First Transit

New York State Legislative Joint Budget Hearing SFY 2026/2027 – Health/Medicaid

First Transit's Written Testimony: Submitted February 10, 2026

First Transit is a transportation services company that provides public transportation, fixed-route, and paratransit options for many rural communities in New York State. We have been a consistent presence and an integral member of New York's public transportation landscape in the communities we serve for over four decades.

We thank the Legislature for the opportunity to present testimony highlighting critical issues that continue to plague rural public transportation systems in New York, stemming from the practices of the centralized broker for Non-Emergency Medical Transportation for Medicaid (NEMT). These issues, which negatively impact the vulnerable disabled, elderly, and economically disadvantaged populations in rural communities, can be substantially improved if the State reverts to a community-based Human Services Transportation Coordination model to address the negative impacts on the rural public transportation county systems, which are not part of the state's Regional Transportation Authorities. Human Services Transportation Coordination has been shown to create opportunities for shared services and reduce redundancy and waste in rural communities with severely limited resources.

Unintended Consequences of Medicaid Redesign's Centralization of NEMT: Erosion of Community-Based Solutions for Medicaid Recipients and Undermining of Social Determinants of Health (SDOH) Progress in Rural Communities

The restructuring and consolidation of Medicaid Non-Emergency Medical Transportation (NEMT) were among the first recommendations implemented by Governor Cuomo's Medicaid Redesign Team. The Legislature granted broad authority to the Commissioner of Health, allowing the takeover of transportation and other Medicaid-funded related services from counties, without built-in feedback mechanisms or transparent monitoring to assess efficacy and impacts on rural public transportation systems and rural public health access overall.

Originally, DOH divided the NEMT Transportation Management service areas to allow for a "regional" approach to NEMT management. However, each regional contract was awarded to the same vendor, enabling statewide consolidation of NEMT Transportation Management instead of a regional approach and, consequently, making the continuation of local transportation coordination impossible.

Although the DOH NEMT Transportation Manager contract states that priority must be given to existing public transportation systems, as required under federal regulations, in practice, this is neither done nor enforced. Ridership numbers are concrete, and year-over-year data in rural counties continue to indicate that public transportation is not being utilized for Medicaid NEMT rides.

Contrary to DOH's position that a reason for the drop-off in the use of public transportation is that patient choice supersedes coordination and use of public transportation as a priority, federal regulations specifically state that the use of a third-party broker by the state for Medicaid NEMT nullifies the priority of patient choice over the use of available public transportation and community-based solutions.

The intent of the broker exception in patient choice is to prevent the very issue we are seeing in rural NY: prioritizing the broker's financial incentives and convenience under the guise of patient choice over the safety of the individual and the health of the entire transportation ecosystem needed for the rural disadvantaged and Medicaid population access to other areas of life as participating and included members of their community.

Studies on Human Services, community resilience, and economic development over the last 2.5 decades have cited the need for effective, efficient, and accessible public transportation to achieve rural community health goals. Workforce mobility, advanced education opportunities, community integration of disabled and veteran populations, and preventing isolation among older adults are just a few of the policy initiatives in response to SDOH and Olmstead that require robust, coordinated public transportation systems to succeed. This is why healthcare experts have identified transportation as one of the top three interventions needed to address SDOH.

Despite DOH's insistence otherwise, there have been no proven savings from the centralization of the management of NEMT for Medicaid. On the contrary, year after year, rural counties fail to see purported savings. In addition, frequent incidents of fraud are reported by the State Comptroller, by unregulated, unchecked private transportation operators, not only in rural counties but also in NYC, which is under the same Medicaid NEMT management vendor as the rest of the state.

