicate that the broker oversight provided by DMAS resulted in better services across the NEMT program, including for managed care members enrolled in the plans.

NEMT program ridership has steadily increased since the COVID-19 pandemic. As of September 2025, Medicaid covers 1,883,006 individuals; all Medicaid members are eligible for NEMT services. FFS program members use more transportation services than managed care Medicaid members. DMAS reports that many Medicaid members enrolled in the FFS service program are individuals who receive services through developmental disabilities (DD) Medicaid waivers who often require regular, frequent (sometimes daily) transportation to access services such as group care facilities, disabilities workshops, and community centers. FFS program members make up only 12 percent of the total number of Medicaid members in Virginia, but the FFS NEMT program accounted for 41.5 percent of all

NEMT rides (1,964,496 rides) provided in 2022 and 39.9 percent of the rides (2,040,771 rides) provided in 2023. From 2022 to 2023, the total number of FFS NEMT program rides increased by 3.88 percent. During the same period, the number of rides provided by the managed care NEMT program increased from 2,770,158 rides in 2022 to 3,064,474 rides in 2023, an increase of 10.62 percent. In total, the number of trips provided through the NEMT program increased by 7.83 percent between 2022 to 2023 (TABLE 2). Stakeholders believe the increase in the total number of trips is a response to the end of the COVID-19 pandemic. During the pandemic, transportation providers reported reduced numbers of riders, and the latest increase in rides is a response to riders requesting rides more frequently again.

TABLE 2. 2022 and 2023 NEMT Ride Totals

NEMT Program	2022	2023	Percent Change
FFS NEMT	1,964,496	2,040,771	3.88
MCO NEMT	2,770,158	3,064,474	10.62
All NEMT Programs	4,734,654	5,105,245	7.83

SOURCE: JCHC analysis of Department of Medical Assistance Services data, 2025.

The NEMT program successfully provides transportation services for Medicaid members

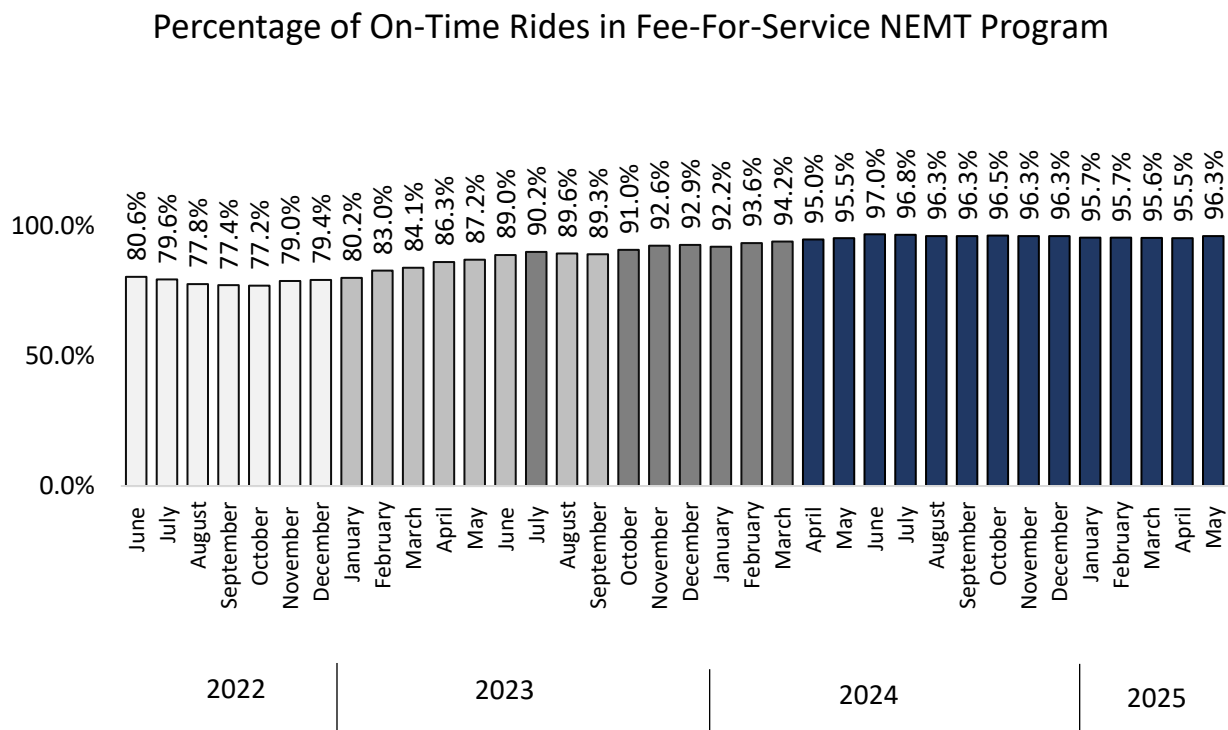
DMAS collects data on multiple performance metrics designed to measure the effectiveness of the FFS NEMT program, including data on on-time performance, unfilled trips, and member satisfaction with the services provided. Medicaid MCOs also collect data on the quality and effectiveness of NEMT services provided. DMAS requires MCOs to collect data on late or missed trips and establishes a benchmark providing that no more than 0.25 percent of all trips may be late and no more than 0.25 percent of all trips in a single day may be missed. However, DMAS does not include any other specific requirements for performance measures or data reporting in contracts between the agency and the MCOs. Rather, MCOs establish their own benchmarks for on-time performance and other measures in their contracts with transportation brokers. As a result, metrics and benchmarks may vary between MCOs. Nevertheless, data on on-time performance provided by the MCOs does provide insight into the performance of the managed care NEMT programs.

NEMT transportation brokers have improved on time performance

Pursuant to the contract between DMAS and Modivcare, the statewide transportation broker providing services for members enrolled in the FFS program, NEMT providers must

meet benchmarks for on time performance for at least 95 percent of all rides provided or receive a financial penalty. Modivcare is assessed a financial penalty for each month that transportation providers fail to meet the contractual benchmarks (APPENDIX 1). From June 2022 to March 2024, Modivcare did not meet the standard established in the contract between the company and DMAS (FIGURE 4). The lowest percentage of on-time performance occurred in late 2022, with on time percentage dropping to as low as 77.2 percent. Stakeholders reported that this was due to inadequate numbers of providers in brokers' networks, which led to brokers' inability to keep up with demand for services. Beginning in January 2023, however, on-time performance began to improve and continued to rise into 2024, with Modivcare consistently reporting on-time performance of more than 95 percent in each month beginning in April 2024. Stakeholders report that this improvement is largely due to efforts by DMAS to hold Modivcare more accountable for on-time performance through aggressive Service Level Agreement penalties, as well as putting pressure on Modivcare to enhance the number of providers in their network to more adequately meet demand.