Individual Medicaid recipients, some of whom are the most vulnerable in the state and need the highest level of care and protection, are subjected to rides in vehicles that are not required to meet quality standards or comply with the same safety regulations as public transportation providers. Many of these private providers' drivers also lack the minimum training requirements or union protections that public transportation drivers have. Medicaid recipients deserve better care and consideration of their safety than they receive under the DOH's Medicaid NEMT Manager

Inherent, Interconnected, and Dependent Relationship between Medicaid Ridership and Rural Public Transportation Systems

Forty-plus years ago, most upstate rural counties lacked public transportation because the upfront capital costs of building a system and the inability of ridership revenues to cover operating costs in these communities made it cost-prohibitive. Rural counties, with some of the highest unemployment rates, are home to some of NY's poorest at-risk populations—poverty-level elderly, disabled veterans, unemployed and underemployed youth, and single-parent families. Unlike New York counties covered by Regional Transportation Authorities, which have urban centers with dense population clusters, the low population of the rural counties meant the ridership volume needed to support fare-based public transit was not there, nor was there a tax base to support a new tax to cover upfront capital and ongoing operating costs.

The expansion of federal Medicaid-funded programs was accompanied by federal mandates, including access to Human Services Transportation for social services recipients.

Consequently, to meet its mandated responsibilities, the New York State Department of Health and Human Services (DOH) entered into operating cost-sharing agreements with individual rural counties to fund and provide public transportation services. As such, rural counties' public transportation was created to serve, first and foremost, residents receiving Medicaid benefits.

- Using each county's Department of Social Services as the coordinating agency, and based on each county's Medicaid recipient numbers, an estimate of public transportation usage was calculated. NYS DOH provided counties' Medicaid NEMT funding, typically as annual lump sums. This method provided counties with the transport usage and funding information needed to plan and budget for their respective transportation needs.

- The counties contracted with private transportation service providers for public transportation. Contracts were structured so that private companies bore upfront capital costs, either solely or through shared-cost agreements, thereby alleviating the need for the counties to fund capital to purchase the vehicle fleet needed to create transportation systems.

Under these circumstances, rural public transportation in New York was born. The systems have remained interconnected and dependent on Medicaid ridership and the corresponding NYS Department of Health funding over the years, as most counties' economic conditions have not improved. Although ridership of the general public grew over the years—lack of densely populated areas, high numbers of poverty-level residents without the tax base to handle additional county funding, and large geographic territories difficult to cover with sustainable routes, ridership never reached a level to supplement operating costs independently, even with the addition of formula State Operating Assistance (STOA), Medicaid ridership remained the biggest funding source. In fact, Medicaid ridership remained between 25% and 50% of operating revenue for rural public transportation systems when the centralized Medicaid NEMT Manager was instituted under Cuomo's major Medicaid redesign agenda implemented in 2013.

Restoring the Foundation of Medicaid NEMT Ridership and Ensuring the Sustainability of Rural Public Transportation Systems

Medicaid NEMT ridership must be restored to rural public transportation, and New York must prioritize the health of rural communities by allowing county-level coordination of NEMT services, where officials know their communities' needs and the public transportation resources available to best serve their disadvantaged populations.

In response to the current realities of rural counties and rural public transportation systems outlined above, and the failure of the centralized Medicaid NEMT management broker experiment to realize cost savings, eliminate fraud, and provide adequate service, we respectfully request that the Legislature and Governor:

- **Revert to Human Services County-Coordinated Transportation**, prioritizing rural public transportation for Medicaid NEMT services.

- **$6M supplemental funding for upstate transportation rural counties** (defined as the rural 'formula' transportation systems), a continuation and increase of the previous years $4M for the purposes of sustaining rural public transportation systems impacted by DOH Medicaid NEMT Management broker. Sustaining systems until a pivot back to community-based coordination can be resumed. This funding has remained flat since its implementation.

- **Release of the $4M supplemental funding for rural public transportation systems, approved in the SFY 2025-2026 budget immediately.**
    - Each year, the funding release is pushed further out, forcing public transportation providers to operate without full payment for services for years at a time.

We thank you in advance for your consideration of our requests, and we are available to answer any questions arising from our written testimony.

For More Information, Please Contact:
Jennifer Carlson (518) 813-8735
jc@abrahamcrown.com