FIGURE 4. FFS on-time percentages from June 2022 to May 2025

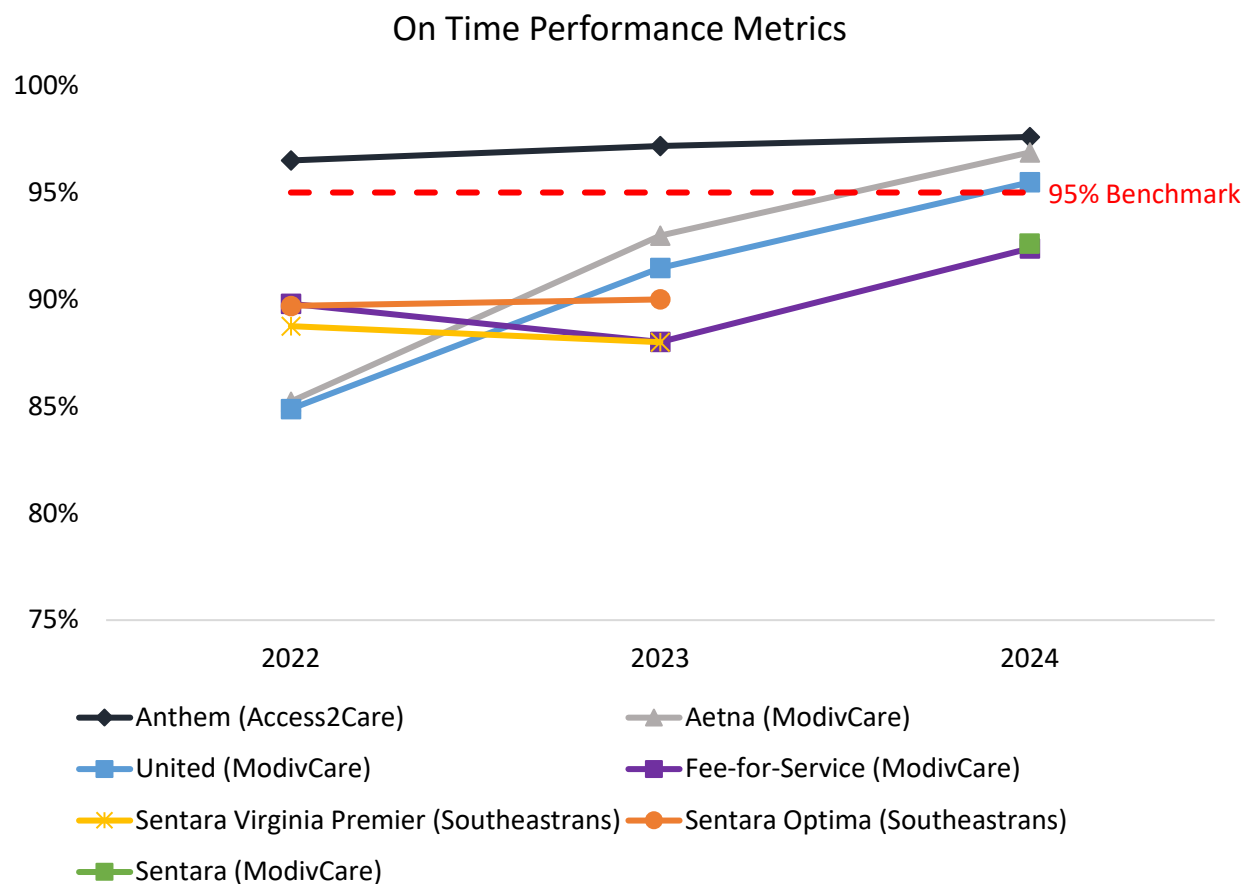


SOURCE: Department of Medical Assistance Services data, 2025.

For each MCO, data provided by DMAS indicate Modivcare's on-time performance varies. In 2022, Modivcare's on-time performance for Aetna (85 percent) and United (85 percent) were lower than the company's performance for the FFS NEMT population (90 percent). However, beginning in 2023, Modivcare provided better on-time performance for NEMT

services with Aetna (93 percent in 2023 and 97 percent in 2024) and United (91 percent in 2023 and 95 percent in 2024) than with DMAS for the FFS population (88 percent in 2023 and 92 percent in 2024) and Sentara (93 percent in 2024). Access2Care provides transportation services for Anthem and consistently outperforms other transportation brokers on on-time performance. Overall, on-time performance improved for all NEMT programs in Virginia between 2022 and 2024 (FIGURE 5).

FIGURE 5. MCO and FFS on-time performance percentages



*In 2024, Sentara merged Virginia Premier and Optima health plans into one single health plan, Sentara Health Plan.

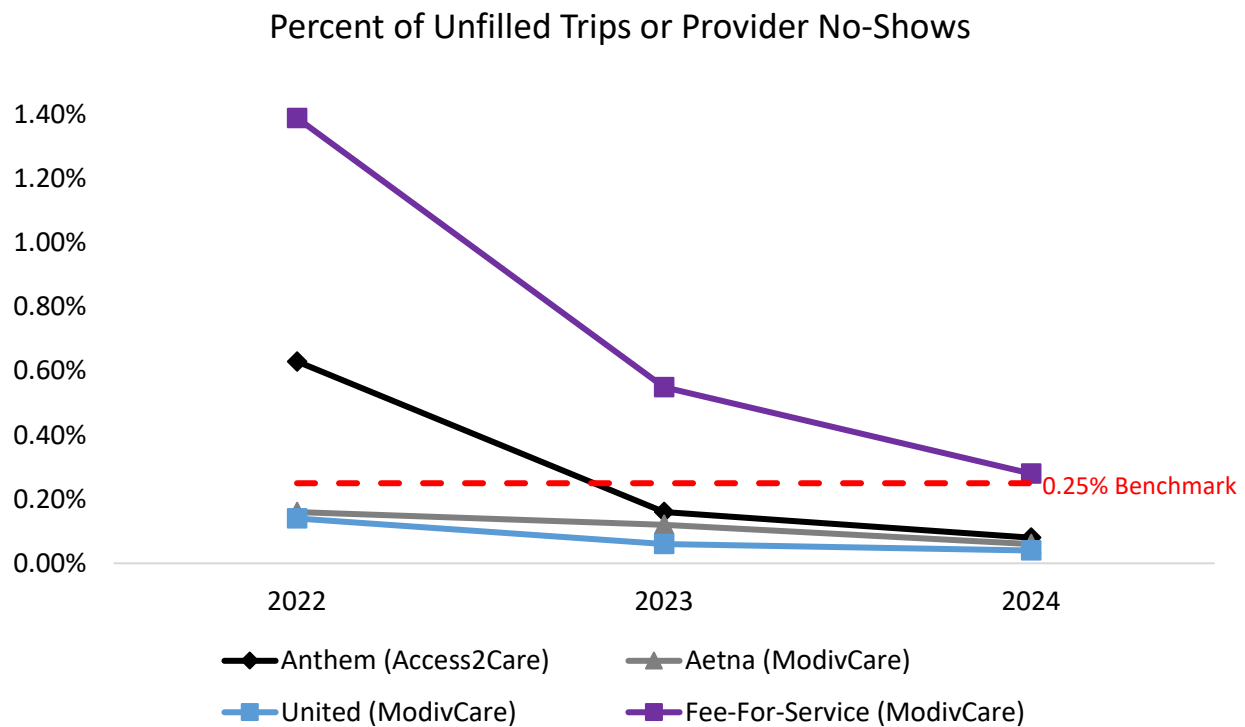
SOURCE: JCHC staff analysis of Medicaid managed care and fee-for-service data, 2025.

NEMT brokers have improved performance related to unfilled trips

Unfilled trips are defined as cases in which an eligible member requests a ride, but the ride is not provided because the broker does not have a transportation provider or vehicle available or the transportation provider failed to pick up the member at the appropriate

time. Within its FFS contract, DMAS requires Modivcare to keep the number of unfilled trips at or below a number equal to 0.25 percent of the total number of trips requested each month. For any month that the number of unfilled trips exceeds 0.25 percent, Modivcare is subject to a financial penalty. In 2022, ModivCare reported that 1.39 percent of trips were unfilled for the FFS program (FIGURE 6). The rate of unfilled trips improved substantially between 2022 and 2024, with Modivcare reporting that 0.28 percent of trips were unfilled in 2024 for the FFS program. For MCOs, including Aetna, United, and Sentara which also use Modivcare, unfilled trips have been below the 0.25 percent established by DMAS as the benchmark for performance in the FFS NEMT program. For all NEMT programs, the unfilled trip rate has decreased over time.

FIGURE 6. MCO and FFS unfilled trip percentages



NOTE: Sentara did not provide data on this metric.

SOURCE: JCHC staff analysis of data from Medicaid managed care organization and DMAS, 2025.

Strategies to Address Transportation Related Barriers to Health Care

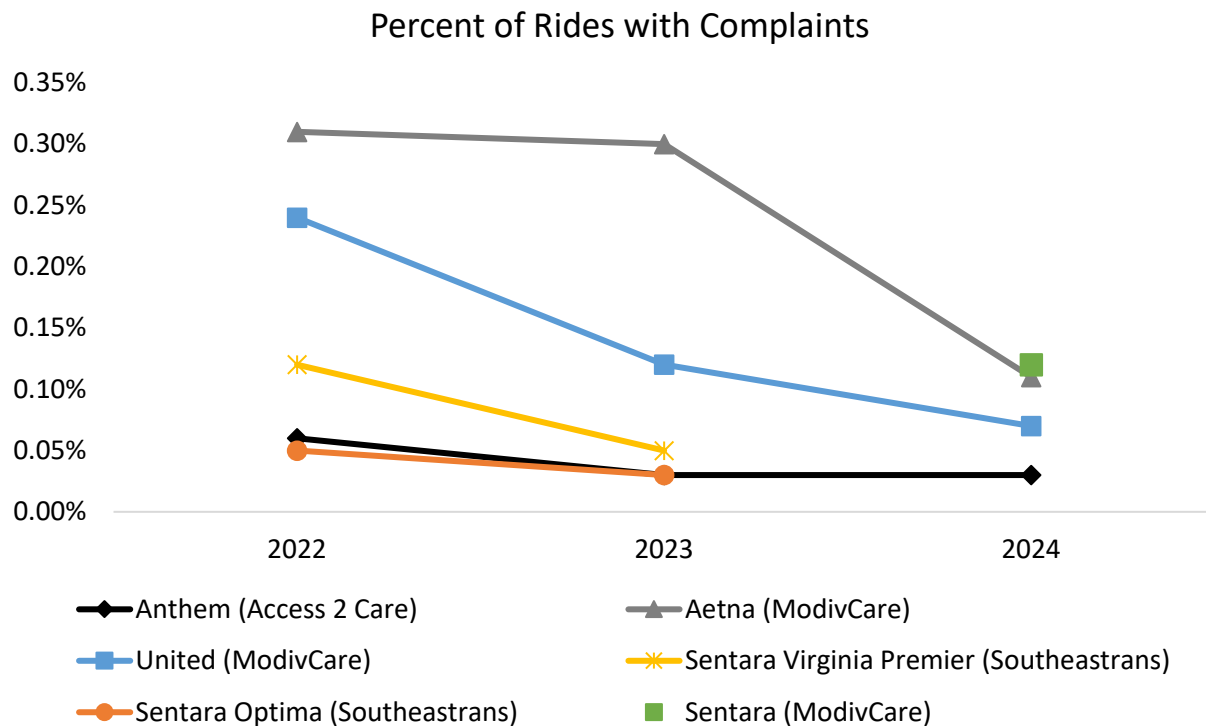
Molina Case Study. JCHC staff did not include Molina in the analysis of MCOs due to missing data from 2023; however, the data provided by Molina provides insight into the impact of transportation broker selection. Prior to 2024, Molina contracted with MTM as their statewide broker. During this time their on-time performance and their unfilled trip rate were consistently below acceptable levels. In 2024, Molina switched transportation brokers to Access2Care and these metrics significantly improved. Molina saw a significant change in on-time performance and unfilled rides. This highlights the importance of selecting a broker which can meet the needs of the patient population being served.

Year (Broker)	On-Time Performance Percentage	Unfilled Ride Percentage
2020 (MTM)	72%	6.08%
2021 (MTM)	72%	5.90%
2022 (MTM)	68%	7.10%
2024 (Access2Care)	97%	0.13%

Client complaints about NEMT services are low

DMAS requires Modivcare to provide complaint information about FFS NEMT services. Analysis of complaint data indicates FFS NEMT clients are satisfied with the transportation services they receive. From July 2022 to March 2025, Modivcare provided a total of 5,910,788 trips for members enrolled in the FFS program and received complaints for 10,025 trips, or 0.17 percent. Within the 33-month period, the complaint percentage never went above 0.23 percent in any given month and for some months the complaint average was as low as 0.10 percent. The most common complaints reported by members were late arrival of provider (44.95 percent of complaints), provider no show (31.93 percent), and no vehicle available (13.02 percent).

Complaint rates for NEMT services provided contracted through Medicaid MCOs are similarly low. All four MCOs for which data were available report low complaint rates, with rates averaging less than 0.05 percent (FIGURE 7). For some of the MCOs, like Anthem, the complaint rates are very low at close to zero percent of rides resulting in a complaint.

FIGURE 7. MCO complaint percentages

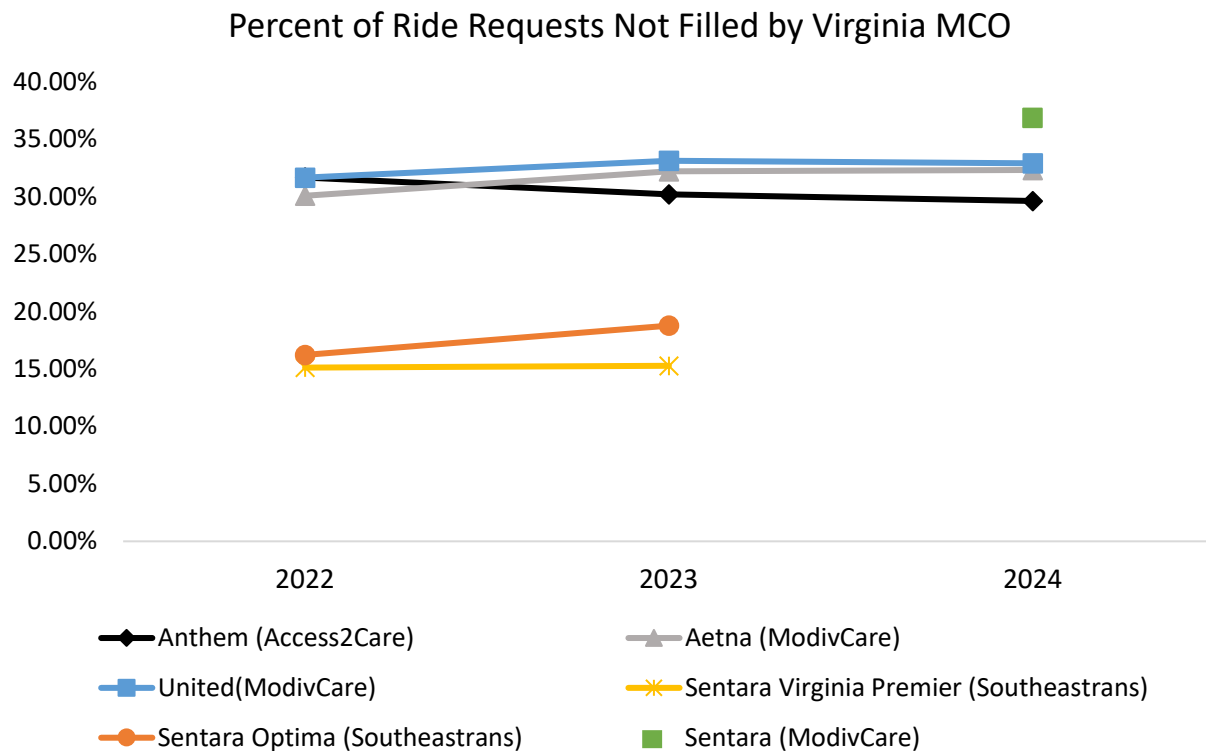
*In 2024, Sentara merged Virginia Premier and Optima health plans into one single health plan, Sentara Health Plan.

SOURCE: JCHC staff analysis of data from Medicaid managed care organization and DMAS, 2025.

MCOs report a significant number of unfilled ride requests, highlighting the need for additional data collection

MCOs report that significant number of requests for rides received by contracted transportation brokers are not completed. Rides not completed is a different metric than unfilled rides. Rides can be deemed not complete for multiple reasons, including patients requesting rides outside of the required window or patient cancellation. United, Aetna, and Anthem all reported that around 30 percent of rides requested were not completed (FIGURE 8). Sentara reported lower percentages of ride requests not filled in 2022 and 2023 under their previous broker, Southeastrans, but had the highest percentage of rides not completed at almost 37 percent in 2024 after they switched the Modivcare. MCOs were not able to provide data on the specific reasons for the brokers' inability to complete ride requests. Additional data on this measure could improve decision makers' understanding of the success of the Medicaid NEMT program in meeting the need for transportation to health care services and could help identify areas in which performance could be improved.

FIGURE 8. Ride requests not filled by Virginia MCOs



*In 2024, Sentara merged Virginia Premier and Optima health plans into one single health plan, Sentara Health Plan.

SOURCE: JCHC staff analysis of data from Medicaid managed care organization and DMAS, 2025.

Currently, DMAS does not have outlined standards for NEMT brokers in their contracts with the MCOs

DMAS collects performance data for the FFS NEMT program on several metrics including on-time performance, hospital discharge pick up, same day non-emergency urgent care transportation, timely recurring medical appointments, timely life sustaining trips, and unfilled trips (APPENDIX 1), consistent with minimum standards for NEMT brokers suggested by experts. However, DMAS does not specify performance metrics for MCOs to include in contracts with transportation brokers providing NEMT for enrolled Medicaid members, except for “late” or “missed trips”. As a result, Virginia’s Medicaid MCOs are tracking and collecting performance metric data differently, making strong comparisons between programs and efforts to understand program quality difficult.

- ➔ **Option 1:** The JCHC could direct the Department of Medical Assistance Services to amend contracts with Medicaid managed care organizations (MCOs) to require the MCOs to adopt performance metrics for Medicaid Non-Emergency Medical Transportation (NEMT)

brokers consistent with performance metrics implemented for the Fee for Service NEMT program and to report annually to the Department regarding the performance of the NEMT brokers on such metrics.

NEMT program restrictions can also create barriers to accessing transportation

NEMT program prior authorization requirements for trips over a certain length can create barriers to accessing transportation for Medicaid members, particularly those who live in rural areas of Virginia. The requirement for prior authorization of trips over a certain length may prevent members who live farther from health care services than the distance allowed from accessing health care services altogether as prior authorization requirements create an additional administrative barrier for Medicaid patients who may not be able or willing to navigate the processes required to obtain prior authorization.

Neither federal nor state regulations impose requirements for prior authorization of trips over a certain length for NEMT services for eligible Medicaid members. CMS guidance requires that, "when covering necessary transportation, states must pay for the least costly mode of transportation that most appropriately meets the needs of a beneficiary to access covered services." Virginia regulations provide that that NEMT, "recipients shall be furnished transportation services that are the most economical to adequately meet the recipients' medical needs." Due to the open-ended nature of these regulations, MCOs have elected to implement prior authorization requirements for trips over a certain length to control costs and ensure cost effectiveness. Stakeholders suggest that MCOs may be implementing stricter limitations than necessary due to a lack of guidance from CMS and DMAS regarding allowable miles that are considered cost effective.

Some states have made program requirements more clear by defining the mileage amount that triggers the need for prior authorization. For example, to reduce barriers to accessing care in rural areas, Nevada removed long distance verification requirements altogether after finding that 90 percent of NEMT trips in rural counties met the minimum 100-mile distance requirement. North Carolina only requires prior authorization for trips which are 75 miles or longer; trips exceeding 75 miles must be medically necessary, with specific criteria like end-stage renal disease or cancer treatment. These states could serve as potential models for Virginia.

- ➔ **Option 2:** The JCHC could direct the Department of Medical Assistance Services (DMAS) to develop guidance to Medicaid managed care organizations (MCOs) regarding nonemergency medical transportation mileage prior authorization requirements. DMAS should develop a recommended mileage amount for which prior authorization is not allowable.

Enhanced Mobility of Seniors and Individuals with Disabilities (49 U.S.C 5310) is a federal program administered by DRPT

The Enhanced Mobility of Seniors and Individuals with Disabilities program, administered by the Federal Transit Administration (FTA) in accordance with 49 U.S.C. 5310, known as the Section 5310 Program, provides funding to states to enhance mobility for seniors, aged 65 and older, and persons with disabilities – populations that face substantial transportation related barriers to accessing health care – by removing barriers to transportation services. Federal funds are awarded to states through a formula that takes into account the state’s population of individuals in the two target groups. Funds provided

Human services transportation is accessible, on-demand transportation services to seniors and persons with disabilities. Human services transportation is distinct from traditional “paratransit”, which is provided through transit agencies and for which only people with disabilities are eligible. Most providers are nonprofit organizations, such as Area Agencies on Aging, or local governments that provide transportation services in addition to or in place of traditional transit services where transit does not exist.

to states must be allocated to projects following a formula set out in federal rules: 60 percent of the funding received must be allocated to projects serving large urbanized areas, 20 percent to projects serving small urban areas, and 20 percent to projects serving rural areas. Funding for projects in small urban and rural areas is appropriated to the state agency charged with administering the Section 5310 Program while funding for large urban areas is appropriated to recipients designated by the Governor.

In Virginia, DRPT is charged with administering federal Section 5310 Program funds for all rural and small urban areas, and the large urbanized areas of Richmond, Roanoke, and Hampton Roads/Virginia Beach. DRPT does not manage Section 5310 Program funding for the large urbanized DC-Metro area; rather, Section 5310 Program funding for the DC-Metro area is managed by the Metropolitan Washington

Council of Governments. Funds administered by DRPT are awarded to grantees that provide human services transportation services to the target groups (SIDEBAR). Grantees may use Section 5310 Program funding for capital expenses, such as vehicles, operating expenses, and other capital programs, such as mobility management services, a form of case management in which a patient receives assistance from a mobility manager to access transportation services.

The Section 5310 Program includes state and local matching requirements. States must provide at least 20 percent of the total amount spent on eligible capital costs and at least 50 percent of the total amount spent on operating assistance for selected programs, while localities must provide 30 percent. In Virginia, state matching funds for the Section 5310 Program are provided through the Commonwealth Mass Transit Fund and administered by DRPT. Federal rules allow states and localities to use funds received through other federal programs as state matching funds. Braiding of federal funds offers opportunities to maximize funding available to transportation programs.

5310 Funds in Action. *Seniors First* is the Area Agency on Aging located in the Shenandoah region of Virginia. *Seniors First* has been providing transportation services to their community using the Enhanced Mobility of Seniors and Individuals with Disabilities 5310 Grant since 2009 and is the second largest Section 5310 Program in the Commonwealth. They provide rides for over 300 unique older adults and persons with disabilities in their community with some riders utilizing the service once a month, while others may use the service up to 200 times a year. In 2024, they received both operating and capital funding from the 5310 program and were able to provide over 7,000 rides, 95 percent of which were for medical purposes. When asked about their experience with the *Seniors First* Program, participants responded that the program, “has been a “Life Saver” for me from a financial point of view for me at this particular time in my life,” and that the program has “been so good to us. We’ve used this service for over 6 years and never had a complaint. All the drivers have been great!”



DRPT awards local agencies Section 5310 Program funding each fiscal year

DRPT administers the Section 5310 Program by awarding individual grants to human services transportation providers through an annual application process. Any human services transportation provider in Virginia may apply for funds. Programs operated by human services transportation providers fill critical gaps in access to medical and quality of life services for the two target populations, who often need personalized and recurring assistance with transportation.

In FY25, \$7,655,501 of federal Section 5310 Program funding and an additional \$1,376,884 in state matching funds was awarded to 34 human services transportation providers for 50 projects distributed across DRPT regions (See APPENDIX 2 for details on each project). Awarded projects in FY25 include funding for operating funds, capital funds, and other capital, such as mobility management (TABLE 3). Projects range in costs from \$5,500 to \$850,000.

TABLE 3. Section 5310 Program funds for FY25

Project Type	Awardees	Federal Funding	State Funding	Total Project Cost
Operating	17 recipients, 17 projects	\$1,041,981	\$833,585	\$2,083,961
Capital	22 recipients, 22 projects	\$3,897,022	\$0	\$4,871,280
Other Capital	10 recipients, 11 projects	\$2,716,498	\$543,299	\$3,395,623
Total	34 recipients, 50 projects	\$7,655,501	\$1,376,884	\$10,350,864

SOURCE: JCHC analysis of Department of Rail and Public Transportation data, 2025.

DRPT recently selected 52 projects and 35 recipients for FY26 Section 5310 Program funding. For FY26, the amount of federal Section 5310 Program funding appropriated to Virginia increased substantially, to \$11,622,900 (TABLE 4). State matching funds included amounts appropriated to DRPT for FY26 plus additional funds drawn from DRPT's unspent balance of unobligated "paratransit" funding appropriated in prior fiscal years. DRPT was also able to award approximately \$436,000 in additional one-time capital project awards using unspent unobligated funding carried over from prior years. While DRPT was able to use unspent balances to provide additional funding for Section 5310 Program grant recipients in FY26, the agency cannot sustain these amounts without additional appropriations.

TABLE 4. Section 5310 Program funds for FY26

Project Type	Awardees	Federal Funding	State Funding	Total Project Cost
Operating	18 recipients, 18 projects	\$1,631,746	\$1,305,397	\$3,263,493
Capital	20 recipients, 22 projects	\$3,488,348	\$436,044	\$4,360,436
Other Capital	11 recipients, 12 projects	\$6,502,804	\$660,561	\$8,128,506
Total	35 recipients, 52 projects	\$11,622,901	\$2,402,002	\$15,752,435

SOURCE: JCHC analysis of Department of Rail and Public Transportation data, 2025.

The FTA and DRPT closely monitor implementation of Section 5310 Program funding

The FTA requires DRPT to provide a Coordinated Human Services Mobility (CHSM) Plan for Section 5310 Program funding. The plan assesses current services and transportation needs of seniors and people with disabilities, identifies strategies to address service gaps, and sets priorities for project implementation. Federal rules require DRPT to complete a comprehensive update of the plan at a minimum of every four years. For each plan update, DRPT collects public input through provider and rider surveys, as well as obtaining guidance and recommendations from a statewide steering committee.

DRPT leverages the CHSM plan to track Section 5310 Program grantees and projects through the development of goals and action items over the course of the four-year plan. All Section 5310 Program grantees must also develop a work plan and provide quarterly reports that outline the project activities for that quarter. Requirements for reporting vary based on the types of projects being implemented (APPENDIX 3). DRPT conducts ongoing compliance reviews of all Section 5310 Program grantees to ensure state and federal rules and regulations are satisfied. Compliance reviews are conducted both annually and triennially; the triennial process is more comprehensive. Grantees report that DRPT's review processes are very thorough, requiring grantees to provide extensive data and information.

Fixed funding amounts that do not consider the growing costs of operations hinder expansion of transportation services

Section 5310 Program grantees indicate that the demand for transportation services has intensified. They expressed a desire to expand services but report that they are prevented from doing so by the increasing cost of providing services and lack of available funding. Multiple grantees reported that the rising capital costs and costs of program operations without an increase in funding makes it virtually impossible for them to expand services. One grantee reported that, "the vehicles pretty much doubled in price since COVID. Buses were \$65,000. They're \$125,000 now. The minivans were \$36,000, then they went up to \$68,000, and now they're \$78,000." Grantees must choose between serving large numbers of patients in a smaller geographic area or serving smaller numbers of patients in a larger geographic area because their resources are not growing to accommodate both. One stakeholder explained, "I always tell people that our number one question is always... Do you prioritize frequency? So, do you prioritize people being picked up on a bus every 15 to 20 minutes? Or do you prioritize coverage, making sure that we are able to provide some sort of service in the largest footprint possible. Because you can never have both."

Fixed federal funding and limited state funding for transportation services limit resources available to Section 5310 Program grantees. The fixed allocation formula for Section 5310 Program funds established in federal rules further limits the funding available for

transportation programs in small urban and rural areas of the Commonwealth. Because 60 percent of all federal funds must be allocated to programs in large urban areas, rural and small urban areas together share only two-thirds of what large urban areas receive. Additionally, funds designated for one category of projects cannot be transferred to another category. If a large urban area, such as Hampton Roads, does not use all their Section 5310 Program funding, DRPT cannot reallocate the funding to other areas of the Commonwealth. DRPT reports that they are often expending all funds allocated to rural areas but not using all the funding allocated to large urban areas. This lack of flexibility means that states must use state funds to meet transportation program needs that cannot be met with federal funding.

Human services transportation providers require additional funding to meet community needs. In Virginia, as older adults live longer and the older adult population continues to increase in size, the demand for specialized transportation providers that serve these populations will continue to increase as well. Human services transportation providers will require additional funding to meet the needs of their target population. If federal and state funding does not increase to reflect changing demand for services, human services transportation providers will not be able to meet growing demand.

State funding for human services transportation programs serving older Virginians and Virginians with disabilities is provided through the Commonwealth Mass Transit Fund (the Fund). The General Assembly has designated \$1.5 million of the total amount included in the Fund for 'paratransit' capital projects and enhanced transportation services for the elderly and disabled. Historically, this \$1.5 million has been used as state matching funds for human service transportation programs which provide services to older adults and persons with disabilities funded through the Section 5310 Program, paying the state share of operating expenses.

The \$1.5 million designated for paratransit and enhanced transportation services for older adults and persons with disabilities is a small portion of the approximately \$533 million dollars included in the Fund in FY 2025, and the appropriation is minimal when compared to amounts appropriated for other transportation priorities, such as the \$210 million appropriated for public transportation services through the Washington Metropolitan Area Transportation Authority (WMATA). Additional funding for human services transportation programs that provide paratransit and enhanced transportation services for older adults and persons with disabilities may be available from the Fund, but competing demands make securing additional appropriations difficult as funding would need to be taken from another program funded through the Fund. However, it is important to note that even a small increase in funding for human services transportation programs funded through the Fund would be highly impactful and instrumental in expanding services for older Virginians and Virginians with disabilities, for whom lack of transportation poses significant barriers to accessing necessary services, including health care services.

Increasing state funding for human services transportation available through the Fund would give Virginia additional flexibility in operating the Section 5310 Program and allow the state to expand funding available through the Program. For example, for FY 26, DRPT has utilized balances of unobligated funds for paratransit services and enhanced transportation services for older adults and persons with disabilities to cover vehicle-related capital expenses for Section 5310 Program grantees. This was a tremendous help to 5310 grantees dealing with increased capital expenses. With additional state funds, DRPT would have the flexibility to choose where and what types of human services transportation projects should be funded in Virginia, consistent with state needs.

The General Assembly could expand funding for human services transportation programs for older Virginians and Virginians with disabilities by increasing the amount of funds in the Fund set aside for paratransit and enhanced transportation services for older adults and persons with disabilities. The General Assembly could amend the Appropriation Act to change the fixed dollar amount to a percentage-based amount to allow funding to increase over time as the total amount in the Fund increases. This approach could eliminate the need for future legislative action to update amounts available to support human services transportation programs.

- **Option 3:** The JCHC could introduce a budget amendment to increase the portion of the Commonwealth Mass Transit Fund (the Fund) dedicated to supporting human services transportation programs that provide paratransit services and enhanced transportation services for older adults and persons with disabilities to 0.0045% of the total amount included in the Fund.

Changing the funding for paratransit and enhanced transportation services for older adults and persons with disabilities from \$1.5 million to 0.0045% of the Fund would increase the amount of available funding to just under \$2.4 million for FY27 and just over \$2.4 million for FY 28.

Braiding federal funds is an opportunity to meet local match requirements for expanded programs. Federal rules allow Section 5310 Program grantees to use funds from other federal programs to meet matching requirements. However, Section 5310 Program grantees expressed difficulty managing transportation funding from multiple sources, which can discourage grantees from seeking additional funding for which they may be eligible. Many Section 5310 Program grantees are small non-profits that feel that they do not have the staff or resources to manage another funding stream and the administrative burdens that may come with it. One recipient said, “If you're running a 5310 program, you almost have to have a totally separate program for Medicaid because your finances have to be separate and your capital equipment would have to be non-5310. When I was asked to look into that early on, I decided we don't have the staff, and we don't have the financial department structure big enough to run two separate programs.”

Lack of capacity to manage multiple funding streams is particularly problematic when Section 5310 Program grantees do not have sufficient state or local funds to meet local match requirements for federal transportation grants. In these cases, grantees may use federal funds from sources other than the U.S. Department of Transportation, such as payments for transportation provided through the Medicaid NEMT program, to satisfy local match requirements. This braiding of federal funds allows grantees to maximize available resources to support service delivery. In stakeholder interviews, Section 5310 Program grantees expressed an interest in learning more about how to braid federal funds to build program capacity. DRPT could collaborate with other state agencies, such as DMAS, to provide technical assistance to Section 5310 Program grantees on how to best capitalize on these opportunities.

- **Option 4:** The JCHC could introduce a budget amendment to add \$500,000 per year to the Commonwealth Mass Transit Fund for the Department of Rail and Public Transportation (DRPT) to provide technical assistance on program financial management to Section 5310 Program grantees, including guidance on braiding of federal funds and how to establish themselves as Medicaid Non-Emergency Medical Transportation (NEMT) providers. The budget amendment should require the Department of Medical Assistance Services to provide information and assistance to DRPT as needed. These allocations should be designated for “paratransit” capital projects and enhanced transportation services for older adults and people with disabilities.

Lack of regional coordination of transportation services reduces access to care for patients

Transportation services exist in most areas of Virginia; however, limited awareness of available services and difficulty coordinating between transportation providers limit individuals’ ability to utilize available services. Confusion about eligibility requirements and who to contact to schedule services may keep some individuals from accessing transportation services while system complexity or the need to coordinate trips across several different service providers may deter others. While DRPT incentivizes coordination through the Section 5310 Program and the Coordinated Human Services Mobility Plan, ultimately it is the responsibility of local agencies to take steps to implement coordination in their regions.

Transportation services in Virginia are mostly siloed

In Virginia, transportation services are offered through a variety of different programs and providers, each with their own eligibility requirements, service areas, and processes and procedures. The complexity of the siloed transportation system makes it difficult for patients to find appropriate services, and leaves many patients frustrated when they must interpret different eligibility requirements, service areas, and other service guidelines on

their own. One stakeholder said, “In Virginia, the different agencies are siloed and you have to go one place for one [service], and another place for one [service], and so transportation is just another one of those things where it's like, okay, am I calling my county? Am I calling this Area Agency on Aging?”. Transportation system fragmentation can also result in patients having to navigate multiple routes or use multiple modes of transportation to reach their destination. Moving between routes or modes of transportation may be time consuming and inefficient. One stakeholder shared a client story in which the client “lives eight miles from where she needs to go. And it was a three-hour bus trip.” Coordinated transportation occurs when multiple transportation agencies work together to deliver transportation services. Coordinating transit services can “provide more rides for the same or lower cost, simplify how services are accessed, and improve the rider's satisfaction with services.”

Coordination of transportation services can occur at the agency level

Regional transportation hubs are formalized, coordinated initiatives among transportation service providers, such as transit agencies, nonprofits, and local or regional government bodies. Regional transportation hubs are often housed in Metropolitan Planning Organizations (MPOs) or Area Agencies on Aging. Organizations participating in regional transportation hubs can share resources, information, and funding to increase their capacity to provide trips, the availability of transportation options for riders, awareness of services, and the efficiency of regional transportation services.

Several regional transportation hubs exist in Virginia. For example, the Rappahannock-Rapidan Regional Commission (RRRC) operates the Regional Transportation Collaborative (RTC) to provide transportation for individuals in the counties of Culpeper, Fauquier, Madison, Orange and Rappahannock. The RTC's Mobility One-Call/One-Click Center serves as a central access point for patients needing transportation services. RTC uses cloud-based software to collect rider and service data to coordinate ride requests across transit agencies and transportation programs. Transportation programs can participate at varying levels based on their capacity, a model which encourages the involvement of various transit agencies and organizations that may not otherwise feel comfortable participating due to a lack of capacity. RTC has developed their hub in a way that is replicable, meaning it could be implemented in other regions of Virginia as well.

Coordination of transportation services can occur at the individual level

Mobility management programs work with individual clients to provide information about transportation options in their area and coordinate transportation that is most appropriate for the client's needs. Stakeholders identified mobility management as a tool that could benefit Virginians attempting to access transportation services, particularly when patients may be unaware of transportation services in their area or unsure of how to access those services. For example, stakeholders report that patients, “have often either spoke[n] to or

been transferred to three to four different departments or made three to four separate phone calls,” before they find the correct service.

Current technological initiatives in Virginia, such as Virginia Navigator and the DRPT TRIP planner, are web-based tools intended to assist patients in identifying and selecting transportation services in their area. However, stakeholders report that they can be difficult for certain populations to navigate, such as older adults or individuals with visual or cognitive impairments. Mobility managers could add value to Virginia’s existing transportation coordination tools by providing personalized assistance to populations who may have increased need for transportation to medical care and difficulty navigating online resources.

Regional transportation hubs and mobility management could be expanded in Virginia

Expanding regional transportation hubs and mobility management services in Virginia is an opportunity to improve transportation coordination across the Commonwealth. With additional funding, DRPT could support the development of existing and additional regional transportation hubs and mobility management services, modeled after the RTC, using a tiered approach. The tiered approach has been used in other states, such as Ohio’s Statewide Mobility Management Program, to allow local agencies to offer mobility management services or become transportation hubs for their region.

- **Option 5:** The JCHC could introduce a budget amendment to provide up to \$8 million per year for the Department of Rail and Public Transportation (DRPT) to establish a competitive grant program for private, non-profit organizations and state or local government agencies to plan, establish, and sustain mobility management services or regional transportation hubs that include mobility management services. The budget amendment should require DRPT to report annually by November 1 to the Senate Finance and Appropriations Committee, House Appropriation Committee, and the JCHC regarding the grant program.

The first annual report should set out a plan for implementation of the program, including grant application requirements, eligibility requirements, data reporting requirements for grantees, provisions for grant disbursement, and any other implementation considerations. Subsequent reports should include information about the results of the grant program, including the number and amount of grants awarded, localities receiving grants, projects for which grant funds are used, or other relevant information.

DRPT stakeholders report that five Section 5310 Program grantees spend approximately \$1 million per year on mobility management activities, including cost of staff members and marketing and supplies. As such, \$2 million per year could fund up to ten mobility management sites, \$3 million per year could fund up to fifteen mobility management sites, and \$4 million per year could fund up to twenty mobility management sites. Twenty sites

would include statewide coverage for mobility management and would establish mobility management hubs in each planning district area (not including northern Virginia).

If grant recipients were interested in establishing a more comprehensive approach to transportation coordination, they could consider establishing regional transportation hubs in addition to mobility management sites. These hubs would include mobility management but would be more comprehensive in their approach to regional coordination. DRPT stakeholders report that five grantees spend a total of \$1.9 million each year on transportation hub services. As such, \$4 million per year could fund up to ten regional transportation hubs, \$6 million per year could fund up to fifteen regional transportation hubs, and \$8 million per year could fund up to twenty regional transportation hubs. Twenty regional transportation hubs would provide statewide coverage for regional transportation hubs by establishing hubs in each planning district area (not including northern Virginia).

Rural areas of Virginia need additional transportation options and resources

Per Pew Research Center, national data demonstrates rural residents live an average of 10.5 miles from the nearest hospital, compared to 4.4 miles in urban areas. Individuals in urban areas typically have access to some form of public transportation, which is less common in rural areas of Virginia. Stakeholders also report that when public transportation is available in rural areas, it may not serve the entire population. This makes accessing health care services difficult for residents of rural communities and places additional burden on human service transportation providers that provide rural clients with demand response transportation services.

The federal Formula Grants for Rural Areas Program, or Section 5311 Program, provides some funding to states to support rural transportation services. Similarly to the Section 5310 Program, the Section 5311 Program provides funding for capital, planning, and operating assistance to states, but the Section 5311 Program is specifically focused on funding to support public transportation in rural areas with populations of less than 50,000. The Section 5311 program includes a local match requirement but does not include a state match requirement and no state funds are appropriated for the program. Federal Section 5311 Program funds are administered by DRPT, which passes funding through to the local agencies.

Stakeholders report that costs for operating and capital expenses for Section 5311 grantees have grown significantly over the last few years and federal revenues have not kept pace with those rising costs. As a result, DRPT has few resources to provide any sustained funding for rural transit expansions or service improvements.

Microtransit could increase transportation to health care in rural areas

Microtransit is a demand response transportation service that optimizes its route as riders request rides to provide the most efficient route for picking up and dropping off passengers (FIGURE 9). Riders request rides through a mobile app or call center and are picked up by shuttles which carry other microtransit riders within a set service area. Microtransit is a model of transportation that blends aspects of traditional fixed-route and demand response transit services. It is more complex than fixed-route services because it follows an optimized route that is developed by microtransit technology; however, it is more limited than demand response services because it only provides pick-up and drop-off points within the designated service area.

FIGURE 9. Microtransit services



SOURCE: The Shared Use Mobility Center, 2025.

Microtransit has been successfully implemented in rural areas of Virginia

Microtransit is particularly effective in rural areas because it connects rural residents to nearby city centers and transportation hubs by bringing them from the outskirts of town to more prominent locations, known as last-mile connectivity. This improves accessibility of transportation services for individuals and increases the cost effectiveness of programs. The 2023 DRPT Rural Microtransit Case Study and Report found that, “replacing fixed-route

services with microtransit often results in an increase in the population with access to transit and growth in ridership.”

In Virginia, two agencies have successfully implemented microtransit programs. In 2020, the FTA awarded DRPT \$160,930 through the Integrated Mobility Innovation Program (SIDEBAR). In partnership with DRPT, Mountain Empire Older Citizens, Inc. (MEOC) used these funds to implement Mountain Empire Transit in Southwest Virginia while Bay Transit launched microtransit services in the Northern Neck. Both agencies serve extremely rural areas of Virginia and both programs saw continual growth in ridership throughout the pilot period, demonstrating high demand for these services. Riders for MEOC utilized the service an average of 4.5 times per week and the riders for Bay transit utilized the service 3.2 times per week. Both Mountain Empire Transit and Bay Transit have an average cost per vehicle hour of around \$40. However, it is anticipated that as ridership grows, the average cost per ride and cost per mile will decrease. Currently, these programs are partially funded utilizing Section 5311 program funding to assist in sustaining their microtransit programs, however this funding is not sufficient to assist in expanding services.

Integrated Mobility Innovation (IMI) Program.

The IMI demonstration program is a Federal Transit Administration Grant Program which unifies three research focus areas: Mobility on Demand, Transit Automation, and Mobility Payment Integration.

The goals of IMI are to:

- Explore new business approaches and technology solutions that support mobility
- Enable communities to adopt innovative mobility solutions that enhance transportation efficiency and effectiveness
- Facilitate the widespread deployment of proven mobility solutions that expand personal mobility

A microtransit grant program for rural areas of Virginia could expand services

Currently, agencies wanting to start microtransit programs in Virginia can apply for Demonstration Project Assistance through DRPT’s Making Efficient and Responsible Investments in Transit (MERIT) grant. This grant allows transit agencies to test out new transit services or to develop technology and innovative transportation projects. However, this funding is only available to programs for one to two years and does not provide an opportunity to build sustainability for continued operations of microtransit services. A state-funded, long-term, sustainable grant program could assist transit agencies with start-up funding as well as funding to build sustainability for microtransit. A grant program focused exclusively on rural areas of Virginia could also assist in filling federal funding gaps. With a state funded grant program, DRPT would have oversight of eligibility details, ensuring funding is awarded to agencies serving communities with the highest need.

➔ **Option 6:** The JCHC could introduce a budget amendment to provide up to \$5 million per year to the Department of Rail and Public Transportation to establish a competitive grant program to provide funding to localities to plan, establish, and sustain microtransit services in rural areas of Virginia. The budget amendment should require DRPT to report

annually by November 1 to the Senate Finance and Appropriations Committee, House Appropriation Committee, and the JCHC regarding the grant program.

The first annual report should set out a plan for implementation of the program, including application requirements, eligibility requirements, data reporting requirements for grantees, provisions for grant disbursement, and any other implementation considerations. Subsequent reports should include information about the results of the grant program, including the number and amount of grants awarded, the localities receiving the grants, and the types of projects for which grant funds are used.

Program costs estimate that one rural microtransit service zone costs roughly \$250,000 to \$400,000 per year. This includes both capital and operating costs. DRPT stakeholders indicated that providing \$2.5 million per year would fund between 6-10 rural microtransit zones per year, while providing \$5 million per year would fund between 12-20 zones per year.

Appendix 1. NEMT Fee-for-Service Transportation Broker Performance Requirements

Requirement	Description	Metric	Penalty
Hospital Discharge	Transportation after Hospital Discharges (Members that are discharged from hospitals and emergency rooms).	All Hospital Discharges shall be picked up within three (3) hours of receipt of the request from the Member, member's representative, or hospital staff	<p>Supplier will be assessed the following graduated penalty each month the on time pick-up % for Hospital Discharges is less than 95%</p> <ul style="list-style-type: none"> ≥ 95% = no penalty 90% – 94.99% = \$25,000 penalty 85% – 89.99% = \$50,000 penalty < 85% = \$75,000 penalty <p>Additionally, the financial remedies will double the value listed above for each consecutive month the on time % is less than 95%.</p>
Same Day Non-emergency Urgent Care Transportation	transportation to urgent care appointments on the same day that the appointment is scheduled	Member must be picked up within one (1) hour of trip verification or the determined pick-up time.	<p>Supplier will be assessed the following graduated penalty each month based on on-time pickups:</p> <ul style="list-style-type: none"> ≥ 95% = no penalty 90% – 94.99% = \$25,000 penalty 85% – 89.99% = \$50,000 penalty < 85% = \$75,000 penalty <p>Additionally, the financial remedies above will double the value listed above for each consecutive month the Supplier fails to meet the minimum 95% performance standard</p>
Recurring Appointment	routine recurring health services appointments	The Member (excluding Life Sustaining Trips) shall be dropped off for their appointment no more than 15 minutes late in accordance with the requirements.	<p>Supplier will be assessed the following graduated penalty each month based on on-time drop offs:</p> <ul style="list-style-type: none"> ≥ 95% = no penalty 90% – 94.9% = \$25,000 penalty 85% – 89.9% = \$50,000 penalty < 85% = \$75,000 penalty <p>Additionally, consecutive months less than 95% the penalty doubles the amount matching the percentage</p>

Strategies to Address Transportation Related Barriers to Health Care

Requirement	Description	Metric	Penalty
Life Sustaining Trips	Appointments for Dialysis, Chemotherapy, Critical Care, Substance Abuse, and Wound Care appointments.	Members must be dropped off no later than 15 minutes after the scheduled drop off time to be classified as on-time.	<p>Supplier will be assessed the following graduated penalty each month based on the on-time percentage:</p> <ul style="list-style-type: none"> • $\geq 95\%$ = no penalty • $90\% - 94.9\%$ = \$25,000 penalty • $85\% - 89.9\%$ = \$50,000 penalty • $< 85\%$ = \$75,000 penalty <p>Additionally, consecutive months less than 95% the penalty doubles the amount matching the percentage.</p>
Unfilled Trips Requirements	An unfilled trip is an eligible trip requested by a Member that is not fulfilled (provided) due to: (1) "Provider No Show," (2) Supplier having "No vehicle available" to transport the member, (3) Supplier having "No provider willing to transport" the Member, or (4) Any other similar inability of the Supplier to secure NEMT transport for the member at the scheduled time.	Supplier shall report number of unfilled trips in relation to total number of trips each calendar month.	<p>Supplier will be assessed the following graduated penalty each month based on unfilled trip %:</p> <ul style="list-style-type: none"> • $\leq 0.25\%$ = no penalty • $0.26\% - 0.50\%$ = \$25,000 penalty • $0.51\% - 0.75\%$ = \$50,000 penalty • $0.76\% - 0.99\%$ = \$75,000 penalty • $> 1.0\%$ = \$100,000 penalty <p>Additionally, consecutive months more than .25% the penalty doubles the amount matching the percentage</p>

Appendix 2. FY25 Section 5310 Program Projects Awarded in Virginia

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Hampton Roads	Senior Services of Southeastern Virginia	Senior Services of Southeastern Virginia (SSSEVA)	FTA 5310 Operating	5500	2200	2750	550	FTA 5310 - Large Urban Hampton Roads
Richmond	Powhatan County Department of Social Services	Powhatan County Department of Social Services	FTA 5310 Operating	13959	5584	6980	1396	FTA 5310 - Rural
Salem	Southern Area Agency on Aging	Southern AAA	FTA 5310 Operating	28110	11244	14055	2811	FTA 5310 - Rural
Richmond	Chesterfield Community Services Board	Chesterfield CSB	FTA 5310 Other Capital - IT Equipment	28483	4557	22786	1139	FTA 5310 - Large Urban Richmond
Culpeper	Rappahannock-Rapidan Planning District Commission	Rappahannock-Rapidan Regional Commission (RRRC)	FTA 5310 Operating	45000	18000	22500	4500	FTA 5310 - Rural
Richmond	Hanover County, Virginia	Hanover DASH	FTA 5310 Operating	46064	18426	23032	4606	FTA 5310 - Large Urban Richmond
Salem	Giles Health & Family Center	Giles Health & Family Center	FTA 5310 Other Capital - Mobility Management	67212	10754	53770	2688	FTA 5310 - Rural
Richmond	Chesterfield County, VA	Chesterfield County	FTA 5310 Operating	75000	30000	37500	7500	FTA 5310 - Large Urban Richmond

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Richmond	Greater Richmond Transit Company	Greater Richmond Transit Company (GRTC)	FTA 5310 Operating	75000	30000	37500	7500	FTA 5310 - Large Urban Richmond
Staunton	Grafton School, Inc.	Grafton School	FTA 5310 Expansion Vehicle (1)	77304	0	61843	15461	FTA 5310 - Small Urban
Staunton	Pleasant View Inc	Pleasant View	FTA 5310 Replacement Vehicle (1)	77304	0	61843	15461	FTA 5310 - Small Urban
Fredericksburg	Healthy Generations Area Agency on Aging	Healthy Generations AAA	FTA 5310 Replacement Vehicle (1)	77304	0	61843	15461	FTA 5310 - Small Urban
Staunton	Valley Program for Aging Services	Valley Program for Aging Services (VPAS)	FTA 5310 Replacement Vehicle (1)	77304	0	61843	15461	FTA 5310 - Small Urban
Staunton	Valley Program for Aging Services	Valley Program for Aging Services (VPAS)	FTA 5310 Operating	82494	32998	41247	8249	FTA 5310 - Small Urban
Salem	Giles Health & Family Center	Giles Health & Family Center	FTA 5310 Operating	85000	34000	42500	8500	FTA 5310 - Rural
Hampton Roads	Peninsula Agency on Aging, Inc.	Peninsula Agency on Aging (PAA)	FTA 5310 Operating	87617	35047	43808	8762	FTA 5310 - Large Urban Hampton Roads
Lynchburg	Central Virginia Alliance for Community Living Inc	Central Virginia Alliance for Community Living (CVACL)	FTA 5310 Operating	88773	35509	44386	8877	FTA 5310 - Small Urban

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Lynchburg	Central Virginia Alliance for Community Living Inc	Central Virginia Alliance for Community Living (CVACL)	FTA 5310 Replacement Vehicle (1)	89988	0	71990	17998	FTA 5310 - Small Urban
Bristol	Henry County Parks & Recreation Senior Services	Henry County Parks & Recreation Senior Services	FTA 5310 Replacement Vehicle (1)	89988	0	71990	17998	FTA 5310 - Rural
Hampton Roads	Peninsula Agency on Aging, Inc.	Peninsula Agency on Aging (PAA)	FTA 5310 Expansion Vehicle (1)	89988	0	71990	17998	FTA 5310 - Large Urban Hampton Roads
Fredericksburg	Healthy Generations Area Agency on Aging	Healthy Generations AAA	FTA 5310 Other Capital - Mobility Management + Contracted Transportation	95664	15306	76531	3827	FTA 5310 - Small Urban
Hampton Roads	Colonial Behavioral Health	Colonial Behavioral Health	FTA 5310 Replacement Vehicle (1)	118763	0	95010	23753	FTA 5310 - Large Urban Hampton Roads
Salem	Edwards Adult Day Center	Edwards Adult Day Center	FTA 5310 Replacement Vehicle (1)	118763	0	95010	23753	FTA 5310 - Rural
Richmond	Chesterfield Community Services Board	Chesterfield CSB	FTA 5310 Expansion Vehicle (1)	121175	0	96940	24235	FTA 5310 - Large Urban Richmond
Staunton	Rockbridge Area	Rockbridge Area Transportation System (RATS)	FTA 5310 Operating	125000	50000	62500	12500	FTA 5310 - Rural

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
	Transportation Sys Inc							
Richmond	Senior Connections: The Capital Area Agency on Aging	Senior Connections	FTA 5310 Operating	150455	60182	75228	15046	FTA 5310 - Large Urban Richmond
Salem	Giles Health & Family Center	Giles Health & Family Center	FTA 5310 Replacement Vehicle (2)	154608	0	123686	30922	FTA 5310 - Rural
Staunton	The Arc of Harrisonburg and Rockingham Inc	The Arc of Harrisonburg and Rockingham	FTA 5310 Expansion Vehicle (2)	154608	0	123686	30922	FTA 5310 - Small Urban
Richmond	Crater District Area Agency on Aging	Crater District AAA	FTA 5310 Replacement Vehicle (2)	164292	0	131434	32858	FTA 5310 - Large Urban Richmond
Richmond	Heart Havens	Heart Havens	FTA 5310 Replacement Vehicle (2)	173976	0	139181	34795	FTA 5310 - Large Urban Richmond
Salem	Southern Area Agency on Aging	Southern AAA	FTA 5310 Other Capital - Mobility Management + Contracted Transportation	191219	30595	152975	7649	FTA 5310 - Rural
Salem	County of Roanoke	CORTAN	FTA 5310 Other Capital - Contracted Transportation (Rural)	204765	32762	163812	8191	FTA 5310 - Rural

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Salem	Lutheran Family Services of Virginia	enCircle	FTA 5310 Expansion Vehicle (2)	208751	0	167001	41750	FTA 5310 - Small Urban
Culpeper	Thomas Jefferson Planning District Commission	Thomas Jefferson PDC	FTA 5310 Other Capital - Mobility Management	215230	34437	172184	8609	FTA 5310 - Small Urban
Salem	New River Valley Community Services Board	New River Valley Community Services (NRVCS)	FTA 5310 Operating	217016	86806	108508	21702	FTA 5310 - Small Urban
Lynchburg	Piedmont Senior Resources Area Agency on Aging, Inc	Piedmont Senior Resources AAA	FTA 5310 Operating	250000	100000	125000	25000	FTA 5310 - Rural
Hampton Roads	Senior Services of Southeastern Virginia	Senior Services of Southeastern Virginia (SSSEVA)	FTA 5310 Replacement Vehicle (3)	257280	0	205824	51456	FTA 5310 - Large Urban Hampton Roads
Richmond	Senior Connections: The Capital Area Agency on Aging	Senior Connections	FTA 5310 Other Capital - Mobility Management + Contracted Transportation	274050	43848	219240	10962	FTA 5310 - Large Urban Richmond
Fredericksburg	Healthy Generations Area Agency on Aging	Healthy Generations AAA	FTA 5310 Operating	308182	123273	154091	30818	FTA 5310 - Small Urban

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Richmond	SOAR365	SOAR365	FTA 5310 Replacement Vehicle (4)	309216	0	247373	61843	FTA 5310 - Large Urban Richmond
Salem	New River Valley Community Services Board	New River Valley Community Services (NRVCS)	FTA 5310 Replacement Vehicle (3)	319654	0	255723	63931	FTA 5310 - Small Urban
Salem	New River Valley Senior Services, Inc.	New River Valley Senior Services (NRVSS)	FTA 5310 Replacement Vehicle (4)	359952	0	287962	71990	FTA 5310 - Rural
Fredericksburg	Rappahannock Area Community Services Board	Rappahannock Area CSB	FTA 5310 Replacement Vehicle (2) + Expansion Vehicle (2)	359952	0	287962	71990	FTA 5310 - Small Urban
Richmond	Chesterfield County, VA	Chesterfield County	FTA 5310 Other Capital - Contracted Transportation	375000	60000	300000	15000	FTA 5310 - Large Urban Richmond
Staunton	Shenandoah Area Agency on Aging	Shenandoah AAA	FTA 5310 Operating	400791	160316	200396	40079	FTA 5310 - Small Urban
Salem	County of Roanoke	CORTAN	FTA 5310 Other Capital - Contracted Transportation (Urban)	470000	75200	376000	18800	FTA 5310 - Large Urban Roanoke
Richmond	Hanover County, Virginia	Hanover DASH	FTA 5310 Other Capital - Contracted Transportation	624000	99840	499200	24960	FTA 5310 - Large Urban Richmond

Strategies to Address Transportation Related Barriers to Health Care

District	Recipient	Organization/Service Detail	Project Name	Project Cost	State Funds	DRPT Federal Funds	Match	DRPT Federal Program
Culpeper	Encompass Community Supports	Encompass Community Supports	FTA 5310 Replacement Vehicle (4) + Expansion Vehicle (2)	639308	0	511446	127862	FTA 5310 - Rural
Bristol	Mount Rogers Community Service Board		FTA 5310 Replacement Vehicle (5) + Expansion Vehicle (4)	831802	0	665442	166360	FTA 5310 - Rural
Culpeper	Rappahannock-Rapidan Planning District Commission	Rappahannock-Rapidan Regional Commission (RRRC)	FTA 5310 Other Capital - Mobility Management + Contracted Transportation	850000	136000	680000	34000	FTA 5310 - Rural

Appendix 3. Required Reporting Requirements for 5310 Program Recipients

Required metrics include:

For All Projects:

- Provide transportation (or transportation services) to the eligible population
- Report the total number of clients who receive services. You may choose the eligible population that is most relevant to your provision of service (you do not need to provide numbers for both populations)
- Indicate whether transportation services are advertised on your website. Note any changes (This is optional for CSBs)

For Operating Work Plans:

- Number of rides requested by eligible population
- Number of rides provided for eligible population. Unlinked passenger trip = each time a passenger boards a vehicle. Total number of hours transportation services were available to the eligible population.
- Report the number of clients surveyed for feedback on services
- Indicate whether transportation services are advertised on your website. Note any changes
- Grantee may choose what to report on but can indicate any circumstances or events that arise during the award period that are relevant to the project execution, unique needs in the community that come to the grantee's attention, or successes of program

For Other Capital/Mobility Management Workplan:

- Report the number of rides that the agency directly provided or coordinated for clients.
- Report the number of referrals to other transportation providers.
- Report on the relevant promotions for the program. Can be the same metric as in the All Projects Work Plan.
- Describe meaningful engagements with community partners, either existing or in development.
- Required if applicable to the program (i.e. if they provide travel training):
- Report the number of people in the eligible population who received travel training.
- Report the number of other people who received travel training.

For Capital Vehicle Work Plan:

- Number of rides provided for eligible population. Unlinked passenger trip = each time a passenger boards a vehicle.

Strategies to Address Transportation Related Barriers to Health Care

- 1 lift = one complete cycle per person. A cycle being one person rides the lift up to get into the vehicle and then down to get off the vehicle.
- Report the total number of clients who use a mobility device, such as a wheelchair, that receive services.



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